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Summarized Report of Investigation

SERIOUS INJURY OF A SEVEN-YEAR-OLD BOY DUE TO ABUSE AND NEGLECT AFTER THE FAMILY WAS INVOLVED IN A NON-COURT CASE

The Office of the Inspector General of Nebraska Child Welfare (OIG) provides independent investigation and performance review of Nebraska's child welfare system. The primary aim of the OIG's investigations and reviews is improving child welfare operations through identification of systems issues and needed policy changes. The Office of Inspector General of Nebraska Child Welfare Act (Neb. Rev. Stat. §§43-4301 to 43-4331) sets out duties for the OIG, including investigating the serious injury of any child who is provided services by the Nebraska Department of Health and Human Services (DHHS) within 12 months of case closure.[1]

The following is a report of the OIG investigation into the serious injury of a seven-year-old boy, "Ben", due to abuse and neglect by his parents, Mitchell and Stephanie.[2] The family was DHHS-involved eight months prior to the critical incident due to the family participating in a non-court case.

CRITICAL INCIDENT

In November 2015 a priority two intake was accepted by the Child Abuse and Neglect Hotline (Hotline) alleging physical neglect and abuse of Ben, then seven years old, by his parents, Mitchell and Stephanie. The report alleged Ben had told school personnel that his parents withheld food from him for several days and was asking staff for food. Ben had not returned to school the following two days. The reporter indicated that when the father was contacted about the absence, he stated that Ben had been kept home as a result of having a bowel movement and spreading feces all over himself. The report also alleged that Ben appeared malnourished, underweight and pale, along with concern that he was being teased by other students as he was coming to school smelling of urine due to his parents not allowing him to bathe. The reporter stated that there was a history of Ben reporting food being withheld from him as a form of punishment.

A medical evaluation conducted at the child advocacy center found Ben, who was about one month away from his eighth birthday, to weigh 31 pounds, have a distended abdomen, and nearly disintegrated teeth, along with bruising and scratches in various stages of healing on multiple areas of his body. During the forensic interview, Ben disclosed that he was often locked in his bedroom, was forced to go to the bathroom in the corner of the bedroom, and was denied food.

The family home consisted of the mom, dad, and four children ages nine, seven (Ben), four, and one.

Ben and his three siblings were removed from the custody of Mitchell and Stephanie and placed with kin. At the time, Mitchell was employed by a contracted DHHS provider and had

[1] Neb. Rev. Stat. §43-4318 (1)(b).

[2] Every effort has been taken to keep the actual identity of the child confidential. All names of persons were changed throughout this summary of investigation. The OIG includes details about the case in an effort to be transparent about what was discovered in this investigation and why specific recommendations were made, without compromising the identity of persons involved.

previously worked for the Nebraska Department of Health and Human Services – Division of Children and Family Services.

The family had participated in a Child Protective Services[3] (CPS) non-court case from December 2014 through March 2015.

The father and mother each plead guilty to five counts of felony child abuse with serious bodily injury connected to the abuse and neglect of Ben and both were sentenced to five to ten years of incarceration.

SYSTEM INVOLVEMENT PRIOR TO THE CRITICAL INCIDENT

Ben was born to Justina and Christopher in December 2007. At six weeks of age, Ben was removed from the custody of Justina and Christopher when the infant presented at the emergency room with multiple skull fractures under suspicious circumstances. Three months after being removed from his parents, Ben was placed with Mitchell and Stephanie, who eventually adopted him in 2010.

CPS history for this family started in October 2012. Four-year-old Ben wandered into a local restaurant, naked, and asking for food. Ben walked approximately six blocks from his home at six o'clock in the morning to a local restaurant where he entered and asked for food, saying he was hungry. The manager of the establishment called law enforcement who were on scene at 6:16 a.m. Thirty minutes later Mitchell contacted 911 to report his son missing. The responding officer was informed by Mitchell that Ben was their adopted son, that he'd suffered three skull fractures after birth, had tested positive for both methamphetamine and marijuana, had special needs, had been tested for autism in the past, and that he often took his clothes off after wetting the bed. The Hotline did not accept the report for assessment, and screened it as Does Not Meet Definition (DNM) due to the child reportedly being autistic and law enforcement not citing the parents for abuse/neglect.

Over the course of the next three years the family was the subject of 14 reports to the Hotline; six screened out as DNM, five accepted for investigation as priority two intakes, and three determined to be multiple reports.

[3] The Nebraska Department of Health and Human Services Division of Child and Family Services is responsible for a broad range of services including child protection. For the purpose of this report, the child protective service functions of that division will be referred to as CPS, including the private provider ongoing case management function in the Eastern Service Area.

Ben's Intake Summary 2012-2015

DATE	REPORTER	ALLEGATIONS	HOTLINE SCREENING
10-2012	Law Enforcement	Entered restaurant naked- asking for food	**Not Accepted**: Child is autistic. Police did not cite parents.
12-2013	Educational Staff	Physical abuse Denied food	**Accepted** for assessment: Concerns of abuse to the child. He was out of school for three days last week, possibly to delay him being seen
01-2014	Educational Staff	Physical abuse Denied food	**Not Accepted**: Information does not meet the statutory guidelines for abuse/neglect. LE made contact with the child and did not have any concerns of abuse/neglect. The previous CPS worker noted that Ben has been known to be a very active 6 year old and plays roughly with his brother and pets.
02-2014	Educational Staff	Physical abuse Denied food	**Not Accepted**: Police did a well check and found no marks or bruises. Police called back another worker. (CPS) Supervisor said close intake as does not meet definition (DNM). (Old concerns with the family were re-evaluated).
04-2014	Educational Staff	Physical abuse Denied food	**Accepted** for assessment: Physical Abuse. Child suffered injury due to parent's use of physical discipline also use of cruel punishment.
05-2014	Educational Staff	Physical abuse Denied food	**Accepted** for assessment: Mother made child stand on his head on a rough surface (vent) for a long enough time that child has a red knot on the top of his head.
10-2014	Educational Staff	Physical abuse	**Not Accepted**: Does not meet Definition - Ben has not had any known injuries from abuse.
11-2014	Anonymous Relative	Physical abuse Emotional abuse Denied food	**Accepted** for assessment: Emotional/Physical Abuse and Physical Neglect- Stephanie tells her 6 year old adoptive son Ben that she doesn't want him around and is going to send him to a group home when he turns 8 and also calls him stupid. She hits him and jerks him around by the arm in a rough manner that could cause harm (bruises have been noted in the past). Mitchell is failing to protect Ben and condones Stephanie's treatment of Ben saying that the child is "deceptive and horrible".
11-2014	Educational Staff	Emotional abuse Physical neglect	**Not Accepted**: No abuse or neglect indicated
12-2014	Educational Staff	Physical abuse	**Multiple Reporter**: The concern identified was already called in to the CPS Hotline in November and was accepted for Safety Assessment. This new report is being concluded as a "Multiple Reporter" to that prior intake.

