

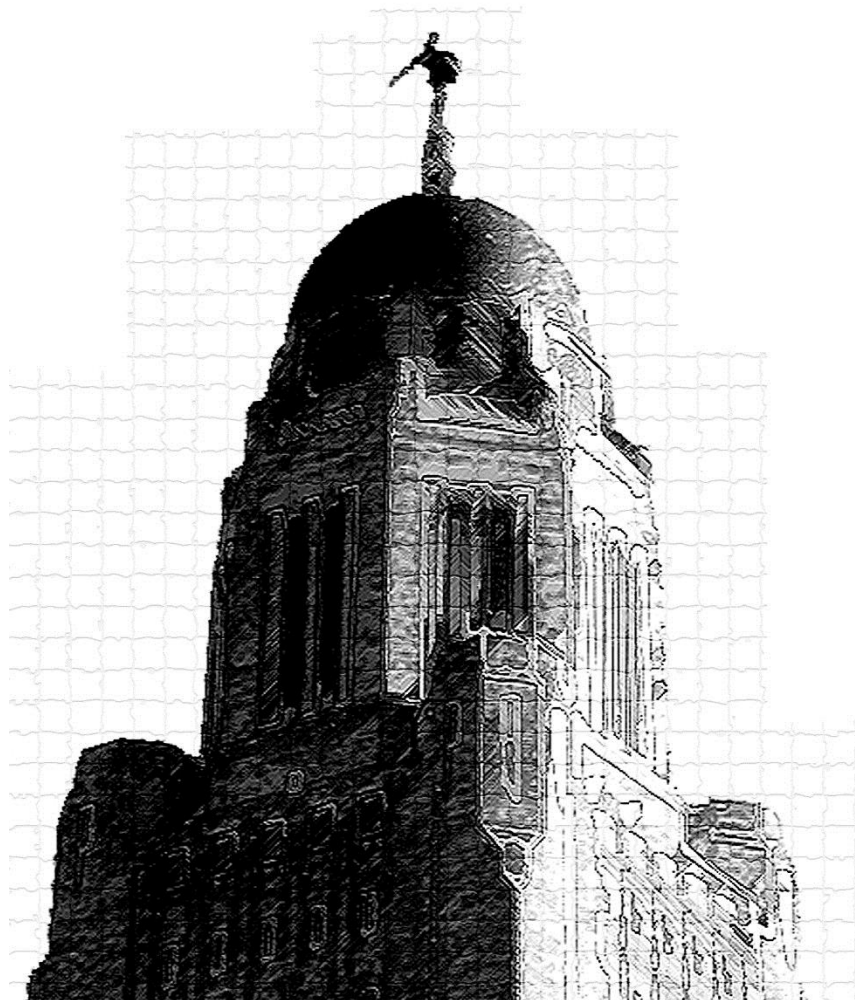
Office of  
Inspector General of Nebraska Child Welfare

---

# Annual Report

2014-2015

---



As set forth by the Office of Inspector General of Nebraska Child Welfare Act (Neb. Rev. Stat. §§43-4301 – 43-4331), the Office of Inspector General of Nebraska Child Welfare (OIG) is established to provide increased accountability and oversight of the Nebraska child welfare system through a full-time investigation and performance review program. This includes:

- Assisting in improving operations of the Department of Health and Human Services relating to the Nebraska child welfare system;
- Improving Nebraska's juvenile justice system with Juvenile Probation, the Nebraska Commission on Law Enforcement and Criminal Justice, and juvenile detention facilities;
- Providing an independent form of inquiry (an official effort to collect and examine information) for concerns regarding the actions of individuals and agencies responsible for the care and protection of children youth in the Nebraska systems;
- Providing a process for review and investigation to determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system or juvenile justice system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system or the juvenile justice system.

The OIG is required to complete an annual report by September 15 of each year about the progress of these actions.

The OIG thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide help and advice, the Health and Human Services Committee and Judiciary Committee in particular. The Ombudsman's Office goes above and beyond in assisting the office in countless ways—operatively and substantively. The most sincere and heartfelt appreciation for all of the time, talent, and counsel that has been offered.

Finally, please note that the Department of Health and Human Services continues to be very responsive and timely in any request that has been made of them from the OIG during the preceding year (2014-2015), as have private child and family serving and law enforcement agencies.

Julie L. Rogers  
*Inspector General*

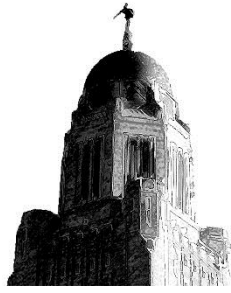
Sarah Forrest  
*Assistant Inspector General*

Sarah Amsberry  
*Intake Executive Assistant*

September 15, 2015

*OIG@leg.ne.gov*  
State Capitol  
P.O. Box 94604  
Lincoln, NE 68509-4604  
[nebraskalegislature.gov/divisions/oig.php](http://nebraskalegislature.gov/divisions/oig.php)  
402-471-4211 or 855-460-6784

JULIE L. ROGERS  
Inspector General



STATE OF NEBRASKA  
OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE  
State Capitol, P.O. Box 94604  
Lincoln, Nebraska 68509-4604  
402-471-4211  
Toll Free 855-460-6784  
Fax 402-471-4277  
[oig@leg.ne.gov](mailto:oig@leg.ne.gov)

September 15, 2015

Governor Ricketts, Chief Justice Heavican, and Members of the Legislature:

Accountability is essential to both public trust in our institutions and efficient, effective government operations. Perhaps no systems are more in need of good governance, rigorous oversight, transparency, and high performance than those which impact the well-being of Nebraska's children and families. The stakes of the State of Nebraska's action or inaction are tremendous when it comes to strengthening our families, protecting our children, and responding to troubling actions of our youth.

Over the past few years, Nebraska has enacted significant policy change and devoted additional monetary resources to reform our state's child welfare and juvenile justice systems. Among the expressed goals of these efforts were better outcomes for children and families, a reduction in Nebraska's heavy reliance on out-of-home placement of children, and more effective and astute use of the financial resources devoted to these system. Without accountability and transparency, however, even the strongest of mandates and best of intentions may not produce the desired results.

Created in 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) is charged with providing independent accountability, investigation and performance review of Nebraska's child welfare system, in addition to identifying areas for system improvement and policy change at the administrative and legislative levels. In 2015, LB 347 added the whole of juvenile justice to the subject matter jurisdiction of the OIG by including juvenile probation, juvenile detention, and juvenile justice programs funded through the Nebraska Commission on Law Enforcement and Criminal Justice in its conception of the child welfare system. The OIG's formal examination of these new child welfare functions became operative on August 30, 2015.

Since beginning its operations, the OIG has witnessed positive changes to the systems serving Nebraska's children and families. Leadership on child welfare issues across branches of government is paying off with new opportunities and better methods of keeping children, families, and communities safe. The OIG has also been pleased to see an increased commitment to transparency, identification and correction of errors, and honest problem-solving from the Department of Health

and Human Services' Division of Children and Family Services. It is the OIG's hope that this will continue to act as a solid base for continued improvements in the State of Nebraska's response to children in need of protection.

Despite considerable progress, however, challenges remain and further improvements are needed. The following report provides a summary of the OIG's activities from July 1, 2014 through June 30, 2015, including the complaints and critical incidents received, the recommendations made in reports of investigations, and the cross-cutting issues identified. It also provides information on the OIG's preliminary assessment of Nebraska's juvenile justice reform efforts and the need for increased transparency in this area in particular, as the Office begins its review of these state functions in earnest.

Noteworthy to all Nebraska child-serving agencies and institutions is the *dedicated front line staff*—caseworkers, probation officers, detention center and Youth Rehabilitation and Treatment Center staff, guardians ad litem, juvenile court attorneys, and all of those providing direct service to children, youth, and families across this state. They should be commended for the hard and meaningful work that they do every day in service to others.

Like all Offices of Inspector General, the OIG strives through all its actions to, “hold government officials accountable for efficient, cost-effective government operations and to prevent, detect, identify, expose and eliminate fraud, [...] illegal acts and abuse.”<sup>1</sup> As a new year of operations begins, the OIG remains committed to fostering accountability, integrity, and high performance in the systems that impact Nebraska's children and families. The OIG looks forward to working with leaders, stakeholders, and committed professionals to ensure efficient government and a bright future for our Nebraska children and families.

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

Sincerely Yours,

A handwritten signature in blue ink, reading "Julie L. Rogers". The signature is fluid and cursive, with the first name "Julie" being the most prominent.

Julie L. Rogers, JD, CIG

---

<sup>1</sup> “PRINCIPLES AND STANDARDS FOR OFFICES OF INSPECTOR GENERAL” Association of Inspectors General: <http://inspectorsgeneral.org/files/2014/11/AIG-Principles-and-Standards-May-2014-Revision-2.pdf>.

**TABLE OF CONTENTS**

Executive Summary	6
Overview of the OIG	7
Juvenile Justice	8
System Reform Facing Questions	8
Need For Transparency	14
Contact to the OIG, 2014-2015	17
Critical Incidents	17
Deaths	18
Serious Injuries	19
Issues & Trends	21
Professionalism of the Workforce – Caseload Challenges Remain	21
Mental Health & Trauma	22
Concerns with Residential Facilities	23
Youth Rehabilitation and Treatment Centers	25
Reporting Child Abuse & Neglect	27
Foster Home Safety	28
Racial & Ethnic Disparities	29
Due Process for Children & Families	29
Data & Transparency	30
Appendix: List of Recommendations and Implementation Status	32
Appendix: Legislative History and Authority; Committee Membership	41
Appendix: Office of Inspector General of Nebraska Child Welfare Act	43

## EXECUTIVE SUMMARY

The Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and knowledge of Nebraska's child welfare system in order to make better informed policy decisions regarding system-involved children and youth. The OIG investigates complaints, system-involved deaths and serious injuries, and other critical incidents involving Nebraska's state wards and youth in the juvenile justice system. In every instance, the OIG looks for system-wide implications.

During the 2014-2015 fiscal year, the OIG:

- Received a total of 410 contacts, including 132 complaints, 276 critical incidents, and 2 reports of grievances. Of the critical incidents, 21 were child deaths and 34 rose to a level of serious injuries to system-involved children.
- Made a total of 14 recommendation to the Department of Health and Human Services (DHHS) relating to:
  - Mental and behavioral health;
  - Psychotropic medications;
  - Improvement of home study processes;
  - Providing stronger supports for kinship families;
  - Child abuse and neglect hotline training;
  - Immigrant community focused prevention;
  - Increasing support for Prison Rape Elimination Act implementation at YRTC-Geneva; and
  - Clarification of policies governing sexual assaults and harassment.

This annual report also identifies significant child welfare challenges and issues. In addition to mental health care and trauma, residential facility concerns, foster home safety, and due process for children and families, professionalism of child welfare's front line professionals is of utmost importance. Caseworkers are charged with making crucial decisions about children's safety, parent engagement, and access to needed services. A skilled and stable child welfare workforce is key to successful outcomes for children and families and the child welfare system as a whole. This is achieved when front line staff have, among other things, manageable caseloads and workloads. High caseloads remain an obstacle to effective DHHS child welfare operations and improvements.

Concerns have been identified about juvenile justice reform not yet achieving the desired results of cost savings and reducing out-of-home placements. The OIG began official oversight of all state-funded and administered juvenile justice functions on August 30, 2015. With the new responsibilities now fully in effect, the OIG will begin examining juvenile justice issues more closely in the coming year, despite barriers created to access information on how Juvenile Probation operates.

## OVERVIEW – THE OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

The Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of Nebraska's child welfare system, including any public or private individual or agency serving children in the state's care. The “child welfare system” refers to any child-serving government or government supported entity in Nebraska which includes child protection and safety as well as juvenile justice.

The OIG investigates (1) child welfare-related systems issues; (2) death or serious injury of a system-involved child or youth; and (3) complaints of wrongdoing to children and families being served by or through child-serving agencies and institutions.<sup>2</sup> The OIG provides accountability and oversight of Nebraska's child welfare system by tracking issues and themes. System improvement recommendations are made both informally and formally to leaders of child-serving agencies, policymakers, and decision-makers.

The OIG is the first established inspector general's office within Nebraska state government as provided for in state statute.<sup>3</sup> As such, it is important to understand the concept for inspectors general offices. The core values of an office of inspector general are honesty, integrity, and trustworthiness. This is accomplished through inspector general standards of independence and confidentiality. The fundamental objective of inspectors general offices is to promote accountability, transparency, good government, and high performance, thereby leading to public trust and the answers to whether policy goals are being achieved. The OIG's objective is to promote these as it specifically relates to child welfare—any child-serving government or government-supported entity—in Nebraska.

*“...The public expects OIGs to hold government official accountable...and to prevent, detect, identify, expose and eliminate fraud, [...] illegal acts and abuse. This public expectation is best served by inspectors general when they follow the basic principles of integrity, objectivity, independence, confidentiality, professionalism, competence, courage, trust, honesty, fairness, forthrightness, public accountability and respect...”*

Statement of Principles for Offices of Inspector General, Association of Inspectors General

---

<sup>2</sup> Neb. Rev. Stat. §43-4318.

<sup>3</sup>Other Offices of Inspectors General may exist in Nebraska, but they are more closely associated with the federal government and internal military operations. During the 2015 Legislative Session, the Inspector General of the Nebraska Correctional System was created by Legislative Bill 598.

## JUVENILE JUSTICE

### JUVENILE JUSTICE REFORM FACING QUESTIONS

Since its creation in 2012, the Office of the Inspector General (OIG) has had a role in providing system review to at least some of the State of Nebraska's juvenile justice services and functions. The OIG has always had the ability to investigate complaints and critical incidents related to the Office of Juvenile Services (OJS) within the Department of Health and Human Services (DHHS). This includes continuing oversight of both Youth Rehabilitation and Treatment Centers (YRTCs) and included oversight of OJS operations related to both youth supervised in the community and placed in private residential facilities.

When responsibility for OJS youth was transferred to Juvenile Probation in 2013, the OIG lost the ability to examine, review, and investigate complaints related to many of the most troubled and high risk youth in the juvenile justice system. A narrow exception was created to allow the OIG to look into the cases of youth on Probation who die or are seriously injured while placed out of their homes. However, juvenile justice system challenges, especially those involving youth supervised by juvenile probation, have continued to make their way to the OIG through complaints, discussions at committees where the OIG is represented, critical incidents involving youth who are also involved with DHHS, and continued oversight of the YRTCs.

