Office of

Inspector General of Nebraska Child Welfare

ANNUAL REPORT

2022-2023

September 15, 2023

The Office of Inspector General of Nebraska Child Welfare thanks and acknowledges the Nebraska Legislature and legislative staff for their continued support, particularly the Executive Board and the Health and Human Services and Judiciary Committees.

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Inspector General

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

Website: http://oig.legislature.ne.gov

Email: OIG@leg.ne.gov

State Capitol
P.O. Box 94604
Lincoln, NE 68509-4604

402-471-4211 or 855-460-6784 (toll free)

Nebraska Abuse and Neglect Hotline
1-800-652-1999

National Suicide Prevention Lifeline
Call 1-800-273-8255
or text **988** to access a trained crisis counselor

Nebraska Family Helpline
1-888-866-8660

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Message From the Inspector General

The Office of Inspector General of Nebraska Child Welfare (OIG) is honored to present its Annual Report for the Fiscal Year starting on July 1, 2022 and ending June 30, 2023. As an office dedicated to transparency, integrity, and accountability in government, we are grateful for the opportunity to share our work.

The OIG was created in response to a significant crisis in the child welfare system after a failed attempt at privatization. As part of the Legislature's power of oversight inherent to its branch, the Legislature created the OIG to provide greater accountability in the child welfare system and later the juvenile justice system. The OIG provides the Legislature with the oversight it needs to ensure the children in the state's care and custody and under the state's supervision were being served as the Legislature intended.

The result has been over 11 years of accountability and increased transparency in these systems. In those 11 years, the OIG has received and reviewed over 5,000 intakes including incident reports, complaints, and grievances. It has issued 44 reports of investigation which incorporated case reviews of over one hundred individual children. The OIG has made 115 recommendations for system improvement to the Nebraska Department of Health and Human Services (DHHS), two private providers contracted with DHHS's Division of Children and Family Services, and the Administrative Office of Probation, Juvenile Services Division. Eighty-four of those recommendations have been accepted by those agencies and providers. The OIG's work has informed senators on key issues as they drafted legislation related to child welfare, including but not limited to, Sudden Unexpected Infant Death education, sexual abuse of state wards, oversight of Nebraska's Youth Rehabilitation and Treatment Centers, and the privatization of case management in the Eastern Service Area.

On August 16, 2023, Nebraska Attorney General Mike Hilgers issued Opinion 23-008 regarding the constitutionality of the laws governing the OIGs. In response to this opinion, though the law remains unchanged, DHHS restricted the OIG's access to information previously available to this office. This response has included eliminating the OIG's access to N-FOCUS, DHHS's electronic case management system, as well as additional information crucial to the office's

ability to provide oversight. Consequently, information that has been included in previous annual reports may be missing from this year's report, and such omissions are noted. Although access has been limited, the OIG continues to work to meet its statutory obligations of providing oversight of Nebraska's child welfare and juvenile justice systems.

We remain committed to the law and to the principles of accountability, transparency, integrity, and good government which form the foundation of the work of inspectors general.

As we do each year, we must continue to acknowledge that the stress in the child welfare and juvenile justice systems is felt not just by children and families, but also by the employees working directly with children and families in need. This is difficult, challenging, complex, and often heartbreaking work. The majority of intakes that the OIG receives are handled competently by these professionals. When support for these employees is prioritized, it results in better support for our children and families which benefits all of Nebraska.

I would also like to acknowledge the hard work and professionalism of the OIG staff. The two Assistant Inspectors General conduct our investigations with great care, thoroughness, impartiality, and sensitivity to the difficult subjects of these investigations. We are a small office with a significant mission. We remain committed to meeting the high standards of Inspector General offices and to fostering and promoting accountability in the Nebraska agencies serving children, youth, and families.

Jennifer A. Carter
Inspector General

Executive Summary

As it does each year, this annual report reflects key issues facing the child welfare and juvenile justice systems and the work of the OIG. Challenges remain in both systems. For example, there has been considerable change in the leadership at DHHS, including the Division of Children and Family Services (CFS) which has been without a Director for over six months. Additional challenges remain in these systems as detailed in this report. However, after several years of significant crisis, this fiscal year the focus shifted to other key areas of the system and the opportunity to work towards thoughtful and deliberate improvement in these systems.

Several issues addressed in this report are continuations of issues that were noted in last year's report and are being examined by many stakeholders in the system:

- The use of Alternative Response has increased in the last few years and the discussions and efforts to address oversight of these cases, which do not receive oversight from the courts, are ongoing. The OIG's Year in Review discusses those efforts, including the work of the Nebraska Children's Commission's Alternative Response Subcommittee and its Oversight Work Group.
- The efforts at transformation of the child welfare system through both a practice and finance model as directed by LB 1173, have been underway since February. A consultant was hired and significant work has been done to gather information and input in a variety of ways. LB 1173 Work Group meetings have been held publicly each month and its report of recommendations is due at the end of the year.

This past fiscal year the OIG was able to improve and clarify its required monitoring of sexual abuse allegations, continue its monitoring of the Youth Rehabilitation and Treatment Centers (YRTC), and renew its focus on juvenile detention facilities:

- Since 2017, the OIG has been tasked with monitoring sexual abuse allegations of state wards, juveniles on probation, juveniles in a detention facility, and juveniles in a residential child caring agency. This year, the OIG clarified with DHHS the reporting

requirements regarding sexual abuse allegations of state wards and received all allegations on a monthly basis. The OIG reviewed all these reported allegations.

- The OIG also continued its monitoring of the state's YRTCs. This fiscal year, the YRTCs saw an increase in census as well as increases in almost every type of incident that YRTCs report on. The YRTCs, like many other systems are facing staffing challenges particularly in hiring and retaining enough mental health staff. Additionally, the limitations of the physical plant at the YRTC-Hastings facility continues to create challenges for serving youth at that facility.
- OIG staff visited the juvenile detention facilities to better understand the challenges they face, including an increase in the number of youth that the detention centers are housing for extended periods of time.

The OIG also completed three investigations into the deaths or serious injuries of five system involved children.

- One investigation involved the serious injury of a two-year-old after the child consumed THC. The investigation revealed concerns with DHHS's management of the foster home and the process that allowed that home to be overfilled.
- Another involved the near death of a four-month-old infant as the result of malnourishment in the foster home. The investigation concluded that while all policies were followed, a gap in the current policies and protocols resulted in a lack of verification and monitoring of the infant's health care needs and treatment plan.
- The third investigation related to the deaths by suicide of three youth. The investigation concluded that DHHS and its employees did not contribute in any way to the deaths. Given the increased risk of suicide for youth in the foster care system, the investigation determined that suicide prevention training and support for workers and families caring for this vulnerable population should be enhanced.

A summary of those investigations and the subsequent recommendations for systemic improvement that resulted from those investigations are included later in the report.

Lastly, the OIG continued its important work of receiving complaints from the general public about the child welfare and juvenile justice systems, as well as other intakes and reports of incidents required to be shared with the OIG. The OIG reviews and assesses every intake to determine if they reflect any significant systemic issues or should result in an OIG investigation as required by law. The OIG received 522 intakes during Fiscal Year 2022-2023 (FY 2022-2023), an increase from last year. Based on these intakes, the OIG identified the need to open seven new mandatory investigations into the deaths or serious injuries of system involved children and two additional investigations into the alleged sexual abuse of system involved children.

About the Office of Inspector General of Nebraska Child Welfare

The Office of Inspector General of Nebraska Child Welfare was created by the Legislature following a significant crisis in the child welfare system that resulted in multiple problems, including upheaval in the workforce, increasing the risk to children and the families being served, and the loss of many critical private providers needed to serve children in the system.[1] As part of its inherent power of legislative oversight, the Legislature created the OIG to "[e]stablish a full-time program of investigation and performance review to provide increased accountability and oversight" and to assist the Legislature in improving the child welfare and juvenile justice systems.[2]

The OIG's ultimate purpose is to foster good government and create transparency and accountability in these critical systems.[3] The goal is to ensure the child welfare and juvenile justice systems are serving children and families well and doing so as the Legislature intended. The OIG does this by monitoring and reviewing the child welfare and juvenile justice systems and conducting certain investigations into deaths and serious injuries of children. The OIG's work helps the Legislature assess how these systems are functioning and determine if legislative action is necessary to improve these critical systems.

The OIG provides accountability for and may conduct investigations involving the following agencies: DHHS for both the Division of Children and Family Services (CFS) regarding child

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[1] *See* LR 37 Report: Review, Investigation, and Assessment of Child Welfare Reform at https://nebraskalegislature.gov/reports/health.php.

[2] Neb. Rev. Stat. §43-4302. It should be noted that when the OIG of Child Welfare Act was passed, the DHHS Office of Juvenile Services was responsible for the care and supervision of youth in the juvenile justice system. Therefore, when the Act was passed, those youth and that system were included in the stated intent. When supervision of youth in the juvenile justice system was moved to the Administrative Office of Probation in the judicial branch, the Act was amended to maintain oversight regarding the supervision and care of those youth.

[3] Inspectors General have served as an important part of government in the United States since the Revolutionary War. During the war, George Washington was concerned with the training and readiness of the militia, and the Continental Congress wanted accountability for its investment in the militia. To address these concerns, they looked to Europe where Inspectors General had been utilized for over 100 years. The concept was borrowed, and in 1777 the first Inspector General in the United States was appointed with oversight over the militia. Inspectors General have been used extensively in the United States military since that time. In the 1950s, an Inspector General was appointed within the Central Intelligence Agency and in 1978 the Inspector General Act was passed creating an Inspector General in each of 12 federal departments. Today there are 75 Inspectors General at the federal level and over 200 state and local level offices dedicated to government accountability and oversight.

welfare and the Division of Public Health (Public Licensing) for the licensing of facilities; Administrative Office of Probation, Juvenile Services Division (Juvenile Probation) regarding youth supervised on probation; the Commission on Law Enforcement and Criminal Justice's Juvenile Justice Programs (Crime Commission); private agencies and service providers in the child welfare and juvenile justice systems under state contract; licensed child care facilities; and juvenile detention and staff secure detention centers.

The law requires the OIG to investigate allegations or incidents of:

1. misconduct, misfeasance, malfeasance, or violations of the statutes or rules and regulations of DHHS, Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities;
2. deaths and serious injuries[4] of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation, (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation, or (c) in cases that have had an open investigation for child abuse and neglect in the last 12 months, if, after review, the OIG determines the death or serious injury did not occur by chance.

The OIG must also receive and assess complaints from members of the public and may open an investigation based on those complaints if certain requirements in the law are met. The OIG's process for determining what must be investigated is described in more detail later in this report.

As part of the OIG's review and investigative function, it gathers information, analyzes that information, and provides reports to state agencies and the Legislature with recommendations for system improvement. OIG investigations are focused on identifying issues and gaps in the laws, policies, and procedures in the child welfare and juvenile justice systems. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions.

[4] Serious injury is defined as, "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."

It is important to note that the OIG of Child Welfare does not conduct any abuse and neglect investigations, nor does it conduct any criminal investigations into a death or serious injury of a child. The OIG does not have any law enforcement power.

In addition to investigations, the OIG has several additional statutory duties. The OIG reviews and monitors complaints and incidents related to Alternative Response (AR) cases. The office produces an annual report on Juvenile Room Confinement data reported by juvenile residential facilities. The OIG's monitoring of the YRTCs includes a review of data and information that the YRTCs are required to provide to the OIG. The Inspector General also serves on a variety of committees, commissions, and work groups.

Structurally, the OIG is housed within the Office of Public Counsel, or Ombudsman's office, which is part of the legislative branch. The Inspector General is appointed to a five year term by the Ombudsman with the approval of the Chairs of the Executive Board and Health and Human Services Committee of the Legislature. The OIG also has two full-time Assistant Inspectors General and one half-time Executive Intake Assistant who are all critical to maintaining the significant duties of the OIG.

Year in Review

This section reviews the major issues and topics that arose in the child welfare and juvenile justice systems and upon which the OIG worked in the last fiscal year.

Alternative Response Updates and Oversight

Alternative Response is a different approach to handling reports that are assessed by the Hotline. The goal, as stated by DHHS, is to meet families where they are by connecting families with local community resources, providing economic resources, and finding solutions for families in times of crisis. Unlike traditional response assessments, AR is not a formal investigation as to whether child abuse or neglect occurred. [5] Safety is still assessed, and, if a family is found safe, DHHS attempts to provide resources to address the concerns that prompted the Hotline report. [6] After safety is assessed, AR cases are completely voluntary, allowing families to either accept or refuse the services DHHS offers.

As noted in the OIG's FY 2021-2022 Annual Report last year, there has been a significant increase in the number of AR cases in the child welfare system overall. Since AR transitioned from a pilot project to full implementation in 2020, its usage has continually increased. In the first year of full implementation, there were 1,582 AR cases throughout the state that made up 10.2% of all reports assessed by the Hotline. In 2021, that number increased to 4,089 AR cases comprising 22.6%—nearly a quarter—of all assessed Hotline reports.[7] The OIG is unable to update this data for 2022. This data has previously been included in the public *Child Abuse and*

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[5] Neb. Rev. Stat. §28-710(a).