08-2015	Educational Staff	Physical abuse Physical neglect Denied food	**Not Accepted**: There is no chronic lack of hygiene at this time as school just started and the child has been in school for two days. Parents are having a meeting with the school next week. Child has no bruises.
11-2015 [CRITICAL INCIDENT]	Anonymous Educational Staff	Physical abuse Physical neglect Denied food	**Accepted** Assessment: Parents allegedly withholding food as punishment. Child lost 8 lbs. from end of last school year to the beginning of this year. Children at school are teasing Ben about have a urine smell. On Tuesday, Ben asked R to bring him some food on Wed. He said his s parents withhold food as punishment. Then he did not show up for school on Wed or today. His dad called and said he has not been at school for past 2 days as he had a bowel movement and spread it all over himself.
11-2015	Educational Staff	Physical abuse Denied food	**Multiple Reporter**: The child is saying that the parents will not give him food at home. The child appears to be malnourished and very skinny. This is being accepted as a multiple reporter
11-2015	Educational Staff	Physical abuse Denied food	**Multiple Reporter**: Caregivers reported to be withholding food from child as a form of discipline.

Following the May 2014 intake which alleged Ben had been forced to stand on his head over the top of a heating vent resulting in a knot on the top of his head, Ben was found SAFE. The family scored as HIGH risk for future maltreatment. Based on the risk level, the family was offered a non-court case but declined the offer. The Risk Assessment narrative stated that the parents felt that they were aware of, and had access to, community resources and did not need services.

Accepted intakes in November and December 2014 again led to assessments that found Ben SAFE in the care and custody of his parents with HIGH risk of future maltreatment. Mitchell and Stephanie agreed to participate in a non-court case after the December investigation.

The family's non-court case opened in December.

The non-court case consisted of four team meetings held approximately every 30 days starting in December 2014 and ending in March 2015. The team meetings were noted as brief or cut short by Stephanie. They were attended by the parents and CPS worker(s) with no others in attendance despite the family being asked to identify people they thought could offer support and be willing to participate in the meetings.

By the end of the first 30 days of the case, Mitchell and Stephanie were promoting the idea that their case was ready to close, however, they were told by the worker that the case would have to remain open for 90 days.[4]

[4] Per the *Voluntary Case Management* brochure provided to families at the time of case transfer by CPS, voluntary services are provided to the family for three to six months.

In addition to the team meeting there was a meeting between the parents and school staff in February 2015. Documentation indicated the purpose of the meeting was to discuss Mitchell and Stephanie's concerns with the lack of communication and behavior management by school staff. The caseworker coordinated the meeting. Documentation included Stephanie's concerns with the school and her requests that daily emails be sent detailing Ben's behavior during the day. She requested that he only be given stickers or hand stamps as rewards, and that he not be left alone with other students in the classroom. Stephanie also asked that teachers not leave open containers in the classroom as she had once witnessed Ben spit into a glass of milk belonging to his sister. Finally, the parents directed school staff that Ben be sent to the library during classroom parties or celebrations.

Throughout the non-court case the parents reported that Ben had been evaluated by a mental health provider. They were unable to produce any written reports of diagnosis or professional recommendations, citing that the provider was slow at completing written reports thus they only had verbal information to relay. Both parents freely admitted that since the non-court case had opened they had made no adjustments and were doing nothing different in regards to the treatment of Ben. The parents stated they had no intention of implementing change as a psychiatrist had told them they were doing the best they could to manage Ben's behaviors.

Despite reporting to the worker that Ben's behaviors were getting worse, and expressing frustration with the situation in general, the couple requested the case close in March 2015. Both parents maintained that participation in the case was an intrusion on their family and that it was affecting Mitchell's job. The case was closed at the end of the month. While they did agree to work with an after-care specialist following the case closure, neither parent engaged with services or opportunities offered by that program.

A Risk-Reassessment completed the same day as case closure indicated the parents demonstrated new skills consistent with case plan task outcomes and addressing critical needs. A reduction in the risk score to moderate resulted in a recommendation for case closure. The final narrative of the assessment stated that the worker had no concerns for the children and no further recommendations.

There were no reports of abuse made to the Hotline after the non-court case closed in March through the summer of 2015. Two days after the start of the 2015-2016 school year reports to the Hotline by school staff resumed, culminating with the critical incident in November 2015.

FINDINGS

RELIABLE BEHAVIORAL INDICATORS OF MALTREATMENT WERE REPEATEDLY DISMISSED AS EVIDENCE

Ben's parents transferred him to three different schools without the family moving from their home, between Kindergarten and second grade. School staff from all three schools reported to the Hotline that Ben was disclosing being denied food and subjected to physical abuse by his mother.

Twelve reports from Kindergarten through the first quarter of second grade were made by school personnel who were concerned that Ben was being physically abused or neglected, and specifically that he consistently described being denied food as a form of punishment. All the reports regularly included concerns related to one or more of the following three areas:

1. **Ben was obsessed with obtaining food** to the extent he was stealing it, eating it from the trash, and hyper fixated on it in the classroom. Ben maintained that he was being denied food as a means of punishment while the other children in the home were being fed.