In 2015, the Legislature expanded the OIG's role to include the ability to investigate complaints and incidents of concern related to state-funded or state-regulated juvenile justice operation. Effective August 30, 2015, the OIG began its juvenile justice functions relating to the Juvenile Services Division of the Office of Probation Administration (Juvenile Probation), the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission), and juvenile detention centers. The OIG looks forward to strengthening the juvenile justice system through rigorous oversight, thorough investigations of complaints and incidents of concerns, and thoughtful recommendations for how systems can better serve children and families, protect public safety, and efficiently use government resources.

As this new juvenile justice role begins, the OIG felt it necessary to highlight the history behind Nebraska's recent reform effort, the current status of the reform from the OIG's perspective, and the OIG's concerns about transparency issues surrounding Juvenile Services Division of the Office of Probation Administration that hinders effective accountability within our juvenile justice system, despite clear statutory authority.

#### *Nebraska's Juvenile Justice Reform in Context*

In recent years, efforts to reform the response to youth crime and misbehavior have swept across the United States. These reforms, which contributed to a 37% decrease in youth commitment from 1997 to 2010,<sup>4</sup> have been motivated by the dismal outcomes the juvenile justice system has been achieving

---

<sup>4</sup> Sickmund, Melissa, Sladky, T.J., Kang, Wei, and Puzanchera, C. (2015) "Easy Access to the Census of Juveniles in Residential Placement." Online Author's analysis of OJJDP's Census of Juveniles in Residential Placement 1997,



for youth and public safety despite the significant financial resources expended by county and state governments. Heavy reliance on committing youth to residential facilities – detention centers, jails, prisons, group homes, etc. – for even minor infractions does not reduce the likelihood that youth will commit crimes in the future (and in fact increases it for lower-risk youth). Furthermore, youth commitment to public or private facilities is extremely costly, and many facilities across the nation have struggled to provide safe, appropriate, and therapeutic conditions, making them the subject of scandals and lawsuits.<sup>5</sup>

While reform trends made progress across the country, data indicated that Nebraska's youth were committed to residential facilities at the 3<sup>rd</sup> highest rate in the country as of 2011.<sup>6</sup> Beginning in 2012, the Nebraska Legislature passed a series of bills aimed at replicating successful reform efforts in other states. Broadly, these bills focused on providing youth with access to rehabilitative services in their communities, reducing unnecessary system involvement and duplication of services for children and families, limiting the use of detention and commitment, improving the quality of the Youth Rehabilitative and Treatment Centers (YRTCs), promoting evidence-based services, and using Nebraska's juvenile justice expenditures more wisely.

A primary strategy used by the reform effort was the significant shift of funding and responsibility from the Office of Juvenile Services (OJS) to the Administrative Office of Probation (LB 561, 2013). This strategy was especially championed by the Administrative Office of Probation after they saw initial success with pilot projects expanding Probation funding and responsibility in Judicial District #4J (Douglas County), Judicial District #11 (North Platte, Lincoln County and surrounding counties), and Judicial District #12 (counties in Nebraska's panhandle). Beginning October 1, 2013, all youth charged with new status offenses or law violations could no longer be made state wards. Instead Juvenile Probation was responsible for providing services and supervision. The law also required that by July 1, 2014 any remaining OJS wards be transferred to Juvenile Probation supervision.

### **REFORM EFFORTS NOT YET ACHIEVING DESIRED RESULTS**

Comprehensive juvenile justice reform and system transformation takes time. As Nebraska approaches the two-year anniversary of the most significant legislative reforms going into effect, it is to be expected that challenges remain. It is also reasonable to expect that more than two years into a coordinated reform effort that there be some movement in the right direction with more tangible improvements on the horizon. However, publicly available data and information, as well as individual complaints and cases that have come to the OIG's attention, indicate that juvenile justice reform is not yet achieving many of its desired results. Many of the areas where the OIG has

---

1999, 2001, 2003, 2006, 2007, 2010, and 2011. Available: <http://www.ojjdp.gov/ojstatbb/ezacjrp/>

<sup>5</sup> Mendel, Richard. *No Place for Kids: The Case for Reducing Juvenile Incarceration*. Baltimore: The Annie E. Casey Foundation, 2011. <http://www.aecf.org/m/resourcedoc/aecf-NoPlaceForKidsFullReport-2011.pdf>.

<sup>6</sup> Youth Residing In Juvenile Detention, Correctional And/Or Residential Facilities. *Kids Count Data Center*. <http://datacenter.kidscount.org/data/Tables/42-youth-residing-in-juvenile-detention-correctional-and-or-residential-facilities?loc=1&loct=2#detailed/2/2-52/false/867,133,18/any/319,17599>.

identified significant shortcomings are directly related to the responsibilities and operations of the Juvenile Services Division of the Administrative Office of Probation.

***No Cost Savings***

One of the major goals of juvenile justice reform was a more efficient use of financial resources. Since LB 561 went into effect, juvenile justice costs to the State of Nebraska have increased at a much greater rate than anticipated, despite a continued decline in youth crime.<sup>7</sup> The largest driver of this increase has been the additional funding provided the Administrative Office of Probation for juvenile services (see Table I). In addition to a large transfer of funds from DHHS, Probation was provided additional funding at the start of reform effort as a cushion for transition costs and to expedite system transformation and reduction of residential placements.

**Table I. Funding Provided to the Probation Administration related to LB 561<sup>8</sup>**

	<b>FY2014</b>	<b>FY2015</b>	<b>FY2016</b>	<b>FY2017</b>
<b>Funds shifted from DHHS</b>	\$15,756,126	\$39,131,653	\$39,131,653	\$39,131,653
<b>Additional Funds provided to Probation</b>	\$ 4,000,000	\$ 4,833,670	\$ 4,833,670	\$ 4,833,670
<b>Total</b>	<b>\$19,756,126</b>	<b>\$43,965,323</b>	<b>\$43,965,323</b>	<b>\$43,965,323</b>

Despite an increase in funding, Juvenile Probation has been running unexpected deficits since reform began. Probation asked for, received, and utilized of \$7.4 million related to a deficit request for FY13-14. Probation received and used an additional \$7 million as a FY15 deficit. They also received an additional \$7 million as a deficit for FY16, which was less than requested.<sup>9</sup> The general expectation is that Probation will ask for an additional deficit appropriation this coming year.

In addition to these increased resources to juvenile Probation, community-based aid dollars to counties under the Juvenile Services Act increased as well. In fiscal years 2012 and 2013, the community based aid was set at \$1,477,575; in fiscal year 2014 it increased to \$3,000,000; in fiscal year 2015 to \$4,950,000; and in fiscal years 2016 and 2017 it is set at \$6,300,000. These dollars are meant to “divert juveniles from the juvenile justice system, reduce the population of juveniles in juvenile detention and secure confinement, and assist in transitioning juveniles from out-of-home placements.”<sup>10</sup>

<sup>7</sup> 10,534 youth were arrested in 2013, a decline from 12,207 in 2012 and a steep decline the high point of arrests in 2006 at 16, 153. Voices for Children in Nebraska. *Kids Count in Nebraska 2014 Report*.

<sup>8</sup> All information in chart provided to the OIG by Doug Nichols, Legislative Fiscal Office. All additional funds were General Fund Dollars.

<sup>9</sup> *Ibid.*

<sup>10</sup> Neb. Rev. Stat. §43-2404.02.

### *Frequent Use of Out-of-Home Placements*

Until January 2015, Probation was not able to make statewide calculations on how many youth under its supervision were placed out-of-home. This lack of data has limited the ability to measure whether or not juvenile justice reform was making progress. Now that data on youth is available, it appears that little or no progress has been made in reducing out-of-home placements since Probation assumed primary responsibility for coordinating services and supervision of youth in the juvenile justice system.

On a single day in July 2015, Probation reported 1,089 youth who were out-of-home.<sup>11</sup> For the purposes of comparison, OJS reported 1,298 youth spent some time in out-of-home care between July 1, 2012 and June 30, 2013, before the transition to Probation went into full effect.<sup>12</sup> These numbers indicate that the use of out-of-home placement has certainly not decreased in Nebraska's juvenile justice system, and may, in fact, have risen on the whole.<sup>13</sup> While the population at the YRTCs has decreased, youth continue to be sent to detention, and most often private, residential facilities (group homes), many of which do not offer treatment. This is concerning as these facilities not only cost more for Nebraska, but also generally do not have positive outcomes for youth or reduce their likelihood of committing crimes in the future.

The likely trend upward in out-of-home placements since reform efforts began seems to be confirmed when looking at available information on out-of-home spending. Based on information made available to the Legislative Fiscal Office, Probation spent more on congregate residential placements (not including foster care) for the 7 months between July 1, 2014 and January 31, 2015 than the entire budget of both YRTCs during SFY 2013-2014. This expenditure is also about \$2 million more than the entire Out-of-Home expenditures, including General *and* Federal Funds, reported by OJS in SFY 2012-2013 (see Table II).

---

<sup>11</sup> This number includes youth in residential placements (group homes, foster homes), detention, YRTC, and on runaway status. While Probation counts youth placed in detention, YRTC, and runaway separately, the OIG has added these youth in to an overall out-of-home count for the purpose of comparison. Numbers provided to the OIG by Probation based on the "Probation Juvenile Justice Reform Efforts: July 2015 Report." <https://supremecourt.nebraska.gov/sites/supremecourt.ne.gov/files/probation/Juvenile/Juvenile%20Justice%20Reform%20Efforts%2C%20July%202015.pdf>.

<sup>12</sup> "Office of Juvenile Services Annual Legislative Report SFY 2012/2013." [http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Health\\_and\\_Human\\_Services\\_Department\\_of/51\\_20130913-144625.pdf](http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Health_and_Human_Services_Department_of/51_20130913-144625.pdf).

<sup>13</sup> It is not ideal to compare data from a single point of time to a count of youth in placement during a whole year, since yearlong counts include more youth a more complete accounting, but it is the best the OIG can calculate based on the information available.

**Table II. Juvenile Justice Residential Facility Expenditures<sup>14</sup>**

<b>Detention</b> (Probation) 7/1/14 – 1/31/15	<b>Non-treatment</b> <b>Residential</b> (Probation) 7/1/14 – 1/31/15	<b>Treatment</b> <b>Residential</b> (Probation) 7/1/14 – 1/31/15	<b>Probation Total</b> 7/1/14 – 1/31/15	<b>Youth</b> <b>Rehabilitation</b> <b>and Treatment</b> <b>Centers</b> SFY 2013-2014	<b>OJS Out-of-Home</b> SFY 2012-2013
\$ 4,365,516	\$ 10,470,532	\$ 8,020,500	<b>\$22,856,548</b>	\$ 18,465,737.93	\$20,876,487.48

***Inappropriate Use of Detention***

Part of the recent reform effort aimed to reduce the unnecessary use of juvenile detention. Among other changes, LB 561 established two purposes for secure detention: “immediate and urgent necessity for the protection of [a] juvenile or the person or property of another or if it appears that [a] juvenile is likely to flee the jurisdiction of the court.”<sup>15</sup> The law further clarifies that it is not permissible to detain youth for status offenses (e.g. - skipping school, running away).<sup>16</sup> However, information available to the OIG indicates that Nebraska is not yet using juvenile detention in accordance with these new provisions and many low-risk youth continue to be detained.

Nebraska law requires that Probation uses a standard risk assessment instrument (RAI) to assess whether or not to detain a youth.<sup>17</sup> A recent study by the Juvenile Justice Institute showed that Probation is not using the tool enough to know whether the tool is valid or can be verified in any way. Probation officers override the RAI 45% of the time. These are youth whose score indicates that they should *not* be detained because they do not pose a risk of failing to appear in court or committing a new crime. The study found that between September 1, 2013 and August 31, 2014, 578 youth who did not score for detention, were placed in detention by Probation. Of those, **251 youth detained scored to be released without any restriction** (e.g. – electronic monitor).<sup>18</sup>

<sup>14</sup> Information in chart on Probation expenditures provided to the OIG by Doug Nichols, Legislative Fiscal Office. YRTC spending cited above can be found in the annual reports for YRTC-G and YRTC-K. OJS Spending found in the OJS report to the Legislature: [http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Health\\_and\\_Human\\_Services\\_Department\\_of/51\\_201\\_30913-144625.pdf](http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Health_and_Human_Services_Department_of/51_201_30913-144625.pdf).

<sup>15</sup> Neb. Rev. Stat. §43-251.01.

<sup>16</sup> *Ibid.*

<sup>17</sup> Neb. Rev. Stat. §43-260.

<sup>18</sup> Moore, Sara and Anne Hobbs. “Analysis of the Nebraska Intake Risk Assessment Instrument – 2015.” Juvenile Justice Institute. University of Nebraska at Omaha, 2015. <http://www.unomaha.edu/college-of-public-affairs-and-community-service/juvenile-justice-institute/files/documents/analysis-of-nebraska-intake-risk-assessment-instrument.pdf>.

*Probation Administration should be commended* for undertaking the study of the RAI and releasing the report. Opening a system up to evaluation is the first step toward purposeful improvement and transparency. The OIG strongly supports Probation continuing constant knowledge, transparency, and evaluation of their system in order to make needed improvements in all areas.

The OIG has also received complaints related to youth already supervised by Probation being inappropriately detained. Often a youth's placement in detention is requested by Probation officers for probation violations – the youth breaking rules or failing to follow the terms of Probation. The OIG has seen cases of youth being detained due to issues such as a lack of available placements, a parent's refusal to follow court orders, and even cursing at adults. Anecdotally, juvenile justice stakeholders indicate that the majority of youth in detention are there for probation violations, not because they pose a danger to public safety. This inappropriate use of detention is both costly to the state and harmful to youth. The OIG will continue to look into this issue in the coming year.

