

*Office of
Inspector General of Nebraska Child Welfare*

Annual Report

2017-2018

The OIG thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide support and advice, particularly the Executive Board, Health and Human Services and Judiciary Committees. In addition, the Public Counsel goes above and beyond in assisting the OIG—we are grateful to work within the Ombudsman’s Office. A most sincere and heartfelt appreciation for all of the time, talent, and counsel that has been offered by all.

Julie L. Rogers
Inspector General

Sharen Saf
Assistant Inspector General

Sarah Amsberry
Intake Executive Assistant

September 15, 2018

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

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

Email: OIG@leg.ne.gov

State Capitol

P.O. Box 94604

Lincoln, NE 68509-4604

402-471-4211 or 855-460-6784

If you suspect child abuse, including sexual abuse, please call the
Nebraska Abuse and Neglect Hotline at
1-800-652-1999

National Suicide Prevention Lifeline
Providing 24/7, confidential, free support for people in distress and prevention and crisis
resources for you and your loved ones.
1-800-273-8255

Nebraska Family Helpline
Providing 24 hour support for families of youth experiencing behavioral challenges
1-888-866-8660

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

September 15, 2018

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

It is with honor to present to you the annual report of the Nebraska Office of Inspector General of Child Welfare (OIG). The OIG is dedicated to fostering and promoting accountability, integrity, and transparency in our governmental agencies serving children, youth, and families.

Entering our 7th year, we continue our work providing accountability related to multiple governmental agencies—those in licensed day cares and group homes; those receiving services through the Department of Health and Human Services (DHHS), whether through alternative response, non-court services, or as a state ward; those held in juvenile detention; those supervised by juvenile probation; and those at the Youth Rehabilitation and Treatment Centers. As has been historically true, of the 520 cases that the OIG received as intakes this year, the majority have been handled competently by system professionals with no major violations of policy or law.

DHHS and Probation Administration, as well as the private agencies they work with, are staffed with many highly capable, professional, and caring people who do complex and sometimes heartbreaking work with families and children on a daily basis. This not only shows in the voluminous information we review, but especially becomes apparent in our conversations with caseworkers, juvenile probation officers, and other front line staff across the state.

The past year has brought positive changes. For example, DHHS has worked cross-divisionally and with various agencies to implement the Nebraska Abusive Head Trauma/Shaken Baby Syndrome Prevention campaign, which kicked off this summer. Not only is abusive head trauma the leading cause of child abuse death within the United States, but our investigations into child deaths have identified the need for better understanding and prevention of abusive head trauma in Nebraska. This

campaign is an important step. Also, caseload numbers have been improving over the past year for DHHS caseworkers. We remain cautiously optimistic that those numbers will continue to improve and expect that caseworker workload will stabilize.

Importantly, DHHS has made progress in 14 of the 18 recommended areas pursuant to our report of investigation, *Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes, & Youth in Residential Placement*.

Despite the positives, we continue our work in detecting both statewide issues as well as problems identified through tragedies in individual cases.

One important issue that challenges the child welfare and juvenile justice systems is attempted suicides and suicidal behavior in general. For the second consecutive year, the OIG Annual report points to the rising number of attempted suicides.

In completing the investigatory work of the OIG, both in looking at individual cases and at system-wide issues, efforts are not to control the uncontrollable, prepare for the unforeseen, or expect performance up to a standard of perfection; but instead to address challenges, create conditions that effectively bring about change, and leverage opportunities for improvement.

Such action requires an openness to come to the table and participate in good faith as well as an openness by agency leadership, not just front line staff, to be proactive in sharing how their respective agencies operate, including both the progress and the challenges, in an honest way.

Stakeholders share a responsibility to provide access to information and data. It is this information that engages the public and informs the decision making process. Correct and timely information provided by the agencies that make up the child welfare system fuels the evidence used to generate informed public policy decisions and its access should be welcomed. Access to information not only provides a foundation for openness to the public, it can result in transformative change in our community.

The Office of the Inspector General contributes to these efforts by giving a system wide perspective that is necessary to “see all the moving parts” and provide the impetus for any needed system modifications.

As always, I genuinely appreciate your support of transparency and the search for truth in government and in the administration of our child welfare and juvenile justice systems. Thank you for your time and attention.

Very sincerely,



Julie L. Rogers

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OVERVIEW & SUMMARY

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

Housed within the Nebraska Legislature, the OIG investigates: complaints and allegations of wrongdoing by agencies and individuals involved in these systems; deaths and serious injuries of system-involved children; system-wide looks at concerning topic areas; and other critical incidents related to children involved with the child welfare and juvenile justice system. The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice system. Instead, investigations and reviews function as part of the Legislature's oversight of these important state functions.

Each year, the OIG is required to publish an Annual Report. The report must provide a summary of the OIG's investigations, including the recommendations it has made and their implementation status.¹ The following summarizes the work of the OIG from July 1, 2017 to June 30, 2018, identifies emerging topics, and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made in prior years.

CONTINUING & EMERGING TOPICS

The following topics are those the OIG has been made aware of and continues to watch, review, and examine.

Caseloads and Workloads

In the past, the OIG has reported on continued caseload and workload issues that have troubled the child welfare system, and the OIG has highlighted that statutory requirements have not been met, but progress has been made over the past year.

DHHS has repurposed 24 full-time positions from within the Division of Children and Family Services (CFS) to caseworker positions. DHHS is exploring a teaming approach to cases. Turnover is decreasing. DHHS reports 93% caseload compliance as of August 2018. Though DHHS continues to be out of compliance with statutorily required caseload standards, caseload numbers are better than ever. A new monthly caseload report can be found on their website, so transparency related to this area has greatly improved. DHHS has called a working group of internal and external stakeholders to look at the current caseload standards to come up with an improved way to measure caseloads for all caseworkers. In addition, DHHS is working towards increasing workforce stability by enhancing retention and filling vacancies in a timelier manner.

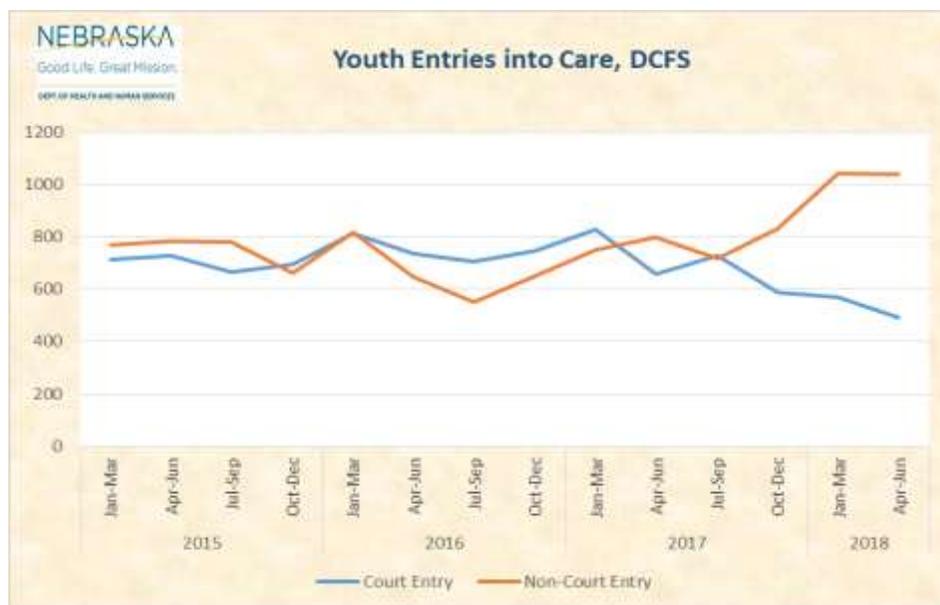
¹ Neb. Rev. Stat. § 43-4331.

The OIG will continue to watch the status of statutory caseload compliance as well as the substantive workload of caseworkers. As caseloads continue to stabilize, the changes in the child welfare system that are coming, as outlined below, could have an impact on workloads for caseworkers. DHHS will need to balance caseload and workload so caseworkers can do their work effectively.

Child Welfare System Changes—State and National Levels

A new director for DHHS’s Division of Children and Family Services (CFS) began his duties in August 2017. Since the change in leadership, CFS has undergone significant modification in child abuse and neglect practice.

Some of these practice changes include more stringent circumstances when suspected drug endangered children are drug tested, fewer child abuse and neglect Hotline intakes being accepted for initial assessment, entries into the child welfare system for *non-court* services increasing, and entries into the child welfare system for *court-involved* youth have decreasing. The number of youth entering the system, whether through non-court or court-involvement, has remained about the same.



During FY 2017-2018 the OIG received multiple complaints related to the safety and wellbeing of children directly connected to these changes in practice. Practice and philosophy has changed, and formal written public policies that should accompany changes like these are expected. The OIG’s attention to these issues is ongoing.

Over the past year, the Child and Family Services Review (CSFR) of Nebraska’s child welfare operations was released to DHHS’s Division of Children and Family Services. DHHS has since been engaged with its federal partners in creating and submitting a performance improvement plan, or PIP, based on findings in the CSFR. Changes in practice have been implemented and more are expected.

On the national level, the Family First Prevention Services Act was passed as part of the Bipartisan Budget Act in February 2018, which reforms the federal child welfare financing streams. The act's aim is to incentivize states to enact and emphasize child welfare services that prevent children entering foster care and other out of home placements. The act does this in several ways, but most significantly by allowing federal reimbursement for mental health services, substance use treatment, and parenting skill-building in the home coupled with trauma-informed prevention planning and the use of evidence-based services.

Much of the guidance about how states will be instructed to carry out the significant provisions of this new reform is scheduled to be released by the U.S. Department of Health and Human Services on October 1, 2018. Change in practice and policy based on these requirements is expected.

Kinship Care

If children are not able to safely stay in their homes, it is understood that it is less traumatic for them to stay in homes with people they know, such as relatives or other people who are close to them. While keeping families together by placing children with relatives is very important, so is ensuring that whatever environment children are placed in is a safe environment and in the child's best interest.

Part of the changes within the Family First Prevention Services Act include funding for states to create a Kinship Navigator Program. DHHS has applied for the funding and hopes to receive it, so changes and improvements in kinship care in Nebraska will be expected.

Importance of Policies in Government Agencies Serving Children & Families

Policies and procedures provide clarity to the public when dealing with accountability issues or activities that are of critical importance when government and state agencies are involved with children, youth or families—especially when the issues children and youth face have serious consequences.

Policies set a plan of action used to guide desired outcomes and act as a fundamental guideline to help make decisions.

The purpose of governmental agency policies is not only to give direction and tools to front line workers who must implement and act on those policies, but well-crafted policies also provide protection to the staff and the children, youth, and families they work with.

Importantly, public policies go hand in hand with integrity, accountability, and transparency. Policies—whether named rules and regulations, administrative memos, procedures, or operational guidance—enable the public to understand each agency and their particular role in the system that serves children, youth, and families.

OVERVIEW OF OIG OPERATIONS

In addition to conducting full investigation and issuing investigative reports, the OIG accepts and reviews hundreds of cases referred to it each year, as well as fulfilling other statutory obligations. In FY 2017-2018, the OIG had 520 intakes, which comprised of 322 critical incident reports, 172 complaints, 21 reports of or requests for information, and 5 grievances and accompanying findings from DHHS.

Increase in Attempted Suicides

In FY 2016-2017, the OIG received 45 reports of suicide attempts. Of these, 23 children were state wards, six were supervised by Juvenile Probation, four were served by both Juvenile Probation and DHHS, two were placed at a YRTC, and three had no system involvement at the time of their suicide attempt. Those numbers were higher than the year before.

This year, attempted suicide numbers reported to the OIG rose again. Of the 52 suicide attempts reported to the OIG, 24 were state wards, 21 were supervised by juvenile probation, six were served by both Juvenile Probation and DHHS, and one was placed at a YRTC.

Youth Rehabilitation and Treatment Center – Kearney

YRTC-Kearney critical incident reports started to increase in FY 2017-2018, after a significant decrease of reports the year prior. Of the total 47 critical incident reports related to YRTC-Kearney, 19 involved escapes and 14 involved assaults. This is compared to 12 critical incident reported escapes and one critical incident report related to a serious assault the year prior.