2. **Ben was regularly presenting with injuries** such as bruises, scratches, knots, and welts. In conjunction with the injuries, Ben described situations in his home that school staff considered to be excessive discipline. For example, Ben reported being kicked in the groin, being forced to urinate on his school supplies, being locked in his room, being thrown against the wall or to the floor, made to stand on his head while on a heating vent, and his parents allowing the three family dogs to harm him by biting and scratching him.

3. **Parental behavior directed towards Ben was inappropriate**. In response to contact from school personnel, teaching staff found the parents to be severe when speaking of their son and punitive to even minor behavioral infractions, denying him participation in school field trips and classroom celebrations. Staff became reluctant to report classroom concerns or behavior issues to the parents as after the contact Ben would return to school relaying that his parents withheld the evening meal. On multiple occasions Ben missed school for days following contact with the parents.

When Hotline calls were accepted for initial assessment, SDM narratives would cast doubt on the disclosures due to Ben's lack of detail, inconsistencies and recanting statements. Safety narratives called attention to Ben's changing versions of events when he was asked for details of the incidents, and also cited law enforcement's evaluation of the physical evidence as support for a finding of SAFE. For example, a Safety Assessment found the children to be SAFE due in part to Ben being unable to recall additional details when the worker asked him to show how the injury happened utilizing a doll. A safety narrative also noted that law enforcement stated that the

bruise on Ben's back was inconsistent with Ben's report as Stephanie's foot was larger than the actual bruise.

Upon review it was found that Ben's disclosures were consistent based on the expectations of his age and cognitive development. Ben's inconsistency in relating the facts often occurred when he was questioned in the home while his parents were present, or when he was required to recount his disclosure multiple times to law enforcement or CPS workers.

Disclosing abuse can be difficult for a child. They may experience a wide range of emotions from not knowing if the abuse is wrong to being fearful for their safety. According to research, only 4-8% of all reported cases of abuse by children are fabricated, and most of those are reports made by adults involved in custody disputes or by adolescents.[5] Research on children who recant abuse allegations found that most children between the ages of 6-9 years who recant are telling the truth when they originally disclose. Additionally, recantation is largely a result of familial adult influences rather than a result of false allegations.[6]

BEHAVIORAL DYNAMICS ALMOST ALWAYS PRESENT IN FAMILIES IN WHICH CHILD ABUSE OCCURS[7] WERE NOT IDENTIFIED WHEN EVALUATING THE RISK FOR FUTURE MALTREATMENT.

Dr. Brandt Steele, a psychiatrist and pioneer in the study of child abuse and victim treatment, found that four dynamics are almost always present in families in which child abuse occurs. (1) Parents must have a predisposition to abuse or neglect their children, (2) abused children are often perceived by abusive parents as different or in some way unsatisfactory, (3) high stress and crisis in the family usually contribute to maltreatment, and (4) maltreating parents often lack interpersonal or environmental support.

Mitchell and Stephanie perceived Ben as different or unsatisfactory. Structured Decision Making® (SDM) narratives contained numerous examples of this. For example, Mitchell would say that Ben was sneaky, and that he would plan out his misbehavior. Stephanie was quoted as saying that due to his mother's drug use, Ben would make himself throw up, and urinate or defecate on himself on purpose. The parents often stated that they would or would not do something related to the care of Ben because it was unfair to the other children in the home. A Risk Assessment conducted in December 2014 notes that Stephanie was directly asked twice by the worker if she wanted Ben in her home; she replied "I want him to be safe and successful. I would love for others to see what we deal with every day with Ben. I would like for Ben to stay

[5] Bruck, M., Ceci, S. J., & Hembrooke, H. (1998). Reliability and credibility of young children's reports: From research to policy and practice. *American Psychologist, 53*(2), 136-151. doi:10.1037//0003-066x.53.2.136

[6] Lawson M., Rodriguez-Steen L., London K. A systematic review of the reliability of children's event reports after discussing experiences with a naïve, knowledgeable, or misled parent. Developmental Review, Volume 49, 2018

[7] Steele,B. (1987). Psychodynamic factors in child abuse. In R.E. Helfer & R.S. Kempe (Eds.), *The battered child*. (4th ed.)Chicago: University of Chicago Press.

but I don't know how much more we can take…I want my family to be successful and I feel like this is tarnishing our name."

Once Ben reached school age he was provided a level of contact with persons outside his home that facilitated his almost immediate and repeated disclosures of abuse. Ben's repeated disclosures and the concern they generated among school staff resulted in attention to the family Mitchell and Stephanie were unaccustomed to. The reports to the Hotline by school personnel brought both law enforcement and CPS into the home creating new stressors.

The parents attributed the intrusions created by the school's calls to the Hotline to Ben's actions. With each new call to the Hotline by school staff, the more they tried to control him and discredit him with teachers. Limiting his participation in school functions such as classroom celebrations or field trips, instructing staff not to provide Ben with snacks or extra food, and returning items such as backpacks, notebooks and winter coats given to him by school staff. When calling the Hotline, staff would note their concern that the parents would change Ben's school at the end of every school year without physically moving into a new district.

Despite self-reports by the parents to the contrary, the couple lacked interpersonal support. The couple admitted they were estranged from Mitchell's family, connection with Stephanie's family was limited to her mother, and with the exception of autism awareness activities, they did not report participation within the community. It was noted that while the family did attend autism support events, Ben was not observed to be with the family during those times. Stephanie was a stay at home mother who identified few personal connections and whose support system was limited to her husband and mother. Mitchell self-reported that his support system was limited.

The Risk Assessment completed prior to the critical incident, noted concerns regarding the care and well-being of Ben. Pointing out that interviews of the other children in the home were ineffective due to age and developmental delay, and suggesting the possibility that the parents were being untruthful about their actions in relationship to the allegations. However, the assessment went on to state that due to insufficient evidence and information the findings would be entered as unfounded.