### ***Indefinite Probation Supervision replaces State Ward Status***

Adults sentenced to probation are given a specific term of months to serve before being free to go about the rest of their lives. Before LB 561's passage, youth in juvenile court were also given a specific and certain time period on probation. With LB 561, the Legislature intentionally took away the option of making youth state wards when they committed crimes or status offenses with the hope of limiting children's involvement in the juvenile justice system. However, courts now seem to be routinely placing youth on juvenile probation for an indefinite period of time, until their 19<sup>th</sup> birthday. It is referred to as "indefinite" because there is a chance that the youth could be released from probation supervision when all conditions of probation have been met. It is the OIG's understanding that Juvenile Probation has encouraged juvenile probation officers to request the court end the youth's term of probation when the youth has successfully completed all items the court has ordered. It may make more sense to limit the probation terms that can initially be imposed on a youth, then giving the courts the discretion and opportunity to extend the probation term if need be.

For youth who have made a mistake or two, but are generally low-risk, extended involvement in the juvenile justice system tends to mean poor outcomes for the youth and a greater risk of criminal offending going forward, not to mention higher costs to the state.<sup>19</sup> The OIG is aware of children as young as 12 and 13 being placed on indefinite probation for charges like criminal mischief. This practice seems to be contrary to the intent of recent reform efforts and may require legislative clarification.

### ***Violent crimes committed by youth on juvenile probation***

Juvenile Probation is charged not only with guaranteeing that youth access necessary rehabilitative services, but also ensuring that public safety is protected through adequate supervision and assessment of youth. Since December 2014, at least two youth supervised by juvenile probation have

---

<sup>19</sup> "Core Principles for Reducing Recidivism and Improving Other Outcomes for Youth in the Juvenile Justice System." National Reentry Resource Center. Council for State Governments: July 2014. <https://csgjusticecenter.org/wp-content/uploads/2014/07/JJWhitePaperExecSummary.pdf>

been charged with homicide.<sup>20</sup> Since the OIG did not have jurisdiction at that time, no specific reviews of either incident has been conducted at this point. However, these high profile incidents raise questions about whether juvenile probation is using effective strategies for working with these youth, whether youth are being correctly assessed and supervised based on their risk level, and whether appropriate services were provided to the youth who went on to commit violent crimes.

### **NEED FOR TRANSPARENCY**

Nebraska's juvenile justice reform has ambitious and worthy goals - ensuring positive youth outcomes, effective, judicious use of taxpayer dollars, and public safety. Passing laws with good intentions is rarely enough to achieve desired outcomes, however. The challenges that Nebraska's juvenile justice reform is facing and areas where it is not yet meeting its targets clearly illustrate that more needs to be done to reach the desired goals of reform.

Key to successful reform is transparency and accountability. Nebraska administrators, policymakers and the public need to better understand why reform is struggling in certain areas so that needed changes can be identified and enacted administratively or legislatively. Decisions need to be made with all true and factual information presented and available. Included in these decision-making considerations are whether certain items should be handled internally to an agency or externally; at the state, county, or local level; and whether a function should reside in a certain branch of government. Considering the resources and responsibilities recently delegated to Probation, oversight and understanding of Probation's operations is particularly important. A single agency cannot be held solely responsible for reform's success or failure. However, the more detailed information available about how Juvenile Probation is functioning and the outcomes it is achieving, the more cooperation that can occur across branches of government and the more efficiencies that can be implemented for the good of Nebraska's youth, families, and communities.

Unfortunately, as the OIG begins its expanded oversight, there are significant concerns about the transparency of the Administrative Office of Probation. While the OIG has been commissioned by the Legislature to act as a mechanism of legislative accountability for Juvenile Probation, they have indicated that they do not intend to comply with the law, including allowing the OIG direct access to electronic databases and expedited access to case files. This places additional burdens on the OIG, Probation staff, and most importantly the courts which now must issue orders for information that the OIG needs in order to make timely and informed decisions. The OIG is also aware that other entities have been denied juvenile probation information access, for example: the Foster Care Review Office, charged with reviewing out of home placements, cannot access policy information to perform their oversight functions.

Probation decided not to release a report by the Council of State Governments in the spring of 2015 that contains analysis and recommendations for how to improve Nebraska's Juvenile Probation

---

<sup>20</sup> Press coverage in the Omaha World-Herald indicates that a 16-year-old supervised by Probation was charged with a double homicide in January 2015. See: "[Bail denied for Omaha teen charged in double homicide.](#)" January 8, 2015. A 15-year-old supervised by Probation was charged with homicide in July 2015. See "[Parents of 12-year-old boy facing murder charge were violent examples.](#)" July 9, 2015.

system. Anecdotally, Probation has shared that they agree with the findings and recommendations of such CSG report, but site that the data is wrong, therefore the report needs correcting. CSG confirmed verbally that they are confident in and will not change their findings and recommendations in the report.

Most concerning, juvenile probation policies and procedures, which govern their operations, are prohibited from being shared with the OIG. Since Probation is housed under the Nebraska Supreme Court, the Administrative Procedures Act does not apply, so the policies that Probation uses to determine how to keep youth and communities safe and how to efficiently use taxpayer dollars are not open to public review. The OIG requested complete access to Probation's policies in order to understand Nebraska's juvenile probation system, but was formally denied.<sup>21</sup>

Access to policies and procedures is absolutely necessary to the OIG's role as they serve as the basis for both the investigation of complaints and formulation of recommendations that the OIG makes to agencies. Inspector General work is formal—trusting what is said, but *always* verifying and supporting with documentation.

The lack of openness is concerning for those beyond the OIG as well. There is no avenue that families and youth who are involved with Probation have to understand or give input to the processes that impact their lives so significantly. Nor is there an opportunity for other agencies which must attempt to work cooperatively to achieve better outcomes for youth and families to share input and information about Probation's functioning with their staff. This inevitably leads to unnecessary confusion about system roles and responsibilities. Finally, a lack of publically available and clear policy and procedure inevitably leads to confusion as legislative decisions are made related to appropriation of funds.

Despite the obstacles, the OIG remains committed to providing oversight of the juvenile justice system and Juvenile Probation in particular to the greatest degree possible. While the challenges are significant, the OIG remains hopeful that progress can be made towards creating a transparent, efficient juvenile justice system in Nebraska that serves youth, families, and public safety well.

---

<sup>21</sup> Steel, Corey. Letter to Julie L. Rogers. 10 Sept. 2015. TS.

### **Juvenile Justice Complaint from 2014-2015**

“Johnny”<sup>1</sup> is a 13-year-old who has been in detention almost continuously for 5 months. This is his first time in the juvenile justice system. He has multiple mental health diagnoses and is on a number of medications, some of which are psychotropic. The OIG was called because of concerns about Johnny not receiving his medications in detention or experiencing delays in medication administration, his glasses disappearing, his hearing aids not having batteries, and facility staff causing bruises on Johnny’s arm and responding harshly to his behaviors.

As is standard protocol whenever a complaint comes into our office, the OIG reviewed publically available court records and any information available through the Department of Health and Human Services’ NFOCUS system to see if any other issues meriting investigation were present. Although the OIG did not have the jurisdiction at the time to investigate any of the issues raised, records did reveal additional concerns and systemic issues within the juvenile justice system:

- **Use of indefinite probation:** Johnny was placed on indefinite probation (5 years and 231 days) by the court for criminal mischief and third degree assault. An adult convicted of similar charges could only be supervised by probation for a maximum of 2 years.
- **Children’s status based on parent’s actions:** Johnny’s probation order required his mother to complete parenting classes.
- **Placement instability:** Johnny has had 6 placement changes. Three different foster placements lasted less than two weeks. Within the first month after a charge was filed, Johnny had been removed from his home and been to 3 additional and different placements
- **New charges filed while youth on probation:** A new 3<sup>rd</sup> degree assault charge was filed against Johnny after less than 2 months on probation.
- **Long stays in detention:** Johnny spent approximately 5 months in detention, much of it waiting for placement.
- **Lack of available, suitable placements:** The judge gave probation the authority to use the least restrictive placement, including foster care. However, no foster families where Johnny was placed were able to successfully care for him and he returned to detention. Johnny is ordered to be placed in a group treatment home and was transferred to an out-of-state group home shortly after the OIG received the complaint.
- **Unaddressed child welfare concerns:** Throughout Johnny’s childhood up until just a few months before he was charged in the juvenile justice system there have been numerous intakes to the child abuse and neglect hotline raising concerns about the care provided to Johnny. No formal child welfare services have been provided to Johnny or his family.



## CONTACTS TO THE OFFICE OF INSPECTOR GENERAL

The work of the Office of Inspector General of Nebraska Child Welfare (OIG) is determined by the information that it receives. Information generally comes to the office in the form of complaints from the public, critical incident notifications from DHHS or Probation, and copies of grievance findings from DHHS. The OIG conducts a preliminary inquiry and document review on every complaint, critical incident, and grievance finding to determine whether or not to open a full investigation and what, if any, additional actions may be appropriate.

Between July 1, 2014 and June 30, 2015, the OIG received a total of **410 contacts**, including:

- **132** complaints (over two-thirds were received by telephone);
- **276** critical incidents (273 from DHHS and 3 from Probation)<sup>22</sup>; and
- **2** reports of grievances and accompanying findings from DHHS.

The Legislature recently gave the OIG the authority to investigate complaints and incidents of concern related to cases referred to Alternative Response (AR),<sup>23</sup> a new pilot project that DHHS began in October 2014. Although, the OIG's contact information has been given to all families who participate, the OIG received no complaints, critical incidents, or grievances related to AR.

During the past fiscal year, the OIG worked to improve its own internal system for tracking contacts. The OIG expanded the amount of data it collected from critical incidents, in particular, which account for over two-thirds of the staffed cases. The hope is that this information can be used to track trends and identify systemic issues that may require investigation. This information can also help the OIG track its own performance and learn to more efficiently use its limited resources. Starting July 1, 2015, the OIG expanded and refined the data it collects related to complaints as well. Detailed data is only available for critical incidents in this report.

### DATA ON CRITICAL INCIDENTS

Both DHHS and Probation have set policies related to reporting critical incidents internally and to the OIG. DHHS has chosen to include the OIG on all internal critical incident reports, while Probation chose to send special reports to the OIG related to death and serious injury only during the last fiscal year.<sup>24</sup>

As Figure I illustrates, these reports bring a large range of incidents to the OIG's attention. The highest number of incidents reported to the OIG involved a youth escape or attempted escape from a state facility. 20 reports involved youth at YRTC-Geneva, 26 reports involved youth at YRTC-

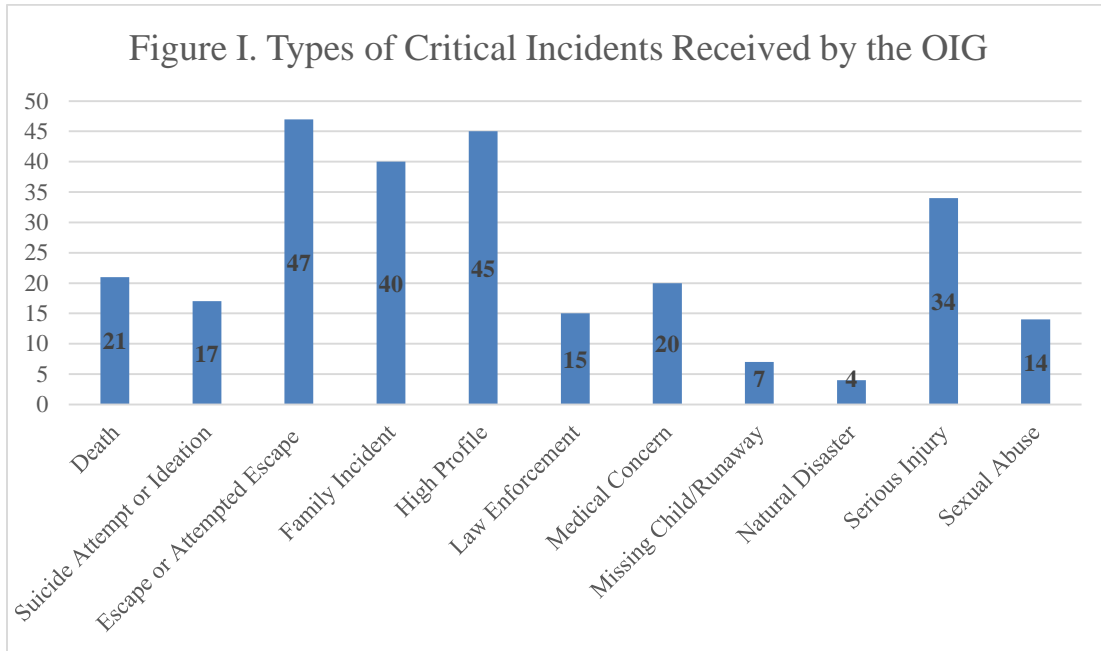
---

<sup>22</sup> The OIG captures data by each child involved in a critical incident. A single critical incident often involves more than one child. Furthermore, some children were involved in more than one critical incident in the course of the year. They are counted each time a critical incident was received in the count of contacts, but are unduplicated for data on critical incidents as a whole.

<sup>23</sup> Neb. Rev. Stat. §28-712.01 (5).

<sup>24</sup> Probation Administration has reconsidered only sending special reports and has indicated that the OIG will now receive all of juvenile probation's critical incident reports.

Kearney, and 1 report involved youth at the Hastings Juvenile Chemical Dependency Program. Escapes and attempted escapes present a challenge to both YRTC's.



Many other types of reported incidents were related to family members of youth in DHHS custody (e.g. – car accident, criminal arrest) or other “high profile” events (e.g. – media coverage of child abuse). The OIG also received over 50 reports of deaths or possible serious injuries, which the OIG is tasked with closely examining. Additional data breakdowns on these areas are provided in the following sections.

Of the children mentioned in critical incident reports:

- 42% were teenagers (between 13 and 19 years of age);
- 28% were under the age of two;
- 33% were DHHS wards;
- 18% were supervised by Probation;
- 17% had no prior system involvement; and
- 16% had a current or prior child abuse investigation.

### **DEATHS REPORTED TO THE OIG**

During the last fiscal year, the OIG was tasked with investigating all deaths and serious injuries of children: (1) placed in out-of-home care, a residential facility, or in the care of a licensed day care facility; (2) currently receiving or have received child welfare services from DHHS in the past twelve months; and (3) the subject of a child abuse investigation (initial assessment) in the past twelve months. This criteria will expand next year to include the death of any child receiving services from Probation.