Increase in Reports of Sexual Abuse

The OIG went from receiving 29 reports related to child sexual abuse in FY 2016-2017 to 45 reports in FY 2017-2018. After the OIG investigation on the sexual abuse of child welfare-involved children and youth, the legislature passed a provision² requiring that all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and juvenile in a residential child-caring agency be reported to the OIG.

OIG INVESTIGATION SUMMARIES AND UPDATES

This year, the OIG completed one system-wide investigation regarding sexual abuse of state wards and 11 individual child death investigations.

Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes, & Youth in Residential Placement

The OIG report of Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes, & Youth in Residential Placement was made public in December 2017. The report contained 18

² Legislative Bill 1078, 2018.

DHHS recommendations and seven action items for the child welfare system as a whole. DHHS accepted 11, rejected four, and requested modification of three of the recommendations. DHHS has already made progress on 12 of the recommendations and has completed two.

FY 2017-2018 Child Death & Serious Injury Investigations

Over the past year, the OIG completed 11 child death investigations. None of these contained recommendations. Investigations where no recommendations are made are generally cases where the death, or other incident, revealed no issue about the administration of an agency that required further action.

OIG Recommendations

As part of the OIG's investigative reports, 81 formal recommendations have been made, with 18 being made in FY 2017-2018. Several additional action items for the child welfare system have been identified for improvement.

OPERATIONS OF THE OFFICE OF INSPECTOR GENERAL

2017-2018

The following section of the Annual Report provides information on the operations of the OIG during FY 2017-2018. This includes cases reviewed by the OIG in the past fiscal year as well as death and serious injury investigations that were opened.

CASES REVIEWED BY THE OFFICE OF INSPECTOR GENERAL

The work of the OIG is largely determined by the intake information that it receives. Information generally comes to the office in the form of “critical incident reports” from the Department of Health and Human Services (DHHS) or the office of Juvenile Probation, complaints from the public, reports/requests for information and copies of grievance findings from DHHS.

During the fiscal year of 2017-2018 (FY 17-18) starting July, 1, 2017 through June 30, 2018, the OIG received 520 total intakes comprised of:

- 322 Critical Incident Reports;
- 172 complaints;
- 21 reports of or requests for information; and,
- 5 grievances and accompanying findings from DHHS.

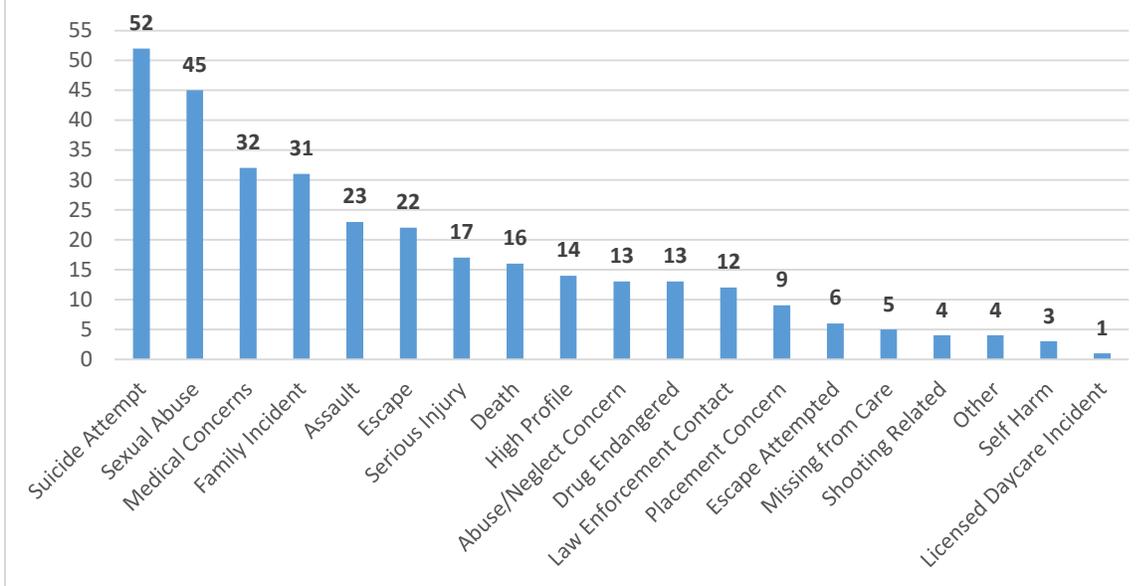
After a review of the initial intake, the OIG conducts a preliminary investigation, including a document review, on every complaint, critical incident, and grievance finding. Based on the preliminary investigation, the OIG then determines whether a full investigation is justified or required and what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

Critical Incidents Received by the OIG

Critical incident reports bring a range of issues to the OIG’s attention. Figure 1. shows the general type of incidents included in the 322 reports involving 298 youth that were reported to the OIG in the past year. Twenty-four youth were involved in multiple incidents.

After review of the critical incident, the OIG categorizes each into various categories.

**Figure 1. Critical Incidents Received by OIG, 2017-2018
Reported by Incident Type**



Of the 322 critical incidents reported to the OIG:

- 214 were reported by DHHS;
- 108 were reported by Probation

Critical Incident Reports and category definitions vary between reporting agencies. This variance may affect the volume and type of information received by the OIG from DHHS and Probation. Categories listed on the DHHS Critical Incident Report form include the following categories:

- Death of a child/youth resulting from abuse or neglect where abuse or neglect is a possible cause or contributing factor of child death, or in any case of unexpected child death where there is not a clearly identified medical cause such as an illness, a trauma event such as a motor vehicle accident, or something similar;
- Near Fatality - a life threatening condition or serious injury resulting from abuse or neglect;
- Suicide or Attempted Suicide of a state ward or a child with whom DHHS is involved;
- Elopement of a youth from a state run facility;
- Law Enforcement: Legal allegations or arrests of DHHS youth for serious illegal/criminal activity (i.e. homicide, manslaughter; near fatality of another person, sexual assault, 1st or 2nd degree assault, aggravated or armed robbery, etc.);
- High Profile: any other event that is highly concerning, poses potential liability, or is of emerging public interest, such as contacts involving the media; and
- Other.

Juvenile Probation Incident Reports include the following categories:

- Death of a juvenile;
- Serious Injury/ Illness;

- Alleged Assault - physical or sexual;
- Suspected Abuse including neglect or maltreatment;
- DHHS Licensure Issue;
- Potential Ethical Concern;
- Potential for Media Exposure/Public Interest; and
- Other.

Placement at the time of the incident was determined to either be In Home, Out of Home, or Missing from Care. Out of home placement includes: foster care (kinship, relative and traditional), developmental disability placements, group homes, shelters, detention facilities, psychiatric residential treatment facilities, YRTC placements, and independent living. Table I. indicates placement based on youth involvement in the system at the time of the critical incident report.

Table I. Youth’s Placement at Time of Critical Incident Report FY2017-2018

System Involvement	In Home	Out of Home	Out of State	Missing from Care
No Prior System Involvement	29	1	1	
DHHS Involved	38			
Juvenile Probation	19	64	10	5
State Ward	15	69	2	1
Dually Adjudicated		20	1	
YRTC Placement		47		

Of those placed out of state, 6 were categorized as sexual abuse, 2 attempted suicide, 2 medical concerns, 2 placement concerns, 1 drug endangered, and 1 missing from care. The OIG generally does not have jurisdiction or oversight of the involved placements or providers that are located out of state.

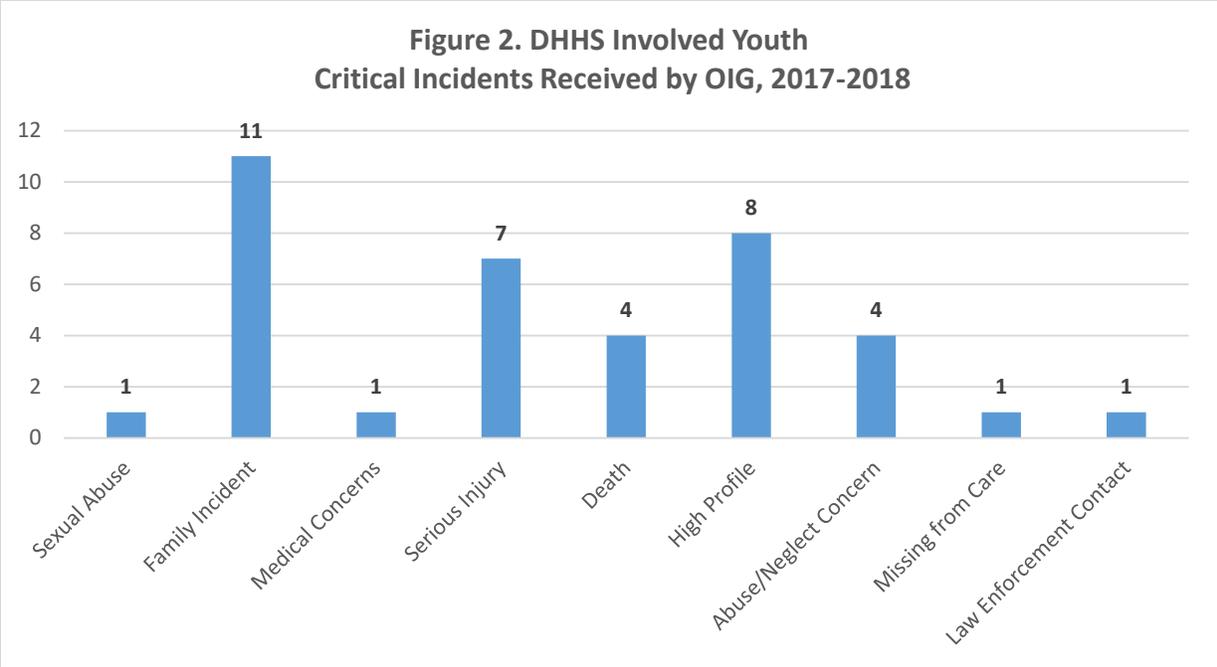
The following sections break down the categories of youth into the types of incidents.

DHHS INVOLVED YOUTH – TOTAL: 38

The OIG considers a family or youth involved with DHHS the following ways: an intake was received at the Hotline; an Initial Assessment investigation, an Alternative Response case or a non-court case. The type of involvement is either active or within the last twelve (12) months. Table II. indicates the number of critical incident reports at each level of DHHS-CFS involvement. Figure 2. breaks down the numbers by the type of incidents reported.

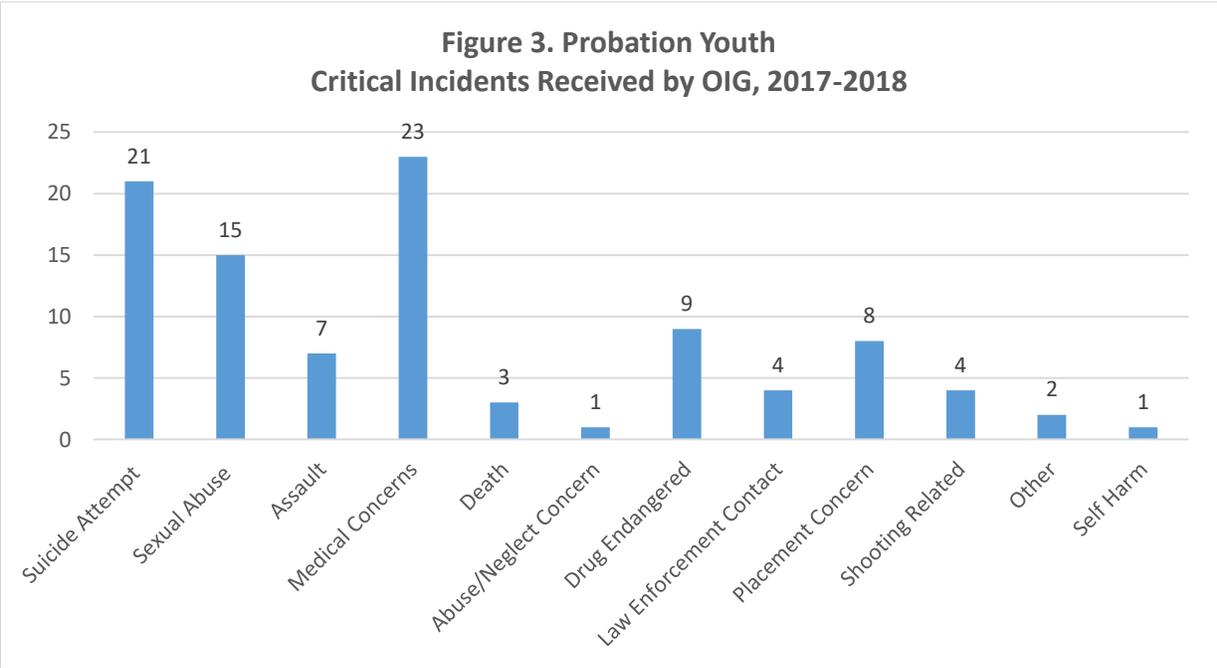
Table II. DHHS Involved Critical Incident Report FY2017-2018