[6] Neb. Rev. Stat. §28-712.01(1)(b)(i), (ii), (x), (xiiii). There are certain types of cases that do not qualify for AR. These exceptions reflect instances where the risk to the safety of the children are higher, such as allegations involving the murder of a child, sexual abuse of a child, a history of termination of parental rights, or allegations that a household member is illegally manufacturing methamphetamine.

[7] Nebraska Department of Health and Human Services. *Child Abuse and Neglect Annual Report 2021*. https://dhhs.ne.gov/Pages/Children-and-Family-Services-Reports.aspx. (Retrieved on September 12, 2022). In 2021 there were 36,393 reports made to the Hotline, and of those, 18,101 reports were assessed by CFS. The 4,089 AR assessments were 22.6% of the 18,101 total reports assessed—meaning the remaining approximate 78% of assessed reports were traditional response. In 2020, there were 14,981 assessed Hotline reports with 1,528 AR cases comprising 10.2% of all assessed intakes. The approximate 12% difference in one year demonstrates that AR is being used to address a significant portion of assessed Hotline reports.

Neglect Annual Report posted by DHHS each year. At the time of this writing, that report had not been made public and DHHS did not respond to the OIG's request for the data for 2022.

Oversight of Alternative Response Cases

Given the significant increase in the proportion of child welfare cases that are addressed as AR and given the nature of AR cases – that they are both voluntary, yet involve families with significant challenges – oversight is critical. It is important to know whether and how well AR is serving families and if there is any effect on the safety of children. There are quality assurance measures in place within DHHS. However, the usual external mechanisms for oversight, such as court oversight, are not present in AR cases. (By definition, these cases do not involve the courts.)

There are efforts, however, to provide some external oversight of these cases. The OIG is required to receive notice of any deaths or serious injuries to youth, including those in AR cases. It also has an additional obligation to summarize in its annual report any AR cases the OIG reviews.[8]

For the first time last year, the OIG was notified of serious injuries involving children in active AR cases or who had an open AR case in the prior 12 months. Four of those cases resulted in mandatory investigations by the OIG. In addition, the OIG also saw a stark increase in the number of AR cases the OIG reviewed, either as a result of complaints or incidents reported to the OIG. This year, the number of cases the OIG had to review increased again to 20 (from 17): 12 as a result of complaints and 8 from reported incidents. Two of those incidents involved deaths of children where there had been a prior AR with the family. These two are mandatory investigations for the OIG.

In addition, in 2020, AR moved from a pilot program with a robust evaluation component, to full implementation.[9] With the pilot program and formal evaluation of AR ending, the Legislature created the Alternative Response Subcommittee of the Nebraska Children's

[8] Neb. Rev. Stat. §43-4331. Please see page 43 of this report for the AR summaries.

[9] Neb. Rev. Stat. §27-712. The law includes some clarifications of definitions and changes to the exclusionary criteria.

Commission to examine the ongoing use of AR. The law designates a representative of the OIG as a member of this subcommittee. The OIG has participated in the Nebraska Children's Commission's AR Subcommittee since its inception. Personnel from DHHS have been very helpful and instrumental in educating the subcommittee members on AR, its purpose, goals, and how it functions differently than cases handled through traditional response in the child welfare system. As part of the AR Subcommittee's work, the Inspector General was asked to co-chair a work group on oversight of AR cases.

The Oversight Work Group began meeting monthly starting in November 2022. The group reviewed data, existing mechanisms for oversight both inside and outside DHHS, and brainstormed the key issues and questions to be answered by oversight. Some of those key questions include: Is AR reaching the right families, and how can we determine this? Is AR keeping families from going deeper into the system? Relatedly, has there been any effect, positive or negative, on the safety of children in the system? Are families receiving the services they need through AR?

The group has made some initial recommendations contained in the Nebraska Children's Commission's report[10] and will continue to discuss what information and oversight would be most helpful to understand how AR is working for families.

LB 1173 Reimagine Well-Being Efforts

In 2022, in the wake of the challenges in the Eastern Service Area (ESA) and at the recommendation of the LR 29 Committee which examined issues in the ESA, the Legislature passed LB 1173 to structure and support a plan for systemic transformation of the child welfare system. The law requires the creation of a practice and finance model with input from all three branches of government. To that end, LB 1173 created a work group and a leadership group with representation from all three branches of government. The 1173 Work Group consists of DHHS Division heads from CFS, Behavioral Health, Developmental Disabilities, Medicaid and Long-Term Care, and Public Health; the State Court Administrator and a designee of the Judicial

[10] Nebraska Children's Commission report available at:
https://childrens.nebraska.gov/PDFs/Reports/NCC/NCC%20Annual%20Report%202022-2023%20(Final).pdf

Branch; and a representative of each federally recognized Indian Tribe. The LB 1173 Work Group is required to work in consultation with several groups including the OIG.

In addition, LB 1173 required that the Work Group and Leadership Group enlist the assistance of a contracted consultant who is an expert in child welfare system transformation. The Stephen Group was hired as the consultant and began their work in early 2023.

The Stephen Group's efforts began with an initial kick off meeting where perspectives and concerns about the child welfare system were solicited. Since the kick off, The Stephen Group has also convened community forums throughout the state and conducted interviews and surveys of various key stakeholders and those directly engaged in the child welfare system such as CFS case managers and supervisors. The LB 1173 Work Group meetings are held every month both in person and virtually. The Work Group meetings include presentations on a variety of aspects and efforts regarding the child welfare system in Nebraska. The Stephen Group also regularly provides an overview of key themes they are hearing from their information gathering efforts.[11]

The OIG has been engaged and attended the Work Group meetings throughout this process. The Stephen Group's efforts at community engagement have resulted in the gathering of important information and have revealed many key trends. The OIG is eager to see what recommendations the Stephen Group will make and which recommendations will be accepted and pursued by the LB 1173 Work Group.

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[11] The LB 1173 meeting is also being called "Reimagine Well-Being." DHHS has created a Reimagine Well-Being page on their website which houses the dates of all the meetings and has materials distributed at those meetings: https://dhhs.ne.gov/Pages/LB-1173-Child-and-Family-Well-Being-Working-Group.aspx.

Sexual Abuse Data Monitoring

Nebraska law requires DHHS, Juvenile Probation, detention facilities, and staff secure facilities to report to the OIG "all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and a juvenile in a residential child caring agency."[12] It is critical to note that the required reports to the OIG are **allegations**; meaning an accusation of sexual abuse has been reported, but an appropriate CFS assessment and law enforcement investigation has yet to occur.

The number of allegations reported to the OIG increased dramatically in FY 2022-2023. However, *this reflects a correction to the reporting process and should not be read to indicate a stark increase in sexual abuse allegations of state wards.*

Table 1.

Total Reports of Alleged Sexual Abuse by Fiscal Year & Reporting Agency

Fiscal Year	Total	Reported by DHHS	Reported by Juvenile Probation
17-18	45	26	19
18-19	41	31	10
19-20	46	15	31
20-21	69	14	55
21-22	70	21	48
22-23	311	271	40

As was reported in the FY 2021-2022 OIG Annual Report, over the past five years, the OIG noted a steady decrease in reports from DHHS. The OIG communicated with DHHS on several occasions to understand the decrease in reports and discovered a misunderstanding on how DHHS was interpreting the reporting requirements. This misunderstanding was corrected and during FY 2022-2023, DHHS sent the OIG all allegations of sexual abuse of state wards on a monthly basis.[13]

When an allegation of sexual abuse is received by the Hotline it can be screened as: (1) requiring no further assessment because the allegations either did not meet the definition of abuse and neglect, or they were already assessed as part of an existing case; (2) accepted by CFS to assess the family for safety and risk in conjunction with law enforcement evaluating for

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[12] Neb. Rev. Stat. §43-4318(2)(b). This change in the law came after the 2017 OIG report Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement.

[13] Because the OIG has not received the full number of allegations in the recent past, the OIG cannot determine if the number of allegations this year reflects an increase from prior years.

criminal wrong doing; and (3) it can be referred to law enforcement, commonly known as a "Law Enforcement Only" intake.

As the OIG currently understands the Law Enforcement Only process, the Hotline refers allegations to law enforcement when the information suggests: the involved family or perpetrator resided in another state, but the incident occurred in Nebraska; when the alleged victim is currently 19 years of age or older but was a child at the time of the alleged sexual abuse; or the alleged perpetrator is not a family member of the child's household and no longer has access to the child. All intakes alleging child abuse or neglect that are assigned for law enforcement investigation only do not include direct CFS involvement. However, Hotline staff are tasked with contacting the assigned law enforcement agency via phone or email every three months or searching the *Nebraska Criminal Justice Information System* to obtain updates on the investigation for the purpose of updating the results of the intake.

DHHS reported 271 allegations of sexual abuse of state wards in FY 2022-2023. Juvenile Probation reported 40 sexual abuse allegations which is down slightly from the prior fiscal year. The OIG analyzed the 271 allegations of sexual abuse of state wards reported by DHHS and learned the following:

- 205 individual state wards were involved in sexual abuse allegations;
- The youth were often between the ages of 11-15 years;
- The majority of the intakes were from the Eastern and Southeast Service Areas; and,
- Most frequently the alleged abused occurred in either the family home or the foster home.

Figure 1.

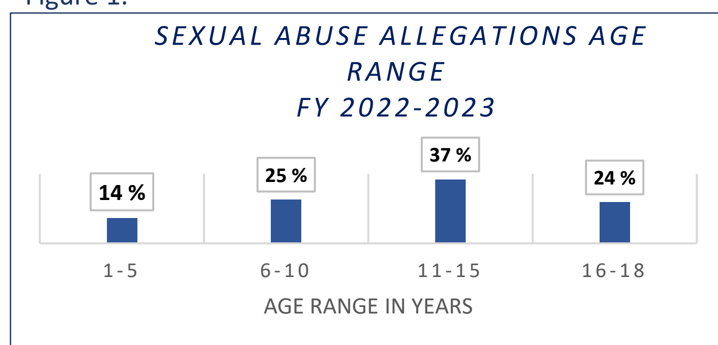

Table 2.

Sexual Abuse Allegation Reports by CFS Service Area	
Service Area	**Total**
Eastern	100
Southeast	89
Central	32
Northern	30
Western	20

Of the 271 total sexual abuse intakes reported to the Hotline, 80 required no further assessment by CFS. Seventy-four of the intakes were accepted for assessment by CFS. The majority of the intakes, 117, were referred to the appropriate law enforcement agency without requiring assessment by CFS.

Once again, this data reflects **allegations** and does not reflect the number of substantiated instances of sexual abuse. As a result, the OIG requested data regarding how many of the allegations were substantiated or found to be true. It is important to note, even this data may not be representative of the full problem. Rather, it represents those cases in which there was enough evidence for DHHS to substantiate the allegation or for criminal charges to be brought.

Of the 271 intakes in FY 2022-2023 that alleged the sexual abuse of a state ward, 191[14] were accepted for investigation by law enforcement only or by CFS in conjunction with law enforcement. Thus far, four of the cases have been substantiated by the court, two have been substantiated by DHHS,[15] and eight are awaiting outcomes from court proceedings. Thus, only six cases have clear outcomes and eight had enough evidence to result in charges. Fifty-eight of the 191 intakes were assessed to have unfounded allegations.

Table 3.

Results of Intakes Accepted for CFS Assessment

Result	Total
Unfounded	57
Court Pending	5
Other	5
Court Substantiated	4
Agency Substantiated	2
Outcome Not Entered	1

[14] Seventy-four accepted for assessment by CFS and 117 referred to law enforcement.

[15] Substantiation by CFS requires a preponderance of the evidence, meaning more likely than not that the abuse occurred. If an allegation is substantiated by CFS, the perpetrator is listed on the Central Registry. Substantiation by law enforcement means the perpetrator has been charged with a crime that requires adjudication through the courts and evidence beyond reasonable doubt. Substantiation by law enforcement can result in sentencing by a judge and inclusion on the National Sex Offender Registry.

The majority of intakes alleging the sexual abuse of a state ward in FY 2022-2023 were assigned to investigation by law enforcement only. At the time DHHS reported the data to the OIG, the results of 110 law enforcement investigations were not entered into CFS's system. This means more than half of 191 investigations done by CFS or law enforcement do not have results entered. As a result, it is difficult for the OIG to speak to the prevalence of the issue.

Table 4.

Results of Intakes Accepted for Law Enforcement Investigation Only

Result	Total
Outcome Not Entered	110
Court Pending	3
Declined Investigation	3
Unfounded	1

As noted, this was the first year the OIG received the full array of data from DHHS so this year serves as a baseline for monitoring any changes or trends that relate to sexual abuse allegations. The OIG will continue to monitor this data going forward.

Youth Rehabilitation and Treatment Center Monitoring

After the crisis at YRTC-Geneva in 2019, the Legislature passed a law to require the YRTCs to report to the OIG on key indicators regarding the operations of the YRTCs. Neb. Rev. Stat. §43-4318(3) requires the Office of Juvenile Services (OJS), which oversees the YRTCs, to report to the OIG "as soon as reasonably possible" when the following instances occur: assaults, escapes or elopements, attempted suicides or self-harm, property damage not caused by normal wear and tear, the use of mechanical restraints, a significant medical event suffered by a juvenile, and internally substantiated violations of the Prison Rape Elimination Act (PREA). The goal of this legislation was to create additional oversight with respect to some of the specific issues and concerns that arose during the crisis at Geneva. The intention was to ensure that issues were caught and addressed before they could result in another crisis.