Reviewed SDM assessment narratives, including Safety Assessments, Risk Assessments, Family Strengths and Needs Assessments and Risk Reassessments all contained evidence that Mitchell and Stephanie viewed Ben as different and unsatisfactory, that the parents were under increasing levels of stress and were becoming more controlling of Ben in addition to lacking a support system. Yet, these individual dynamics that are often present in cases of abuse were never put together as a totality indicator of risk to the safety of Ben.

INEFFECTIVE CHILD PROTECTION PRACTICES ENABLED THE MALTREATMENT TO CONTINUE

When assessing for safety and risk, Mitchell and Stephanie were permitted to rationalize or deny the repeated injuries to Ben, and reject any culpability.

According to the U.S. Department of Health and Human Services Administration for Children and Families' Child Welfare Information Gateway, recognizing child abuse includes noting parents who deny the existence of – or who blame the child for problems in school or at home. It also suggests that physical abuse should be considered when the parent or other adult caregiver offers conflicting, unconvincing, or no explanation for the child's injury.[8]

A review of SDM narratives revealed that both parents consistently stated that the injuries to Ben were not injuries at all, but instead benign occurrences. The parents minimalized the marks on Ben's body, attributing them to normal rough play with an older sibling, the family dogs, or family time activities such as putting a belt around his feet so he could learn to hop like a bunny. Several assessments document the parents ascribing Ben's injuries to him hurting himself because he asked his three-year-old sister to teach him how to do a back bend or headstand after her tumbling class.

Ben was found to be safe in the care of his parents on four separate occasions due to Stephanie denying that she caused the injuries, Stephanie stating that she took Ben to the doctor, and a denial by the parents that they used excessive physical discipline. The Safety Assessments noted that others in the household denied the use of physical discipline. Aside from the parents, others in the home who would have been able to deny the excessive use of physical discipline would have been an older sibling who was non-verbal due to Autism, and a younger sibling between two and three years of age at the time of the intakes.

All Risk Assessments completed from December 2013 through November 2015 contained the statement: "[Stephanie] does not blame Ben or the other children for the situation and does not justify maltreatment of Ben as she denies any wrongdoing or maltreatment". The Risk Assessment requires workers to evaluate the primary caregiver's assessment of the incident, focusing on whether the caregiver is blaming the child for the incident or justifying the maltreatment of the child. SDM guidance does not include when a primary caregiver provides a conflicting assessment of the incident, provides unconvincing explanations for the child's injury, or provides no explanation at all.

[8] Recognizing Child Abuse and Neglect: Sign and Symptoms. www.childwelfare.gov/pubPDFs/signs.pdf. Retrieved August 19, 2019.

Collateral contact with people outside of the home, including classroom teachers and medical professionals, was limited.

One individual collateral contact who was socially familiar with the family was used in all four of the initial assessments. At the time of the December 2013 intake, a former 2006 co-worker of Stephanie's who was a current family friend was asked about her observations of the family. She stated that she saw the family weekly and had no concerns for abuse/neglect. This same collateral statement was documented in all subsequent Risk Assessments without an updated statement and without the addition of any new sources of information. The family indicated that their daughter was in tumbling/dance class, that they participated in autism awareness activities and that Mitchell's co-workers were a source of support to him. Documentation did not include any information from these additional sources.

Documentation of collateral contact with school staff did not consistently include Ben's primary classroom teacher. Information obtained from staff peripheral to Ben's daily routine, such as principals, assistant principals and guidance counselors, while valuable, may not have been based on consistent day to day contact similar to that of a classroom teacher. Reports made by school personnel that were accepted for investigation included the concern that communication between teachers and the parents resulted in excessive disciplining of Ben. This concern was so pervasive teachers would refrain from reporting behavioral incidents to the parents in a daily behavior log out of fear that Ben would suffer harm. Because Ben attended multiple schools in a relatively short period of time, documentation from classroom teachers may have been helpful in identifying patterns of behavior displayed in multiple settings similar in nature.

There is no evidence of verification of medical appointments and diagnoses through collateral contact. The parents' claim that Ben's physical condition was the result of prenatal drug exposure, early childhood trauma, and a matter of genetic predisposition offered in the narratives were not validated or verified with medical professionals, thus indirectly endorsed. Unverified medical recommendations also provided an opportunity for the parents to credibly preserve the idea that they were appropriately responding to the behaviors they assigned to Ben per professional recommendations and to assert that he had a condition attributed to a behavioral issue.

Per DHHS policy[9] a collateral contact is defined as a person that provides information. Policy and procedure documents do not specifically prescribe the number and type of collateral contacts that should be engaged other than to say they will be used as part of good social work practice to collect additional information as needed. There are two exceptions to this broad collateral policy. The specific use of collaterals to complete the Family Strengths and Needs Assessment (FSNA) and to complete any assessment involving medical issues or where the alleged child victim is

[9] Nebraska Department of Health and Human Services Division of Children and Family Services Protection and Safety Procedure #2-2018 and #34-2016.

seen by a doctor or hospital. In the case of medical issues, policy states written information from medical providers will be obtained and placed in the case file.

In Ben's case, documentation indicated that as part of the Initial Assessment, medical records were requested from a primary care physician following the December 2014 intake. The Risk Assessment dated three weeks later states the records were not provided by the physician. CPS can request medical information as part of an abuse/neglect investigation, however, medical providers are not mandated to provide the information to DHHS. The OIG did not locate evidence that medical records or collateral information from providers was pursued beyond the initial request for information from one primary care doctor.

Precautionary steps due to Mitchell having extensive knowledge and involvement in the Nebraska Child Welfare System were not taken.

Mitchell had previously been employed by DHHS. Following his non-voluntary termination from this position, he gained employment with a DHHS-contracted provider within the service area he and his family lived. His affiliation with his employer was noted at the time of the December 2013 intake. A later intake alleged that both Mitchell and Stephanie asserted that if anyone "called them in" Mitchell would have connections.