During the last fiscal year, the OIG received reports of **21 child deaths**. Of these reports:

- Over **90%** of deaths involved children **under the age of 2**;
- **57%** of the children who died were **male**; and
- **15** deaths met the criteria for a full investigation.

Most of the 15 investigations into these deaths are not yet complete, however the OIG does have preliminary data available on the cause of death and level of system involvement (see Table III).

Over two-thirds of the deaths reported to the OIG were caused by medical conditions or Sudden (Unexplained) Infant Death Syndrome (SIDS). Abuse or neglect were the cause of death in 3 of the 15 cases, one involving an active non-court case and two involving recent child abuse investigations. Finally, one youth on juvenile Probation and placed at a home for the developmentally disabled died due to hypothermia.

The OIG is committed to completing thorough investigations in all these cases to identify issues in these individual cases and areas where systemic improvements are needed to better care for Nebraska’s children.

**Table III. Cause of Death in New OIG Investigations, FY 14-15**

<b>Cause of Death</b>	<b>State Wards</b>	<b>Initial Assessment in Past 12 Months</b>	<b>Non-Court Case</b>	<b>Licensed Child Care Facility</b>	<b>Probation Supervision</b>
<b>Medical</b>	6	0	0	0	0
<b>SUIDS/SIDS</b>	1	2	0	2	0
<b>Abuse &amp; Neglect</b>	0	2	1	0	0
<b>Hypothermia</b>	0	0	0	0	1
<b>Total</b>	<b>7</b>	<b>4</b>	<b>1</b>	<b>2</b>	<b>1</b>

**SERIOUS INJURIES REPORTED TO THE OIG**

The Office of Inspector General of Nebraska Child Welfare Act defines a serious injury as, “injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.”<sup>25</sup> If an injury meets this definition and the criteria outlined in the previous section, the OIG must open a full investigation.

During the last fiscal year, the OIG received reports of **34** suspected serious injuries. Of these reports:

- Over **85%** involved children **under the age of 2**;
- **67%** of children injured were male;

<sup>25</sup> Neb. Rev. Stat. §43-4318

- Over **55%** of children seriously injured had no prior contact with the child welfare system; and
- **11** met the criteria for a full OIG investigation.

Table IV shows preliminary information available on the types of injuries for children who had current or prior child welfare system involvement.

**Table IV. Type of Serious Injury in Critical Incidents by System Involvement, FY 14-15**

Type of Serious Injury	Initial Assessment in past 12 months	State Ward	Case Closed in Past 12 Months
Abusive Head Trauma	4	0	1
Accident	2	0	0
Skull Fracture or Brain Bleed	1	2	0
Neglect	1	1	0
Unknown	2	0	0
<b>Total</b>	<b>10</b>	<b>3</b>	<b>1</b>

10 of the suspected serious injuries reported occurred to children who were the subject of a recent child abuse investigation. Another trend worth noting is that over a third of serious injuries to children who had contact with the child welfare system were related to abusive head trauma. Formerly referred to as “shaken baby syndrome,” abusive head trauma is commonly defined as, “an injury to the skull or intracranial contents of an infant or young child (< 5 years of age) due to inflicted blunt impact and/or violent shaking.”<sup>26</sup> These types of injuries can often leave children with permanent disabilities. In the coming year, the OIG will be closely examining and investigating these cases to identify issues and make thorough recommendations.

<sup>26</sup> “PEDIATRIC ABUSIVE HEAD TRAUMA RECOMMENDED DEFINITIONS FOR PUBLIC HEALTH SURVEILLANCE AND RESEARCH.” Centers for Disease Control. April 2012. <http://www.cdc.gov/violenceprevention/pdf/pedheadtrauma-a.pdf>

## ISSUES & THEMES

One of the main charges of the OIG is identifying significant child welfare challenges and issues.<sup>27</sup> Although the OIG's work is based on investigating individual cases and complaints, many of the issues identified through our investigations are systemic in nature. The following section describes broad challenges that Nebraska's child welfare system is facing.

The OIG has made recommendations to DHHS related to many of these areas (full recommendations can be found in Appendix A). However, long-term solutions and improvements in most of the areas below will require the dedicated leadership and cooperation of private providers, different state agencies, and branches of government.

### **PROFESSIONALIZATION OF THE WORKFORCE – CASELOAD CHALLENGES REMAIN**

Child welfare's front line professionals have extremely challenging jobs. They are charged with making crucial decisions about children's safety, engaging struggling parents and families, and ensuring youth have access to the care, services, and loving, supportive relationships that they need to succeed. Front line child welfare jobs frequently require those who take this enormous task on to respond to the urgent needs of children and families every day of the week and all hours of the day and night.

A skilled and stable child welfare workforce is key to successful outcomes for children and families and the child welfare system as a whole. This is achieved when front line staff have manageable caseloads and workloads, when they are well-trained and educated, and when turnover is minimized. Increasing the professionalization and stability of the child welfare workforce has received significant attention in Nebraska in recent years from the Legislature, DHHS, and others. Efforts to improve the child welfare workforce through better training, education, recruiting, and retention show promise. However, these efforts are being undermined by Nebraska's persistently high caseloads, which have been shown to increase worker turnover and limit a worker's ability to achieve good outcomes for children and families.<sup>28</sup>

In 2012, the Legislature required DHHS caseloads not be greater than 17.<sup>29</sup> At the end of July 2015, the actual caseload for ongoing cases in all DHHS Service Areas was between 20 and 30 families for each worker. The caseload limits set forth in statute are mandates, not goals. With the significant changes in funding available for frontline child welfare staff due in large part to the shifts of case management between DHHS, private child welfare agencies, and Probation before and since 2012, it

---

<sup>27</sup> Nebraska Revised Statute 43-4302 "determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system."

<sup>28</sup> Social Work Policy Institute. "High Caseloads: How Do They Impact Delivery of Health and Human Services." January 2010.

<sup>29</sup> Nebraska Revised Statute 68-1207

is impossible to know whether enough funding was ever or is currently allocated to allow DHHS to meet statutory compliance.<sup>30</sup>

DHHS CFS administrators have been diligent in efforts to address workforce challenges – expanding opportunities for front line staff and working closely with HR to refine hiring practices and promote retention. However, these efforts have not reduced caseloads. A national consultant brought in to assist Nebraska with caseloads by Casey Family Programs in July 2015 shared that to successfully meet caseload standards it was important to appropriately account for both turnover rates and leave that employees take (maternity leave, sick and vacation time) in determining how many positions are necessary. Building in a cushion or forward fill of approximately 20% is often recommended.

Going forward, if caseload standards in law are actually to be implemented rather than aspirational, the Legislature and DHHS must work together to ensure that funding levels are appropriate and that resources are being expended where the Legislature intended. Additionally, the Legislature must assess whether Probation, which has no statutorily mandated caseload standards, has enough staff to function appropriately and whether caseloads should also be mandated for juvenile Probation.

### **MENTAL HEALTH AND TRAUMA**

Experiencing certain traumatic events in childhood, among them abuse, neglect, parental separation, and witnessing violence, has been shown to adversely impact children’s development and brain functioning. Research shows a remarkable prevalence of trauma in our systems-involved children. A national study of adult foster care alumni found that 25.2% had PTSD, nearly double the rate of US war veterans. Other research offers evidence that the number for juvenile offenders could be nearly twice as high. Childhood trauma increases the likelihood of mental and behavioral health challenges.<sup>31</sup>

Given the prevalence of trauma and mental and behavioral health challenges for youth in the child welfare and juvenile justice systems, the OIG identified the implementation of “trauma informed care” in Nebraska’s child serving systems as one of its key recommendations in the OIG Annual Report 2013-2014.<sup>32</sup> Nebraska’s child welfare system must have the policies, procedures, resources, and training to provide trauma informed care. This includes efforts to identify children and youth who are suffering the effects of acute and chronic traumatic experiences, to ensure proper treatment.

---

<sup>30</sup> Memo from Liz Hruska, Legislative Fiscal Office. The Legislature also provided DHHS with approximately \$4.8 million (SFY 11-12) and \$13.5 million (SFY 12-13) solely for hiring additional staff and reducing caseload ratios. With juvenile justice reform efforts, DHHS transferred \$1.9 million (SFY13-14) and \$5.5 million (SFY14-15) in administrative funding used for salaries to the Administrative Office of Probation. Probation has no caseload requirements in statute

<sup>31</sup> Gerrity, Ellen and Cynthia Folcarelli. “Child Traumatic Stress: What Every Policy Maker Should Know.” The National Child Traumatic Stress Network: 2008.

[http://www.nctsn.org/sites/default/files/assets/pdfs/PolicyGuide\\_CTS2008.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/PolicyGuide_CTS2008.pdf).

<sup>32</sup> Office of the Inspector General of Nebraska Child Welfare Annual Report 2013-2014, pages 17-21, [http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Inspector\\_General\\_of\\_Nebraska\\_Child\\_Welfare/285\\_2\\_0140915-233256.pdf](http://nebraskalegislature.gov/FloorDocs/103/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_2_0140915-233256.pdf), (September 15, 2014).

When a court orders a juvenile to the care of DHHS and becomes a ward of the state, that child is subject to the legal custody and care of DHHS.<sup>33</sup> DHHS is then responsible for making decisions regarding medical care and treatment, including mental health treatment and any psychotropic medications prescribed, involving the parent as much as possible.<sup>34</sup> DHHS plays a crucial role in ensuring that the children it serves get the care that they need.

Though Juvenile Probation does not have the same strict burden of providing informed consent for mental health treatment, Juvenile Probation is tasked with case management, supervision, and services of youths placed on probation. Probation officers act as “agents of change” rather than only “enforcers” of orders, thereby developing juveniles and their service delivery to help them and influence behavioral change,<sup>35</sup> which oftentimes includes mental health treatment. In addition, when youth on probation are in out-of-home placement, they continue to be supervised by a probation officer who monitors the juvenile’s progress, behavior, treatment, and continued need for placement.<sup>36</sup> Understanding the trauma effects of every change of placement is key to successful probation supervision. Juvenile probation officers have great influence not only on the youth they supervise, but also in the communication and recommendations they make to decision-makers such as prosecutors and judges.

While DHHS efforts to make the child welfare system more trauma informed have continued, much more remains to be done. The OIG identified a number of shortcomings in Nebraska’s approach to trauma and mental health for those in the child welfare system over the course of the past year. An OIG death investigation of a state ward found that DHHS’s lack of clear policies and procedures for mental health and oversight of psychotropic medication for those in foster care, contributed to a lack of coordination which the resulted in the delivery of insufficient, ineffective care, and likely played a role in the youth’s eventual suicide.<sup>37</sup>

To remedy these concerns, the OIG proposed a number of recommendations including the prompt adoption of policies on appropriate use and oversight of psychotropic medications and processes for informed consent, mental health trauma screening and treatment, and the sharing and updating of all aspects of a youth’s medical (including mental health) information among medical professionals and caretakers. The OIG also recommended expanded training for DHHS staff and others who work directly with children and youth in the state’s care and an expansion of data measures and quality assurance processes on mental health. All recommendations were accepted and details on their implementation status can be found in Appendix A.

### **CONCERNS WITH RESIDENTIAL FACILITIES**

Research on child development consistently shows that children do best in families. Despite this research and federal mandates that children live in the least restrictive (most family-like) setting, many

---

<sup>33</sup> Neb. Rev. Stat. §43-285.

<sup>34</sup> 390 Nebraska Administrative Code (NAC) 11-002.04F

<sup>35</sup> <https://supremecourt.nebraska.gov/10805/juvenile-case-managementsupervision-and-services>

<sup>36</sup> <https://supremecourt.nebraska.gov/10807/juvenile-placement>

<sup>37</sup> See Appendix A

children in the child welfare and juvenile justice system are placed in group residential facilities, often referred to as congregate care. These placements are more expensive than foster care and have been shown to have especially negative effects on young children and children who do not have mental or behavioral health needs that might justify such a placement.<sup>38</sup>

Nationally, about 20% of children in the child welfare system will experience congregate care placement at some point during their time in care. Available Nebraska data seem to show similar numbers.<sup>39</sup> Youth in the juvenile justice system are also frequently placed in congregate care facilities. Nebraska in particular places juvenile justice youth in residential facilities (including detention and YRTCs) at the 3<sup>rd</sup> highest rate in the nation.<sup>40</sup> Like most other states, Nebraska has more work to do to appropriately reduce the use residential facilities for vulnerable children and youth.

Ideally, residential facilities should be used rarely – only in cases where children have significant needs that cannot be met in a family setting in the community. These facilities must have high standards of care and well-trained staff to ensure children’s safety and well-being. Facilities should do everything possible to minimize the potential harm that congregate placement can bring. Unfortunately, a number of specific concerns about the inappropriate use of residential facilities and confusion about facility requirements and standards have come to the OIG’s attention over the past year.

The OIG received a number of complaints about Nebraska youth being sent to out-of-state facilities. In looking into many of these complaints, the OIG found that most of these facilities did not offer intensive mental health treatment, but instead were usually privately run facilities, more equivalent to either group homes or Nebraska’s YRTCs. The OIG did not have jurisdiction to open investigations on the complaints, so it was unclear why youth were sent there instead of equivalent facilities in Nebraska, closer to their community and family. In an effort to address concerns, the OIG is currently participating in a legislative interim study examining these issues and hopes more can be done reduce the unnecessary use of out-of-state facilities.

The OIG is also aware of general uncertainty about how Nebraska residential facilities should be licensed. Nebraska has two entities that license or inspect residential facilities for children - the Jail Standards Board of the Crime Commission and the Division of Public Health of DHHS. The Legislature made a general distinction between facilities run by counties (licensed by Jail Standards) and those run by private providers (licensed by DHHS) in 2013. However, questions persist about whether facility standards established by the entities meet the needs of the children housed there and whether facilities can or should be licensed by both entities. An example that came to the OIG’s

---

<sup>38</sup> The Adoption and Safe Families Act of 1980 adopted the “least restrictive setting” standard. For research on potential negative outcomes see Wulczyn, Fred et al. “Within and Between State Variation in the Use of Congregate Care.” Chapin Hall, The Center for State Child Welfare Data: June 2015. [https://fcda.chapinhall.org/wp-content/uploads/2015/07/Congregate-Care\\_webcopy.pdf](https://fcda.chapinhall.org/wp-content/uploads/2015/07/Congregate-Care_webcopy.pdf).