DHHS Involvement Point	Total
Intake	16
Initial Assessment	19
Non-Court Child & Family Services Case	2
Alternative Response Case	1



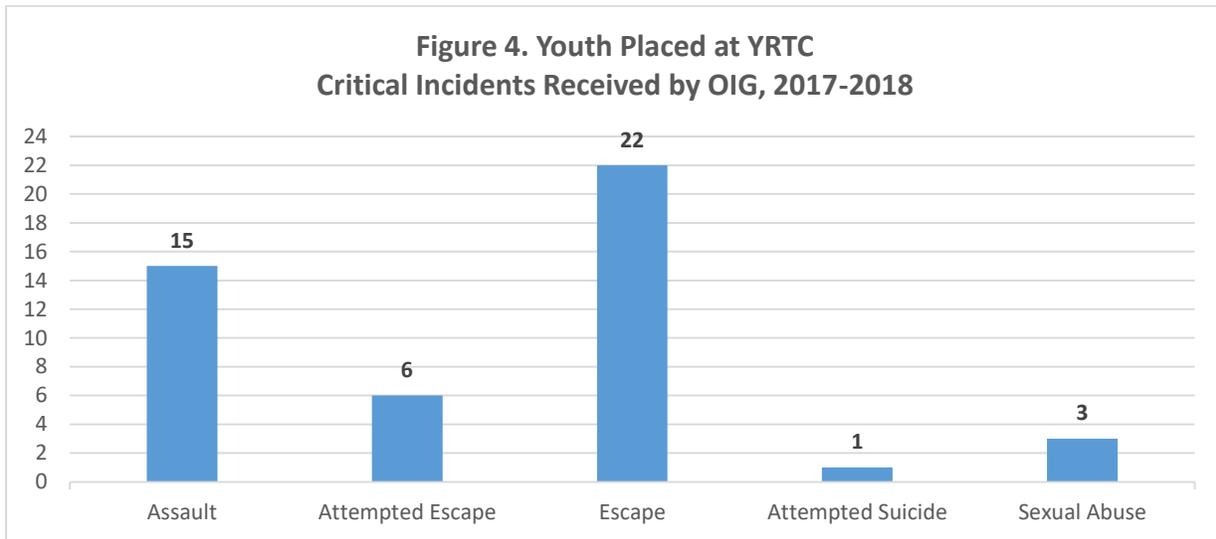
PROBATION YOUTH – TOTAL 98

Probation Youth include those who, at the time of the incident, are supervised by Juvenile Probation, but not placed in at the youth rehabilitation and treatment centers. Medical concerns is the highest reported category for this group and includes accidents and unintentional injury.



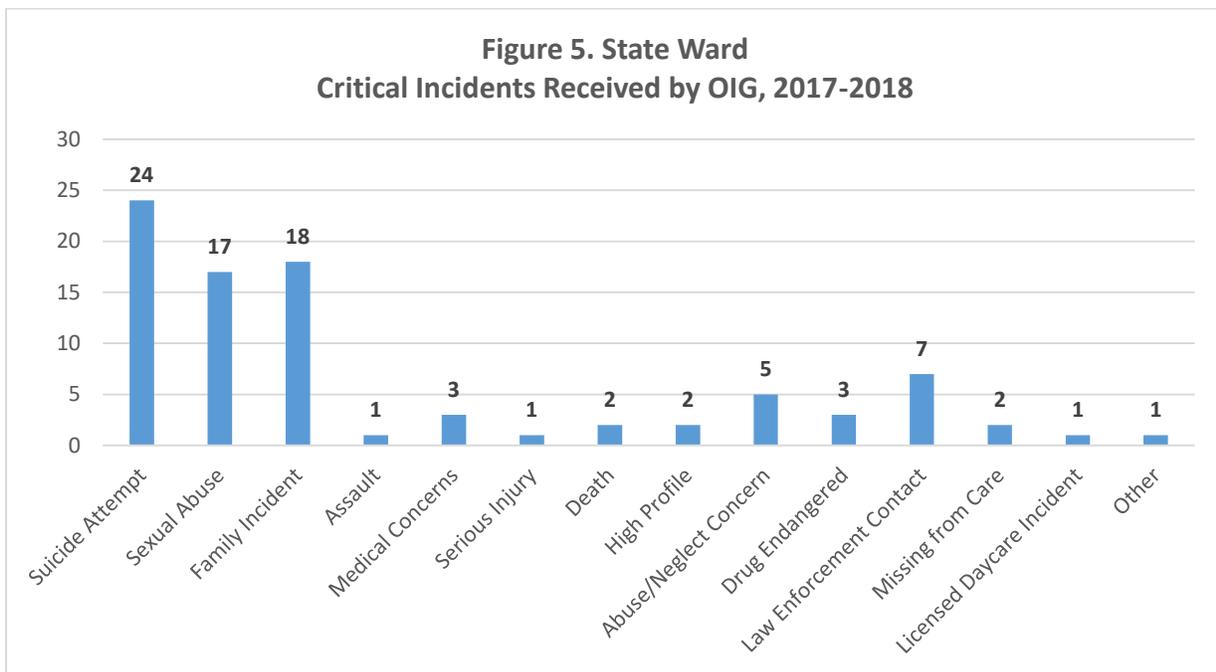
YRTC – TOTAL 47

The YRTC Placement category are youth who are committed to the Youth Rehabilitation and Treatment Center (YRTC), operated by the Department of Health and Human Services-Office of Juvenile Services Division. Included in this category are both youth placed at the Youth Rehabilitation and Treatment Center from Juvenile Probation as well as youth placed there by a tribe in Nebraska.



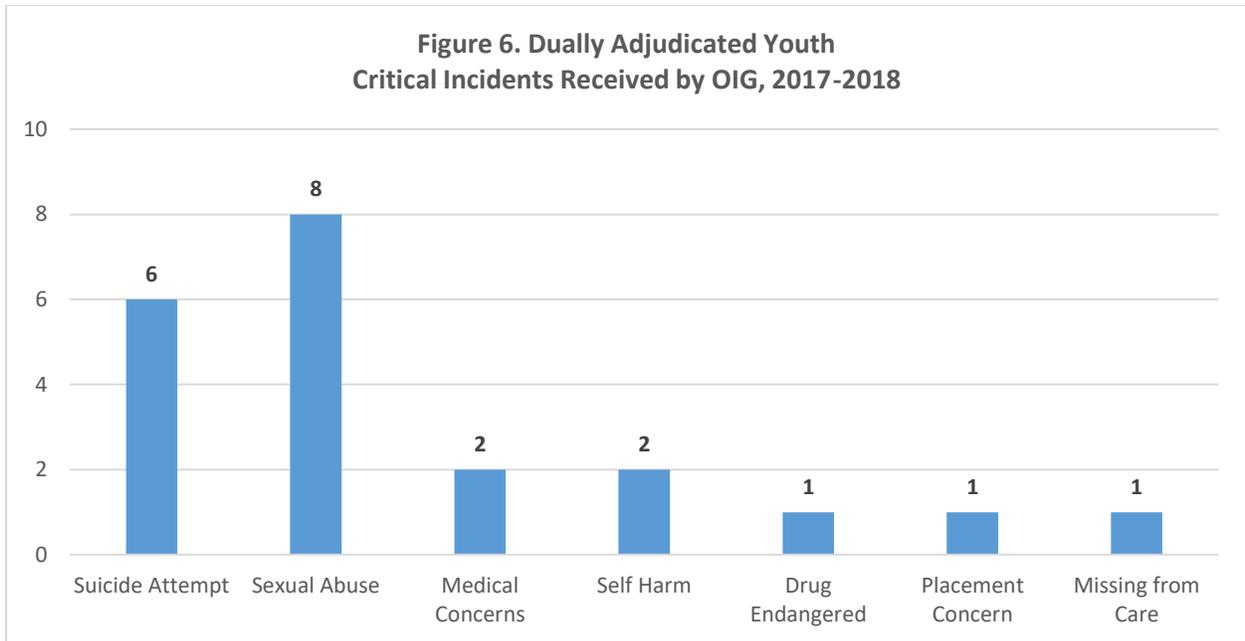
STATE WARDS – TOTAL 87

The State Ward category includes youth who, at the time of the incident, was court ordered to be under the care, custody and control of the Department of Health and Human Services.



DUALLY ADJUDICATED – TOTAL 21

A dually adjudicated youth is, at the time of the critical incident, supervised by both Juvenile Probation and is a state ward with the Department of Health and Human Services.



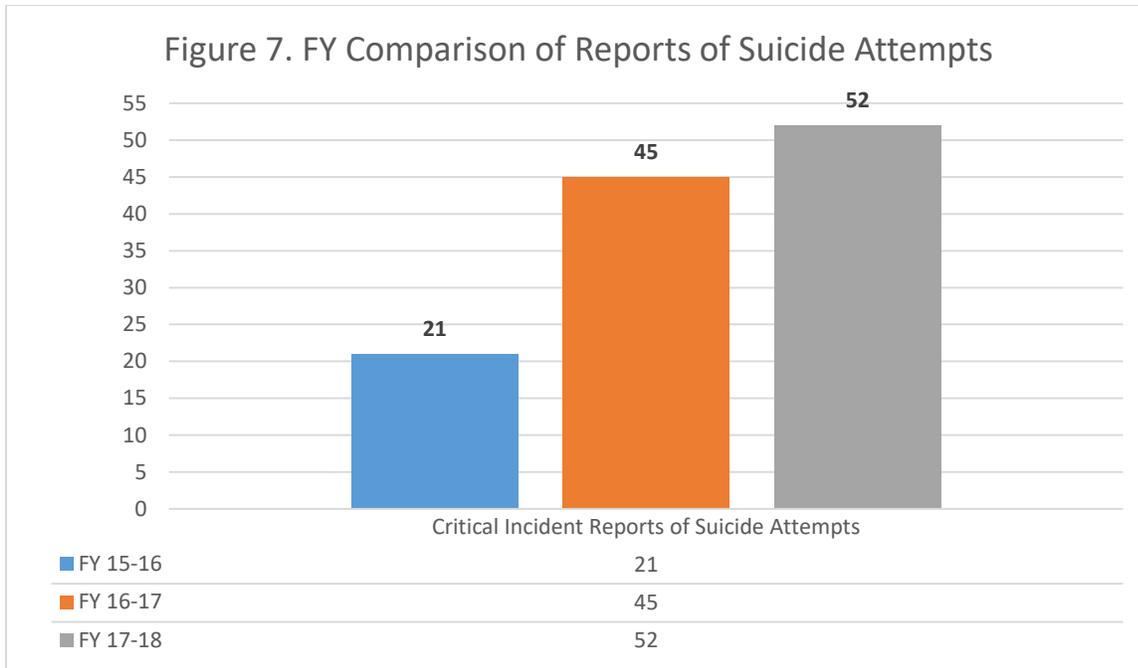
Among the notable trends in the critical incident data this year were:

- A continuous increase in reports of youth involved in the system who have attempted suicide.
- An increase in reports of sexual abuse of youth involved in the system.
- After decreasing last year, an increase in YRTC-Kearney Critical Incident Reports this year.

Attempted Suicide

The OIG received 52 reports of attempted suicide this year, up from 45 in fiscal year 16-17. The 52 reports included 49 youth ages twelve to eighteen who attempted suicide, with three youth making multiple attempts. 34 were female youth and 15 were male youth. A majority of the youth were placed out of home, with 41 incidents. 11 were in the home. System involvement of youth attempting suicide included 24 state wards, 21 probation youth, 6 youth who were dually adjudicated, and 1 in a YRTC placement.