Mitchell would have been able to use his extensive knowledge of the procedures, safety threat definitions and SDM tools used to investigate alleged abuse to his advantage. For example: based on his previous experience, Mitchell would know that when completing the Risk Assessment, workers are instructed to exclude situations in which the caregiver claims the one child injured another child or in which the caregiver claims that the child injured himself when assessing the caregiver's response of the incident. Additionally, via his current position with a DHHS service provider, Mitchell was in frequent and direct contact with professionals within the child welfare system.

The OIG found little evidence that Mitchell's knowledge of the child welfare system and current employment position were addressed in the assessment of the maltreatment or the management of the non-court case. There was only one instance noted where action was taken to address the situation. At the time of the December 2014 intake the CPS supervisor personally met with Mitchell as part of the Initial Assessment process. When the resulting non-court case was offered that same supervisor sent an email to her counterpart handling the non-court case indicating the need for vigilance in regards to the handling of the case. Email communications referenced staffing the situation, but documentation did not contain specific information about how the situation was addressed or confirmation that the staffing occurred.

Throughout the course of the investigation, the OIG encountered no documentation indicating that *prior* to the critical incident, this case was ever referred to or discussed by a multi-disciplinary (1184) team or that Ben was forensically interviewed at the child advocacy center – both of which would have been prudent actions under the circumstances.

MALTREATMENT CONTINUED DUE TO INEFFECTIVE ONGOING CASE MANAGEMENT OF THE NON-COURT CASE

The case plan solely focused on behavior issues ascribed to Ben by his parents.

As a result of the November and December 2014 intakes, the family agreed to a non-court case. A caseworker made contact with the family, and the SDM Family Strengths and Needs Assessment (FSNA) and case plan were completed.

The case plan identified all 9 FSNA assessment areas as strengths for Mitchell and Stephanie, including coping skills, social support system and parenting skills. The narratives for each of the domains consisted of copied narratives from previously written assessments of safety and risk with little additional information. The assessment did identify emotional/behavioral needs for Ben. The assessment narrative detailed Ben's disruptive behavior in the home and at school, citing that he is lying, stealing and manipulating. The assessment also referenced a diagnosis of Rumination Disorder and Other Disruptive Behavior Disorder. The FSNA provided no collateral documentation of these diagnoses from a provider, or anecdotal evidence based on verbal communication with the medical/mental health provider or school personnel. The assessment relied only on information provided by the parents.

The resulting case plan provided one goal for the parents: Stephanie and Mitchell will use appropriate behavior management strategies when parenting Ben's difficult behaviors. Strategies for accomplishing this goal included: meeting with the school on at least two occasions to discuss communication strategies and behavior management of Ben in the classroom in addition to following through with all treatment recommendations for Ben. Of the 14 intakes regarding the family, none were based on concerns that Mitchell and Stephanie were not interacting with the school in addressing behavior problems or communication issues in the classroom.

The Risk Reassessment inaccurately captured the family's level of involvement and progress.

Risk Reassessment combines items from the original Risk Assessment with additional items that evaluate a family's progress towards case plan goals. The Risk Reassessment guides the decision to keep a family's case open or to close it.[10]

The Risk Reassessment for the family was completed the same day as case closure and resulted in a score of moderate risk due to two or more prior neglect/abuse investigations of the household, and a child with a diagnosed developmental delay in the home.

[10] DHHS Division of Children and Family Policy and Procedure Memo #34-2016

When completing the Risk Reassessment workers are to consider whether the household previously had an open ongoing service case (non-court or court ordered) due to child abuse or neglect. The family had declined an offer for a non-court case in May of 2014. The question does not specify situations in which a family has been offered a non-court case but declined it, thus additional risk was not assessed to the family's situation, not because there had been no non-court case, but because they had declined it.

Per DHHS policy and procedure, it was within Mitchell and Stephanie's rights to close the non-court case regardless of the Risk Reassessment score; the case was voluntary and without court intervention. The significance of a Risk Reassessment score that accurately reflects the family's level of contact with CPS prior to the current assessment is that, had the family continued to be at high risk of future maltreatment when they requested case closure, a mandatory supervisor consultation should have resulted in further evaluation of the case.

The Risk Reassessment also indicated that the caregivers demonstrated new skills consistent with case plan outcomes and/or were actively involved in services and activities to gain new skills consistent with case plan outcomes.

Narratives from multiple sources within SDM narratives did not support the reassessed risk rating. To the contrary, numerous documentation narratives indicated that the parents were refusing to develop their parenting skills, were unable to follow through with treatment recommendations and resisting engaging with any services.

The parents were allowed to restrict the worker's access to Ben.

During the three-and-a-half months the case was open, the worker had contact with Ben a total of four times as part of monthly team meetings. During those four meetings, contact with Ben occurred once fully in the presence of Stephanie, and three times when at least one parent was within hearing distance and/or visible to Ben. This posed a significant obstacle to the assessment of Ben and his family as school staff had reported numerous times that they feared Ben was harshly punished any time the school shared information about him with the parents or when the parents thought Ben was freely sharing information with school staff.

In a non-court case parents do not have to allow CPS workers to meet privately and speak with their children in the home or at other locations such as school. Due to this, Ben was not given the opportunity to speak openly with the worker about what was happening in his home, nor was the worker able to verify information provided by the parents with Ben.

The parents were not required to sign release of information forms.

Documentation during the non-court case stated that the parents refused to sign releases of information (ROI) for medical and/or mental health providers. Case plan goals and monitoring

for progress hinged on the parents meeting Ben's needs by following through on medical/mental health appointments and recommendations made as a result of evaluations. Without the signed ROIs, professionals would have been unable to discuss pertinent information with the worker, leaving the worker to rely solely on what the parents reported.

The parents were not required to accept services from providers.

In a December 2014 email sent to the caseworker and supervisor by the DHHS supervisor, it was specifically recommended there be in-home services as a means of gaining further insight in the family functioning and parenting dynamics. There is no evidence of the family being offered support through community resources and no completed referrals in an attempt to put formal services in the home. Documentation repeatedly stated that the family has refused to allow any providers in the home or to engage with services outside of the home.