In addition, the OIG monitors the YRTCs through regular visits, communication with the administration and staff of the facilities, and, when appropriate, conversations with the youth. What follows is a summary of the data and the OIG's observations from this fiscal year.

YRTC-Hastings

As noted in last year's OIG annual report, there are, and continue to be, challenges in operating a YRTC on the Hastings campus. The physical plant, originally designed as a substance use treatment program for male youth, is not conducive to handling the challenges presented by the youth at the YRTC. This year, the issue has been compounded by an increase in the census on campus.

The facility's daily census began trending upwards towards the end of FY 2022-2023. For the first three quarters of the fiscal year, YRTC-Hasting's monthly census fluctuated between 10 to 13 youth. Beginning in April, the census jumped to 18 and reached its height in May at 19. Although 19 does not seem like high census, the facility has a maximum capacity of 24 youth. This higher census has created additional challenges.

Currently, the campus consists of an administration building, a chapel, a program building which is also used as the school, and two living units which can accommodate up to 12 girls each. The youth are housed in the two living units each consisting of one common area with two hallways – each hallway consists of 6 rooms and a bathroom. The common area itself is not large enough to comfortably accommodate all 12 youth at one time, particularly given the emotional and behavioral issues of the population served.

Before the increase in census, the units were separated, meaning each unit went to different classes at school, ate separately from the other unit, and recreated at different times. The increase in census necessitated the youth being separated by hallway in addition to unit. This protocol is informed in part by the reality that many of these youth have prior experiences with each other, and the facility needs to separate youth who may have ongoing conflicts and trauma. This protocol is difficult given the limited space at YRTC-Hastings.

Other challenges of the physical plant include very limited indoor and outdoor recreation space on campus. For example, the chapel is currently utilized as the gym. While there is a great deal of green space, it is rarely used. More attention should be paid to the needs of this facility to make better use of the ample amount of space on that campus for both indoor and outdoor recreation.

Like many places, YRTC-Hastings has been affected by staffing issues and has experienced consistent staff turnover. The effect of the staffing challenges is compounded by the increase in the census. Before the census increase, the administration could maintain a 1 to 4 staff youth ratio, which is the ratio DHHS determined as a goal in the YRTCs' five-year strategic plan. Since the increase, YRTC-Hastings is at a 1 to 6 ratio. Additionally, YRTC-Hastings has struggled to keep a dedicated mental health practitioner on site. Without a dedicated mental health staff, YRTC-Hastings has had to rely on mental health practitioners from other YRTC facilities to come and ensure that youth are receiving individual therapy. Limited staffing also affects programming. For example, YRTC-Hastings has not been able to provide the youth many opportunities for community engagement. Staff are needed to escort youth while they are in the community whether that is volunteering or taking extra classes. If staff are not available, youth cannot go out into the community.

During regular visits to YRTC-Hastings, the OIG has talked with youth about their experiences there. Youth have raised many concerns with the OIG that are similar to the issues discussed above, ranging from complaints about staff, issues with their limited programming, access to mental health, and the amount of time they spend outside. With permission from the youth, the OIG has shared these broad concerns with the Administration. The OIG has appreciated the Administration's openness to hearing these concerns and their efforts to help the OIG better understand the issues and challenges the YRTCs face.

As noted earlier, the OIG receives monthly reports from each facility regarding several types of incidents. Given the staffing challenges and the increase in the census, it is perhaps not surprising that FY 2022-2023 saw increases in nearly every type of incident compared to what was reported to the OIG in FY 2021-2022. For FY 2022-2023, YRTC-Hastings reported 38 assaults on staff compared to 19 the previous fiscal year. Two of these assaults required staff to receive medical treatment off campus and 14 required basic first aid. There were 18 youth on youth assaults, none of which required any medical treatment. There was one incident of property damage that exceeded $500.

An important challenge for YRTC-Hastings is the number of incidents of self-harm by youth. This fiscal year there was an increase with a total of 59 incidents of self-harm by youth compared to last fiscal year's 22 incidents. Additionally, there were three attempted suicides at YRTC-Hastings for the fiscal year. Out of the self-harming incidents and suicide attempts, four youth required a visit to an emergency room or a hospital admission.

Lastly, for FY 2022-2023 there were 46 incidents of staff needing to use mechanical restraints[16] on youth compared to the 21 incidents last fiscal year.

In addition to the statutory reports, the OIG is notified of significant incidents that occur at an YRTC "as soon as reasonably possible" after they occur. The OIG was made aware of one such incident involving a use of force on a youth at YRTC-Hastings. In cases like this, the OIG will conduct a more thorough review to determine if a full investigation is required. In this case, the OIG reviewed video of the incident and observed a training of the physical restraint technique used at the YRTCs called "Handle with Care." The OIG also had extensive conversations with the YRTC Administrator about how the incident was being handled, the challenges the incident reflected, and ways incident reviews and staff training might be improved. A full investigation was not required.

YRTC-Kearney

Like YRTC-Hastings, YRTC-Kearney also had an increase in census beginning in the last quarter for FY 2022-2023. YRTC-Kearney's monthly census began the fiscal year at 50 and climbed to its highest monthly census for the fiscal year at 64 in May.

The OIG last visited YRTC-Kearney at the end of FY 2022-2023. During this visit, the OIG toured the facility and received an update on progress of new housing units approved and funded by the Legislature to provide individual rooms rather than barrack style dorms. It is also experiencing issues with staffing both with front line and mental health staff. Compounding the problem, YRTC-Kearney has been sharing two of their mental health staff with YRTC-Hastings to cover for its lack of mental health staff.

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[16] Mechanical restraints refer to wrist and ankle restraints.

Despite staffing challenges, YRTC-Kearney has continued to improve its programming, specifically increasing community engagement and volunteer opportunities for youth. The facility has also partnered with an equestrian program that allows the youth to help care for horses and eventually ride with them if they so choose.

Regarding the FY 2022-2023 monthly reports, YRTC-Kearney also saw increases in nearly every type of reported incident. In FY 2022-2023, YRTC-Kearney had 72 assaults on staff compared to 36 staff assaults in FY 2021-2022. Seven of the incidents this year required staff to seek outside medical attention. There were also 71 youth on youth assaults compared to last fiscal year's 40. Twenty-four assaults resulted in youth needing first aid and six required on-campus medical treatment beyond first aid. YRTC-Kearney used mechanical restraints on youth 156 times—compared to last fiscal year's 54 uses of mechanical restraints. YRTC-Kearney also had one off-campus elopement and five attempted elopements. Administration has attempted to fix this problem by placing razor wire above certain sections of fence. This fiscal year there were four instances of property damage that exceeded $500 and eight significant medical events—four for staff and four for youth. Incidents of attempted suicide and self-harm were similar to last fiscal year's numbers with one attempted suicide and nine instances of self-harm.

YRTC-Lincoln

The YRTC facility at the Lancaster Youth Services Center houses both males and females, with the two populations kept separate. Both YRTC-Kearney and YRTC-Hastings send youth to YRTC-Lincoln in order to stabilize a youth's behaviors. Other youth are placed directly at YRTC-Lincoln through the court. YRTC-Lincoln benefits from a low census which never exceeded ten for FY 2022-2023. As with YRTC-Hastings and Kearney, YRTC-Lincoln experienced higher numbers of reported incidents in nearly every category.

For female youth, there were 13 reports of assaults on staff—compared to last fiscal year's seven. Additionally, there were three youth on youth assaults and 24 incidents of self-harm. There were 30 uses of mechanical restraints and five significant medical events requiring youth to go to the emergency room—higher than any other facility.

For male youth, there were 17 reports of assault on staff and four youth on youth assaults. There was one attempted suicide and 13 instances of self-harm. Lastly, mechanical restraints were used 49 times compared to last fiscal year's 19 instances.

PREA Allegations

The YRTCs also report allegations of violations of PREA. PREA sets strict boundaries around any touching of or between youth. As a result, YRTCs must address a wide range of PREA allegations, from incidents of touching between youth to more serious allegations of sexual abuse occurring between youth or by staff. The OIG receives documentation of all PREA allegations from each facility. All three YRTCs reported higher numbers of PREA allegations compared to the previous fiscal year.

Of the PREA incidents shared with the OIG:

- YRTC-Kearney had 43 reports, 15 of which were substantiated. Thirteen of the substantiated allegations involved inappropriate touching by youth. The two other substantiated allegations involved a youth sexually harassing another youth and a staff member inappropriately touching a youth unrelated to official duties. Lastly, one youth made an allegation of a sexual relationship with a staff member, which was investigated by the Nebraska State Patrol. Comparatively, for FY 2021-2022 there were 17 PREA reports, with 9 substantiated.
- YRTC-Hastings had 28 reports, 17 of which were substantiated. All but one of the substantiated incidents involved inappropriate touching by youth. One of the substantiated incidents involved sexual harassment between two youth. Comparatively, for FY 2021-2022, there were 17 PREA reports with 12 substantiated.
- YRTC-Lincoln reported 23 PREA incidents, 13 of which were substantiated. All but one of the substantiated incidents involved inappropriate touching by youth. One of the substantiated incidents involved sexual harassment between two youth. Comparatively, for FY 2021-2022, there were four PREA incidents with three substantiated.

Education

The ongoing collaboration and partnership with the Nebraska Department of Education appears to have been beneficial to the educational programming at the YRTCs. As noted last year, there continues to be a move away from online credit recovery in favor of classroom instruction. This is more consistent with a traditional educational setting, helping to prepare youth to return to school when discharged. In addition, efforts are being made at both YRTC-Kearney and YRTC-Hastings to provide educational and vocational opportunities for youth.

Inequity Between Male and Female YRTCs

This year, as the end of the pandemic protocols allowed the YRTCs to return to more regular programming, the OIG observed that the inequities between the male and female facilities were more pronounced. As noted, YRTC-Hastings' physical plant is more limited than YRTC-Kearney's. Female youth are spending significant amounts of time indoors with more limited programming and opportunities for community engagement. Indeed, as noted in last year's OIG Annual Report, most of the windows in the living units are covered, limiting even a view of the outdoors. YRTC-Hastings has a large campus spotted with trees and ample greenspace that is not fully utilized by the facility. Conversely, YRTC-Kearney possesses a campus comprised of many housing units, program buildings, a chapel, school, gym, weight room, pool, disc golf course, softball field, as well as a fenced in area that allows youth more opportunity to be outside. This campus affords youth more opportunities for movement and recreation. They also have more opportunities for community engagement.

YRTC-Kearney is not without challenges to its physical plant as evidence by its barrack-style dormitories, but there is a plan to replace them. In addition, each facility has staffing challenges particularly with mental health staff. But in general, the physical limitations and the limitations on activities for the female youth compared to the male youth is pronounced. The OIG would encourage the Legislature to assess the needs of the facility for female youth.

YRTC Five-Year Strategic Planning Advisory Group

DHHS created a five-year strategic plan for the YRTCs as required by statute. The OIG was included as part of an advisory group for that plan which had been meeting quarterly for

updates. Unfortunately, those meetings have not occurred this fiscal year. The OIG continues to recommend that DHHS and the Legislature include a more comprehensive and visionary look at what Nebraska needs the YRTCs to be.

Juvenile Detention Facilities

Juvenile Detention facilities are operated by the counties for the "lawful custody and care of juveniles" in a facility that is secure. Detention centers are not meant to be residential facilities but rather secure facilities for short-term housing of youth as they await adjudication and proper placement.[17]

The four juvenile detention facilities in Nebraska – Lancaster County Youth Services Center, Douglas County Youth Center, Northeast Nebraska Juvenile Services, Inc. (in Madison County), and the Patrick J. Thomas Juvenile Justice Center (in Sarpy County) – are within the OIG's jurisdiction and the office can, and does, receive complaints regarding these facilities. In addition, the law requires detention facilities to report any deaths or serious injuries to the OIG and tasks the OIG with reviewing the juvenile room confinement data from these facilities.

Visits to Facilities

This year the staff at the OIG visited each juvenile detention facility (with the exception of the Northeast Nebraska Juvenile Services due to scheduling issues). As a result of the pandemic, newer staff, including the Inspector General, had not previously had an opportunity to tour the facilities or meet the directors and staff. The OIG team appreciated the time and opportunity to view the facilities, to learn each detention center's approach to the work and the challenges they face, and to talk about the OIG's role with regard to juvenile detention centers.

The OIG heard a few consistent challenges across the juvenile detention centers. One of the biggest issues facing the facilities is the increase in the number of youth that the detention centers are housing for extended periods of time - months to over a year. Most often this occurs when a youth is charged as an adult but is not old enough to be housed at an adult facility. In other cases, appropriate placements are not being identified, and the youth remains

[17] Neb. Rev. Stat. §43-251.01 and §43-253.

in detention awaiting a different placement. This creates a challenge because detention centers are not intended for long term stays. A juvenile detention center's purpose is to house youth for short periods of time until appropriate placements are found. As a result, detention centers are not set up to meet a youth's longer-term needs. For example, although each detention center does provide school for youth, the facilities do not have extensive programming for the youth.

An additional challenge is that an increasing number of youth in detention facilities have mental health needs, and the detention centers are not equipped to support those needs. Again, given the law's assumption that a youth's stay will be time-limited, the mental health services in detention centers are focused on crisis management. They are not intended to provide for the ongoing treatment a youth may need.