<sup>39</sup> *Ibid.* Available Nebraska data showed that approximately 20% of DHHS wards on December 31, 2013 were placed in congregate care. *Kids Count in Nebraska 2014 Report*.

<sup>40</sup> Youth Residing In Juvenile Detention, Correctional And/Or Residential Facilities. *Kids Count Data Center*. <http://datacenter.kidscount.org/data/Tables/42-youth-residing-in-juvenile-detention-correctional-and-or-residential-facilities?loc=1&loct=2#detailed/2/2-52/false/867,133,18/any/319,17599>.



attention this year is the Northeast Nebraska Juvenile Services Center, a non-profit, that runs a detention center but also has a staff-secure detention wing that is now licensed by Public Health as well. This means the same wing that primarily serves youth in the juvenile justice system who have committed crimes is allowed to house abused and neglected youth as young as 8 as a shelter. There is also confusion about what the difference is between both secure and staff-secure detention and staff-secure detention and other congregate care facilities.

Generally, licensing and inspection standards are intended to be minimum standards that ensure children's safety and well-being in facilities and compliance with any state or federal requirements. Jail Standards requirements for juvenile detention facilities were last updated in 1993 and Public Health regulations governing Residential Child Caring Facilities (group homes and shelters) were last updated in 2003, although new legislation was passed in 2013. Currently, both DHHS licensing standards and Jail Standards for both secure and "staff-secure detention" are being updated or created. The OIG is hopeful that these updated standards help increase children's safety and also clear up confusion about the intended purpose of different types of facilities and the types of children that are appropriate to be placed in each facility. However, additional legislative clarification may be helpful to these agencies.

### **YOUTH REHABILITATION AND TREATMENT CENTERS**

Nebraska has two youth rehabilitation and treatment centers (YRTCs) that serve as the placement of last resort for children in our juvenile justice system. The facility for girls is located in Geneva (YRTC-G) and the boys' facility is in Kearney (YRTC-K). The population at both YRTCs has been declining, most recently due to the legislative requirement within Legislative Bill 561 (2013) which requires that, during a hearing, the court finds that all available community-based resources were exhausted; all levels of probation supervision be exhausted; and placement at a YRTC is of immediately necessary to protect the juvenile or the person or property of another or it appears that the juvenile is likely to flee.<sup>41</sup>

Nebraska will always need youth placements of last resort. Because best practice dictates that residential treatment facilities need to be therapeutic, these facilities belong within CFS or Behavioral Health rather than Corrections or Probation. Without the YRTCs, Nebraska would likely send more youth to out-of-state facilities, place more youth in county detention facilities, or try more youth as adults. None of these are desired outcomes.

Despite the shrinking population at both YRTCs, challenges such as:

- Managing low risk youth with high risk youth;
- Establishing evidence-based treatment programs for a wide variety of youth, from those who are violent and aggressive to those with other deviant behaviors to those with developmental disabilities;

---

<sup>41</sup> Neb. Rev. Stat. §43-286(1)(b)(ii)

- Multiple psychotropic medications being taken by a number of youth; and
- Elopements from the facilities, which many times results in additional criminal charges for youth.

### **Prison Rape Elimination Act**

In 2003, the federal government passed the Prison Rape Elimination Act (PREA), intended to create basic standards to address sexual violence and victimization in confinement. In June 2012, the Department of Justice released the final standards facilities must follow, including specific standards for juvenile facilities - facilities which are, “primarily used for the confinement of juveniles pursuant to the juvenile justice system or criminal justice system.”<sup>42</sup> These facilities include detention centers, correctional facilities, and group homes and other congregate placements where youth in the juvenile justice system are placed. While compliance with PREA standards is not mandatory for state and local governments, failure to implement PREA does result in a loss of federal funding. Additionally, failure to comply with PREA may increase the likelihood of civil litigation against states and local governments, since these standards are now widely accepted as minimum requirements for ensuring safety of those housed in confinement facilities.<sup>43</sup>

PREA implementation is important to youth safety and well-being. National research by the Bureau of Justice Statistics (BJS) estimated that in 2012, 9.5% of youth in juvenile facilities experienced sexual victimization while confined. In general, youth at all-male facilities were more likely to experience victimization by staff, while youth in all-female facilities were more likely to be victimized by other youth. YRTC-Geneva, an all-female facility, did have a number of youth who participated in the BJS survey in 2012. Results showed that 4.2% of youth reported experiencing sexual victimization at the facility, all by other youth. The BJS survey also indicated that youth who experienced sexual victimization prior to admission were significantly more likely to be victimized while in confinement at that facility.<sup>44</sup> This is particularly important to note because at YRTC-Geneva, staff interviewed by the OIG estimated that between 70 and 95 percent of youth admitted to the facility have experienced prior sexual victimization. This places them at heightened risk of victimization at the facility.

While Nebraska is not yet fully compliant with PREA, the Governor’s office has given assurances to the Department of Justice (DOJ) that at least five percent of Nebraska’s DOJ funding is being used to bring all facilities under the control of the executive branch in Nebraska into compliance.<sup>45</sup>

Accordingly, DHHS has taken steps to implement new policies at both Youth Rehabilitation and Treatment Centers (YRTCs). Staff have been designated as PREA coordinators, new training has

---

<sup>42</sup> “Understanding the Impact of the Prison Rape Elimination Act (PREA) Standards on Facilities That House Youth.” Center for Children’s Law and Policy: <http://www.cclp.org/documents/PREA/PREA%20Quick%20Ref.pdf>.

<sup>43</sup> “Analysis of the Prison Rape Elimination Act (PREA) Implementation in Texas.” Texas Criminal Justice Coalition.

<sup>44</sup> *Sexual Victimization in Juvenile Facilities Reported by Youth, 2012*. US Department of Justice: Bureau of Justice Statistics: June 2013. <http://www.bjs.gov/content/pub/pdf/svjfry12.pdf>.

<sup>45</sup> FY 2015 List of Certification and Assurance Submissions. <https://www.bja.gov/Programs/15PREA-AssurancesCertifications.pdf>.

been provided, and new policies on identifying and responding to sexual abuse have been adopted. Additionally, DHHS has designated a statewide PREA Manager for both YRTCs and is planning independent PREA audits.

An OIG investigation revealed that staff and administration at YRTC-Geneva were struggling to understand and comply with PREA. DHHS Central Office is making changes in its staff structure for PREA implementation efforts. Central Office will need to ensure adequate resources exist to support and oversee PREA at YRTC-Geneva and better engage staff in PREA implementation. Staff and youth training on PREA and sexual abuse should be expanded.

**Central Office Oversight, Culture & Programming Changes.** YRTCs house and care for some of Nebraska’s highest need and highest risk youth. The OIG cannot express enough how important it is that DHHS Central Office provide proper support and foundation for intense problem-solving and improvements to YRTC administration. Staff oftentimes struggle to establish a therapeutic and trauma-informed environment. Many staff have a “correctional” mentality, and do not understand youth trauma, seeing all behaviors as a form of delinquency. The OIG recommends that DHHS Central Office provide additional guidance to and oversight of YRTC-Geneva to help implement needed culture change and ensure staff and management adhere to newly implemented policies and programs intended to better serve youth. Based on current capacity, the OIG believes additional Central Office staff may be necessary to ensure appropriate oversight of and support for the YRTCs.

Sustainable evidence-based practice implementation at the YRTCs must have DHHS Central Office committed and engaged. Unless top management provides strong leadership and support, changes to improve the workplace, culture, and treatment for youth at YRTCs will be for naught.

### **REPORTING CHILD ABUSE AND NEGLECT**

Nebraska law requires anyone with, “reasonable cause to believe that a child has been subjected to child abuse or neglect,” to make a report to either Nebraska’s child abuse and neglect hotline, administered by DHHS, or law enforcement.<sup>46</sup> The law further specifies that DHHS and local law enforcement agencies must share reports and coordinate with each other.<sup>47</sup> Ensuring that professionals and the public appropriately report concerns and that law enforcement and DHHS respond correctly is an important tool for connecting families with needed resources and keeping children safe.

In 2014, the DHHS hotline received over 33,000 reports, 93% of which were related to child abuse and neglect. However, only 38%, or 12,221 reports were accepted for assessment by DHHS.<sup>48</sup> The majority of reports currently being referred to the hotline do not meet Nebraska’s child abuse and

---

<sup>46</sup> Neb. Rev. Statute §28-711

<sup>47</sup> Neb. Rev. Statute §28-713

<sup>48</sup> “Child Abuse and Neglect: Annual Data Calendar Year 2014.” NE DHHS.  
[http://dhhs.ne.gov/children\\_family\\_services/Documents/2014CANReport.pdf](http://dhhs.ne.gov/children_family_services/Documents/2014CANReport.pdf).

neglect definition. These data suggest that there can be more done to ensure appropriate child abuse reporting in our state.

The OIG made three recommendations to DHHS to improve child abuse reporting hotline operations. These recommendations dealt with creating training for professionals who frequently report to the hotline, like law enforcement, school employees, and medical personnel; establishing a policy for how photographs should be handled by the hotline; and clarifying procedures for notifying law enforcement when serious incidents like sexual assault are reported. All of the recommendations were accepted and more details on their implementation status can be found in Appendix A. While DHHS has a key role to play, the OIG believes that long-term improvements to accurate and efficient child abuse reporting will require cooperation and leadership across agencies and with many different professional groups.

### **FOSTER HOME SAFETY**

Children deserve to grow up in safe, loving homes. When families are not able to keep their own children safe, Nebraska's child welfare system is tasked with stepping in and taking appropriate action to ensure that child's safety. This often includes temporary placement in a foster family home.

Children in foster care have already experienced traumatic events – the maltreatment that caused them to be removed from the family home and the removal itself. The traumatic history of those in the child welfare system makes safe, quality foster care even more essential. Recent increases in the reimbursement given to foster parents, funded by the Legislature, illustrate that the need for quality foster care is recognized and supported across branches.

Unfortunately, complaints and critical incidents received and investigated by the OIG in the past year have made it clear that Nebraska has not yet taken all the necessary steps to ensure child safety and well-being in foster care. Some Nebraska children in foster care have been physically or sexually abused by their foster parents. The OIG has seen numerous instances where foster parents have not been adequately prepared to work with children's families or meet the needs of the children in their care (especially mental and behavioral health needs), resulting in placement disruption or worse.

In Nebraska, private agencies do most of the work to recruit, license, prepare, and support both traditional foster homes and kinship and relative foster homes.<sup>49</sup> This work is financed and overseen through Agency Supported Foster Care contracts with DHHS and voucher payments through Probation. As our state seeks to improve foster care safety, private agencies, DHHS, and Probation must work together to fix shortcomings and achieve better outcomes for children.

The OIG made a number of recommendations related to foster care safety to DHHS in the past year. These have included changes to Nebraska's home study process, the provision of better supports to kinship and relative families, and changes to ensure that an assessment of foster homes is completed whenever law enforcement responds to a call at the house. The OIG is also aware of a number of

---

<sup>49</sup> Relative and kinship foster homes are those which have a prior significant relationship or familial relationship with the child in their care.

initiatives that DHHS is working on to improve foster home safety. DHHS recently reorganized Resource Development (RD) – those within the division of Children and Family Services (CFS) who oversee contracts and foster home work – to make it easier to standardize practice across service areas and monitor outcomes.

More information on DHHS' recent actions related to implementation of the OIG's recommendations is available in Appendix A. It should be noted that full implementation of many of these recommendations depends on both negotiations and successful, thorough oversight of private foster care providers. The OIG is hopeful that recent and forthcoming changes will improve foster care safety in Nebraska.

### **RACIAL & ETHNIC DISPARITIES**

Nebraska's children and families of color are overrepresented in our state's child welfare and juvenile justice systems. In 2013, children of color made up less than 30% of Nebraska's child population, but over 40% of those receiving child welfare services from DHHS or supervised by Probation, and over 50% of those detained or sent to the Youth Rehabilitation and Treatment Centers (YRTCs).<sup>50</sup> Given the large numbers of children of color in Nebraska's child welfare and juvenile justice system, the success of these systems will depend on how effectively they are able to meet the needs of children, families, and communities of color.

This year, the OIG recommended in a report of investigation that DHHS conduct an assessment of the availability of child abuse prevention initiatives in diverse communities, with a specific focus on immigrant, refugee, and limited English proficient households. DHHS accepted the recommendation and is working with prevention partners to assess and expand services (see details in Appendix A). Much more work will need to be done going forward across systems and agencies to identify strategies that can achieve better outcomes for children of color and consequently our child welfare system as a whole.

### **DUE PROCESS FOR CHILDREN & FAMILIES**

**Developmental Disability Application Appeals.** It came to the attention of the OIG that the policy of the DHHS is that caseworkers under the Division of Children and Family Services are not allowed to appeal or assist in an appeal of developmental disability (DD) eligibility denials on behalf of children who are state wards. DHHS has care, custody, and control of state wards. The OIG is concerned that this policy leaves state wards without an adequate opportunity to appeal, especially when parental rights have been terminated. The OIG understands that DHHS has drafted a process that provides notice of eligibility denial to the juvenile court to then decide whether to appoint an attorney to handle the appeal. Vulnerable children in the state's care should be ensured a fair opportunity to appeal any denial of benefits.

**Court Issues.** Scheduling problems in juvenile cases continue to be a problem. Individual cases out have come to the attention of the OIG, and upon further inquiry, the biggest systems issue is that

---

<sup>50</sup> Voices for Children in Nebraska. *Kids Count in Nebraska 2014 Report*.

even though a motion has been filed by one of the parties, because of full dockets, it may not be heard for months. In some situations, hearings on one issue cannot be heard in a timely manner, and the hearing is set for different days, months apart. This causes delays in permanency. By the time a motion is heard in the case of a 6-month old, for example, waiting 6 months to hear the motion is half of the child's life.