While Mitchell and Stephanie agreed to participate in a non-court case, they refused to allow any outside support into the home, stating that it was unfair to the other children to have someone come to only see Ben, and that it disrupted their daily routines. The family effectively barred outside verification as to the functioning of the family, and the opportunity for Ben to receive additional support.

Documentation by the worker indicated that she was concerned that Ben was always in a state of being punished, that Stephanie and Mitchell were unable to say anything positive about him, and that she observed the subtle ways the parents treated Ben differently from the biological children. Team notes indicated that Stephanie continued to report that things were getting worse with Ben's behaviors, such as he was purposely urinating on the carpet on a nightly basis. All of these issues went unaddressed as the family refused to engage with service providers.

The non-court case did not include a referral to a multi-disciplinary (1184) team and/or consultation with the county attorney before closing.

The non-court case was open for three-and-a-half-months. During that time the family refused to sign ROI forms allowing workers to speak with medical/mental health providers and they were unable/unwilling to produce written verification of diagnosis or professional recommendations. They participated in four monthly family team meetings, but would not include any one other than the worker in the meetings. They would not provide the worker access to Ben out of their presence and they did not allow support providers into their home. After the first thirty days, Mitchell and Stephanie began advocating for the case to close and by the time the case had been open 60 days, they indicated that they would not voluntarily participate beyond 90 days – the case closed at their request during the same month as the 90 day benchmark was achieved.

DHHS policy[11] states that non-court cases failing to make sufficient progress or parents refusing to work with DHHS will be evaluated through a mandatory consultation for determination about whether the case should be referred to the multi-disciplinary (1184) team, law enforcement should be asked to consider immediate removal, and/or the county attorney should be contacted to request court intervention. The OIG found no evidence that there was a supervisor consultation about this case due to lack of progress, that a referral was made to the multi-disciplinary (1184) team for staffing, or that there was a discussion about contacting the county attorney in regards to providing an affidavit in support of court intervention.

[11] DHHS Division of Children and Family Policy and Procedure Memo #34-2016.

RECOMMENDATIONS

The OIG is tasked with making recommendations for improved operations of Nebraska's child welfare system.[12] Time has passed since the incident; please note the recommendations made in the report are based on today's Nebraska child welfare system and issues needing addressed presently. Recommendations are intended to address systemic issues that have been identified at the time of the report.

Based on the issues identified, information gathered, and interviews conducted, the OIG recommends that DHHS[13] take the following steps:

I. Create 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.

In the process of investigating the serious injury of Ben, the OIG discovered a gap in policy related to the Initial Assessment and protection and safety procedures when alleged perpetrators have extensive and/or specific knowledge of the Nebraska child welfare system and Structured Decision Making tools.

Protection and Safety Procedure document # 1-2017 details requirements when a report of abuse/neglect includes a DHHS employee, a family member of an employee or others having access to the information found on the N-FOCUS database. This document does not address those who would have critical knowledge of the child welfare policy, procedure and SDM tools without access to N-FOCUS. For example; former CPS employees, CPS service providers, county attorneys and law enforcement officers.

DHHS Reponse: Request Modification

DHHS is requesting to add training of workers and supervisors as an option in meeting this recommendation. The Division of Children and Family Services (CFS) has a few Program Improvement Plan (PIP) strategies that could contribute to this recommendation. DCFS will ensure the recommendation is considered and addressed in at least one of the following PIP items.

- PIP item: 1.1.1 Implement a standardized case staffing model. DCFS will assess whether this would be an avenue to add a process regarding the assessment of individuals with extensive or specific knowledge of Nebraska Child Welfare systems

[12] Neb. Rev. Stat. §§43-4302, 43-4327.

[13] Because CPS, or any private provider of case management services, must comply with DHHS policy, these recommendations are made directly to DHHS. The expectation would be that after changes to policy are made, all of those providing case management services in Nebraska would abide by such improved policies.

to ensure rigorous and balanced assessments.

- PIP item: 1.1.5 Modify Structured Decision Making (SDM) Safety Assessment Tool and instruction to ensure accurate decisions about safety and risk are made by staff. With the assistance of the National Council on Crime & Delinquency (NCCD) we will evaluate the instruction regarding safety and risk assessments to clearly define and include mental health, substance abuse, developmental disabilities and domestic violence as "Complicating Factors" within SDM Safety Assessment Tools. DCFS could include in the discussion with NCCD situations when the alleged perpetrator has extensive and/or specific knowledge of Nebraska's Child Welfare System. This would also include conducting refresher training to ensure understanding of changes to SDM instructions.
- PIP item: 2.2.3 CFS will increase case manager's proficiency in completing comprehensive and accurate SDM assessments and be able to clearly articulate SDM recommendations to the court and legal parties. DCFS could include training and guidance to staff and supervisors regarding ways to ensure that complete and accurate information is gathered to make informed decisions that are supported by facts as a way to ensure accuracy of information gathered from individuals with extensive or specific knowledge of Nebraska's Child Welfare system.

OIG Determination: The original OIG recommendation did not include training, but was added after accepting DHHS's request for modification.

NON-COURT CASE RECOMMENDATIONS

Non-court cases can be effective if families fully participate in them. Successfully engaging parents in the process is a critical task, a review of empirical literature notes there are critical components of engagement in child welfare services including service components and caseworker behaviors.[14] Participation by parents must include both collaboration and compliance. When collaborating with CPS, parents participate in assessing the family's strengths and needs, contribute to the construction of case plan goals, and take part in team meetings to discuss progress and continuing needs. Along with collaborating, parents must also be compliant in that they display such behaviors as making appointments, keeping appointments, completing tasks, and cooperating with the process in general.[15] Research indicates that influencing collaboration and compliance is most successful when interventions are as follows:

- Requests are specific rather than vague;

[14] Dawson, K.; Berry, M. Engaging Families in Child Welfare Services: An Evidence-Based Approach to Best Practice. *Child Welfare*, [s. l.], v. 81, n. 2, p. 293, 2002.
[15] Little, J.H.,& Tajima, E.A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Services Review*, 74, 405-435.