Figure 7. shows the upward trend in critical incident reports of attempted suicide.



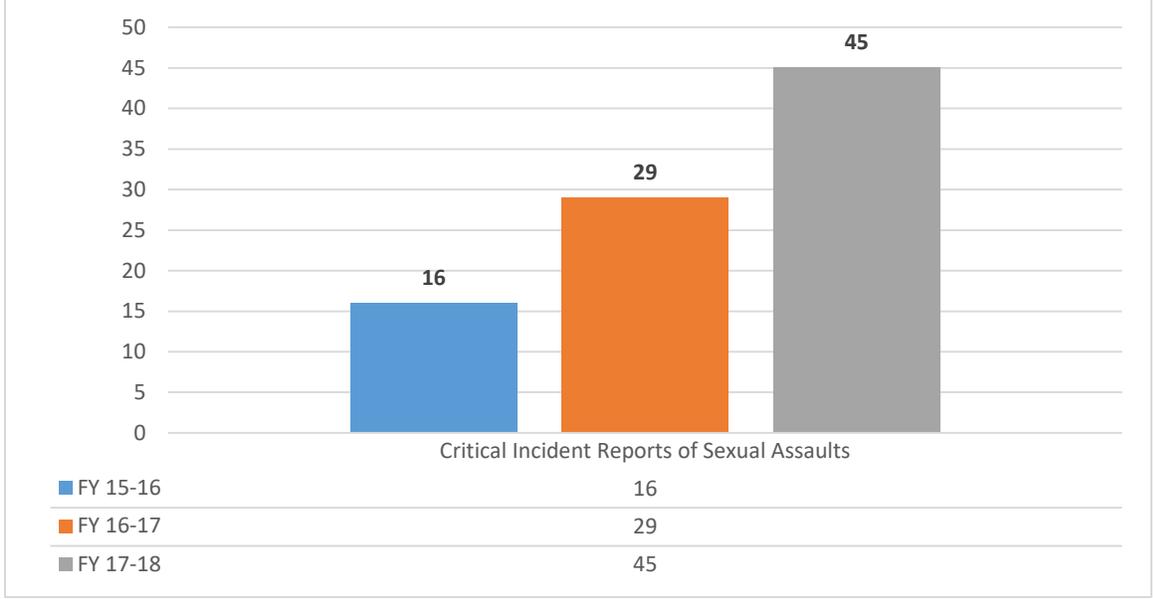
Sexual Abuse Reports

The OIG received 45 reports of sexual abuse of youth in FY 2017-2018. During fiscal year 16-17 there was an 81% increase from the 15-16 fiscal year. The 45 reports (38 reporting victimization and 7 reporting perpetration) included 43 youth ages five to eighteen years, with one youth having multiple incident reports. Table III. identifies the system involvement for critical incident reports of sexual abuse. Figure 8. shows the sexual abuse critical incidents reported during the past three fiscal years. While the increase in reports is troubling, it would be expected that the number of reports increase as awareness of the issue increases and as provisions of LB 1078, passed in 2018, requiring reporting of sexual abuse to the OIG, go into effect.

Table III. Sexual Abuse Critical Incidents Reported by System Involvement.

No Prior History	1
DHHS Involved	1
Probation	15
YRTC Placement	3
State Ward	17
Dually Adjudicated	8

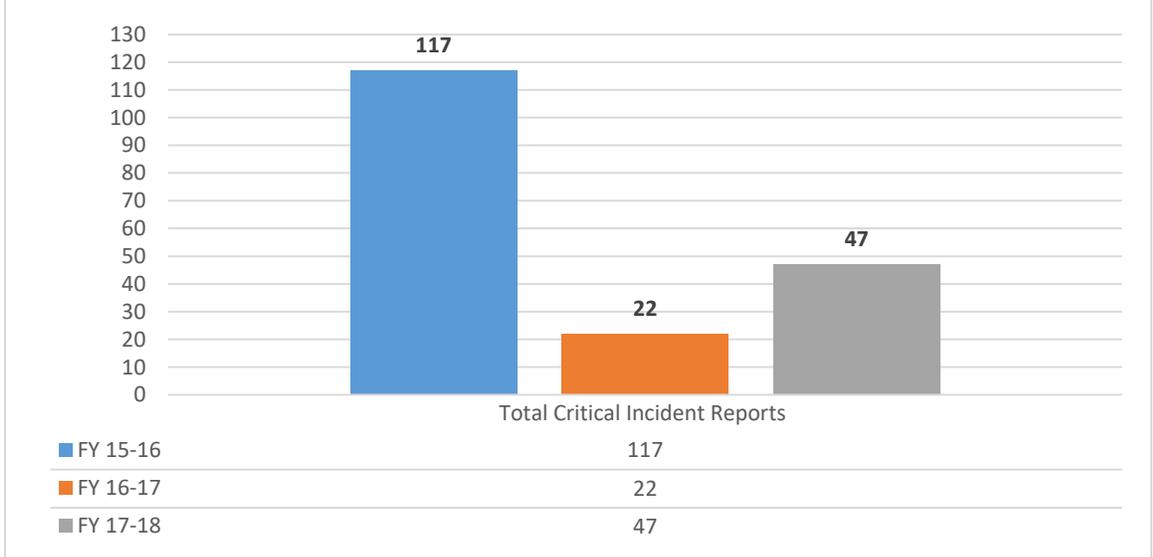
Figure 8. FY Reports of Sexual Assaults



YRTC-Kearney Critical Incident Reports

YRTC-Kearney reported 47 critical incidents during FY 17-18, this is an increase from 22 in FY 16-17. The majority of the incidents in FY 17-18 involved escape, and assault. This is a noticeable change when compared to the trend in critical incidents noted in the 2016-2017 OIG Annual Report, which saw critical incident reports for the Kearney facility decrease by 81% from FY 2015-2016 to FY 2016-2017.

Figure 9. FY Comparison of YRTC-Kearney Critical Incident Report Totals



Death and Serious Injuries Reported to the OIG

The OIG is required to investigate deaths and serious injuries of system-involved children who are: (1) placed in out-of-home care, a licensed residential facility, or in the care of a licensed child care facility; (2) currently receiving or have received child welfare services from DHHS in the past twelve months; (3) currently receiving or have received services from the Juvenile Services Division of Probation in the past twelve months; and (4) the subject of a child abuse investigation (initial assessment) in the past twelve months. The OIG is not required to investigate deaths that occurred by chance. Serious injury is defined as, “injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.”³ The OIG opens death and serious injury investigations based on critical incident reporting.

Of the 16 reported child deaths in 2017-2018, six had sufficient contact or involvement in the child welfare or juvenile justice system to merit opening an investigation.

Table IV. OIG Opened Investigations of Child Deaths, FY17-18

Total	Cause of Death	System Involvement
2	Sudden Unexpected Infant Death	DHHS Involved
1	Sudden Unexpected Infant Death at a Licensed Daycare Facility	Public Health Licensing
1	Abuse ⁴	State Ward
2	Suicide	Probation

Of the 17 serious injuries reported to the OIG this year, three met the requirements to open an investigation.

Table V. OIG Opened Investigations of Child Serious Injuries, FY17-18

Total	Cause of Serious Injury	System Involvement
1	Near Drowning	DHHS Involved
1	Near Drowning at a Licensed Daycare	State Ward
1	Head Injury at a Licensed Daycare	Public Health Licensing

Complaints Received by the OIG

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

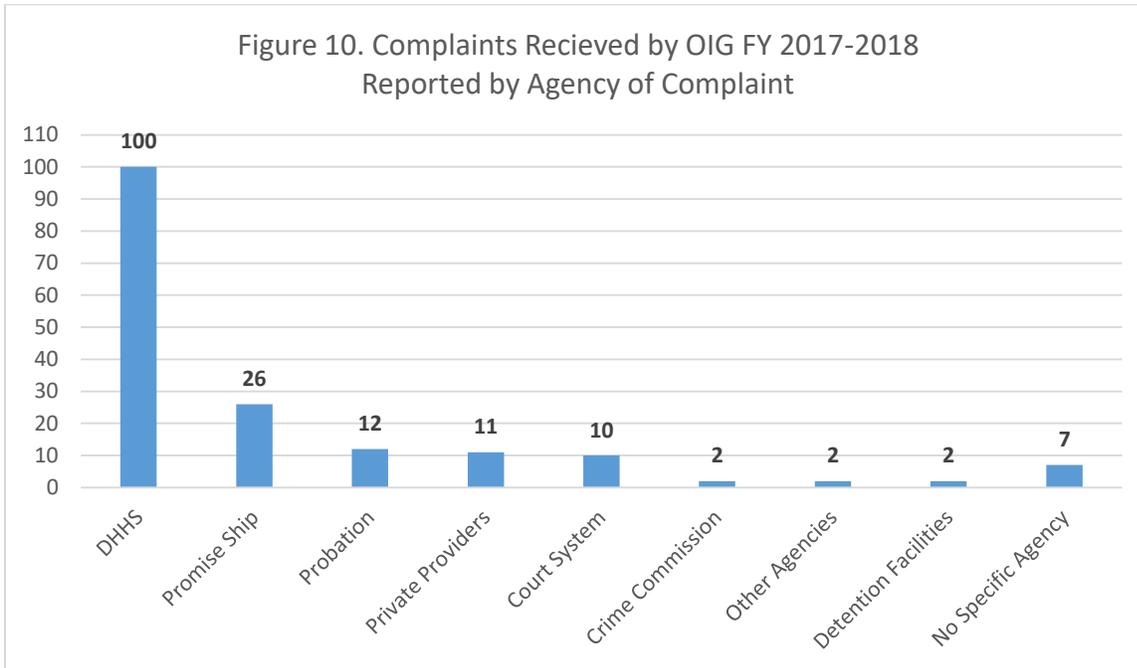
1. DHHS;
2. Juvenile Services Division (Probation);

³ Neb. Rev. Stat. § 43-4318 (2).

⁴ See 2-month Old State Ward Death Investigation Summary, page 35.

3. The Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) juvenile justice programs;
4. Private child welfare agencies, foster parents, licensed child care facilities, and contractors of DHHS and Juvenile Probation; and
5. Juvenile detention and staff secure detention facilities.⁵

In the past year, the OIG received 172 complaints. The agencies and issues varied and represented all areas and points in the system.



Examples of types of issues received in complaints during FY 2017-2018 were sorted into the following categories:

- Case Management
- Child Safety
- Initial Assessment
- Hotline
- Removal from Home
- Contact or Visitation
- Permanency
- Laws/Policy & Procedure
- Placement
- Financial
- Licensing

Complaints are multifaceted and most encompassed more than one specific incident of concern. For the FY2017-2018, half of the complaints generated were inclusive of two or more issues. Specifically, there were two issues identified in 73 of the complaints, and three or more issues identified in 22 of the complaints.

⁵ Neb. Rev. Stat. § 43-4318 (1)(a).

Alternative Response Cases Reviewed by the OIG

The OIG is specifically tasked with reviewing and investigating critical incidents and complaints related to Alternative Response, a pilot project that began in 2014.⁶ Alternative Response was implemented by DHHS to change the way the system responds to some child abuse and neglect reports. By statute, the OIG must report on any alternative response (AR) cases it reviews in its Annual Report.⁷

This year, the OIG received one complaint related to AR and one critical incident report involving AR. The OIG conducted a preliminary review of the cases, which did not result in full investigation.

The following issue was reported to the OIG concerning Alternative Response:

- A system professional reported that DHHS's Child Abuse and Neglect Hotline (Hotline) is screening out reports of educational neglect. Nebraska Public Schools are required to show due diligence in working with the youth and family to get the youth to school. They are required to prepare a plan and try to identify and alleviate any barriers. If the family does not cooperate and truancy is still an issue, schools can call the Hotline and make a report. If the Hotline screens out these types of cases, then the schools will contact the local county attorney and a juvenile petition will most likely be filed. The system professional suggested DHHS should screen these cases as AR, so families get the services they need without court intervention.

The following critical incident was reported to the OIG concerning Alternative Response:

- A 5-year-old boy was found to have injuries to his genitals. The child told law enforcement his step-mother had twisted his genitals because he'd wet the bed. Law enforcement indicated other injuries were found on the child including marks on his neck, a scratch above his knee and faint bruises on his legs. After an investigation, law enforcement arrested the step mother for child abuse. The Hotline received an intake on this family six months prior. The allegations were physical abuse and neglect by the step mother. This intake was accepted for Alternative Response. After the alternative response intervention, the youth was found safe. DHHS offered the father and step mother AR services, but they refused and the case was closed.