**Dually Adjudicated Youth.** At the present time, many youth continue to be dually adjudicated, meaning that they are both a state ward and supervised on juvenile probation. Clarifying roles and services provided when a child either becomes a state ward and is served by DHHS, or is placed on probation and is supervised by Juvenile Probation. The creation of 2 parallel child-serving systems is not the intent of the reform, but rather each system is to be expert in serving their respective populations. This includes educating all stakeholders in the systems about which cases should properly belong under the jurisdiction of DHHS or under Juvenile Probation supervision. Neb. Rev. Stat. §43-247 lays forth the juvenile court's jurisdiction and the category each juvenile case fits into. Some have suggested that the "(3)(a) No-Fault" category which states that "the child is homeless or destitute, or without proper support through no fault of his or her parent, guardian, or custodian"<sup>51</sup> is the category local jurisdictions make cases "fit" when they do not want Juvenile Probation to supervise the case.

**Juvenile Court Quality Representation.** The OIG has identified two major concerns with attorney representation in juvenile court. First, there is concern when the OIG is reviewing a case and the juvenile has waived his/her right to an attorney, so proceeds through the process with no legal representation. Weighty decisions about a youth's future are made in juvenile court and without legal representation, not all information available may be presented properly to the court or the youth to make the most informed decisions possible. In one case reviewed by the OIG, a youth had been involved in the juvenile justice system for 6 years and sent to the YRTCs multiple times without any legal representation.

Second, the Supreme Court adopting new practice standards for guardians ad litem is a very *positive* step in the right direction, but all juvenile court attorneys—whether the youth's attorney, the parent's attorney, or the county attorney—could benefit from enhanced juvenile court specific practices and standards knowledge. Some attorney offices in Nebraska—whether it is county attorney or public defender or other—assign their most inexperienced attorneys to juvenile court, essentially using juvenile court as a proving ground for future trial attorneys, who hope to "move up" to be criminal prosecutors or defenders. This undermines the rehabilitative intent of juvenile court in Nebraska and diminishes the status of juvenile court practice.

## **DATA & TRANSPARENCY**

Quality data is essential to measuring how the systems that serve Nebraska's children and families are performing and identifying where improvements need to be made. As the OIG pointed out in last year's report, DHHS CFS has consistently focused on improving the quality of its data over the past

---

<sup>51</sup> Neb. Rev. Stat. §43-247 (3)(a).

few years and makes detailed data reports publically available on a monthly basis. CFS has also integrated data more effectively into decision-making and policy and practice improvements through its monthly Continuous Quality Improvement (CQI) meetings.

Over the last year, the OIG made three recommendations to DHHS through reports of investigation on capturing and reporting data and expanding quality assurance (QA) efforts in specific areas: mental health and medications, maltreatment in foster homes, and home studies. DHHS has accepted all of the recommendations and full details on their implementation status can be found in Appendix A. The OIG is particularly impressed with changes to the DHHS database, NFOCUS, in March 2015 which now allow medical appointments, diagnoses, and medications to be entered more easily. These changes will allow DHHS to more closely monitor the medical and mental health care children are receiving.

Outside of formal investigations, the OIG also identified an issue where a number of children were listed as “Non-Court” in the DHHS data system but had active court cases. This data error occurred due to a court practice common in the Southeast Service Area (especially Lancaster County) where children’s cases are supervised by the court for long periods of time, but they are not made state wards. DHHS changed its “Non-Court” label on the point in time report to “Non-Ward In-Home Families,” to ensure that these cases were more accurately represented.

Going forward, the OIG looks forward to a continued and increasingly effective use of data and robust quality assurance processes to improve child welfare operations in Nebraska. A piece of this is ensuring appropriate use of and fidelity to tools used by agencies, like Structured Decision Making (SDM), the Youth Level of Service (YLS), and Detention Risk Assessment Instrument (RAI). It is the OIG’s hope that Probation and other juvenile justice agencies follow DHHS’ lead in making detailed performance data more accessible to the public on a frequent basis and incorporating data into quality improvement efforts.

## APPENDIX A: OIG INVESTIGATION RECOMMENDATIONS

The Office of the Inspector General of Nebraska Child Welfare (OIG) is tasked with making recommendations in all its reports of full investigation. Recommendations may focus on systemic reform or case-specific action (Neb. Rev. Stat. §43-4327). The following contains brief, anonymized summaries of the investigations completed by the OIG during the past year, the general recommendations made to the Department of Health and Human Services (DHHS) and each recommendation's implementation status.

The OIG made a total of 14 recommendations to DHHS. DHHS accepted 13 of the recommendations and requested a modification on one recommendation related to changing Nebraska's home study format and process. The OIG issued a modified recommendation. The OIG did not make any formal recommendations to other state government entities or their contractors during the past year.

The following tables give an abbreviated version of the OIG formal recommendations, DHHS responses, and the recommendations' general status of implementation. No recommendations have been fully implanted. Several of the recommendations have been acted on and progress has been made, but action remains for full implementation. "DHHS" generally refers to the Division of Children and Family Services (CFS).

OIG has been impressed by the overall attitude and seriousness that DHHS receives and contemplates these reports, however, there remains frustration that accepted recommendations are not acted on in a timelier manner, for many reasons. Cautious optimism remains that DHHS will continue to implement the recommendations, improving their processes, finding efficiencies, and identifying barriers to implementation. Only by addressing the barriers can we move forward for a better system.



**CHILD DEATH INVESTIGATION 1**

**Summary:** A 17-year-old, diagnosed with developmental disabilities and mental health disorders, and placed in the custody of the Office of Juvenile Services (OJS), committed suicide.

**Findings:** The OIG found a number of systemic failures that contributed to the youth’s death – inadequate provision of mental and behavioral health care; a lack of DHHS policies, procedures, and training to help staff manage mental health and psychotropic medications; and a failure to focus on and provide services around child and family needs identified in evaluations.

**Recommendations:** DHHS accepted all recommendations contained in the report on January 23, 2015.

OIG Recommendation	DHHS Actions	Overall Status
<p><b>Adopt federally mandated mental &amp; behavioral health policies</b>, including those on:</p> <ul style="list-style-type: none"> <li>• Use and oversight of psychotropic medications (informed consent process, mandatory review of special cases, compliance monitoring)</li> <li>• Mental health and trauma screening and treatment (health screening protocol, identification of needs in case plan)</li> <li>• Guidelines on sharing and updating of medical information</li> </ul>	<ul style="list-style-type: none"> <li>• A plan to develop and adopt required policies was included in the Health Care Oversight Committee (HCO) Strategic Plan 2015-2019 finalized in May 2015.</li> <li>• <a href="#">Program Memo 18-2015</a> adopted in May 2015, which includes minimum standards for health visits and documentation.</li> </ul>	<p><b>Incomplete – no anticipated date of completion</b></p> <p>DHHS reports its progress has been slow due to staffing issues. There have been challenges working across Divisions.</p> <p>The OIG will continue to monitor this area and attempt speed along development and implementation of these critical policies.</p>
<p><b>Expand training on mental and behavioral health</b></p> <ul style="list-style-type: none"> <li>• Ensure all CFS staff have training</li> <li>• Develop guide/provide information to medical professionals serving system-involved children and youth</li> <li>• Review training content to ensure suicide, developmental disabilities, and psychotropic medication are covered adequately</li> </ul>	<ul style="list-style-type: none"> <li>• The Trauma Informed Care Strategic Plan 2015-2019 includes expanding trauma training to CFS staff beginning in February 2015</li> <li>• CFS Deputy Director has provided training to staff on substance abuse</li> </ul>	<p><b>Incomplete – no anticipated date of completion</b></p> <p>DHHS provides its training through a contract with the Center for Children, Families, and the Law (CCFL). Since a contract is already in effect, adding content comes with a cost. There is not flexibility to quickly adapt. DHHS discussed concerns about adding training requirements before caseloads and workloads are manageable.</p>

**CHILD DEATH INVESTIGATION 1, CONTINUED**

<b>Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications</b>	<ul style="list-style-type: none"><li>• NFOCUS was updated in March 2015 to allow for easy input and tracking of medical appointments, diagnoses, and medication information.</li><li>• Drug Use Review (DUR) for wards on Medicaid with 4+ psychotropic medications completed.</li></ul>	<b>Progress</b>  DHHS is seeking national technical assistance to improve its continuous quality improvement (CQI) process. Once enough data is available, DHHS will incorporate it into CQI meetings.
--	---	--

**CHILD DEATH INVESTIGATION 2**

**Summary:** A 22-month-old died after suffering abusive head trauma, including a brain bleed, skull fracture, and other bruising, while in the care of his relative foster parent.

**Findings:** The OIG found that DHHS did follow policy in placing the child in the relative foster home. However, a number of systemic failures that contributed to the child’s death – the home study approval process was inadequate, needed supports were not provided to the relative foster home, and DHHS was slow to react to indications that a new placement was needed. The OIG also found that the way DHHS calculates maltreatment in foster care meant that the child’s death was not reflected in data reports.

**Recommendations:** DHHS accepted OIG recommendations on providing supports for kinship and relative families and changing the calculation of absence of maltreatment in foster care on March 24, 2015. DHHS requested a modification of the OIG recommendation on home studies, and the OIG issued its final version on April 14, 2015.

OIG Recommendation	DHHS Actions	Overall Status
<p><b>Improve Home Study Process</b></p> <ul style="list-style-type: none"> <li>• Adopt uniform, standardized home study process and questionnaires</li> <li>• Create additional mandatory fields for home studies on relative and kinship homes</li> <li>• Expand quality assurance and improvement processes related to home studies</li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">Program Memo 9-2015</a> adopted clarified current home study format and requires that kinship/relative placements should be asked specific questions and information on needed supports documented.</li> <li>• Workgroup of agency providers and CFS staff meet to discuss potential modifications to home studies.</li> <li>• CFS working to identify how to expand quality assurance and conduct CQI</li> </ul>	<p><b>Incomplete</b></p> <p>DHHS feels it has made significant improvements in home studies already and will continue to monitor progress through Resource Development (RD) which was reorganized in 2014.</p> <p>Most home studies in Nebraska are conducted by private contractors. Any changes must be negotiated with providers, which can slow progress.</p>
<p><b>Provide stronger supports for kinship and relative families</b></p> <ul style="list-style-type: none"> <li>• Develop a protocol for providing supports to kinship families in all service areas</li> <li>• Expand availability of kinship-specific resources and training</li> </ul>	<ul style="list-style-type: none"> <li>• Protocol for kinship support established in all service areas</li> <li>• RD administrators reviewing training curricula for relative/kinship homes</li> <li>• Program Guidance Memo drafted for release in November 2015</li> </ul>	<p><b>Progress</b></p> <p>Most support to kinship and relative families is provided by private agencies through contracts with DHHS. Any additional changes will have to be negotiated with providers, which can slow progress.</p>

**CHILD DEATH INVESTIGATION 2, CONTINUED**

<p><b>Ensure “Absence of Maltreatment in Foster Care” is as accurate as possible</b></p>	<ul style="list-style-type: none"><li>• DHHS cannot agency-substantiate abuse while awaiting court action, so cases awaiting trial are not included.</li><li>• DHHS is switching to a new calculation in the updated federal measures. This will capture data 18-months at a time.</li></ul>	<p><b>Progress</b></p> <p>In order for cases to be included in the measure, there must be substantiated abuse or neglect.</p> <p>The OIG will continue to work with DHHS to see if other data can be published to make up for the measure’s shortcomings.</p>
--	--	---

**CHILD DEATH INVESTIGATION 3**

**Summary:** A developmentally-delayed, 19-month-old died due to blunt force trauma to the head less than two weeks after law enforcement investigated and unfounded a child abuse report made by hospital staff. The report was shared with Child Abuse Hotline which decided not to accept it for initial assessment.

**Findings:** The OIG found that state law was followed in the reporting possible abuse and that DHHS followed policy in choosing not to accept the report. However the OIG also found that not all available information was available to the hotline when making its screening decision. The OIG also found that cultural and language barriers between professionals and the family were not fully assessed.

**Recommendations:** DHHS accepted all recommendations contained in the report on June 8, 2015.

OIG Recommendation	DHHS Actions	Overall Status
<p><b>Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.</b> Specifically provide information on:</p> <ul style="list-style-type: none"> <li>• Definition of abuse and neglect</li> <li>• When to report cases that do not meet definition</li> <li>• Information to include in child abuse reports</li> </ul>	<ul style="list-style-type: none"> <li>• Assisted League of Municipalities in putting together training modules for law enforcement</li> <li>• Providing Child Abuse Hotline &amp; Emergency Placement training at Nebraska State Patrol new investigator training</li> <li>• Provided contact cards for hotline to Nebraska Law Enforcement Training Center (NLETC)</li> </ul>	<p><b>Progress</b></p> <p>DHHS reports they always accept invitations to present on the hotline and provide information when requested.</p> <p>The OIG will continue to work with DHHS to ensure training is made widely available to frequent reporters (e.g. - educators and medical professionals.)</p>
<p><b>Create a protocol for asking for and receiving photos at the child abuse and neglect hotline.</b></p>	<ul style="list-style-type: none"> <li>• DHHS developed research questions to be addressed by a Program Guidance Memo</li> </ul>	<p><b>Incomplete – anticipated progress by January 2016</b></p> <p>CFS will work to develop a comprehensive memo with Legal Services.</p>
<p><b>Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.</b></p>	<ul style="list-style-type: none"> <li>• Facilitated focused conversations with the Child Abuse Prevention Fund on prevention efforts in immigrant communities. The Fund voted in July to develop Spanish language materials</li> </ul>	<p><b>Progress</b></p> <p>DHHS-CFS will explore cooperative strategies with the Division of Public Health, Office of Health Disparities and Equity, to measure additional needs and identify ways to ensure (con’t)</p>

**CHILD DEATH INVESTIGATION 3, CONTINUED**

	<ul style="list-style-type: none"><li>Planned review of CCFL study on immigrant and refugee children in the system with prevention partners in Fall 2015</li></ul>	prevention efforts are reaching all communities.
--	--	--

**GENERAL INVESTIGATION 1**

**Summary:** A 17-year-old committed to YRTC-Geneva alleged she had been sexually assaulted by another youth in a transportation van. On initial inquiry, there was no documented follow up to the incident report by DHHS, YRTC, or law enforcement.

**Findings:** The OIG found that current transportation arrangements to and from the YRTCs do not ensure youth safety, that YRTC-Geneva did not follow protocols established to comply with the Prison Rape Elimination Act (PREA), and that the child abuse hotline did not properly screen the report of sexual assault or notify law enforcement correctly. The OIG also found challenges with implementing PREA at YRTC-Geneva including a pattern of delaying or failing to report allegations made by youth.