- Overt commitments are made by the clients;
- Training in performing tasks is provided;
- Positive reinforcement of the task is supplied; and
- Client participation in the selection and design of tasks is ensured.[16]

Ben's case exemplified the need for clarity and structure in managing non-court cases. DHHS Division of Children and Family Services Protection and Safety Procedure document #34-2016 (Ongoing Case Management) states the following in regards to non-court cases:

- *The non-court case requires that the family voluntarily agrees to work with the department on identified safety and risk issues.*
- *Non-court involved cases must be provided the same access to services as court involved cases.*

During the course of a non-court case accurate medical/mental health information and participation in services is vital to assuring child safety and assessing progress towards case plan goals. As was evidenced in this case, without a mandate from the court, parents are under no obligation to provide information or engage in recommended services, thus making an accurate assessment of the family difficult if not impossible.

Because non-court cases are without court mandate, they can be confusing to the family and/or more easily manipulated than court cases. Non-court cases need clear protocols, policies, and expectations for families who are freely and voluntarily agreeing to participate in them. The OIG recommends DHHS:

II. 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.**

DHHS Response: Request Modification to:

Create non-court case policy establishing that participating in a non-court case <u>where there is an active safety-threat</u> requires the following.

[16] Rooney, R.H. (1992). *Strategies for work with involuntary clients*. New York: Columbia University Press.

OIG Determination: No modification

As referred to earlier in this report, based on research, outcomes are significantly better when the expectations are clear and supported prior to the acceptance of a voluntary, or non-court, case.

The adoption of standards, should the family voluntarily abide by them, does not change the non-court process, but rather makes the process clearer. If a family will not accept the expectations set forth, whether there is a safety threat or not, they still have the right to decline the case, and the options available to DHHS and the caseworker do not change—they can offer the family information about community supports; offer to make referrals; consult with, and forward the case to, the county attorney (especially when there's a safety threat and the family chooses not to work a non-court case); and/or close the case as declined. This coupled with the implementation of Safety Organized Practice to help caseworkers engage with families, should help put more structure around non-court cases, leading to better outcomes.

A family can either abide by the standards or choose not to, regardless of safety or risk, DHHS has no official capacity to require the family to work a non-court case. The existence of standards increases the probability that families involved in non-court cases will follow them.

III. Create a handout/brochure to be provided to the family at the time the non-court case is offered that includes:

- **a. A clearly written explanation of what a non-court case is;**
- **b. The legal rights of the parents;**
- **c. The responsibilities and expectations of the parent(s) agreeing to a non-court case;**
- **d. The role and expectations of the caseworker;**
- **e. An outline of when information is shared with the county attorney and/or multi-disciplinary (1184) teams;**
- **f. An outline of when a referral to the county attorney can be/is made; and**
- **g. Contact information for, and an explanation of, the Office of Inspector General of Nebraska Child Welfare and the Office of Public Counsel (also known as the State Ombudsman's Office).**

DHHS Response: Accept

DHHS is creating new materials to satisfy this recommendation.

IV. 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.

DHHS Division of Children and Family Services Protection and Safety Procedure document #34-2016 (Ongoing Case Management) states the following in regards to apprising county attorney offices of progress in non-court cases:

- *Non-court cases may move to be court involved if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying the child safety concerns and risk of harm. The worker will have a mandatory consult with his/her supervisor to determine if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention.*
- *In cases where there are no identified safety threats but there is high or very high risk and the family refuses to work with the department, the worker will have a mandatory consult with his/her supervisor to determine if a referral to the 1184 investigation/treatment team should be made and/or the county attorney should be contacted to request court intervention.*
- *The worker is encouraged to involve the investigative and/or treatment team (LB 1184) in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.*

The function of non-court cases is to provide services to a family while the child (usually) remains in the home and without court intervention. To have children remain in the family home is an important option when achieving positive outcomes for families. However, timely and well informed decisions are critical in cases where child safety issues or risk of future maltreatment has been identified.

The evaluation of non-court case progress and the potential need for court intervention is best made with cooperation between DHHS and the county attorney's office. The two professional groups often use different kinds of information when assessing child abuse and neglect. CPS workers often rely on information about the severity and pattern of abuse and on information about the services offered in the past and parental responses to those services. Research indicates prosecutors often rely more heavily on information about the likelihood of a reoccurrence of abuse.[17] Both of these perspectives are necessary for an unbiased evaluation of progress in a non-court case and provides a check-and-balance approach.

[17] Britner, P.A., & Mossler, D.G. (2002). Professionals' decision-making about out-of-home placements following instances of child abuse. Child abuse & neglect, 26 4, 317-3.

DHHS Response: Request Modification to:

Modify the Department's instruction to staff to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case, where there continues to be an active-safety threat, no less than 60 days after opening.

OIG Determination: No modification

Whether there is an active safety threat or not, a non-court case that is not progressing should be communicated to the county attorney's office. Furthermore, under current policy, if there is a safety threat, DHHS must put a safety plan in place. If there's no improvement, and there continues to be safety concerns, the worker should already be communicating with the county attorney about the lack of progress under the current process. This recommendation does not have to do with whether there is a safety threat or whether the family is at high risk for child abuse and/or neglect, but rather the status as a non-court case versus a court case.

V. 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.

While DHHS policy indicates a mandatory supervisor consultation shall occur with the caseworker when deciding a course of action for non-court cases that are refused by the caregivers or that are not progressing, DHHS supervisors and administration report that there is no formal supervisor training or evaluation criteria when deciding whether a non-court case requires multi-disciplinary or county attorney review, or court intervention. Such criteria and accompanying training is key in assisting with these important decisions.