⁶ Neb. Rev. Stat. § 28-712.01 (5).

⁷ Neb. Rev. Stat. § 43-4331.

OIG Capacity Challenges

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

Since its creation in 2012, it has grown increasingly difficult for the OIG to complete statutorily-required investigations in a timely manner. The OIG has completed and issued reports on 42 death or serious injury investigations. As of June 30, 2018, the OIG had a total of 34 pending death and serious injury investigations. These investigations are required by statute but not yet complete.

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

Additionally, the OIG has been tasked with collecting quarterly data regarding the use of juvenile room confinement and release an annual report about the matter. The first annual report was released in late 2017.

The OIG has also been working to increase efficiencies internally - improving intake and investigative processes. The Legislature has also given the OIG additional flexibility by not requiring it to investigate deaths that occur by chance. However, given the number of cases referred to the OIG each year, the backlog of investigations, and other duties assigned to the OIG, capacity challenges continue to hinder the ability of the OIG to provide timely and thorough oversight to the child welfare and juvenile justice system.

The OIG encounters a number of issues or system-wide issues that may merit a deep look into the subject area, and priorities are continuously being adjusted in order to spend staff time wisely.

JUVENILE ROOM CONFINEMENT IN NEBRASKA 2016-2017 REPORT SYNOPSIS

The OIG released its first annual report on the use of juvenile room confinement in December 2017. The full report with findings can be found on the OIG's website.

Nebraska law requires a wide variety of facilities that serve children and youth to document information every time a child is placed in room confinement - involuntarily restricted to a room, cell, or other area alone - for an hour or longer. Facilities must report quarterly on the use of room confinement to the Nebraska Legislature.

Nebraska law also charges the OIG with preparing an annual report on the use of juvenile room confinement. The annual report must contain:

- An assessment of juvenile room confinement in each juvenile facility. "Juvenile facility" (facility) is defined broadly to include state-run correctional facilities and local detention centers, which house children in the justice system, as well as residential child-caring agencies⁸ - mental health centers, group homes, and shelters- which can serve any child;⁹
- Model evidence-based criteria on the use of room confinement; and,
- Identified changes which may lead to a reduction in room confinement.¹⁰

The report examined juvenile room confinement in Nebraska between July 1, 2016 and June 30, 2017, the first fiscal year that juvenile facilities were required to report.

Throughout the process of reviewing reports and identifying juvenile facilities, the OIG discovered that juvenile room confinement encompasses a wide variety of practices at different types of facilities where youth are being served in different ways. Based on its definition in Nebraska law, juvenile room confinement is an umbrella term.¹¹ Different facilities keep youth involuntarily alone by using practices which may be known as segregation, restrictive housing, special management, isolation, seclusion, disciplinary confinement, time-out, and room restriction, among others.¹²

Depending on the specific practice and facility, youth in room confinement receive different levels of contact with staff and other youth, privileges, and care. Facilities and the interventions used by each fall under a variety of state and even federal requirements, depending on the type of facility and the services that particular facility provides to youth.

⁸ Neb. Rev. Stat. § 83-4,125.

⁹ This refers to both privately placed youth and youth served through Nebraska's child welfare and juvenile justice systems.

¹⁰ Neb. Rev. Stat. §83-4,134.01.

¹¹ Neb. Rev. Stat. § 83-4,125 states, "Room confinement means the involuntary restriction of a juvenile to a cell, room, or other area, alone, including a juvenile's own room, except during normal sleeping hours."

¹² Individual facilities have specific definitions and practices for each type of room confinement. These practices are discussed in detail in sections on types of facilities.

Overview of Juvenile Room Confinement

In general, juvenile room confinement has been used as a means to control or respond to youth behavior in situations where youth pose a safety threat to themselves or others, in situations where youth have violated facility rules, or both. Room confinement is often used to assist facility operations and to protect the safety of youth, staff, and the facility as a whole. A variety of forms of room confinement have been developed and have evolved over time. Regulations, policies, and practices on when, how, and why juvenile room confinement is used differ among types of facilities and specific interventions.

While the different forms of room confinement have been developed to serve specific purposes at facilities, research is in agreement that there can be harmful impacts when children are involuntarily placed alone. These impacts can include an increased risk of self-harm and of exacerbating mental illness, especially for children who have been victims of abuse or prior trauma. For youth in the justice system, room confinement has been linked with an increased risk to re-offend.¹³

Given the risks highlighted in research, numerous professional and accrediting organizations have developed standards and policies that are intended to govern and restrict the use of many different forms of room confinement and limit the harm it may cause. These standards generally recommend that juvenile room confinement be:

- **Used as a last resort.** Room confinement should be used only in cases of threats to the safety of the individual or other residents and when other less intrusive interventions have failed. Room confinement should not be used for punishment, retaliation, or a matter of administrative convenience;
- **Time-limited.** Youth should be released from room confinement as soon as they are safely able to be. According to most standards, room confinement of youth should not last longer than 24 hours. Some standards for specific types of facilities have enacted stricter limits of one, two, or four hours;¹⁴ and,
- **Closely Monitored.** Youth in room confinement should be checked on by staff frequently while in room confinement. It is also recommended that youth in room confinement for long periods of time be seen by mental health professionals. All instances of room confinement should be recorded and reviewed through a quality assurance program at each facility. Administrative approval should be sought to use room confinement in certain instances.

While these standards have been developed based on research, none have been sufficiently evaluated to qualify as evidence-based practices on the use of room confinement. Nonetheless, they represent best practices in the fields of mental health and juvenile justice.

Although organizational standards are in agreement on the need to limit the use of room confinement, success at doing so has been uneven across states and individual facilities. Those that have successfully reduced room confinement have had to implement significant and ongoing

¹³ See Overview of Juvenile Room Confinement for full summary.

¹⁴ The exception on time limits is the American Correctional Association which allows up to 5 days of disciplinary room confinement.

changes to facility culture, policy, and practice to find new and different ways to respond to youth behavior and safety concerns. Effective strategies used by other states and facilities are documented further in the body of the report.

Nebraska's Use of Juvenile Room Confinement

Nebraska juvenile facilities reported a total of 2,383 incidents of juvenile room confinement during FY 16-17. This number is likely an undercount of actual incidents of juvenile room confinement, however.

Some Nebraska juvenile facilities did not report or partially reported, submitting some information, but not all reports required quarterly by law.¹⁵ Furthermore, the OIG was not able to verify the accuracy of the room confinement reports submitted by juvenile facilities.

Of those facilities that did report, 11 indicated use of room confinement. Data measures were calculated on the use of room confinement at seven facilities that reported more than 50 instances of room confinement during FY 16-17.

The data measures were chosen by the OIG because they are used by a national organization, Performance-based Standards, to allow for analysis of the use of room confinement at facilities, serving as a means to compare changes in individual facility use over time.¹⁶

The OIG analyzed the use of room confinement by facility type to provide as much context as possible on factors that influence the use of room confinement, including the differences in function of facilities, the type of population served, and specific policies and standards.

¹⁵ Requirement for quarterly reporting are found in Neb. Rev. Stat. §83-4,134.01.

INVESTIGATIONS, 2017-2018

The Office of the Inspector General (OIG) investigates deaths and serious injuries of Nebraska children and youth who were:

- Being taken care of at a licensed facility, such as a day care or group home;
- The subject of an abuse or neglect assessment (also referred to as an investigation) in the previous twelve months, but the family did not receive services through DHHS;
- Engaged in an alternative response case, voluntary, or non-court case, and received services through their DHHS involvement, but were not involved in a formal court case;
- Placed at a juvenile detention center;
- Supervised by juvenile probation;
- Placed at a Youth Rehabilitation and Treatment Center; and/or
- Involved in a juvenile court case and DHHS had custody of the child, also known as being a state ward.

The Inspector General receives notifications of death and serious injury from the Department of Health and Human Services and from Probation Administration through what the OIG refers to as “critical incident reports”.

The OIG responds to and investigates complaints by employees, administrators, foster parents, biological parents, grandparents, family members, attorneys, and the general public about various aspects of the child welfare system, the juvenile justice system, and DHHS Licensure Unit as it pertains to children and youth.

Sometimes reviewing critical incident reports and complaints reveal a more system-wide subject matter that the OIG determines needs prioritization and a formal, system-wide investigation is opened.

OIG Investigatory Processes

Both a critical incident report and a complaint generates a preliminary review to determine whether further investigation is warranted and proper under the OIG Act. If all documents are not readily accessible, sometimes document requests are made at this point to make the determination of properness, warranty, and priority. If further investigation is warranted and proper, all documents—including, but not limited to, autopsy reports, law enforcement reports, agency case management systems documents, statutes, rules, regulations, policies, procedures, forms, and other information—are collected and comprehensively reviewed. Data is oftentimes requested and reviewed to gain a better understanding of issues faced by the child welfare and juvenile justice systems.

Investigations are prioritized depending on issues, whether the subject area is already being addressed, how old the case is and whether actions have been taken to already address issues, and whether the issue can be handled informally.

When a determination is made by the OIG that a full investigation will be conducted, the OIG follows established processes with the administrative agency that is a subject of any such investigation.

At the conclusion of a full investigation, which can range from several weeks to several months, the OIG issues an investigative report to the agency involved. Within 15 days, the agency must respond to the OIG and accept, reject, or request modification of the OIG's recommendations. Also, the agency takes this time to correct any factual errors. The report becomes final either after the 15 days or after modifications have been considered.

[FY 2017-2018 Completed OIG Investigations](#)

The following sections provide more detail on the investigations that were completed during FY 2017-2018. Those include a system-wide investigation into sexual abuse of child welfare involved children and 11 child death investigations.

Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes, & Youth in Residential Placement, Reported July 2013-October 2016

Over the years, the OIG received numerous reports related to the sexual abuse of children involved with or adopted from the child welfare system or involved with the juvenile justice system.

A continuing flow of these types of sexual abuse reports caused the OIG to open an investigation into what was being done to prevent and respond to sexual abuse of youth in state care. For purposes of the report, “youth in state care” refers to children served by the Nebraska Department of Health and Human Services (DHHS) either as a state ward, or a child placed at a state-run facility or a private residential facility licensed through the Division of Public Health. As part of this investigation, the OIG reviewed cases of children who were sexually abused while in state care, and cases where children were sexually abused in the adoptive and guardian homes in which the state had placed them.

The OIG’s final report of investigation was issued to DHHS in October 2017. A summarized final report of investigation was released pursuant to *Neb. Rev. Stat. §43-4325*, “in order to bring awareness to systemic issues” in December 2017.

The full report can be found on the OIG website.

Background on Child Sexual Abuse

Child sexual abuse remains a widespread problem in the United States. Recent estimates show that 1 in 10 children will be subject to sexual abuse involving sexual contact before the age of 18, either by an adult or another youth.¹⁷ Child sexual abuse is generally understood to include everything from child rape and molestation, sexual touching, and coercing or persuading a child to engage in any type of sexual act to exposure to pornography, voyeurism, and communicating in a sexual manner by phone or Internet. In an estimated 90 percent of cases, children are sexually abused by someone they know and trust.¹⁸

Between 2013 and 2016, there were 1,284 substantiated victims of child sexual abuse in Nebraska.¹⁹ While DHHS did not track how many of those victims were involved with the child welfare system, national research indicates that youth in this system are at higher risk of experiencing sexual abuse and exploitation than their peers in the general population. Exact numbers of child sexual abuse victims are difficult to calculate because many victims do not report sexual abuse or wait for long periods of time before disclosing. Available research indicates that false reporting of child sexual abuse is extremely rare – occurring in only 4 to 8 percent of cases.²⁰

¹⁷ Townsend and Rheingold, *Estimating a Child Sexual Abuse Prevalence Rate*, 21.

¹⁸ Finkelhor and Shatuck, *Characteristics of Crimes against Juveniles*, 5.

¹⁹ DHHS CFS Administrator, email to OIG, Feb. 17, 2017. Data was provided by DHHS and further analyzed by the OIG.

²⁰ Everson and Boat, “False Allegations of Sexual Abuse.”