These are issues the OIG will continue to monitor and are issues that the Legislature should be aware of as well. These new challenges may require the state, and the Legislature, to re-evaluate how youth in detention centers are treated.

Complaints Regarding Juvenile Detention Centers

As noted, the OIG does receive complaints related to the juvenile detention facilities. In the last fiscal year, the OIG received five complaints related to the Lancaster County Youth Services Center (LCYSC). Three of the complaints related to the use of room confinement. Specifically, the complainants alleged that room confinement was used excessively and not documented appropriately. As discussed later in this report, the OIG is required to review and analyze the room confinement data the detention centers report to the Legislature under Neb. Rev. Stat. §83-4,134.01. The OIG vetted these complaints to the extent possible and reviewed current policy at LCYSC. However, as the OIG has noted in its room confinement reports each year, the OIG is not required to and has no way of verifying the data that is submitted. It is the Nebraska Crime Commission and the Jail Standards Board that interpret the law for the facilities in its jurisdiction and set out clear standards, expectations, documentation requirements, and ways to verify juvenile room confinement—standards that can be applied consistently across each facility.

The two other complaints related to alleged inappropriate uses of force at LCYSC. In these cases, the OIG asked for documentation to vet the complaints to see if they were supported and to determine if a full investigation was warranted. LCYSC cooperated with the OIG and provided documents and videos (when available) of the incidents. The OIG did not open a full investigation in either case.

Placement Availability and Stability

Last year in its Annual Report, the OIG noted that there was a concern regarding the availability of appropriate and stable placements. This appeared to be a national problem and may be a lingering impact of the pandemic. The OIG has continued to monitor this issue and some of the complaints the OIG has received in the last fiscal year reflect this ongoing challenge.

In one case that the OIG reviewed, seven children were removed from their family. They were initially placed with a family member who kept placement of them for two months. After the family member was no longer able to keep placement, DHHS had extensive issues trying to find a foster home that would take placement of any of the children and had to search statewide for options. Eventually the children were split up and placed into separate foster homes. Several of the children were placed in separate towns which made siblings visiting each other and their parents difficult. In addition to this case, the OIG reviewed many other instances that highlighted the shortage of foster homes in Nebraska.

In addition, this fiscal year, the OIG received an increase in complaints from foster parents concerning their frustrations. Examining the reimbursement rates for foster parents continues to be important, however, the frustration expressed by the individuals who contacted the OIG rarely focused on reimbursement rates. Overall foster parents expressed that they do not feel supported by the state, struggle with not having control over their schedules, and were not given enough training and resources to succeed. Challenges like those expressed in these complaints may compound the difficulty in finding and maintaining available placements in Nebraska.

Committees and Commissions

The Inspector General participates in several initiatives and attends meetings of groups created to oversee and coordinate efforts to improve the systems serving children and youth in the state's care. Participation in these committees and commissions provides the Inspector General with a helpful and up-to-date understanding of the challenges in the child welfare and juvenile justice systems, the efforts to address those challenges, and any other changes or system improvements being made. All this information helps the OIG make better and more relevant recommendations in its reports.

Most notably the Inspector General participates in the following groups:

- Nebraska Children's Commission (statutory member)
    - Alternative Response Subcommittee (statutory member)
    - Co-chair, AR Subcommittee Oversight Work Group
- Child Death Review Team (statutory member)
- Nebraska Supreme Court Commission on Children and the Courts
- Commission for the Protection of Children
- Statewide Juvenile Detention Alternatives Initiative
- LB 1173 Work Group

National Inspectors General Certifications

The Office of Inspector General of Nebraska Child Welfare Act requires that any person appointed to the position of Inspector General obtain certification as a Certified Inspector General by the Association of Inspectors General (AIG) within two years of appointment. The mission of the AIG is to promote excellence in the Inspector General community by establishing and encouraging adherence to quality standards. The AIG fosters and promotes public accountability and integrity in the prevention, examination, investigation, audit, detection, elimination, and prosecution of fraud, waste and abuse.

The Inspector General and one Assistant Inspector General are already certified. As part of the OIGs efforts to operate at the highest standards, this year the OIG's second Assistant Inspector General became certified as a Certified Inspector General Investigator by the AIG. The Certified

Inspector General Investigator® program incorporates seven broad areas of core competency for inspector general investigators: the investigative process, investigative techniques, legal issues, standards for conducting investigations, procurement fraud, ethics in investigations, and working with auditors. With this latest certification, every OIG staff member that conducts investigations is certified.

Investigations, Reports, and Recommendations

Each year the OIG receives notices regarding deaths or serious injuries of system involved youth from various agencies in the form of incident reports. The OIG is required to investigate deaths and serious injuries of youth who are: (1) placed in out of home care; (2) receiving child welfare services from DHHS; (3) receiving services from Juvenile Probation; (4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months; and (5) youth in a licensed facility.

The OIG thoroughly vets each incident to determine if it is within the OIG's jurisdiction and if the law requires the OIG to conduct a full investigation. By statute, the OIG is only required to investigate deaths or serious injuries that did not "occur by chance" and which may have resulted from abuse and neglect. The OIG refers to these as "mandatory investigations."

A full investigation by the OIG includes:

- Comprehensive review of all documents relevant to a case – from agencies, local law enforcement, and others;
- Investigative interviews with key persons and personnel involved in the case;
- Review of relevant Nebraska statutes, agency rules, regulations, policies, procedures, and protocols; and,
- Additional research on best practices to formulate recommendations.

At the conclusion of a full investigation, the OIG issues an investigative report and shares the report with the state agency for its review. The state agency must respond to the recommendations by accepting, rejecting, or requesting a modification of the recommendations and may also make any factual corrections if necessary. If a private agency is also the subject of the report, that private agency also has an opportunity to review the report and respond to the recommendations.

Fiscal Year 2022-2023 Deaths and Serious Injuries

This year, DHHS reported 11 deaths, the same number reported in FY 2021-2022. Juvenile Probation reported no deaths compared to one death reported last fiscal year. Of the DHHS deaths reported, two will require a mandatory investigation by the OIG.[18]

The number of serious injuries reported by DHHS for FY 2022-2023 was slightly higher than last fiscal year with 15 reported compared to 13 last year. Of those serious injuries, five are mandatory investigations.

It is possible that the number of mandatory investigations will increase. The OIG has requested additional records from DHHS for several incidents of death and serious injury that DHHS reported to the OIG. The OIG is still waiting on records before being able to fully determine if certain incidents require mandatory investigation.

Table 5.

Deaths & Serious Injuries by Reporting Agency FY 2021-2022 compared to FY 2022-2023		
	FY 21-22	**FY 22-23**
DHHS - Deaths	11	11
DHHS - Serious Injuries	13	15
Juvenile Probation - Deaths	1	0
Juvenile Probation - Serious Injuries	0	0

Table 6.

Type & Number of Mandatory Investigations Resulting from DHHS Reported Incidents FY 22-23	
Deaths	2
Serious Injuries	5

Open Investigations

In addition to mandatory death and serious injury investigations, the OIG is expected to substantively investigate current key systemic issues affecting Nebraska's child welfare and juvenile justice systems. The OIG's workload fluctuates with the number of mandatory investigations identified each fiscal year. The OIG must continually assess and balance these priorities with the resources available and will have multiple open investigations at any given time. The OIG continually strives to meet the highest standards to ensure the office conducts timely yet thorough and accurate investigations.

[18] One death investigation has already been completed. It was included in the *Death by Suicide-A Three Case Review* report released in August and summarized in a later section of the report.

At the end of FY 2022-2023, the OIG had 20 mandatory investigations pending involving children served by DHHS. The OIG is also mandated to investigate 18 deaths and 7 sexual abuse allegations of youth being supervised by Juvenile Probation. However, as noted repeatedly in past OIG Annual Reports, Juvenile Probation has chosen to require an investigation protocol that would compromise the integrity of the OIG investigation. As a result, the OIG has not been able to complete those investigations.[19]

Table 7.

Mandatory OIG Reports Added in FY 2022-2023					
Report Type	**Cause**	**Age of Child**	**System Involvement**	**Time of System Involvement**	**Reporting Agency**
Death	Neglect	Less than 1 yr.	Alternative Response	Within 12 Months	DHHS-CFS
Death	Suicide	11 yrs.	Alternative Response	Current	DHHS-CFS
Serious Injury	Abuse	1 yr.	CFS-State Ward	Current	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	Licensed Daycare	Current	DHHS-Public Licensing
Serious Injury	Abuse	1 yr.	CFS-State Ward	Within 12 Months	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	Licensed Daycare	Current	DHHS-Public Licensing
Serious Injury	Abuse	Less than 1 yr.	Open Initial Assessment	Within 12 Months	DHHS-CFS

Table 8.

OIG Pending Investigation			
	Reported by DHHS	**Reported by Juvenile Probation**	**Resulting from Complaints**
Death	5	18	0
Serious Injury	15	0	0
Sexual Abuse	1	7	1
			Total 46

[19] Some of the pending investigations require the completion of criminal investigations and judicial involvement before the OIG is able to obtain relevant information. In some cases this process can take many months to resolve.

Summaries of OIG Reports of Investigation

In FY 2022-2023, the OIG completed three mandatory investigations into the death or serious injury of five system involved youth.[20] Those investigations are summarized below.

I. Serious Injury of a 2-year-old State Ward while in Foster Care

On December 1, 2021, the OIG received notice from CFS indicating that on November 26, 2021, a two-year-old state ward had been seriously injured while placed in a traditional foster home. The toddler had been admitted to a pediatric intensive care unit presenting with an altered mental state, acute respiratory failure, and inability to maintain consciousness. After being intubated and undergoing a full body scan, a spinal tap, and multiple diagnostic blood and urine tests, a urine drug screen was positive for cannabinoids attributed to the consumption of THC, which was linked to the presenting condition. A review of the events leading up to the serious injury indicated that the foster parent had allowed the toddler and siblings to leave the foster home with their biological mother unsupervised for a period of eight or more hours while the foster mother went to work. The foster parent allowed the unsupervised visit to occur without getting permission from the necessary parties. Medical information suggested that it was possible that the toddler could have ingested the THC while with the biological mother or once back in the foster home and under the supervision of the foster parent.

The scope of the report included the serious injury of the state ward, CFS's assessment of the serious injury, and a review of the management, supervision, and use of the foster home. Based on a review of the information, the OIG was concerned that the toddler and two siblings had been placed in a traditional foster home that was inappropriately overfilled and lacked support as prescribed by policy and procedure. Additionally, the OIG was concerned that the assessment of the foster home after the serious injury did not adequately follow policy and procedure, thus allowing the foster parent to continue to provide foster care services despite contributing to the serious injury of a state ward.

[20] One of the investigations was accomplished through FY 2022-2023 but was not finalized with DHHS until August of 2023.

The case originated in the ESA. At the time of the serious injury, case management in the ESA was provided by Saint Francis Community Services in Nebraska, Inc. The licensed foster home was supported by the Saint Francis Community Services in Nebraska Inc. Child Placing Agency.

The foster care provider began providing foster care as an unlicensed kinship placement in February 2020. In June 2021, the home transitioned to a Licensed Foster Care Provider which allowed it to take placement of children who did not have a significant pre-existing relationship with the provider. Prior to the placement of the toddler and two siblings, all of the placements were teens. Most of the teens represented hard to place adolescents with extensive CFS involvement, gang affiliation, and criminal histories with detainments at the Douglas County Youth Center and Juvenile Probation supervision. The toddler and two siblings were placed with the provider in September 2021 and were the only young children placed in the home.

The OIG's investigation identified several issues with the management, supervision, and use of the foster home. In addition, the investigation identified issues with the overfill process utilized with the foster home twice prior to the serious injury. Through the investigative process, the OIG found evidence that indicated:

- The foster parent had not been forthcoming with important information during the licensing process about her employment, education, and finances;
- Before the young children were placed in the foster home, there were known issues with the provider following foster care rules;
- Once the three siblings were placed in the home, there were issues with appropriate supervision of all the young children and teenagers in the home; and,
- The foster home was filled over its license capacity twice, even when placing more children in the home may not have been in their best interest.

CFS was required to complete two assessments related to the serious injury. Both assessments, completed by the same worker, found the children were unsafe in the care of their biological mother and foster care provider. The allegations of physical neglect by the biological mother and foster care provider were unfounded, indicating CFS determined either the allegations did

not rise to the legal definition of neglect as set forth in Neb. Rev. Stat. §28-710, or there was not a preponderance of the evidence to support that either adult committed child neglect.

Through its investigation of the serious injury, the OIG found:

1. The assessments conducted after the serious injury lacked clarity in process and analysis.
2. The lack of response to the issues and concerns with the foster home created a risk to the safety and well-being of the children placed in the foster home.
3. Procedures for Allowing an Overfill of a Foster Home were not followed.

Based on its findings, the OIG identified areas where systemic improvements should be made to improve the quality of the management, supervision, and use of the foster home. The OIG recommended that DHHS:

1. Review and revise its policies and procedures to create a method to verify that the overfill process has been followed by the CFS and licensed Child Placing Agencies and to ensure ongoing quality assurance and accountability in that process.

DHHS requested a modification to this recommendation. [21]

2. Review current policy, procedure, and contract language with providers to assure the expectations for communicating concerns about foster homes is done in a timely manner.