DHHS Response: Accept

DHHS is currently working toward implementing this recommendation, including developing guidance for staff and training for supervisors. Two DHHS documents pertaining to this recommendation were noted: the *Working Instruction Document for 1184 Treatment and Investigative Team Meetings* and the Division of Children and Family Services Protection and Safety Procedure #23-2017, *Collaborating with Child Advocacy Center (CAC).*

The OIG has previously made two recommendations pertinent to this investigation, noting that DHHS has not implemented either of these recommendations. These recommendations are emphasized here as they speak broadly to the bases of social work best practices. Central to the child protective service process are the many decision-making points included in gathering and accurately assessing information, identifying the causes of maltreatment and implementing services to eliminate them while strengthening the family's ability to protect and care for their children.[18]

#16-10 Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.

The use of SDM® was adopted in Nebraska statewide in 2012 to provide a foundation to CPS workers assisting them in making accurate and consistent decisions about how to keep children safe. The OIG will remain committed to highlighting the importance of ensuring that these tools remain valid as they provide guidance to caseworkers and supervisors in their decision-making.

DHHS Response:

The Department acknowledges that during the critical incident involving [Ben], fidelity to the SDM tool was inconsistent by Hotline staff. Since then, the Department contracted with an independent consultant, The Stephen Group (TSG) to evaluate the Hotline's fidelity to the SDM tool. The attached *SDM Design and Technical Assistance Project Final Report* provided in November of 2018 noted that, "two key external assessments found that DCFS was effectively implementing and managing the SDM system with high fidelity and adherence to the decision-making logic of each tool."

In addition, the Department contracted with Scott Burdick of Orange County, CA for advanced training for supervisors regarding *"Improved Assessments for Improved Outcomes for Supervisors*." This one-day training for all CFS supervisors was held August 19-23, 2019. Mr. Burdick also provided the curriculum to integrate into an ongoing training for new CFS supervisors. The objectives of this training focused on

1) *Understanding the role of bias and strategies for managing bias in making assessments;*
2) *Understanding the roles of engagement in making thorough assessments;*
3) *Assessing for risk and safety threats for families in reunification and family preservation;*
4) *Assessing for family strengths and needs;*
5) *Conducting balanced assessments for reunification to include key elements, including*

[18] Rycus, J.S. & Hughes, R.C. (1998). Child Welfare Values. *Field Guide to Child Welfare, Volume 1, Foundations of Child Protective Services*, 123-128. Washington, DC: Child Welfare League of America.

case plan progress, visitation evaluation and safety assessment;
6) *Understanding the benefit and use of decision support tools;*
7) *Understanding the supervisor's responsibility in helping staff make effective assessments.*

The training provided information to supervisors about helping staff develop critical thinking skills and using decision making tools to make informed decisions. DHHS believes this strategy is an effective initial step to build and maintain a competent, well-trained workforce, able to make informed decisions regarding safety of children.

#19-06 Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.

The OIG will continue to recommend that caseworkers and supervisors be required to complete additional SDM logic training, including refreshers on how to utilize the SDM tools using critical thinking skills. As demonstrated by this case, this type of training is especially critical when an SDM tool does not give specific guidance for a unique situation. For example, SDM Risk Assessment guidance does not include when a caregiver provides a conflicting assessment of an incident, provides unconvincing explanations for the child's injury, or provides no explanation at all. As referenced in the November 2016 Case Reading Report by NCCD's Children's Research Center, Nebraska DHHS was advised that staff would benefit from a logic refresher. According to NCCD, it was "the biggest shortcoming in terms of SDM system fidelity in Nebraska . . . It would help workers avoid getting stuck in technically supportable interpretations that nonetheless clearly miss the intent of the item . . . Providing training on using the SDM system to organize clear and concise case notes may strengthen documentation and help reduce workload" (A2-A3).[19]

DHHS Response:

The Department contracted with Scott Rudnick of San Diego County, CA for Advanced SDM training for supervisors. CFS supervisors in each service area attended required SDM refresher training in August. The Department supports SDM refresher training, especially if it includes case review, inter-rater reliability reviews, and updates to the model in various dynamics. Safety Organized Practice (SOP) is also being delivered to CFS caseworkers and supervisors across the state. SOP training enhances engagement, provides interviewing tools and improves information gathering skills designed to better assess for safety and risk.

OIG Comment:

It is exemplary that DHHS initiated this technical assistance project around SDM, culminating in The Stephen Group (TSG) *SDM Design and Technical Assistance Project Final Report*. As DHHS noted,

[19] National Council on Crime and Delinquency, *Case Reading Report, Structured Decision Making System November 2016*.

they said this, “Two key external assessments found that DCFS was effectively implementing and managing the SDM with high fidelity and adherence to the decision-making logic of each tool.” (page 15).

One assessment was from the National Council on Crime and Delinquency Children Research Center (NCCD/CRC), which audited the intake tool designed to assess implementation. Nebraska workers did indeed score well, a compliment to CPS workers given the expertise of NCCD/CRC on the SDM algorithm and its applications. However, the same report also noted that risk validation and recalibration analysis is recommended every five years (page 14). TSG specifically recommended obtaining a newer version of the Risk Assessment tool, or have the one they have recalibrated, and they pointed out that other, specialized tools may be of interest as well.

Nebraska has used SDM since 2012, with no formal Nebraska validation process undertaken. Workers have identified issues with both the process and the available tools (pages 9-10).

TSG specifically discussed the issue of Safety “Safe” versus Risk “High/Very High” when they conflict, and notes the high rates of recidivism among these families. (page 29). The recommendation on page 31 states, “DCFS should establish reports for regular executive and management review of all of the instances in which case action is taken contrary to the tools and on the types of over-rides used, which would allow trends to be identified at a system level and interventions to be designed as appropriate (i.e., staff coaching or re-training).”

Application and fidelity to the tool do not mean the tool is valid. Given that CPS relies so heavily on the SDM tools for crucial decision-making within the child welfare system, the OIG remains of the view that they be validated.

DHHS should be commended for the significant improvements in further training the CPS supervisors, and for supporting SDM logic refresher training with case review, inter-rater reliability reviews, and updates to the model.