The impact of child sexual abuse can be lifelong - placing survivors at heightened risk for physical and mental health diagnoses, increasing the likelihood they will encounter academic problems and engage in risky behaviors, and even negatively impacting lifetime earnings.

Findings and Recommendations of the OIG Investigation

Through its investigation, the OIG identified cases of child sexual abuse of state wards, of youth in residential facilities, and of youth reaching permanency through the child welfare system. The OIG used these cases as a starting point in identifying systemic issues that hinder DHHS and the child welfare system's ability to appropriately prevent and respond to cases of child sexual abuse.

Throughout the report, the OIG also made recommendations to DHHS for system improvements, in addition to identifying action items for the child welfare system as a whole. Of the 18 recommendations made, DHHS accepted 11. The OIG also added DHHS's response to each recommendation and action item.

Cases of Child Sexual Abuse

The OIG identified 50 children who were victims of sexual abuse that had been substantiated by DHHS or the courts, or where the case was court pending. Substantiated cases are those where it has been determined sexual abuse occurred. Court pending sexual abuse cases are cases that have been investigated and enough evidence exists that sexual abuse occurred that a juvenile or criminal court action was filed. The outcome of such juvenile or criminal proceeding has not yet been determined.

Twenty-seven victims were in state care at the time of their sexual abuse and 23 were sexually abused in an adoptive or guardian home in which the state had placed them. The 23 youth who were sexually abused in adoptive or guardian homes were no longer involved in the child welfare system when the abuse was reported, although for some the sexual abuse they experienced began before permanency was achieved.²¹ All of the sexual abuse allegations were reported to DHHS between July 2013 and October 2016.

The OIG also identified, reviewed, and analyzed some sexual abuse allegations of children in state care that were listed as unfounded or were never investigated. Under Nebraska law, all reports of child abuse or neglect not classified as court substantiated, court pending, or agency substantiated are to be considered unfounded.²² Although these allegations were not substantiated, at times correctly, the cases nonetheless illustrated concerns about how the child welfare system was functioning. Seven of these cases are highlighted in the report.

The OIG reviewed and gathered information on each case of sexual abuse to identify trends and systemic issues. Each case is summarized in the report.

The victims and cases identified by the OIG should not be considered a comprehensive list of children who were sexually abused while in state care or in adoptive and guardian homes. That number remains unknown, in large part due to the reluctance of child victims to report sexual

²¹ These adoptions or guardianships were finalized between 2003 and 2015.

²² Neb. Rev. Stat. § 28-720.01.

abuse, as well as the issues this investigation documented with reporting, investigating, and substantiating sexual abuse.

Systemic Issues Identified

Through its investigation, the OIG identified systemic issues in a number of areas. In each of these areas, the OIG also made recommendations and identified action items to address shortcomings.

Attitudes towards sexual abuse of youth in state care

The OIG came across system professionals and caregivers who had problematic attitudes towards child sexual abuse and children who have spent time in the state's care.

- At times, children's sexual abuse disclosures were dismissed and never reported. In these cases, caregivers and professionals often assumed children were lying or "acting out" because they were troubled.
- Some children were exposed to continuing sexual abuse through professional and system inaction after concerns were noted.
- Some children were blamed by caregivers and system professionals for causing the sexual abuse that they suffered.

These attitudes contributed to many of the errors and issues that left the child welfare system unable to effectively prevent and respond to child sexual abuse of youth in its care.

Reporting and screening child sexual abuse allegations

There were issues with how child sexual abuse allegations were reported to and screened by the DHHS Child Abuse and Neglect Hotline (Hotline).

- Although it violates state law to fail to call the Hotline or law enforcement, some adults and system professionals who were aware of child sexual abuse allegations did not report them to the proper authorities.
- If and when a report reached the Hotline, the use of overrides (a certain process to screen out reports) allowed some child sexual abuse cases to go without investigations and left children vulnerable to ongoing abuse.
- Instances were discovered where reports of youth sexually abusing other youth were incorrectly determined to not meet the definition of child sexual abuse at the Hotline.
- The Hotline has a practice of screening law enforcement only reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse. This practice is not authorized in DHHS policy, masks the number of child sexual abuse allegations, and creates opportunities for errors to occur.

Investigations of child sexual abuse

There were several areas surrounding the investigations of child sexual abuse allegations that need improvement.

- Despite requirements in state law, not all allegations of child sexual abuse were investigated by DHHS or law enforcement. Further, DHHS was not assessing for risk of harm and providing needed services in all child sexual abuse cases.

- DHHS investigations of child sexual abuse at residential facilities, called “out of home assessments,” were not being conducted according to DHHS policy, leaving issues at these facilities unresolved.
- Across the state, some child sexual abuse cases were difficult to substantiate due in part to limitations in gathering evidence and poor coordination in multidisciplinary investigations.
- Child sexual abuse substantiations were inconsistent across Nebraska, even when evidence of child sexual abuse is present. This was due to differences in court practice and a lack of guidance by DHHS to accurately and uniformly apply a preponderance of the evidence standard.

Workforce ability to prevent and respond to sexual abuse

High caseload, workload, and workforce turnover contributed generally to DHHS being unable to effectively prevent, identify, and respond to sexual abuse of youth in state care.

- Timeframes for completing child sexual abuse investigations were missed in a number of cases, sometimes by years. The OIG found 184 DHHS investigations and 1,350 law enforcement only investigations reported between 2013 and 2016, where timeframes were not met.
- Ongoing cases suffered as turnover and high workload made it difficult to identify signs that sexual abuse was occurring or made it difficult to provide effective case management to children who had been abused.
- The OIG also identified that the DHHS workforce was many times uncomfortable with discussing child sexual abuse.
- Not all staff were prepared to give youth while in state care the information they need about child sexual abuse to help them stay safe and know who they can talk to if something concerning does occur.

Child sexual abuse in foster, adoptive, and guardian homes

Thirty-seven of 50 sexual abuse cases identified by the OIG occurred in foster, adoptive, or guardian homes. The OIG identified several deficiencies with how homes are chosen and prepared to care for children.

- Completion of home studies alone is not adequate to ensure that placements are safe and suitable for children.
- A shortage of appropriate placements created pressure to put children in homes that may have met minimum standards for placement but had suitability concerns.
- Foster and adoptive parent training did not include key information on preventing and reporting child sexual abuse. In many instances, foster and adoptive parents were not able to respond appropriately to sexual abuse allegations or protect children.

Child sexual abuse in residential facilities

The OIG identified three substantiated child sexual abuse cases in residential facilities - two in privately run facilities one at a state-run facility. The OIG also reviewed a number of concerning sexual abuse cases at a wide range of facilities that were never substantiated.

- The Division of Public Health, which licenses most residential facilities through the *Children's Residential Facilities and Placing Licensure Act*, did not have the capacity to adequately investigate and respond to sexual abuse allegations at residential facilities.
- The standards established for facilities related to sexual abuse are inadequate to minimize the risk of child sexual abuse.
- Where the U.S. Department of Justice's Prison Rape Elimination Act Juvenile Facility Standards had been implemented, staff took appropriate steps to respond to allegations and incidents of sexual abuse.

Recommendations to the Department of Health and Human Services

In each of the areas where systemic issues were identified, the OIG made recommendations to DHHS.

1. Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.

DHHS Response: Reject

Status Update: **Progress.** LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations to the OIG. DHHS is currently developing an implementation plan.

2. End the practice of screening law enforcement reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.

DHHS Response: Request Modification

Status Update: **Incomplete.** DHHS reports that the Hotline Administrator and other staff are reviewing reasons why intakes are being re-screened and adopting definitions. The CQI team has begun to perform qualitative reviews to determine whether sexual abuse allegation intakes are following proper practice and policy. So far, the sample is very small. In a quarterly review conducted May 2018, out of 407 intakes alleging sexual abuse, 11 were reviewed by the CQI team. 2 of the 11 were rescreened to Does Not Meet Definition, and in both cases, the CQI reviewer agreed. No questions in the CQI analysis have to do with whether the sexual abuse allegation meets DHHS's definition of child sexual abuse, whether the rescreen to Does Not Meet Definition is based on practice or policy, and whether the practice of rescreening, if still meeting the definition, is acceptable.

3. Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.

DHHS Response: **Accept**

Status Update: **Incomplete.** DHHS reports that the Hotline Administrator is reviewing the intake process. QA staff have put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed by the CQI team to ensure appropriate use of policy and discretionary overrides. So far, the sample is very small. For example, in a quarterly review conducted May 2018, out of 407 intakes alleging sexual abuse, 11 were

reviewed by the CQI team. An override was used in 3 of the 11 cases, and in the 3 cases, the reviewer agreed with the closing status.

4. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.

DHHS Response: Accept

Status Update: Progress. DHHS has begun working with UNL's Center on Children, Families, and the Law (CCFL) on revisions for training all CFS staff.

5. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.

DHHS Response: Accept

Status Update: Progress. DHHS has created a new finding: Law Enforcement Refusal, which indicates that law enforcement is not choosing to investigate the allegation. This change in Hotline protocol has been piloted in the Eastern Service Area and will be rolled out to the rest of the state in September 2018. Staff at the Hotline will continue to reach out to law enforcement.

6. Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.

DHHS Response: Reject

Status Update: DHHS reports that this is already occurring, based on assessments and referrals that take place at the Hotline. Hotline staff will connect families to other hotlines and the CACs when appropriate. DHHS is rolling out a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. Any referral will be documented on NFOCUS.

7. Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.

DHHS Response: Accept

Status Update: Complete. DHHS reports that a curriculum has been developed on the preponderance of the evidence standard. Trainings for all supervisors occurred across the state beginning in April 2018.

8. Adhere to policy on out of home assessments and enhance quality assurance.

DHHS Response: Accept

Status Update: Progress. DHHS is relooking at the policy on out of home assessments, including engaging front-line workers who complete these assessments in creating any new policy. Part of the analysis will focus on how involved Central Office will be in these

assessments. Once the policy is redone, an implementation process will be developed and acted on.

9. Review, modify, and enforce process for gathering information and making findings in Law Enforcement Only cases.

DHHS Response: Accept

Status Update: Complete. DHHS has transferred the responsibility for entering findings to the Hotline for investigations conducted by law enforcement only. (Program Memo #33-2017). In May 2018, Hotline staff began addressing the backlog of law enforcement cases where no findings have been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked.

10. Meet the statutorily required caseload standard for initial assessment and ongoing case management.

DHHS Response: Accept

Status Update: Progress. DHHS has repurposed 24 positions to CFS specialist positions. DHHS believes they have enough FTE to meet CWLA caseload, including a 10% vacancy rate. DHHS is exploring a teaming approach to cases. Turnover is decreasing. Though caseload numbers are better than ever (DHHS reported 93% in compliance as of August 2018), DHHS continues to be out of compliance with statutorily required caseload standards. A monthly caseload report can be found on their website. CFS has called a working group of internal and external stakeholders to look at the current caseload standards and come up with an improved way to measure caseloads for all caseworkers.

11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.

DHHS Response: Accept

Status Update: Progress. DHHS is exploring language to add to foster parenting/child-placing agency contracts on this topic. DHHS administrators have had several meetings with Project Harmony and other stakeholders to look for input. For consistency sake, similar language will also be included in caseworker training.

12. Review and revise training on child sexual abuse for DHHS staff.

DHHS Response: Accept

Status Update: Progress. DHHS has begun working with CCFL and with Project Harmony on revisions. Nothing has been formally implemented.

13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.

DHHS Response: Accept

Status Update: Progress. DHHS is revising contracts and looking at provisions on the use of respite, revisions to training requirements, disruptions in placement. DHHS is also working on better aligning caregiver and child needs. Many of these strategies are incorporated into the DHHS Performance Improvement Plan as required by Nebraska's federal partners.

14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.

DHHS Response: Accept

Status Update: Progress. DHHS is changing the application process for foster parenting and issuing a request for proposal for home studies. DHHS has considered modifications to regulations to limit foster parents whose license has been revoked from re-applying within a certain timeframe. These changes are expected to roll out October 2018.

15. Include a component on child sexual abuse prevention in foster and adoptive parent training.

DHHS Response: Reject

Status Update: Progress. Foster parent training and guidance is being revisited and modifications are being made to contracts. DHHS has reached out to Project Harmony and other stakeholders for input.