DHHS accepted this recommendation.

II. Death by Suicide – 3 Case Review

Between December 2018 and December 2022, the DHHS notified the OIG of three system-involved youth who had died by suicide. The youth ranged in age from 11 to 16 years, they were from different areas of the state, their family dynamics were diverse, and their families

[21] The OIG has revised this recommendation based on a formal request for modification from DHHS and a subsequent meeting between the Inspector General and the Deputy Director of Protection and Safety in which the recommendation was discussed. The recommendation as it appears in the final report includes some of the modified language requested by DHHS.

were involved with CFS at three different points of the system. What they had in common was a suicidal crisis resulting in their deaths.

While adolescents in general are at an increased risk of death by suicide, youth involved with the child welfare system are impacted at an even higher level than when compared to their peers. Youth involved in the child welfare system report higher rates of suicidal ideation and self-harm behaviors. Youth who have been made wards of the state and placed in foster care face unique challenges given their adverse life experiences, transient home placements, and disruptions in social support networks, making them three times more likely to attempt suicide than those youth involved with the child welfare system, but not in state care. It is important to note that this increased risk and impact does not necessarily mean that all adolescents involved in the child welfare system will experience suicidal thoughts or behaviors. However, the impact of the increased risk does highlight the need for awareness and an equally impactful response.

It is generally understood that suicide can be deterred through awareness, prevention practices, and targeted training and policy efforts. This report presents the findings of an OIG review conducted to assess suicide prevention practices within CFS. The investigation aimed to understand the existing policies, procedures, and training related to suicide prevention within CFS, with a specific focus on case management, foster care support, and foster parents.

While the review identified that DHHS, along with various partners within the state, is committed to reducing instances of suicide in Nebraska, inconsistencies were found in the implementation of suicide prevention practices within CFS.

The OIG found that within CFS there is a distinct lack of policy and procedure articulating suicide prevention protocol or a cohesive suicide prevention plan. Additionally, the OIG found that within CFS there are training gaps related to suicide prevention. The OIG concluded that it is crucial for DHHS-CFS to establish a comprehensive and standardized approach to suicide prevention, integrating training requirements, clear policy and procedure guidance, and a cohesive plan that ensures consistent and effective prevention efforts across the Department as a means of better protecting the well-being of vulnerable youth and families.

As a result of these findings the OIG made the following recommendations to DHHS:

1. Develop a comprehensive suicide prevention plan.
2. Develop dedicated suicide prevention policy and procedure.
3. Mandate gatekeeper training for all staff members.
4. Standardize training requirements for Child Placing Agencies.
5. Provide suicide prevention content including required gatekeeper training to foster care providers.
6. Actively participate in the State Suicide Prevention Coalition.

DHHS accepted all the recommendations and committed to implementation by 2025.

III. Serious Injury of a 4-month-old State Ward while in Foster Care

On April 24, 2019, the OIG received notice from DHHS indicating a four-month old state ward had been seriously injured while placed in an unlicensed relative foster home. The baby was admitted to the hospital in serious condition with medical professionals reporting to DHHS that, had the baby not been taken to the hospital at that time, the baby would have likely died. The baby's physical condition was described as "being skeletal, and near death." Medical professionals determined the infant was underweight and severely malnourished because of not being properly fed. The case originated from CFS's Northern Service Area.

The scope of the report included the serious injury, a review of policy and procedure related to the management of health care of state wards, and the management and supervision of the foster homes.

The baby was made a ward of the state in January 2019 and shortly thereafter received their first medical appointment as a state ward. At this appointment the infant was diagnosed with multiple medical conditions including gastroesophageal reflux disease, milk and soy protein intolerance, failure to thrive, and other conditions. At this first medical appointment, the baby weighed 6lbs and 13ozs. At the time of the serious injury three months later, the baby only weighed 7lbs and 15ozs. The baby's doctor had prescribed a regimented feeding plan with a

specialized formula to ensure appropriate weight gain. Between the time the baby was made a state ward in January and the serious injury in April, the infant attended nine different medical appointments while placed in two different foster homes, was observed by a case manager or foster care support worker at least 15 times, and had visits with their biological parents supervised by a family support worker over 50 times.

All assessments, narratives, reports, case plans, mandatory contacts, and team meetings were conducted and documented as directed by DHHS policy and procedure or provider contract language. Although policy and procedure was followed, this four-month old infant nearly died of malnourishment while in foster care.

The OIG's investigation identified several issues with the communication, monitoring, and verification of the infant's health care needs before the serious injury occurred.

Each DHHS policy and mandatory document serves a specific and useful purpose, but no document or policy creates a way to centralize and synthesize the health care information and treatment plans for a child. Rather, health care information is compartmentalized, requiring a case manager to examine several different documents stored in several different places in the system in order to understand health care interventions and treatments a child may need so that the case manager can monitor and verify they are being done. Similarly, this makes it challenging for all parties in a case to share a common understanding of a child's health care needs.

Also critical to effective monitoring of a child's health care needs is communication. Current policy does not create a health care information loop whereby important, comprehensive, and accessible health care information is communicated from the CFS case manager to other involved parties and health care updates are reported back to the case manager.

The baby's failure to thrive condition was manageable but required a strict adherence to her feeding regimen and treatment plan. An understanding of this treatment plan by all parties was necessary to monitor and ensure that it was being followed. Despite the fact that all documents were completed and policies followed, it is clear that not all parties understood or were fully aware of the baby's conditions and treatment plan. There does not appear to have been a

shared understanding of how critical it was to monitor the feeding regimen and baby's progress in gaining weight. The compartmentalization of the gathering and sharing of medical information in current policy exacerbated this. As a result, the baby's health reached a crisis point.

Through its investigation of the serious injury, the OIG found:

1. Despite CFS meeting all requirements of existing policy and procedure, the infant nearly starved to death while in out of home care, revealing a gap in DHHS policy and procedure.
2. After the serious injury, CFS and involved agencies increased monitoring, verification, and communication of the baby's health care needs.

Based on its findings, the OIG identified where systemic improvements should be made to the process of managing the health care needs of state wards, and recommend DHHS should:

1. Develop a comprehensive health care management plan for state wards. This health care management plan would synthesize all of a state ward's pertinent medical and health information into one mandatory document; ensure all parties are aware of a state ward's medical conditions and the interventions required; and direct how a child's health care needs are monitored to ensure compliance with a child's treatment needs.

DHHS accepted this recommendation.

Juvenile Room Confinement in Nebraska

The following summary is based on the OIG Annual Juvenile Room Confinement Report 2021-2022, which was released in December 2022. In addition to releasing the annual room confinement report during FY 2022-2023, the OIG also provided information to senators pertaining to juvenile room confinement as part of efforts to introduce legislation that would clarify reporting requirements as described in Neb. Rev. Stat. §83-4,134.01. The full report can be found on the Nebraska Legislature's website.[22]

In 2016, Nebraska adopted a definition of juvenile room confinement as well as documentation and reporting requirements designed to "provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility." Certain juvenile facilities in Nebraska are required to document the use of juvenile room confinement and report data to the Legislature each quarter. The OIG is required to review the juvenile room confinement data reported by facilities to assess the use of room confinement and prepare an annual report of the OIG's findings, including any changes in policy or practice that might lead to a decrease in the use of juvenile room confinement.

For the past two years the OIG has evaluated the use of juvenile room confinement in comparison to best practices, namely that juvenile room confinement (1) be used as a last resort, (2) is time-limited, (3) recognizes the potential physical and psychiatric consequences, (4) ensures the youth is closely monitored, and (5) allows youth access to their belongings. It is important to note that the OIG's assessment of juvenile room confinement in Nebraska relies on the data as submitted by the facilities. The OIG does not verify the accuracy of that information. In addition, this year, the OIG did not review the facility data for duplication, errors, and other inconsistencies as the office has done in the past. This work is not statutorily

[22] The OIG 2021-2022 Juvenile Room Confinement Report can be retrieved at: https://nebraskalegislature.gov/reports/public_counsel.php

mandated, diverts the OIG's limited resources from other statutorily required duties, and is ultimately the responsibility of the facilities.

During FY 2021-2022 total hours of juvenile room confinement in Nebraska facilities decreased overall, although the number of incidents of confinement remained steady. In addition, four Nebraska facilities reported ending 95% to 100% of all confinement incidents within 24 hours. YRTC-Kearney made notable progress as that facility reports resolving 95% of all confinements within 24 hours, compared to 2016-2017 when only 34% of confinements were completed within 24 hours.

However, challenges remain. Facilities are still using room confinement to manage difficult behavior. Youth are still occasionally confined due to mental health concerns or attempted suicide.

In addition, as described in the full report, challenges with the data and reporting remain. Those entities with jurisdiction over the facilities, such as the Jail Standards Board, have not provided the facilities with a clear interpretation of the statute or practices and protocols to standardize how juvenile room confinement is used and how the data is collected. Nor are they enforcing the reporting requirements. To meet the stated Legislative goal of reducing room confinement, the OIG would continue to direct the Legislature to the recommendations in previous reports, in addition to the following recommendations offered this year:

1. Require that facilities report all incidents of room confinement. Currently, facilities only report confinement if a juvenile is confined for over an hour, cumulatively, in a 24-hour period. Reporting all incidents of room confinement will provide the OIG and the Legislature with a more accurate and complete understanding of the use of juvenile room confinement in Nebraska.
2. Require facilities to provide an annual summary for the reporting year of key data points. Requiring facilities to review their own data and provide and annual summary of key data points will offer facilities the opportunity to correct that data and provide more accurate information to the Legislature. More importantly, requiring the facilities to compile these key data points will encourage facilities to shift away from simply

compiling information for the purpose of submission and move towards utilizing the data to better understand the use of juvenile room confinement in the facility and, ideally, reduce the use of confinement.

3. Require facilities required to report Juvenile Room Confinement to submit a quarterly statement of fact when there has been no incidents of juvenile room confinement within the facility.

OIG Recommendations Status Update

Reports of investigation issued by the OIG contain recommendations for systemic reform or case-specific action. The OIG's annual report is required to detail recommendations and the status of implementation of recommendations. The OIG and DHHS meet on a quarterly basis to discuss these recommendations and to allow DHHS to highlight any actions taken relevant to the OIG recommendations. The OIG has found these meetings helpful and informative. DHHS administrators have demonstrated a willingness to engage in an open dialog about the status of recommendations.

One of the most significant updates provided in those meetings was progress on a recommendation from the 2015-2016 *Death & Serious Injury Following a Child Maltreatment Investigation* report. In that report, the OIG recommended DHHS contract with an independent entity to perform a validation study of Nebraska's Structured Decision Making Risk Assessment instrument. DHHS accepted the recommendation and, in 2022, reported to the OIG that they had contracted with Evident Change (formerly National Council on Crime and Delinquency) who had recently submitted their final report on Nebraska's fidelity to the SDM model for the Intake Assessment, Safety Assessment and Risk Assessment, including the results of a risk validation study. Evident Change worked with a group of local internal and external stakeholders to review proposed modifications to the Risk Assessment to improve the accuracy, and equity distribution of the assessment. In 2023, DHHS aligned policies and procedures with the selected risk model, provided training and integration with the current N-FOCUS database, and rolled out the first phase of the new Risk Assessment in August, with plans to roll out the second phase in December.

The OIG has made a total of 115 recommendations in the past 11 years. As required by statute, updates regarding the status of these recommendations is attached in the appendix.

OIG Intakes and Data

Intake Process

The OIG's work is driven by the information it receives. Accountability and good government is only possible when information about these government systems and agencies is available. Some of that information must come from the government agencies themselves through basic and necessary transparency. Other critical information comes from people served by those same government agencies. For this reason, the OIG is required to make itself available for complaints, and it relies on complaints and information from the public to understand how the child welfare and juvenile justice systems are working for the people they are meant to serve. The OIG refers to the information it receives as "intakes."

Table 9.