**Recommendations:** DHHS accepted all recommendations contained in the report on July 27, 2015.

OIG Recommendation	DHHS Actions	Overall Status
<b>Adopt and implement standards for transporting youth to and from YRTCs</b>	<ul style="list-style-type: none"> <li>DHHS has developed draft contracts with transportation companies for its services, including child welfare and YRTCs. Negotiations are ongoing.</li> </ul>	<p><b>Incomplete –anticipated completion October 2015</b></p> <p>DHHS is in the process of negotiating contracts with sufficient standards, while attempting to ensure appropriate financial resources to cover the cost of new requirements.</p>
<p><b>Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.</b></p> <ul style="list-style-type: none"> <li>Increase Central Office oversight of and support for PREA efforts</li> <li>Better engage YRTC-Geneva staff in PREA implementation</li> <li>Revise and expand staff and youth training on PREA and sexual abuse</li> </ul>	<ul style="list-style-type: none"> <li>New Statewide PREA Manager began July 1, 2015.</li> <li>New full-time compliance specialist position at both YRTCs in charge of PREA</li> <li>Training revisions taking place under guidance of Statewide PREA Manager</li> </ul>	<p><b>Progress</b></p> <p>DHHS has taken a number of steps to better support the YRTCs with PREA implementation.</p> <p>The OIG will continue to monitor whether Central Office has enough staff, time, and leadership to ensure effective implementation.</p>
<b>Provide increased guidance for culture change at YRTC-Geneva</b>	<ul style="list-style-type: none"> <li>Review of supervisory structure at both YRTCs complete. More responsibility for direct care staff supervision will be placed under psychologists instead of security supervisors</li> </ul>	<p><b>Progress Made</b></p> <p>DHHS is moving forward slowly with initiatives to improve performance at both YRTCs. DHHS cites general system confusion about the desired role of YRTC as a continued obstacle.</p>

GENERAL INVESTIGATION 1, CONTINUED

	<ul style="list-style-type: none"> <li>• DHHS Human Resources is providing an independent facilitator to engage staff</li> <li>• New evidence-based programs are being implemented at YRTC (e.g. - Thinking for a Change, Aggression Replacement Therapy)</li> </ul>	
<p><b>Make clarifications to policies governing sexual abuse and harassment</b></p> <ul style="list-style-type: none"> <li>• Coordination with Law Enforcement</li> <li>• Notifying child abuse hotline of reports</li> <li>• Reporting of abuse, harassment, and assault</li> <li>• Preservation of evidence</li> </ul>	<ul style="list-style-type: none"> <li>• AR 115.17 was issued to cover PREA issues at both YRTCs in August 2015.</li> <li>• Revision of Operating Memoranda for both facilities with additional details is underway</li> </ul>	<p><b>Progress</b></p> <p>DHHS is making changes to ensure both YRTCs have uniform policies and approaches to incidents which fall under PREA</p>
<p><b>Clarify hotline policy and procedure when receiving a report of sexual assault</b></p>	<ul style="list-style-type: none"> <li>• State Patrol Troop region map distributed to all hotline staff</li> <li>• Explored possible NFOCUS changes to automate which law enforcement agency was notified, but this was not possible to achieve without major changes</li> </ul>	<p><b>Incomplete – no anticipated date of completion</b></p> <p>DHHS is currently reviewing its process for notifying law enforcement to determine which situations require an immediate phone call.</p>



## APPENDIX B: LEGISLATIVE HISTORY & AUTHORITY

### COMMITTEE MEMBERSHIP & PARTICIPATION

#### LEGISLATIVE HISTORY & AUTHORITY

In 2011, the Nebraska Legislature adopted Legislative Resolution 37, which directed the Health and Human Services Committee to review, investigate and assess the effects of child welfare reform which began its implementation by the Department of Health and Human Services in July 2009. One of the 18 significant recommendations by the Health and Human Services Committee was to create the position of Inspector General of Nebraska Child Welfare to enhance accountability and facilitate reform in the child welfare system, by being given jurisdiction to investigate state and private entities that serve children.

**Office of Inspector General of Nebraska Child Welfare Act.**<sup>52</sup> The Office of Inspector General of Nebraska Child Welfare Act (Act) was enacted by Legislative Bill 821 during the 2012 Legislative Session. The most significant change in the Act occurred during the 2015 Legislative Session—Nebraska’s juvenile justice system was add the office’s subject matter jurisdiction. The Act, Neb. Rev. Stat. §§43-4301 to 43-4331, sets forth that the Office of Inspector General of Nebraska Child Welfare (Office) is to:

- Provide increased accountability and legislative oversight of the Nebraska child welfare system (child protection and safety as well as juvenile justice);
- Assist in improving operations of all Nebraska’s child-serving agencies;
- Offer an independent form of inquiry for concerns—specifically regarding the actions of individuals and agencies responsible for the care and protection of children and youth in the Nebraska child welfare system and juvenile justice system;
- Provide a process for investigation and review to determine whether individual complaints and issues inquiries reveal a system problem, which then necessitates legislative action; and
- Conduct investigations, audits, inspections, and other reviews of the system.

Julie L. Rogers was appointed to serve as the first Inspector General of Nebraska Child Welfare (IG). She is a certified inspector general (CIG) through the Association of Inspectors General. The Office of Inspector General of Nebraska Child Welfare (OIG) was deemed “opened” when the appointed IG began her duties at the end of July 2012.

**Operation within the Ombudsman's Office.** The OIG was established within the Division of Public Council (Ombudsman's Office) within the Nebraska Legislature. The Ombudsman's Office handles individual complaints about the actions of administrative agencies of state government, including those state agencies serving children and state wards. The Ombudsman's Office

---

<sup>52</sup>The text of the Office of Inspector General of Nebraska Child Welfare Act appears in Appendix C of this report.

investigates and resolves complaints informally by working with parties involved, all the while promoting accountability in public administration. It makes sense, then, that the OIG's establishment be within the Ombudsman's Office in order to most efficiently work towards a shared goal: promoting the accountability of Nebraska's child welfare system.

Specifically, the OIG relies on the Ombudsman's Office for operations—physical space, equipment, office supplies, travel, and the like. Moreover, the OIG relies on the Ombudsman's Office for staffing cases to pinpoint and recognize systems issues within the child welfare system based on their complaint handling; mediating complaints made to the OIG, but that do not rise to the level of a full investigation and are then referred to the Ombudsman's side; and giving input on recommendations to improve the child welfare system based on their experience in working child welfare, mental health, and developmental disability-related individual cases.

### **COMMITTEE MEMBERSHIP & PARTICIPATION**

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

- Nebraska Supreme Court Commission on Children in the Courts
- Statewide Juvenile Detention Alternatives Initiative
- Division of Children & Family Services Director's Alternative Response Steering Committee
- LB 265 Data Advisory Group
- Child and Maternal Death Review Team
- CQI and Operational Meetings at DHHS
- Cross System Collaboration Meetings
- Barriers to Permanency Project
- Out of State Placements Project
- Nebraska Children's Commission:
  - Juvenile Services Committee
  - Lead Agency Taskforce
  - Legal Parties Taskforce/GAL Subcommittee
  - Foster Care Reimbursement Rate Committee
  - Workforce Development Workgroup
  - Structure Sub-Committee
  - Data , Technology, Accountability, and Reporting Workgroup

**APPENDIX C: OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE ACT**

Effective Date: August 30, 2015

**43-4301. Act, how cited.**

Sections 43-4301 to 43-4331 shall be known and may be cited as the Office of Inspector General of Nebraska Child Welfare Act.

**43-4302. Legislative intent.**

(1) It is the intent of the Legislature to:

(a) Establish a full-time program of investigation and performance review to provide increased accountability and oversight of the Nebraska child welfare system;

(b) Assist in improving operations of the Nebraska child welfare system;

(c) Provide an independent form of inquiry for concerns regarding the actions of individuals and agencies responsible for the care and protection of children and youth in the Nebraska child welfare system. Confusion of the roles, responsibilities, and accountability structures between individuals, private contractors, branches of government, and agencies in the current system make it difficult to monitor and oversee the Nebraska child welfare system; and

(d) Provide a process for investigation and review to determine if individual complaints and issues of investigation and inquiry reveal a problem in the child welfare system, not just individual cases, that necessitates legislative action for improved policies and restructuring of the child welfare system.

(2) It is not the intent of the Legislature in enacting the Office of Inspector General of Nebraska Child Welfare Act to interfere with the duties of the Legislative Auditor or the Legislative Fiscal Analyst or to interfere with the statutorily defined investigative responsibilities or prerogatives of any officer, agency, board, bureau, commission, association, society, or institution of the executive branch of state government, except that the act does not preclude an inquiry on the sole basis that another agency has the same responsibility. The act shall not be construed to interfere with or supplant the responsibilities or prerogatives of the Governor to investigate, monitor, and report on the activities of the agencies, boards, bureaus, commissions, associations, societies, and institutions of the executive branch under his or her administrative direction.

**43-4303. Definitions; where found.**

For purposes of the Office of Inspector General of Nebraska Child Welfare Act, the definitions found in sections 43-4304 to 43-4316 apply.

**43-4304. Administrator, defined.**

Administrator means a person charged with administration of a program, an office, or a division of the department or administration of a private agency or licensed child care facility, the probation administrator, or the executive director.

**43-4304.01. Child welfare system, defined.**

Child welfare system means public and private agencies and parties that provide or effect services or supervision to system-involved children and their families.

**43-4304.02. Commission, defined.**

Commission means the Nebraska Commission on Law Enforcement and Criminal Justice.

**43-4305. Department, defined.**

Department means the Department of Health and Human Services.

**43-4306. Director, defined.**

Director means the chief executive officer of the department.

**43-4306.01. Executive director, defined.**

Executive director means the executive director of the commission.

**43-4307. Inspector General, defined.**

Inspector General means the Inspector General of Nebraska Child Welfare appointed under section 43-4317.

**43-4307.01. Juvenile services division, defined.**

Juvenile services division means the Juvenile Services Division of the Office of Probation Administration.

**43-4308. Licensed child care facility, defined.**

Licensed child care facility means a facility or program licensed under the Child Care Licensing Act, the Children's Residential Facilities and Placing Licensure Act, or sections 71-1901 to 71-1906.01.

**43-4309. Malfeasance, defined.**

Malfeasance means a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty.

**43-4310. Management, defined.**

Management means supervision of subordinate employees.

**43-4311. Misfeasance, defined.**

Misfeasance means the improper performance of some act that a person may lawfully do.

**43-4312. Obstruction, defined.**

Obstruction means hindering an investigation, preventing an investigation from progressing, stopping or delaying the progress of an investigation, or making the progress of an investigation difficult or slow.

**43-4313. Office, defined.**

Office means the office of Inspector General of Nebraska Child Welfare and includes the Inspector General and other employees of the office.

**43-4314. Private agency, defined.**

Private agency means a child welfare agency that contracts with the department or the Office of Probation Administration or contracts to provide services to another child welfare agency that contracts with the department or the Office of Probation Administration.

**43-4315. Record, defined.**

Record means any recording, in written, audio, electronic transmission, or computer storage form, including, but not limited to, a draft, memorandum, note, report, computer printout, notation, or message, and includes, but is not limited to, medical records, mental health records, case files, clinical records, financial records, and administrative records.

**43-4316. Responsible individual, defined.**

Responsible individual means a foster parent, a relative provider of foster care, or an employee of the department, the juvenile services division, the commission, a foster home, a private agency, a licensed child care facility, or another provider of child welfare programs and services responsible for the care or custody of records, documents, and files.

**43-4317. Office of Inspector General of Nebraska Child Welfare; created; purpose; Inspector General; appointment; term; certification; employees; removal.**

(1) The office of Inspector General of Nebraska Child Welfare is created within the office of Public Counsel for the purpose of conducting investigations, audits, inspections, and other reviews of the Nebraska child welfare system. The Inspector General shall be appointed by the Public Counsel with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

(2) The Inspector General shall be appointed for a term of five years and may be reappointed. The Inspector General shall be selected without regard to political affiliation and on the basis of integrity, capability for strong leadership, and demonstrated ability in accounting, auditing, financial analysis, law, management analysis, public administration, investigation, or criminal justice administration or other closely related fields. No former or current executive or manager of the department may be appointed Inspector General within five years after such former or current executive's or manager's period of service with the department. Not later than two years after the date of appointment, the Inspector General shall obtain certification as a Certified Inspector General by the Association of Inspectors General, its successor, or another nationally recognized organization that provides and sponsors educational programs and

establishes professional qualifications, certifications, and licensing for inspectors general. During his or her employment, the Inspector General shall not be actively involved in partisan affairs.

(3) The Inspector General shall employ such investigators and support staff as he or she deems necessary to carry out the duties of the office within the amount available by appropriation through the office of Public Counsel for the office of Inspector General of Nebraska Child Welfare. The Inspector General shall be subject to the control and supervision of the Public Counsel, except that removal of the Inspector General shall require approval of the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

**43-4318. Office; duties; reports of death or serious injury; when required; law enforcement agencies and prosecuting attorneys; cooperation; confidentiality.**

(1) The office shall investigate:

(a) Allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of:

(i) The department by an employee of or person under contract with the department, a private agency, a licensed child care facility, a foster parent, or any other provider of child welfare services or which may provide a basis for discipline pursuant to the Uniform Credentialing Act;

(ii) The juvenile services division by an employee of or person under contract with the juvenile services division, a private agency, a licensed facility, a foster parent, or any other provider of juvenile justice services;

(iii) The commission by an employee of or person under contract with the commission related to programs and services supported by the Nebraska County Juvenile Services Plan Act, the Community-based Juvenile Services Aid Program, juvenile pretrial diversion programs, or inspections of juvenile facilities; and

(iv) A juvenile detention facility and staff secure juvenile facility by an employee of or person under contract with such facilities;

(b) Death or serious injury in foster homes, private agencies, child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other programs and facilities licensed by or under contract with the department or the juvenile services division; and

(c) Death or serious injury in any case in which services are provided by the department or the juvenile services division to a child or his or her parents or any case involving an investigation under the Child Protection and Family Safety Act, which case has been open for one year or less and upon review determines the death or serious injury did not occur by chance.