16. Ensure adequate staffing for residential-child caring agency licensing operations.

DHHS Response: Reject

Status Update: DHHS noted in the LB 1079 (2018) fiscal note that an additional staff person would be required to meet a 30 day investigation timeline for uncomplicated cases.

17. Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.

DHHS Response: Request Modification

Status Update: Progress. Public Health reports that goal timelines have been developed and implemented the following: review within 5 days to determine whether to investigate; finalize report within 30 days; and a 90 day timeline for CFS/LE involved reports. For 2018, there have been 12 investigations initiated all within 3 days of receipt of complaint. 6 are complete, 6 pending. 7 complaints were screened out.

18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.

DHHS Response: Request Modification

Status Update: Progress. Public Health reports reviewing the Department of Justice's Prison Rape Elimination Act regulations and incorporating some into draft regulations submitted to DHHS legal, which will then be sent to PRO. Unclear on how long it will take before a hearing is scheduled.

Action Items for the Child Welfare System

The OIG also identified action items for multiple stakeholders and members of the public to address system-wide shortcomings found in the investigation. These include:

- Foster a culture of zero-tolerance for child sexual abuse in the child welfare system.
- Examine strategies to improve child abuse reporting.
- Ensure law enforcement follows their statutory duty to share child abuse reports with DHHS.
- Clarify the Child Protection and Family Safety Act.
- Improve multi-disciplinary coordination in child sexual abuse investigations and ensure all allegations are investigated.
- Improve foster home recruiting to ensure homes are prepared to meet the needs of children.
- Move licensing of residential child-caring and child-placing agencies from the Division of Public Health to the Division of Children and Family Services.

Summaries of Death Investigations

The OIG completed 10 child and youth death investigations in FY 2017-2018. The deaths occurred between September 2013 and August 2017. This is the first year the OIG has completed investigations with no recommendations. Cases where no recommendations are made are generally cases where the death, or other incident, revealed no issue about the administration of an agency that required further action

The OIG has taken note of any child welfare or juvenile justice themes and issues reflected in each investigation. The OIG will track them as part of its effort to identify systemic issues and consider them as topics for future investigations as necessary and appropriate.

3-DAY-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

The following report summarizes the OIG's investigation into the death of a 3-day-old state ward in 2015. The infant was diagnosed with Trisomy 18, a fatal chromosomal abnormality that makes death likely before birth or in the first few weeks of life.²³

The OIG investigation included a review of: autopsy report; hospice notes; DHHS and private provider records available on NFOCUS; interview with private provider foster care administrators; foster home records; training curricula for medical foster parents; and court records.

The OIG made no recommendations to DHHS as a result of this investigation.

Two days after her birth, local DHHS administrators consented to have the infant placed in hospice care. The infant was then discharged to a medical foster parent. The foster mother was instructed to call a hospice nurse and the caseworker if the infant's condition changed, not to seek immediate medical treatment.

The next day, the foster mother noticed the baby stopped breathing while she was feeding her. The foster mother followed the instructions she had received from the hospital and contacted the caseworker and assigned hospice nurse. The hospice nurse arrived at the foster home and confirmed the infant was not breathing and had no pulse. She called the infant's doctor to pronounce death. The doctor then called the Hotline for consent to withhold life support. The Hotline communicated that they could not give that consent, and he was patched through to an Administrator. The doctor instructed the nurse to pronounce the infant's death.

History

The infant was born seven weeks premature and had Trisomy 18. The hospital expected the infant to die soon after her birth.

At the time of the infant's birth, the mother was part of an open child welfare case for her 10-month-old daughter. The older daughter had entered the state's care after

²³ Genetics Home Reference, "Trisomy 18." National Institutes of Health: Feb. 13, 2018. Accessed via: <https://ghr.nlm.nih.gov/condition/trisomy-18>.

testing positive for cocaine at birth. The mother had been receiving inpatient substance abuse treatment. However she had continued to relapse and have positive drug tests throughout her stay and her pregnancy. She was also receiving treatment for a number of severe and persistent mental illnesses, including schizophrenia. One week prior to the infant's birth the treatment center discharged the mother unsuccessfully after she went missing for three days.

At the time of the infant's birth, the mother tested positive for cocaine and was homeless. On that same day, the County

Attorney motioned for temporary custody, and the Court placed the infant in DHHS's care.

The private provider had been aware of the mother's pregnancy since her first trimester and the Trisomy 18 diagnosis for the baby since the second trimester. The mother had also told her caseworker that she wanted the state to take custody as she did not think she could handle dealing with a baby with a terminal condition and that her doctors stated the baby would not survive for long and recommended hospice care.

5-DAY-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

The following report summarizes the OIG's investigation into a five-day-old state ward's death due to pneumonia in 2015.

The OIG investigation included a review of: autopsy report; police records; medical records; DHHS records available on N-FOCUS; records on the foster home and an interview with administrators.

The OIG made no recommendations to DHHS as a result of this investigation.

The infant went to stay with a respite provider for a day and a half at a variety of locations, including her own home and the home of the foster parent's parents (foster grandparents). The five day old infant then returned to her foster parent's care. The foster parent reported that the infant was congested, fussy, and refused her bottle when she returned. The foster parent then placed the infant in her car seat, where she thought she seemed comfortable.

The foster parent prepared to take her children and the foster children to daycare, where the foster parent worked. The foster parent assumed the infant had fallen asleep.

It was not until she arrived at the daycare center that she noticed the infant was not responsive. The foster parent called emergency personnel and the infant was transported to the hospital where she was pronounced dead. The autopsy ruled that the cause of death was acute bronchopneumonia (pneumonia), with extensive amniotic fluid aspiration.

Child Welfare History

DHHS began planning to take custody of the baby before birth, placing the mother on a list circulated to hospitals. The mother had an active case with DHHS, as her four other children were state wards. Hospitals are to call the Child Abuse and Neglect Hotline (Hotline) after a woman on the list, commonly referred to as the "RED list," give birth. A few days before the infant's birth, DHHS drafted an affidavit supporting state custody of the baby, since the mother was homeless, unemployed, uncooperative with DHHS services, and was allowed only supervised contact with her other four children.

At the time of the birth, the hospital staff called the Hotline to report the birth. The Hotline accepted the call and screened it for response within five days. However, DHHS responded to the hospital that same day, and found the infant unsafe. The court granted DHHS temporary custody of the infant.

Shortly after birth, the infant was placed in the neonatal intensive care unit (NICU) due to concern about her rapid breathing (tachypnea) and congestion. Hospital staff observed the infant for withdrawal symptoms, since the mother tested positive for opiates, but did not find evidence that she had been exposed. A chest x-ray was taken at the hospital because of the infant's respiratory issues, but no concerns were noted. It was also discovered that the infant was missing the radii in her arms, likely due to a genetic disorder. Doctors referred this condition for further diagnosis.

While pregnant, the mother attempted to locate someone to adopt her new baby so she could avoid the state taking custody. Through acquaintances, the mother identified a woman as a potential adoptive mother for the baby. The potential adoptive mother and the mother were working with a private attorney to move an adoption forward. However, nothing went forward towards the private adoption due to DHHS becoming involved. The foster parent had placement of the infant's sibling and knew the potential adoptive mother, who would later become the respite care provider for the infant.

DHHS gave the potential adoptive mother/respite provider permission to visit the infant at the hospital, with the condition the foster parent was also present. Hospital staff had concerns about the potential adoptive mother/respite provider acting strange and somewhat erratic. DHHS also conducted a background check on the potential adoptive mother/ respite care

provider and the same day gave consent to provide respite and child care for the infant while the foster parent was at work. DHHS staff also gave instructions for a child specific placement process to begin, with the hope of placing the infant with the respite care provider, as she was the potential adoptive mother chosen by the mother.

The infant was discharged from the hospital to the foster parent. Hospital records show that just before discharge, the pediatrician discussed with the DHHS staff and the foster mother, the infant's status including follow-up appointments with an orthopedic doctor within a month and with the primary care provider within 2-3 days. This discussion included precautions that need to be taken to prevent illness and the importance of the feeding schedule. Her discharge instructions included contacting a doctor if the infant had trouble breathing, ran a temperature, had difficulty waking up, missed feedings, or did not have a certain number of wet diapers. The potential adoptive mother/respite care provider was not present for these discussions with the pediatrician nor for any discharge instructions.

Very shortly after discharge the foster parent dropped off the infant with the respite care provider at her home. The foster parent reported that she was overwhelmed with work projects and care for the infant's two-year-old sibling, and her two adopted sons. DHHS later told police that they had only authorized the respite care provider to care for the infant in the foster parent's home.

The respite care provider cared for the infant by herself at her own home during the afternoon and at some point in the evening, took the infant to the foster parent's parents (foster grandparents) home. The infant spent time in her car seat, a bouncy seat, or a sheet on the floor of the home. The foster grandparent's home was found to be

unsanitary by police, as clutter filled the house and made it difficult to move from room to room. The respite care provider was not able to give an account of the care she provided for the infant and police interviews revealed that there were mental health concerns about her, and that her own son was primarily cared for by the foster grandparents. The foster grandfather reported that he had heard the infant crying in the night and had been unsuccessful at feeding her.

After the infant's death, a report was called into the Hotline and accepted for an out of home assessment. The deceased infant's sibling was moved out of the foster parent home and her foster home was placed on hold. DHHS completed the out of home assessment of the foster parent's home and listed the allegations of abuse and neglect as unfounded. The Out of Home Assessment also recommended that:

"Home remain on hold until the final police report can be obtained with final autopsy report included.

Home be retrained on the use of respite the rules surrounding its use. To include background checks to be completed.

KVC have a walk through done of every respite provided that will provide in home care for a state ward.

Training be provided."

The infant's final autopsy was completed several months later, at which point, the private provider inquired about the status of the foster parent's license. DHHS removed the hold from the foster parent's home and asked the private provider to ensure that the foster parent communicate clearly about respite care use in the future.

2-MONTH-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Abuse

The following report summarizes the OIG's investigation into a two-month-old state ward's death in 2018.

The OIG's investigation into the infant's death included a review of: autopsy report; police records; medical records; DHHS records available on NFOCUS, Court records, and an interview with DHHS staff.

The OIG made no recommendations to DHHS as a result of this investigation.

The family had no prior involvement with DHHS. The infant's involvement with DHHS began with a hotline call after the infant was transported and admitted to a hospital, where he was diagnosed with Traumatic Brain Injury. Police determined

that those injuries were caused by his father who was arrested and taken into police custody. The infant initially remained in the custody of his mother. The infant became a ward of the state the following day, when evidence indicated that his mother was aware the father had committed prior acts of abuse and failed to protect him. The infant remained a ward of the state until his death 2 days after being admitted to the hospital.

No DHHS coordination or court order was required regarding withholding life support as the infant was determined to be dead as defined by Nebraska law.²⁴ Arrangements and approval for organ donation as required by Nebraska state law²⁵ were made.

²⁴ Neb. Rev. Stat. §71-7202.

²⁵ Neb. Rev. Stat. §71-7202.

13-MONTH-OLD TWINS STATE WARD DEATH INVESTIGATIONS SUMMARY

Cause of Death: Medical

This report summarizes the OIG's investigation into the deaths of twin brothers in 2015. Twin A was a state ward at the time of his death and Twin B was a state ward until a day before his death. Their deaths were related to an inherited metabolic disorder, pyruvate dehydrogenase deficiency.

The OIG investigation into the deaths included a review of: autopsy records; police records; death certificates; DHHS records available on NFOCUS; and court records.

The OIG made no recommendations to DHHS as a result of this investigation.

Twin A

Thirteen month old Twin A, was a state ward placed at home. The biological parents found him unresponsive in his Pack'n Play. They began CPR and called emergency personnel. When Twin A arrived at the hospital he was not breathing and had no heartbeat. After approximately an hour of attempting to revive him, doctors pronounced Twin A deceased.

The autopsy determined that the cause of death was severe pneumonia in the lungs and bronchial tubes (bilateral consolidative acute bronchopneumonia with diffuse bronchiolitis). The autopsy also listed twin A's pyruvate dehydrogenase deficiency, as a contributing factor. Death during infancy and childhood is very common for those diagnosed with this metabolic disorder.²⁶ DHHS documents also note that the pathologist who performed the autopsy told

DHHS that he thought twin A's pediatrician had erred when she did not see him in person after his mother called with concerns two days prior to death.