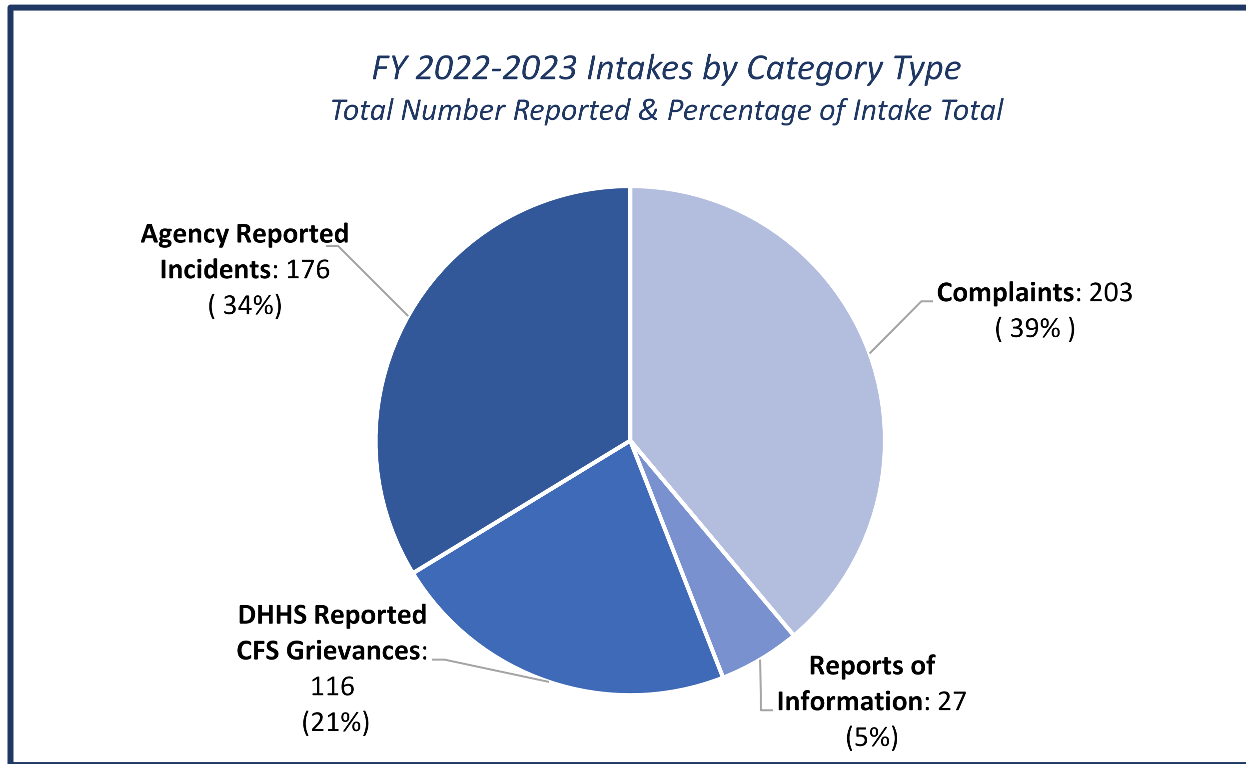
Incidents Reported to the OIG	
Reporting Agency	**Number Reported**
CFS	64
Public Licensing	65
Juvenile Probation	41
Other	6
	Total 176

Table 10.

Other Types of Reports Made to the OIG	
Type of Intake	**Number Reported**
Complaints	203
Reports of Information	27
DHHS Reported CFS Grievances	116
	Total 346

Intakes come in the form of notifications of incidents or reports from agencies; grievances filed with DHHS, including DHHS's response to the grievance; and complaints or reports of information made by members of the public. The OIG assesses every incident report, complaint, information report, and grievance referred to it. Each intake is subject to a vetting process which includes a thorough document review and collateral contacts, if necessary, for complete vetting. Based on the findings of the preliminary review, the OIG then determines if the office has jurisdiction over the incident, whether or not a full investigation is justified or required by statute, and what additional actions may be appropriate. Although a complaint or incident may not result in an investigation, it can assist the OIG in identifying concerning trends or systemic issues that not only may need to be investigated by the OIG but also brought to the attention of the agencies responsible or to the Nebraska Legislature for legislative change.

Figure 2.



This fiscal year, the OIG received a total of 522 intakes, all of which were thoroughly reviewed and vetted. This is an increase from the 451 intakes received by the OIG last year. The breakout of information received is presented in the figure above.

Complaints

The OIG receives complaints from foster parents, grandparents, family members, attorneys, parents, employees, administrators, and concerned citizens regarding various issues related to child welfare and juvenile justice systems. These diverse individuals provide the OIG with insights into a wide range of potential issues within the system.

For FY 2022-2023, the OIG received a large increase in complaints and grievances as compared to FY 2021-2022. The OIG received 203 complaints this year, compared to 138 last year.

As noted, the OIG vets each complaint to determine not only whether the complaint is supported but whether it is an example of a broader systemic issue. The OIG receives many

unsupported complaints and, upon further review, the complaint demonstrates that the agencies appropriately responded to a given situation. Likewise, there are many times a complaint reveals a problem with the child welfare or juvenile justice system either at a local or systemic level.

Individuals who contact the OIG levy many kinds of concerns. The OIG categorizes complaints as a means to identifying trends and themes that may reflect broader systemic problems in the system. A single complaint can contain multiple allegations that not only touch on the specifics of an individual's case but also areas of the broader child welfare system. Often, the OIG's review of a complaint finds that the individual's complaint was not supported by the facts but reveals problems with the broader child welfare system.

Working with the Ombudsman

The OIG receives other complaints about an individual case that are concerning but do not reveal broader problems with the child welfare system. In these cases, the OIG tries to provide assistance by referring the complainant to an appropriate entity to handle that concern. Often, the OIG will refer individual concerns to the Ombudsman's Office. One benefit of housing the OIG within the Ombudsman's Office is that it facilitates efficient coordination. The Ombudsman's Office addresses complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office investigates and resolves complaints informally by working with parties involved while promoting accountability in public administration. If the OIG determines that a complaint may benefit from the help of the Ombudsman's Office, the OIG can refer that complainant. This prevents the complainant from having to repeat the often traumatic circumstances of their complaint. In total, the OIG formally referred 21 complaints to the Ombudsman's Office.

For example, this fiscal year the OIG received a complaint from a youth in foster care. This youth and their siblings were made state wards because of a tragic incident that left them orphaned. This youth and their siblings were in different foster homes, and their main complaint was that their younger siblings were placed in a foster home that did not facilitate

sibling visits. This foster home was set to adopt their siblings, and they were worried that all contact with their siblings would cease after adoption by this foster family. This youth expressed many concerns about how their case was being handled and how they felt their voice was not being heard by DHHS and legal parties. The OIG immediately created a referral to the Ombudsman's Office who could better help address their complaint. The Ombudsman's Office worked with this youth on their complaint which resulted in their siblings being moved to a different foster home that allowed better sibling contact and with whom the youth were more comfortable.

On other occasions, the OIG receives a complaint that necessitates the opening of an investigation. During FY 2022-2023, the OIG opened one investigation into a complaint.

Incidents

The other critical way the OIG receives information is through reports from DHHS (including CFS, Public Licensing, and the YRTCs) and Juvenile Probation. These come in the form of incident reports most importantly involving death and serious injuries of children.

Overall, 176 incidents were reported to or discovered by the OIG in FY 2022-2023 compared to 242 reported in FY 2021-2022. Key differences exist in who reported incidents to the OIG. DHHS houses several divisions and contracts with a number of private providers, all of whom can report incidents to the OIG. The OIG received a similar number of incidents from CFS but a smaller number of incidents from other divisions and private providers. Notably, 23 incidents were reported to OIG from private providers during FY 2021-2022 as compared to only one for this fiscal year.

Public Licensing reported 65 incidents, compared to the 101 reported last fiscal year. The majority of reports from Public Licensing involve minor injuries to children at child cares or potential regulation violations that create a risk to the children at the child care. However, there were two incidents involving serious injuries at child cares that the OIG is required to investigate.

The OIG noticed a similar number of incidents reported by Juvenile Probation as compared to last fiscal year. The vast majority of reports from Juvenile Probation are for allegations of sexual abuse. However, Juvenile Probation is also required to report deaths and serious injuries. The OIG has not received any reports of serious injury to youth on Juvenile Probation for FY 2022-2023 and has not received a report of serious injury in the last six fiscal years.

As with complaints, each incident is thoroughly vetted. The OIG first assesses an incident to determine if it requires a mandatory investigation by statute. As stated above, seven incidents reported by these agencies this fiscal year will require a mandatory investigation. However, most incidents the OIG receives do not require a mandatory investigation by statute. Even if an incident does not require a mandatory investigation, the OIG still reviews the incident for concerning trends and potential systemic issues. These reviews require an extensive amount of work even if they do not result in an investigation.

For example, in reviewing reports from Public Licensing, the OIG began noticing significant delays in the completion and quality of Out of Home Assessments (OHA) in the ESA towards the end of FY 2021-2022 and the beginning of FY 2022-2023. OHAs are child abuse and neglect investigations conducted by DHHS into licensed facilities that care for children like day cares or group homes. DHHS policy requires that an OHA be completed within 30 days of the investigation being accepted. The OIG was consistently seeing OHAs take up to 60 days or longer to be completed. This was concerning as it not only was a violation of DHHS's own policy but also delayed Public Licensing's ability to complete its investigation into these facilities for potential regulatory violations. Generally, Public Licensing waits on the determination of a child abuse and neglect investigation before taking potential disciplinary action on a facility's license. In the worst case scenario, these delays can leave children at risk in unsafe child care homes and facilities. The OIG made DHHS aware of this issue and learned that the team investigating OHAs had been troubled by turnover and was struggling to keep up with their high case load. The OIG appreciated learning about the challenges DHHS faced.

Based upon a reported incident, the OIG was made aware of a licensed facility in the ESA that mishandled an attempted suicide by a youth. At the time of this incident, several OHAs were

open for investigation on this facility and indicated broader issues regarding the care of youth and their mental health. As a result of this incident, both DHHS and Juvenile Probation pulled all state wards and youth on probation placed at this facility. The OIG's role in these cases was to monitor how DHHS, through CFS or Public Licensing, responded to these issues, whether that was being done in accordance with their policies and procedures, and how DHHS was ensuring the safety of youth in their care and custody. DHHS and Juvenile Probation partnered on the investigation, action was taken on the facility's license, and changes were required to be made.

This is a good example of how important transparency and the sharing of information can be. In reviewing this incident, the OIG reached out to Juvenile Probation to get its perspective on the concerns at the facility since it had also removed the youth under their supervision from the facility. Juvenile Probation refused to speak with the OIG on this issue, despite the OIG's clear statement that this did not involve an investigation of Juvenile Probation. However, based upon Public Licensing's investigation and DHHS's response to the facility's mishandling of this incident, the OIG decided that further investigation was not needed.

In another example, the OIG was made aware of sexual abuse allegations of a state ward and youth on probation in an out-of-state placement. The reported allegations indicated that a staff member in the out-of-state facility sexually abused two Nebraska youth placed there by Juvenile Probation and one of whom was a state ward. The OIG opened an investigation into this alleged incident.

Alternative Response Case Summaries

By statute, the OIG Annual Report must include a summary of any case reviewed by the office that included an Alternative Response.[23] Most often AR cases reviewed by the office come in one of three forms— as an incident report related to the death or serious injury of a system-involved child, as a complaint made directly to the office, or as a DHHS grievance provided to the OIG. In the case of death or serious injury, the review is twofold. First, the OIG conducts a review to establish if the report meets the criteria for a mandatory investigation, and second, a review of the AR case is done as required by statute for a summary. In FY 2022-2023, the OIG reviewed 20 AR related cases.

Deaths and Serious Injuries

Infant Death I

The OIG received notice of the death of a two-month-old infant due to physical abuse. The family had a history with CFS including declined services as part of an AR and intakes accepted for traditional response. Their most recent involvement was an intake assigned to AR at the time of the infant's birth. The family declined services at that time as well. The OIG found this incident subject to a mandatory investigation and report.

Infant Death II

The OIG received notice of the death of a five-month-old infant due to Sudden Unexpected Infant Death. The incident report noted that the incident occurred while the infant was co-sleeping with a parent. The infant's family was involved in an AR case that had been open for approximately one month. At the time of the death, the family had been provided with in-home family support, transportation services, assistance with hotel stays, and vouchers for items such as clothing, diapers, and food. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

[23] Neb. Rev. Stat. § 43-4331.

Infant Death III

The OIG received notice of the death of a six-week-old infant due to asphyxia complicated by unsafe sleep. The incident report and Final Autopsy Pathology Report noted that the incident occurred when the infant was co-sleeping while being breastfed. The infant's family was involved in an AR case that had been open for approximately one month. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

Infant Death IV

The OIG received notice of the death of a five-week-old infant. The cause of death is pending an autopsy. The family had recently accepted in-home support services as part of an AR case opened at the time of the infant's birth. The OIG will determine if this death is subject to a mandatory investigation and report at the conclusion of law enforcement involvement and release of autopsy records.

Infant Death V

The OIG received notice of the death of a three-month-old infant due to asphyxia complicated by unsafe sleep. The incident report and Final Autopsy Pathology Report noted that the incident occurred while the infant was co-sleeping with a parent. The infant's family was involved in an AR case that had been open for approximately three months with the parent accepting in-home family support. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

Infant Death IV

The OIG received notice of the death of a six-day-old infant due to medical complications resulting from premature birth at 25 weeks gestation. An intake was accepted for AR on the day the infant was born; however, the case was closed at the time of death as the parents had no other children. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

Death by Suicide I

The OIG received notice of the death by suicide of an 11 year-old youth. The family had an open AR within weeks of the death and had declined services. The OIG found this incident subject to

a mandatory investigation and report, and it was included in the OIG report released to the public in June 2023. The report, *Death by Suicide-A Three Case Review* is discussed on page 28 of this report and the full report can be found on the Nebraska Legislature's website.

Complaints

Complaints Made Directly to the OIG

The complaints received by the OIG this fiscal year involved claims of improper actions by caseworkers, the transition of AR cases to traditional response, lack of services provided in an AR case, and concerns for child safety. It is important to note that while the OIG reviews these complaints, the OIG has not investigated the complaints fully to determine if they are supported or unsupported. Rather, what follows is a summary of the complaints as required by law.