The department, the juvenile services division, each juvenile detention facility, and each staff secure juvenile facility shall report all cases of death or serious injury of a child in a foster home, private agency, child care facility or program, or other program or facility licensed by the department or inspected through the commission to the Inspector General as soon as reasonably possible after the department or the Office of Probation Administration learns of such death or serious injury. For purposes of this subsection, serious

injury means an injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.

(2) Any investigation conducted by the Inspector General shall be independent of and separate from an investigation pursuant to the Child Protection and Family Safety Act. The Inspector General and his or her staff are subject to the reporting requirements of the Child Protection and Family Safety Act.

(3) Notwithstanding the fact that a criminal investigation, a criminal prosecution, or both are in progress, all law enforcement agencies and prosecuting attorneys shall cooperate with any investigation conducted by the Inspector General and shall, immediately upon request by the Inspector General, provide the Inspector General with copies of all law enforcement reports which are relevant to the Inspector General's investigation. All law enforcement reports which have been provided to the Inspector General pursuant to this section are not public records for purposes of sections 84-712 to 84-712.09 and shall not be subject to discovery by any other person or entity. Except to the extent that disclosure of information is otherwise provided for in the Office of Inspector General of Nebraska Child Welfare Act, the Inspector General shall maintain the confidentiality of all law enforcement reports received pursuant to its request under this section. Law enforcement agencies and prosecuting attorneys shall, when requested by the Inspector General, collaborate with the Inspector General regarding all other information relevant to the Inspector General's investigation. If the Inspector General in conjunction with the Public Counsel determines it appropriate, the Inspector General may, when requested to do so by a law enforcement agency or prosecuting attorney, suspend an investigation by the office until a criminal investigation or prosecution is completed or has proceeded to a point that, in the judgment of the Inspector General, reinstatement of the Inspector General's investigation will not impede or infringe upon the criminal investigation or prosecution. Under no circumstance shall the Inspector General interview any minor who has already been interviewed by a law enforcement agency, personnel of the Division of Children and Family Services of the department, or staff of a child advocacy center in connection with a relevant ongoing investigation of a law enforcement agency.

**43-4319. Office; access to information and personnel; investigation; procedure.**

(1) The office shall have access to all information and personnel necessary to perform the duties of the office.

(2) A full investigation conducted by the office shall consist of retrieval of relevant records through subpoena, request, or voluntary production, review of all relevant records, and interviews of all relevant persons.

(3) For a request for confidential record information pursuant to subsection (5) of section 43-2,108 involving death or serious injury, the office may submit a written request to the probation administrator. The record information shall be provided to the office within five days after approval of the request by the Supreme Court.

**43-4320. Complaints to office; form; full investigation; when; notice.**

(1) Complaints to the office may be made in writing. The office shall also maintain a toll-free telephone line for complaints. A complaint shall be evaluated to determine if it alleges possible misconduct, misfeasance, malfeasance, or violation of a statute or of rules and regulations pursuant to section 43-4318. All complaints shall be evaluated to determine whether a full investigation is warranted.

(2) The office shall not conduct a full investigation of a complaint unless:

(a) The complaint alleges misconduct, misfeasance, malfeasance, or violation of a statute or of rules and regulations pursuant to section 43-4318;

(b) The complaint is against a person within the jurisdiction of the office; and

(c) The allegations can be independently verified through investigation.

(3) The Inspector General shall determine within fourteen days after receipt of a complaint whether it will conduct a full investigation. A complaint alleging facts which, if verified, would provide a basis for discipline under the Uniform Credentialing Act shall be referred to the appropriate credentialing board under the act.

(4) When a full investigation is opened on a private agency that contracts with the Office of Probation Administration, the Inspector General shall give notice of such investigation to the Office of Probation Administration.

**43-4321. Cooperation with office; when required.**

All employees of the department, the juvenile services division, or the commission, all foster parents, and all owners, operators, managers, supervisors, and employees of private agencies, licensed child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other providers of child welfare services or juvenile justice services shall cooperate with the office. Cooperation includes, but is not limited to, the following:

(1) Provision of full access to and production of records and information. Providing access to and producing records and information for the office is not a violation of confidentiality provisions under any law, statute, rule, or regulation if done in good faith for purposes of an investigation under the Office of Inspector General of Nebraska Child Welfare Act;

(2) Fair and honest disclosure of records and information reasonably requested by the office in the course of an investigation under the act;

(3) Encouraging employees to fully comply with reasonable requests of the office in the course of an investigation under the act;

(4) Prohibition of retaliation by owners, operators, or managers against employees for providing records or information or filing or otherwise making a complaint to the office;

(5) Not requiring employees to gain supervisory approval prior to filing a complaint with or providing records or information to the office;

(6) Provision of complete and truthful answers to questions posed by the office in the course of an investigation; and

(7) Not willfully interfering with or obstructing the investigation.

**43-4322. Failure to cooperate; effect.**

Failure to cooperate with an investigation by the office may result in discipline or other sanctions.



**43-4323. Inspector General; powers; rights of person required to provide information.**

The Inspector General may issue a subpoena, enforceable by action in an appropriate court, to compel any person to appear, give sworn testimony, or produce documentary or other evidence deemed relevant to a matter under his or her inquiry. A person thus required to provide information shall be paid the same fees and travel allowances and shall be accorded the same privileges and immunities as are extended to witnesses in the district courts of this state and shall also be entitled to have counsel present while being questioned.

**43-4324. Office; access to records; subpoena; records; statement of record integrity and security; contents; treatment of records.**

(1) In conducting investigations, the office shall access all relevant records through subpoena, compliance with a request of the office, and voluntary production. The office may request or subpoena any record necessary for the investigation from the department, the juvenile services division, the commission, a foster parent, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or a private agency that is pertinent to an investigation. All case files, licensing files, medical records, financial and administrative records, and records required to be maintained pursuant to applicable licensing rules shall be produced for review by the office in the course of an investigation.

(2) Compliance with a request of the office includes:

(a) Production of all records requested;

(b) A diligent search to ensure that all appropriate records are included; and

(c) A continuing obligation to immediately forward to the office any relevant records received, located, or generated after the date of the request.

(3) The office shall seek access in a manner that respects the dignity and human rights of all persons involved, maintains the integrity of the investigation, and does not unnecessarily disrupt child welfare programs or services. When advance notice to a foster parent or to an administrator or his or her designee is not provided, the office investigator shall, upon arrival at the departmental office, bureau, or division, the private agency, the licensed child care facility, the juvenile detention facility, the staff secure juvenile facility, or the location of another provider of child welfare services, request that an onsite employee notify the administrator or his or her designee of the investigator's arrival.

(4) When circumstances of an investigation require, the office may make an unannounced visit to a foster home, a departmental office, bureau, or division, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, a private agency, or another provider to request records relevant to an investigation.

(5) A responsible individual or an administrator may be asked to sign a statement of record integrity and security when a record is secured by request as the result of a visit by the office, stating:

(a) That the responsible individual or the administrator has made a diligent search of the office, bureau, division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other provider's location to determine that all appropriate records in existence at the time of the request were produced;

(b) That the responsible individual or the administrator agrees to immediately forward to the office any relevant records received, located, or generated after the visit;

(c) The persons who have had access to the records since they were secured; and

(d) Whether, to the best of the knowledge of the responsible individual or the administrator, any records were removed from or added to the record since it was secured.

(6) The office shall permit a responsible individual, an administrator, or an employee of a departmental office, bureau, or division, a private agency, a licensed child care facility, a juvenile detention facility, a staff secure juvenile facility, or another provider to make photocopies of the original records within a reasonable time in the presence of the office for purposes of creating a working record in a manner that assures confidentiality.

(7) The office shall present to the responsible individual or the administrator or other employee of the departmental office, bureau, or division, private agency, licensed child care facility, juvenile detention facility, staff secure juvenile facility, or other service provider a copy of the request, stating the date and the titles of the records received.

(8) If an original record is provided during an investigation, the office shall return the original record as soon as practical but no later than ten working days after the date of the compliance request.

(9) All investigations conducted by the office shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution.

**43-4325. Reports of investigations; distribution; redact confidential information; powers of office.**

(1) Reports of investigations conducted by the office shall not be distributed beyond the entity that is the subject of the report without the consent of the Inspector General.

(2) Except when a report is provided to a guardian ad litem or an attorney in the juvenile court pursuant to subsection (2) of section 43-4327, the office shall redact confidential information before distributing a report of an investigation. The office may disclose confidential information to the chairperson of the Health and Human Services Committee of the Legislature or the chairperson of the Judiciary Committee of the Legislature when such disclosure is, in the judgment of the Public Counsel, desirable to keep the chairperson informed of important events, issues, and developments in the Nebraska child welfare system.

(3) Records and documents, regardless of physical form, that are obtained or produced by the office in the course of an investigation are not public records for purposes of sections 84-712 to 84-712.09. Reports of investigations conducted by the office are not public records for purposes of sections 84-712 to 84-712.09.

(4) The office may withhold the identity of sources of information to protect from retaliation any person who files a complaint or provides information in good faith pursuant to the Office of Inspector General of Nebraska Child Welfare Act.

**43-4326. Department, juvenile services division, and commission; provide direct computer access.**

(1) The department shall provide the Public Counsel and the Inspector General with direct computer access to all computerized records, reports, and documents maintained by the department in connection with administration of the Nebraska child welfare system.

(2) The juvenile services division and the commission shall provide the Inspector General with direct computer access to all computerized records, reports, and documents maintained by the juvenile services division in connection with administration of juvenile justice services.

**43-4327. Inspector General's report of investigation; contents; distribution.**

(1) The Inspector General's report of an investigation shall be in writing to the Public Counsel and shall contain recommendations. The report may recommend systemic reform or case-specific action, including a recommendation for discharge or discipline of employees or for sanctions against a foster parent, private agency, licensed child care facility, or other provider of child welfare services or juvenile justice services. All recommendations to pursue discipline shall be in writing and signed by the Inspector General. A report of an investigation shall be presented to the director, the probation administrator, or the executive director within fifteen days after the report is presented to the Public Counsel.

(2) Any person receiving a report under this section shall not further distribute the report or any confidential information contained in the report. The Inspector General, upon notifying the Public Counsel and the director, the probation administrator, or the executive director, may distribute the report, to the extent that it is relevant to a child's welfare, to the guardian ad litem and attorneys in the juvenile court in which a case is pending involving the child or family who is the subject of the report. The report shall not be distributed beyond the parties except through the appropriate court procedures to the judge.

(3) A report that identifies misconduct, misfeasance, malfeasance, or violation of statute, rules, or regulations by an employee of the department, the juvenile services division, the commission, a private agency, a licensed child care facility, or another provider that is relevant to providing appropriate supervision of an employee may be shared with the employer of such employee. The employer may not further distribute the report or any confidential information contained in the report.

**43-4328. Report; director, probation administrator, or executive director; accept, reject, or request modification; when final; written response; corrected report; credentialing issue; how treated.**

(1) Within fifteen days after a report is presented to the director, the probation administrator, or the executive director under section 43-4327, he or she shall determine whether to accept, reject, or request in writing modification of the recommendations contained in the report. The Inspector General, with input from the Public Counsel, may consider the director's, probation administrator's, or executive director's request for modifications but is not obligated to accept such request. Such report shall become final upon the decision of the director, the probation administrator, or the executive director to accept or reject the recommendations in the report or, if the director, the probation administrator, or the executive director requests modifications, within fifteen days after such request or after the Inspector General incorporates such modifications, whichever occurs earlier.

(2) Within fifteen days after the report is presented to the director, the probation administrator, or the executive director, the report shall be presented to the foster parent, private agency, licensed child care facility, or other provider of child welfare services or juvenile justice services that is the subject of the report and to persons involved in the implementation of the recommendations in the report. Within forty-

five days after receipt of the report, the foster parent, private agency, licensed child care facility, or other provider may submit a written response to the office to correct any factual errors in the report. The Inspector General, with input from the Public Counsel, shall consider all materials submitted under this subsection to determine whether a corrected report shall be issued. If the Inspector General determines that a corrected report is necessary, the corrected report shall be issued within fifteen days after receipt of the written response.

(3) If the Inspector General does not issue a corrected report pursuant to subsection (2) of this section, or if the corrected report does not address all issues raised in the written response, the foster parent, private agency, licensed child care facility, or other provider may request that its written response, or portions of the response, be appended to the report or corrected report.

(4) A report which raises issues related to credentialing under the Uniform Credentialing Act shall be submitted to the appropriate credentialing board under the act.

**43-4329. Report or work product; no court review.**

No report or other work product of an investigation by the Inspector General shall be reviewable in any court. Neither the Inspector General nor any member of his or her staff shall be required to testify or produce evidence in any judicial or administrative proceeding concerning matters within his or her official cognizance except in a proceeding brought to enforce the Office of Inspector General of Nebraska Child Welfare Act.

**43-4330. Inspector General; investigation of complaints; priority and selection.**

The Office of Inspector General of Nebraska Child Welfare Act does not require the Inspector General to investigate all complaints. The Inspector General, with input from the Public Counsel, shall prioritize and select investigations and inquiries that further the intent of the act and assist in legislative oversight of the Nebraska child welfare system and juvenile justice system. If the Inspector General determines that he or she will not investigate a complaint, the Inspector General may recommend to the parties alternative means of resolution of the issues in the complaint.

**43-4331. Summary of reports and investigations; contents.**

On or before September 15 of each year, the Inspector General shall provide to the Health and Human Services Committee of the Legislature, the Judiciary Committee of the Legislature, the Supreme Court, and the Governor a summary of reports and investigations made under the Office of Inspector General of Nebraska Child Welfare Act for the preceding year. The summary provided to the committees shall be provided electronically. The summaries shall detail recommendations and the status of implementation of recommendations and may also include recommendations to the committees regarding issues discovered through investigation, audits, inspections, and reviews by the office that will increase accountability and legislative oversight of the Nebraska child welfare system, improve operations of the department, the juvenile services division, the commission, and the Nebraska child welfare system, or deter and identify fraud, abuse, and illegal acts. Such summary shall include summaries of alternative response cases under alternative response demonstration projects implemented in accordance with sections 28-710.01, 28-712, and 28-712.01 reviewed by the Inspector General. The summaries shall not contain any confidential or identifying information concerning the subjects of the reports and investigations.