Complaint about AR case moved to Traditional Response I

The complainant alleged that four children were removed from their guardian and made wards of the state after CFS refused to provide appropriate support as part of an AR case. A review of information indicated that over the course of 12 months the children were included in three intakes accepted for AR. The third intake accepted for AR was transitioned to traditional response. Documentation indicated that while the children were initially found safe on the condition of a safety plan, the guardian was not following the safety plan. Based on this lack of cooperation with the safety plan, the children were removed and made wards of the state. According to documentation, services were offered as part of the two prior AR cases and in both instances declined.

Complaint about AR case moved to Traditional Response II

The complainant stated that despite working with CFS, the Nebraska Department of Education, and DHHS Division of Developmental Disabilities, the family's AR case had been transitioned to traditional response by CFS and was being adjudicated. The OIG's review found that a petition based on truancy had been filed at the discretion of the county attorney.

Complaint about the safety of children I

The complainant alleged a child was self-harming as a result of abuse and that the case worker acted in a manner that was "more like a friend" by sharing confidential information with the alleged abuser. The complainant stated that they had reached out to the case worker and the administration three times and was never contacted about their concerns. A review of CFS documentation indicated that the case was accepted for AR, with appropriate collateral contacts made. The children were found to be safe, and the parent declined services.

Complaint about the safety of children II

The complainant alleged that despite providing "proof" of abuse and neglect by a caregiver, a traditional response had not occurred, and the child was not removed from the home. In addition, the complainant reported that follow up contact with the case worker and supervisor had not been taken seriously. A review of CFS documentation revealed that the home was subject to one traditional response intake and two AR intakes. Documentation indicated concerns for neglect that did not rise to the level of a safety threat. In all three instances, the child was found safe. In both AR cases, the caregiver declined services.

Complaint about the actions of a CFS case worker during the course of an AR case I

The complainant alleged that, while engaged in an AR case, the case worker stated that failing a drug test conducted as a condition of probation would lead to the immediate removal of the children. The complainant stated that they believed this was part of an effort to force the case from AR to traditional response. A review of CFS documentation indicated that the family was involved in an AR case where the children were found to be safe on the condition the children stayed with grandparents who would supervise contact between the parent and children should the parent use illegal substances. Reviewed documentation did not contain information pertinent to the complaint.

Complaint about the actions of a CFS case worker during the course of an AR case II

The complainant alleged that a false report of abuse and neglect had been accepted by the Hotline and assigned to AR. The complainant alleged that, when meeting with the CFS case manager, they tried to force the complainant to agree to services by stating, "Nine out of ten

times, I can find something wrong in a home" and threatened to move the case to traditional response so that "charges" could be brought resulting in the complainant being placed on the Central Registry. A review of CFS documentation indicated that after three visits to the home the complainant declined services and the case was closed.

Complaint about the release of confidential information during the course of an AR

The complainant alleged that during an AR contact a CFS case worker told a collateral contact that one of the parents was on the Central Registry, thus violating confidentiality. CFS documentation indicated that the children were found safe with the parents, who then declined services and were given community resource information. Reviewed documentation did not contain information pertinent to the complaint.

Complaint about placement of child resulting from an AR case

The complainant alleged that an AR case was opened while the complainant was homeless which resulted in the children being placed with a non-custodial parent and the case closed. The complainant alleged that they were not offered services that would have allowed the children to remain with the complainant. A review of documentation indicated the children had been placed with the non-custodial parent prior to the accepted intake. The complainant was provided with community resource information and the case closed.

Complaint about lack of services via an AR case

The complainant alleged that despite accepting services as part of an AR case, CFS had only provided $200 towards a deposit for housing and had refused to help with securing mental health services. The complainant also alleged CFS was providing assistance to the non-custodial parent who had physical custody of the children. A review of documentation indicated the complainant had accepted mental health services and received funds to assist with housing. The most recent AR found the child safe due to living with the non-custodial parent for the past several months as part of a living arrangement through Juvenile Probation. The complainant had recently refused services by declining to sign medical release forms. CFS had been providing support to the child and non-custodial parent through AR.

Complaint about conflict of interest related to an AR case

The complainant alleged that while employed by DHHS, but not as a CFS case manager, an intake involving their family was accepted for AR. The complainant stated that intake was not assigned to a case worker outside of the office and that they were threatened with being fired if they did not cooperate with CFS. A review of documentation confirmed that, after consulting with a supervisor, a case worker from within the same office completed the initial contact. After the initial contact, the case was managed by someone from outside the office. Documentation indicated that the child was found safe, and information about community resources was provided. The case was closed without further documentation, and it was reported that complainant moved to a different department in a different office.

Complaint about being unable to reach case worker during an AR case

The complainant alleged that they had been unable to contact their CFS case manager for over six months. It was reported that while the complainant was in another state they were contacted by a CFS case manager and informed that an intake involving the family had been accepted and assigned to AR. Once the complainant returned to Nebraska, contact with the case worker was made; however, the family was not notified of the outcome of the case. The complainant was concerned that an open CFS case for the family still existed and could cause problems for them should they leave the state again. The complainant stated that efforts to reach the case worker had not been successful. The complainant was provided with the ESA Family Line phone number as a means of obtaining information. A review of the documentation reveled that an AR intake had been accepted seven months prior, contact was made with the family five months after the accepted intake, and, 60 days later, the children were found safe and the case closed. The OIG noted that the case worker was no longer employed by DHHS.

Grievances

DHHS Grievance AR Related Case I

The OIG received this case as part of a DHHS grievance review. The grievance alleged inappropriate action by the case worker during an AR case. The complainant indicated that the case worker lied about the facts of the case and did not contact appropriate collateral contacts

to verify information. The OIG found the DHHS grievance response well executed. The response plainly addressed all of the complainant's concerns, provided explanations that clarified the issues, and suggested entities outside of DHHS the complainant could access for support.

Appendix

Fiscal Year 2022-2023 Recommendation Report

OIG Recommendation Report

ADMINISTRATIVE OFFICE OF PROBATION

Juvenile Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-22	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).
Agency Update FY 22-23: No response to OIG request for fiscal year

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-23	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt policy on child welfare referrals and joint case management.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-24	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt policy on documentation and record keeping.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-25	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Increase internal quality assurance efforts at the state level.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-01	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-02	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-03	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Implement guidelines on when it is appropriate to use specific types of alternatives to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-04	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did not Accept or Reject

Recommendation: Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-05	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did not Accept or Reject

Recommendation: Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-06	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did Not Accept or Reject

Recommendation: Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-07	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did not Accept or Reject

Recommendation: Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-08	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did not Accept or Reject

Recommendation: Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-09	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services		Did not Accept or Reject

Recommendation: Assess whether Probation has the authority to monitor alternatives to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status

DHHS

Children and Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-01	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible.
Agency Update FY 22-23: The FSNA tool is still being reviewed for fidelity. Updates to the tool/process are planned upon completion of the fidelity review. The Trauma Screen Tool continues to be utilized in the Adams and Hall County areas as a part of the Through the Eyes of the Child initiative.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-02	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Expand mental health training for DHHS staff and other stakeholder, including medical professionals.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-03	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Enhance continuous quality improvement and quality assurance processes for mental and behavioral health care, including psychotropic medications.
Agency Update FY 22-23: Quality assurance case reviews are conducted on a quarterly basis to monitor the assessment of needs and services to address the child's physical, mental and behavioral health. The reviews includes a review of oversight of the child's prescription medications including psychotropic medications. Review results are utilzed to identify program strengths and areas needing improvement.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-04	2014-2015	Child Death II	DHHS	Children and Family Services	Accepted

Recommendation: Make improvements to the Home Study Process.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-05	2014-2015	Child Death II	DHHS	Children and Family Services	Accepted

Recommendation: Provide stronger supports for kinship and relative foster families.
Agency Update FY 22-23: CFS offered an incentive for Relative and Kinship Foster families to receive a $2500 stipend for completing the licensing requirements and submitted for licensure within 5 months of taking placement in FY22-23. In addition to the incentive for foster families, CFS also incentivized Agencies to support relative and kinship foster families in the process of becoming licensed with a $3000 quarterly incentive payment for meeting recruiting and licensing standards.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-06	2014-2015	Child Death II	DHHS		Children and Family Services	Accepted

Recommendation: Ensure “Absence of Maltreatment in Foster Care” calculation is as accurate as possible.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-07	2014-2015	Child Death III	DHHS		Children and Family Services	Accepted

Recommendation: Develop and provide training to frequent reporters and law enforcement on reporting to the Child Abuse and Neglect Hotline
Agency Update FY 22-23: RFP has been drafted and is tentatively set to be released in October 2023. Contractor will develop the manadotry reporter training for key reporters

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-08	2014-2015	Child Death III	DHHS		Children and Family Services	Accepted

Recommendation: Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-09	2014-2015	Child Death III	DHHS		Children and Family Services	Accepted

Recommendation: Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.
Agency Update FY 22-23: CFS continues to fund the Communication/Community Engagement Coordinator at the Coalition. This position uses a social change, anti-oppression, and participatory lens to enhance statewide capacity to support diverse, marginalized, and/or underserved communities. This position collaborates with the Coalition’s network programs and allied organizations to elevate voices of survivors with often marginalized identities and barriers they face. This position will work closely with the Youth Engagement Coordinator to engage voices of youth while assisting with training, technical assistance, outreach to increase awareness of family violence, domestic violence, and dating violence, and to increase the accessibility of services in the state.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-14	2014-2015	General Investigation I	DHHS		Children and Family Services	Accepted

Recommendation: Clarify Hotline policy and procedure when receiving a report of sexual assault.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-01	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Implement training on the medical aspects of child abuse.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-02	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Adopt policy on photographing injuries during Initial Assessment.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-03	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Develop additional training for Initial Assessment staff.
Agency Update FY 22-23: Protection and Safety now has a Development and Resiliency Manager as well as 2 training coordinators to handle additional training and learning opportunities not only for IA staff, but all case workers, APS, Hotline and FCRD.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-04	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Further define process for utilizing child advocacy centers by Initial Assessment.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-05	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Update and provide additional detail on response priority definitions.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-06	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.
Agency Update FY 22-23: Since the last update, 2 additional teams have been added to the Hotline as well as the creation of a Deputy Hotline Administrator role and we have submitted a request to reclass a vacant position at the Hotline into a Lead Worker position to allow for additional support and guidance to Hotline teammates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-07	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS		Children and Family Services	Accepted

Recommendation: Expand quality assurance and continuous quality improvement (CQI) at the Hotline.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-08	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.
Agency Update FY 22-23: Weekly monitoring of caseload compliance continues across each Region and while we have not reached 100% compliance, we have seen drastic improvements and statewide we are averaging 70-73% compliance.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-09	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Take steps toward greater Initial Assessment workforce specialization and experience.
Agency Update FY 22-23: DHHS continues to explores way in which we can create specializations based on a tiered approach in conjunction with HR.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-10	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.
Agency Update FY 22-23: Validation has been completed and revisions to the tool have been made. Training planning and integration into NFOCUS is currently in progress.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-12	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Increase the capacity for the CFS workforce to participate in pediatric abusive head trauma prevention efforts.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-13	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.
Agency Update FY 22-23: Since the last update, 2 additional teams have been added to the Hotline as well as the creation of a Deputy Hotline Administrator role and we have submitted a request to reclass a vacant position at the Hotline into a Lead Worker position to allow for additional support and guidance to Hotline teammates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-14	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-15	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS		Children and Family Services	Accepted

Recommendation: Collect data on high and very-high risk cases that do not accept services and implement better, more promising approaches to family engagement.
Agency Update FY 22-23: SDM Risk Assessment has been revised to ensure better accuracy, equity, utility and consistency in its use. Additional options have provided to staff to ensure critical thining around service delivery

<table>
<tr><th>Number</th><th>Annual Report</th><th>Report Name</th><th>Agency</th><th>Division</th><th>Agency Response</th><th>Status</th></tr>
<tr><td>16-16</td><td>2015-2016</td><td>Death and Serious Injury Following a Child Maltreatment Investigation</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Restructure the Children’s Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.
Agency Update FY 22-23: CJA taskforce Proposal Guidance was created to ensure that all projects are directly tied to the Three Year Assessment. Recommendations vary based on the Taskforce's focus. The addition of the Alliance for ongoing administrative support, ensures that the strategic plan is updated on a quarterly basis.</td></tr>
<tr><td>16-20</td><td>2015-2016</td><td>Suicides of State Wards</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>16-21</td><td>2015-2016</td><td>Suicides of State Wards</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Enhance efforts to reduce caseworker turnover.
Agency Update FY 22-23: The turnover rate year over year continues to decrease and comparative to national turnover data, Nebraska is doing really well.</td></tr>
<tr><td>16-26</td><td>2015-2016</td><td>Death of Youth Served by Probation and DHHS</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>16-27</td><td>2015-2016</td><td>Death of Youth Served by Probation and DHHS</td><td>DHHS</td><td></td><td>Children and Family Services and Contracted Private Provider</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.
Agency Update FY 22-23: DHHS/CFS is developing a Resource Guide that will encompass any DD specific tools, quick tips, or guidance prevoiusly created in one central location for DHHS/CFS staff to use. DHHS/CFS participates in, schedules, and moderates ongoing child specific staffings where Medicaid, CFS, and DD all participate and collaborate. DHHS/CFS also participates in a monthly meeting to discuss ongoing issues/barriers and general topics between the DHHS divisions of Medicaid, DD, and CFS.</td></tr>
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Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-28	2015-2016	Death of Youth Served by Probation and DHHS	DHHS		Children and Family Services and Contracted Private Provider	Accepted

Recommendation: The Division of Developmental Disabilities should coordinate with Juvenile Probation to improve care to youth with developmental disabilities in the juvenile justice system.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-01	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Rejected

Recommendation: Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.
Agency Update FY 22-23: IS&T is working to automate these reports; however, in the interim reports are being provided to the OIG.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-02	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services and Contracted Private Provider	Accepted

Recommendation: End the practice of screening "Law Enforcement" reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-03	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-04	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-05	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-06	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Rejected

Recommendation: Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-07	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-08	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Adhere to policy on out of home assessments and enhance quality assurance.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-09	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Accepted

Recommendation: Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.
Agency Update FY 22-23: No Changes during Fiscal Year

<table>
<tr><th>Number</th><th>Annual Report</th><th>Report Name</th><th>Agency</th><th>Division</th><th>Agency Response</th><th>Status</th></tr>
<tr><td>18-10</td><td>2017-2018</td><td>Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Meet the statutorily required caseload standard for initial assessment and ongoing case management.
Agency Update FY 22-23: Weekly monitoring of caseload compliance continues across each Region and while we have not reached 100% compliance, we have seen drastic improvements and statewide we are averaging 70-73% compliance.</td></tr>
<tr><td>18-11</td><td>2017-2018</td><td>Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>18-12</td><td>2017-2018</td><td>Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Review and revise training on child sexual abuse for DHHS staff.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>18-13</td><td>2017-2018</td><td>Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>18-14</td><td>2017-2018</td><td>Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Strengthen foster care licensing to remove inappropriate and unsuitable homes.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
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Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-15	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Children and Family Services	Rejected

Recommendation: Include a component on child sexual abuse prevention in foster and adoptive parent training.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-01	2018-2019	Death of a 14-month-old State Ward	DHHS		Children and Family Services	Accepted

Recommendation: Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.
Agency Update FY 22-23: CFS has implemented a change from Standard Work Instructions to Standard Operating Procedures (SOP) all SWIs will be converted and reviewed for any necessary updates through this process. The Foster Home Placement Disruption and Foster Home Hold and Review Process will be updated and revised as part of this process.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-02	2018-2019	Death of a 14-month-old State Ward	DHHS		Children and Family Services	Accepted

Recommendation: Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.
Agency Update FY 22-23: CFS has implemented a change from Standard Work Instructions to Standard Operating Procedures (SOP) all SWIs will be converted and reviewed for any necessary updates through this process. The Participating in a Case Staffing with Managed Care Organizations will be updated and revised as part of this process.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-03	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS		Children and Family Services	Rejected

Recommendation: Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-04	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS		Children and Family Services	Rejected

Recommendation: Clarify the definition of “change in circumstance” as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.
Agency Update FY 22-23: CFS has implemented a change from Standard Work Instructions to Standard Operating Procedures (SOP) all SWIs will be converted and reviewed for any necessary updates through this process. The Initial Assessment SOP will be updated and revised as part of this process.

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<tr><td>19-05</td><td>2018-2019</td><td>Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>19-06</td><td>2018-2019</td><td>Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.
Agency Update FY 22-23: 8 SDM refreshers were created for vaious SDM topics/assessments. These can be utilized at any time there is a need</td></tr>
<tr><td>19-07</td><td>2018-2019</td><td>Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Implement trauma informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.
Agency Update FY 22-23: Restoring Resiliency Response was implemented statewide October 2022. The goal of RRR is to reduce participant’s stress reactions and increase resiliency following a critical incident in order to continue to effectively help families and remain in their role.</td></tr>
<tr><td>20-01</td><td>2019-2020</td><td>Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Create a policy or training to address when the alleged perpetrator or involved caregiver(s) of the named child victim has extensive and/or specific knowledge of the Nebraska child welfare system.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>20-02</td><td>2019-2020</td><td>Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Create non-court case policy establishing that participating in a non-court Case requires the following: Parents sign a release of information for all related medical/mental health providers specific to obtaining collateral information and assessing progress on case plan goals, Parents allow contact between the worker and their children, without caregivers present, and Parents must formally agree to participate in recommended services.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
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<tr><td>20-03</td><td>2019-2020</td><td>Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Create a handout/brochure to be provided to the family at the time the non-court case is offered.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>20-04</td><td>2019-2020</td><td>Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Change DHHS policy to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case no less than 60 days after opening.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>20-05</td><td>2019-2020</td><td>Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Develop specific non-court evaluation criteria to help caseworkers and supervisors determine when a non-court case should be referred to the multi-disciplinary (1184) team and/or county attorney for review, and require formal training for supervisors to ensure they can assist caseworkers in making referral decisions.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>21-01</td><td>2020-2021</td><td>Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Enhance policy and tools specific to the examination of secondary caregivers in an investigation.
Agency Update FY 22-23: No Changes during Fiscal Year</td></tr>
<tr><td>21-02</td><td>2020-2021</td><td>Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregive substance use is affecting the safety of the child.
Agency Update FY 22-23: CFS continues to work with DHHS divisions and stakeholders on process and policy around drug testing and ensure safety of children when a parent is in active recovery. Drug testing continues to be a service contract and reference guides continue to be made available to lead workers, supervisors and administrators.</td></tr>
</table>

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-03	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS		Children and Family Services	Accepted

Recommendation: Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.
Agency Update FY 22-23: CFS teams now has space and time in local offices. Economic Assistance Point of Contact staff are identified for all local P&S offices. Prevention newsletter created monthly to share resources as well as monthly case manager update email from central office with new resources.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-04	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS		Children and Family Services	Accepted

Recommendation: Conduct a work study of Child Protective Services (CPS) Supervisors.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
22-01	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS		Children and Family Services	Rejected

Recommendation: DHHS should terminate the current Eastern Service Area contract with Saint Francis.
Agency Update FY 22-23: In December 2021 there was mutual agreement between DHHS and Saint Francis to terminate the contract effective June 30, 2022. LB 1173 also included language in statute to no longer allow for privatization.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
22-02	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS		Children and Family Services	Rejected

Recommendation: DHHS should end the Eastern Service Area Pilot Project.
Agency Update FY 22-23: In December 2021 there was mutual agreement between DHHS and Saint Francis to terminate the contract effective June 30, 2022. LB 1173 also included language in statute to no longer allow for privatization.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
23-01	2022-2023	Serious Injury of a 2-year-old State Ward while in Foster Care	DHHS		Children and Family Services	Accepted

Recommendation: Review and revise its policies and procedures to create a method to verify that the overfill process has been followed by the Division of Children and Family Services and licensed Child Placing Agencies and to ensure ongoing quality assurance and accountability in that process
Agency Update FY 22-23: New recommendation and the planning process to address is currently underway

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
23-02	2022-2023	Serious Injury of a 2-year-old State Ward while in Foster Care	DHHS		Children and Family Services	Accepted

Recommendation: Review current policy, procedure and contract language with providers to assure the expectations for communicating concerns about foster homes is done in a timely manner
Agency Update FY 22-23: Language has been clarified in contracts and continues to be a topic of discussion in statewide provider meetings and contract management discussions.

<table>
<tr><th>Number</th><th>Annual Report</th><th>Report Name</th><th>Agency</th><th>Division</th><th>Agency Response</th><th>Status</th></tr>
<tr><td>23-03</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Develop a comprehensive suicide prevention plan
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-04</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Develop dedicated suicide prevention policy and procedure
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-05</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: The Department of Health and Human Services Division of Children and Family Services should mandate gatekeeper training for all staff
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-06</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: The Department of Health and Human Services Division of Children and Family Services should standardize training requirements for Child Placing Agencies
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-07</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: The Department of Health and Human Services Division of Children and Family Services should provide suicide prevention content and required gatekeeper training to foster care providers
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-08</td><td>2022-2023</td><td>Death by Suicide - 3 case Review</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: The Department of Health and Human Services Division of Children and Family Services should actively participate in the State Suicide Prevention Coalition
Agency Update FY 22-23: New recommendation. In beginning stages of collaboration with DBH and community.</td></tr>
<tr><td>23-09</td><td>2022-2024</td><td>Serious Injury of a 4-month-old State Ward while in Foster Care</td><td>DHHS</td><td></td><td>Children and Family Services</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: DHHS should develop a comprehensive health care management plan for state wards.
Agency Update FY 22-23: DHHS agreed to develop a “Healthcare Management Plan”, noting the development may be new or an enhancement to existing systems, processes or case management documentation.</td></tr>
</table>

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status

Youth Rehabilitation and Treatment Centers

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-10	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-11	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-12	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Provide increased guidance and oversight from DHHS Central Office for cultural change at YRTC-Geneva.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-13	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-29	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Rejected

Recommendation: Make the OJS Administrator a Full-time Position.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-30	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson Unit.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

<table>
<tr><th>Number</th><th>Annual Report</th><th>Report Name</th><th>Agency</th><th>Division</th><th>Agency Response</th><th>Status</th></tr>
<tr><td>16-31</td><td>2015-2016</td><td>Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Develop Continuous Quality Improvement Process at YRTCs Led by Central Office.
Agency Update FY 22-23: No response to OIG request for fiscal year 202</td></tr>
<tr><td>16-32</td><td>2015-2016</td><td>Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.</td></tr>
<tr><td>16-33</td><td>2015-2016</td><td>Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Digitize Records at YRTC-Kearney.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.</td></tr>
<tr><td>21-06</td><td>2020-2021</td><td>The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.</td></tr>
<tr><td>21-07</td><td>2020-2021</td><td>The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Rejected</td></tr>
<tr><td colspan="7">Recommendation: Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.</td></tr>
<tr><td>21-08</td><td>2020-2021</td><td>The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)</td><td>DHHS</td><td></td><td>Youth Rehabilitation and Treatment Centers</td><td>Accepted</td></tr>
<tr><td colspan="7">Recommendation: Implement a fully digital case management system.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.</td></tr>
</table>

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-09	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS		Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Conduct a detailed analysis of the YRTC workforce and implement a plant to ensure appropriate staffing of YRTC positions at all levels

Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-10	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS		Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Implement evidenced-based programming consistently throughout the YRTC system.

Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-11	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS		Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Implement a Trauma-Responsive environment across the YRTC system.

Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Public Health-Licensure

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-11	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Public Health-Licensure and Contracted Private Provider	Accepted

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

Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-19	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS	Public Health-Licensure	Accepted

Recommendation: Revise regulations to require infant safe sleep training before granting a child care license.

Agency Update FY 22-23: Public Health is following and holding licensees accountable to statute (43-2606). As of January 2023, OCSL is requiring pre-service training for licensees, primary providers, and directors which provides information on sudden unexpected infant death syndrome, abusive head trauma in infants and children, crying plans, and child abuse. OCSL has worked with NDE to ensure that the Safe With You trainings are available for the increased number of providers required to take the pre-service training.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-12	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS		Public Health-Licensure	Accepted

Recommendation: Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-13	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS		Public Health-Licensure	Accepted

Recommendation: Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-14	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS		Public Health-Licensure	Accepted

Recommendation: Adopt clear requirements on medical record-keeping and documentation in regulations.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-15	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS		Public Health-Licensure	Accepted

Recommendation: Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-16	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS		Public Health-Licensure	Accepted

Recommendation: Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-16	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Public Health-Licensure	Rejected

Recommendation: Ensure adequate staffing for residential-child caring agency licensing operations.
Agency Update FY 22-23: Regulations (Title 391, Chapter 7) were made effective 3-22-2021.The Department feels the regulations [005.01 & 005.04(A)] adequately address this recommendation.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-17	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Public Health-Licensure	Accepted

Recommendation: Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-18	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS		Public Health-Licensure and Contracted Private Provider	Accepted

Recommendation: Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-05	2020-2021	Infant Death in Licensed Family Child Care Homes March 2016-Septemeber 2018 (Daycare 2020)	DHHS		Public Health-Licensure	Accepted

Recommendation: Create specific guidelines for how frequently and in what manner sleeping infants should be checked.
Agency Update FY 22-23: Public Health is following and holding licensees accountable to statute (43-2606). As of January 2023, OCSL is requiring pre-service training for licensees, primary providers, and directors which provides information on sudden unexpected infant death syndrome, abusive head trauma in infants and children, crying plans, and child abuse. OCSL has worked with NDE to ensure that the Safe With You trainings are available for the increased number of providers required to take the pre-service training.

DHHS AND PRIVATE AGENCY

Children and Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-17	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS and Private Agency	Children and Family Services and Contracted Private Provider	Accepted

Recommendation: Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.
Agency Update FY 22-23: The SWI has been revised and amended to an SOP, which is currently going through the approval processes, it will be released to the field with the updated information upon approval.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-18	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS and Private Agency	Children and Family Services and Contracted Private Provider	Accepted

Recommendation: Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.
Agency Update FY 22-23: The SWI has been revised and amended to an SOP, which is currently going through the approval processes, it will be released to the field with the updated information upon approval. Additional training opportunities have been updated within the SOP for staff, parents, and caregivers at different junctures of the case and throughout the life of the case.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status

PRIVATE AGENCY

Contracted Private Provider

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-10	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Contracted Private Provider	Accepted

Recommendation: Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.
Agency Update FY 22-23: No Changes during Fiscal Year

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-11	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Contracted Private Provider	Accepted

Recommendation: Implement training on suicide warning signs and prevention in youth.
Agency Update FY 22-23: No Changes during Fiscal Year