Twin B

Three months later, Twin B, a state ward placed at home, suffered cardiorespiratory arrest and was hospitalized in the Pediatric Intensive Care Unit of the hospital. Twin B had been ill since prior to Twin A's death. He was seen by doctors and eventually diagnosed with bacterial pneumonia. Twin B's health continued to deteriorate despite treatment. An MRI showed that Twin B had brain damage and was proceeding toward brain death. The day prior to his death, the County Attorney, at DHHS's request, dismissed the child neglect petition against the parents. Twin B was returned to the custody of his parents, which allowed them to make end of life decisions. Twin B died a day later, at the hospital. No cause of death was noted on the death certificate and no investigation into Twin B's death occurred.

Child Welfare History

The family became involved with DHHS within the first three months after the twins were born. Over the course of three months, there were three separate calls to the Child Abuse and Neglect Hotline (Hotline). Two calls reported the home was extremely cluttered and not safe for the twins, were screened out by the Hotline. Local police had also received calls about the condition of the home and issued warnings to the

²⁶ Genetic and Rare Diseases Information Center, "Pyruvate dehydrogenase complex deficiency," National Institutes of Health. Updated February 19, 2018. Accessed via:

<https://rarediseases.info.nih.gov/diseases/7513/pyruvatedehydrogenase-deficiency>.

parents during this time period. A third call, with similar concerns, received by the Hotline was accepted for an investigation.

DHHS interviewed the 5-year-old brother of the twins at his school. He said he felt safe at home. DHHS then went to the home with local law enforcement. When they arrived the home was packed with garbage and clutter, covering rooms and the kitchen sink. There were dirty diapers throughout the house, flies, and chemicals in reach of children. Law enforcement officers took all three children into state custody. That same day, the County Attorney filed a child neglect petition and the court made all three children state wards.

DHHS and the parents created a safety plan, all three children were placed with their paternal grandparents for a week, until the home was able to be cleaned. Within the week all the children returned home and were found conditionally safe. Drop in visits

from the DHHS and family support workers occurred. The family was not opposed to receiving services and was actively involved with home health visits and early childhood visits, which the twins received because of their metabolic condition, before DHHS involvement. Three days prior to the death of Twin A, DHHS had contact with the family and noted that the twins looked ill and discussed it with the family. The mother informed DHHS that she was talking to the children's doctor to get antibiotics for them, as they seemed to be getting worse. The mother told DHHS that the twin's health was fragile because of their metabolic disorder. The mother shared that she had a previous child die due to this condition, and she suffered from depression. After twin A's death, the DHHS case continued. DHHS provided family support services, and intensive family preservation services to ensure the house remained safe and suitable and to try to assist the family in its grieving process for Twin A.

16-MONTH-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

The following report summarizes the OIG's investigation into the death of a 16-month-old state ward in 2014 caused by invasive pulmonary mucormycosis, a rare fungal infection.

The OIG investigation included a review of: autopsy report; police records; DHHS records available on NFOCUS; court records; foster home records; and interviews with the foster parent and private provider administrators.

The OIG makes no recommendations to DHHS as a result of this investigation.

The foster parent discovered the 16-month-old child having seizures in her crib. The foster parent rushed the child to the hospital, which immediately transported the child to

another hospital that could provide a higher level of care. In the two weeks prior to the child's seizures, the foster parents, had taken the child to her primary care doctor as well as a local hospital for medical treatment a number of times. The child had been ill with a fever, diarrhea, and a suppressed appetite. Providers believed the child had a respiratory infection and had instructed the foster mother to treat the child with an antibiotic and continue to monitor her health.

Upon admission to the second hospital, the child was diagnosed with a serious infection that was beginning to impact her organs. The hospital tried a variety of interventions, but four days later the child was pronounced deceased. An autopsy found the child's

cause of death to be organ failure caused by invasive pulmonary mucormycosis, a rare fungal infection with a high mortality rate.²⁷ The autopsy also found the presence of Enterovirus D68, which causes respiratory infection, and listed it as a contributing factor in the child's death.²⁸

Child Welfare History

Ten days after the child's birth, the Nebraska Child Abuse and Neglect Hotline (Hotline) received a report concerned with the well-being of the child and her one-year-old brother. The reporter stated the child's 17 year-old mother had expressed feelings of being overwhelmed. There were concerns that she was experiencing postpartum depression. The Hotline requested law enforcement to conduct a welfare check on the family. Law enforcement reported the children were safe, so the Hotline screened the call out.

Three months later law enforcement responded to a domestic disturbance call. The mother had been yelling at the father and threatening to leave the child unsupervised. The father shared that the mother was very angry with him and lashing out because she was overwhelmed with the children. Law enforcement again found that there was not an immediate safety concern, as the father and the children's grandmother, were reportedly working to give the mother more breaks.

Forty-five days later the child was taken to the hospital by her parents with a high fever. The hospital discovered numerous fractures to the child's ribs in various stages of healing that were likely caused by abuse. A day earlier a primary care physician discovered a fracture to the child's clavicle

during a routine office visit. The primary care doctor had not reported the injury, but investigators noted that a clavicle fracture in a 4-month-old was indicative of abuse as well.

Law enforcement placed the child and her sibling in state custody after she was hospitalized. Law enforcement was unable to determine who caused the child's injuries and no one was criminally charged. After the child's injury, the father was criminally charged with sexual assault of the mother who had been under the age of consent when the older sibling was conceived.

The child joined her sibling in a foster home, upon discharge from the hospital. The child and her sibling remained in the same foster home throughout their time in care. In addition to the unknown perpetrator, DHHS raised concerns about family placement. The mother and the father were first cousins and the family had allowed them to engage in a relationship even though the mother was very young when it began.

While a state ward, the child received follow up medical care related to recovery from her injuries. Both children received physical and occupational therapy to address developmental delays. Visitation with both parents continued in a supervised and limited fashion. The father and the mother had separate visitation due to the pending criminal trial. Although the mother had initially been allowed to participate in her children's medical appointments, DHHS eventually restricted her involvement as providers thought it was slowing both children's progress. The father was sentenced to five to seven years in prison for the sexual assault charge.

²⁷ Centers for Disease Control, "Mucormycosis Statistics," updated Dec. 31, 2015. Accessed via: <https://www.cdc.gov/fungal/diseases/mucormycosis/statistics.html>.

²⁸ Centers for Disease Control, "Enterovirus D68," updated Oct. 20, 2017. Accessed via: <https://www.cdc.gov/nonpolio-enterovirus/about/ev-d68.html>.

16-MONTH-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

The following report summarizes the OIG's investigation into the death of 16-month-old state ward in 2014, related to complications resulting from his congenital heart condition.

The OIG investigation included a review of: death certificate; DHHS and private provider records available on NFOCUS; court records; foster home records; and an interview with the foster parent.

The OIG made no recommendations to DHHS as a result of this investigation.

Six months after being admitted to the hospital, the child was removed from life support at the hospital and was pronounced deceased. The child had been at the hospital and intubated, his health generally declining, with a number of incidents of cardiopulmonary arrest which he had survived. The child was diagnosed with a congenital heart defect, Hypoplastic Left Heart Syndrome, which carried a risk of sudden death and a ten to 15 percent mortality rate, according to his physicians.

The court granted an order for the withdrawal of life support and "do not resuscitate" (DNR).

Child Welfare History

During the mother's pregnancy with the child, the mother had been placed on a watch list (Red list) circulated to hospitals requesting a report be made to DHHS when the mother gave birth. The Child Abuse and Neglect Hotline (Hotline), received a report regarding the child's birth and concerns about the mother's mental health. Due to the child's congenital heart defect, the hospital reported that he would be in the hospital for

some time for surgery and specialized care, due to his diagnosis of Hypoplastic Left Heart Syndrome. The Hotline screened the call as "Does Not Meet Definition" since there were no active safety concerns.

The Hotline received a call a month later reporting: the mother had serious mental illnesses and had not been taking her medications; the father had a mental illness and appeared to have cognitive deficits; parents were homeless; and the parents would not be able to care for the child who would require tube feeding and a heart monitor. The Hotline accepted the call for an investigation. Five days after the accepted intake, the County Attorney petitioned the court to make the child a state ward based on an affidavit from the hospital. The court placed the child into state custody that same day. Within days, DHHS conducted a safety assessment, and found the child unsafe.

After two months in the hospital the child was discharged to a foster home that specialized in caring for medically fragile children. The child received at least weekly medical appointments, took multiple medications, and was fed through a g-button. All contact between the child and his parents, who remained homeless, occurred at the hospital and medical appointments.

The child was hospitalized again three months later, after contracting a respiratory infection. During hospitalization, he had a stroke and seizures and had to be resuscitated. The child's condition slowly improved after an extended time in the pediatric intensive care unit. He was again discharged to the foster home, but five days later was rushed to the hospital due to

breathing problems. He was intubated on admission.

The child was continuously in the hospital from this point forward, with the exception of a few days. Documents indicate the foster mother visited the child at the hospital and supervised some visitation for the parents at the hospital.

The child was treated for an infection, failure of his kidneys, and his underlying heart condition. Physicians told DHHS that, if he survived, would not be well enough to return to foster care and would need to go a medical facility. The child underwent a surgery, an extensive series of tests, and other medical procedures for which DHHS gave consent. The child went into cardiopulmonary arrest a number of times, but survived.

Throughout the child's case, there was not a single established process for providing

informed consent for medical procedures. At numerous points throughout the child's time as a state ward, the Hotline was called for consent for serious medical procedures and tests on the child, and getting consent was handled in various ways. No documentation was found that notice of the child's possible death was given to the CFS director, as required in regulations.²⁹

During the latter part of the child's life, some hospital staff told DHHS that resuscitating the child could cause him additional pain and suffering. The child's care team informed DHHS that his condition was terminal and verbally recommended a do not resuscitate (DNR) order be put in place. DHHS then received a formal letter from the hospital requesting a DNR and then motioned the court for authority to allow one. The court granted the motion.

16-MONTH-OLD NON COURT INVOLVED DEATH INVESTIGATION SUMMARY

Cause of Death: Abuse

The following report summarizes the OIG's investigation into the death of a 16-month-old DHHS involved child due to hypoxia, the deprivation of oxygen to the brain in 2014. The injuries preceding the child's death occurred while he was in the care of his mother's boyfriend. At the time of his death, the child was an alleged victim in an open child abuse and neglect investigation. DHHS was completing the investigation and a private provider, was tasked with implementing a safety plan and beginning non-court services.

The OIG investigation included a review of: autopsy report; police records; DHHS and private provider records available on

NFOCUS; and interviews with DHHS staff and private provider staff.

The OIG made no recommendations to DHHS as a result of this investigation.

The 16-month-old child was transported to a medical center unresponsive and not breathing. It was reported that he had choked on a bottle cap while in the care of his mother's boyfriend. Shortly after arrival at the hospital he was transported to another hospital for a higher level of care, where doctors noted possible signs of child abuse, including abrasions on the child's face and ear and a scar on his knee. X-rays showed a healing fracture to the child's wrist (radius

²⁹ Death or Imminent Death of a Ward, 390 Neb. Admin. Code 11-002.01D.

and ulna). Hospital testing revealed hemorrhaging in the child's brain and behind both retinas, which doctors told police was indicative of abuse. Doctors eventually diagnosed the child with severe hypoxic injury to the brain (depriving the brain of oxygen). The child was declared brain dead two days later. The autopsy found the cause of death to be hypoxia and did not find significant evidence supporting shaken baby syndrome/abusive head trauma.

During the investigation into the child's death, the mother's boyfriend did not give a consistent story related to what happened to the child. At various times he told law enforcement that he had slapped and shaken the child, shoved a hairbrush in his mouth/down his throat, thrown him in the bathtub, run water over him to dislodge the bottle cap and woke him up once he became unresponsive. He told an informant in jail that he had been using alcohol and "wet" (PCP) and that he had thrown and shaken the child and put the hairbrush in his mouth after he stopped breathing. Law enforcement interviewed people who said the boyfriend had a short temper when children cried and had been physically abusive the past. The boyfriend was initially charged with intentional child abuse resulting in the child's death, he later pled guilty to negligent child abuse resulting in the child's death and was sentenced to 18 to 20 years in prison.

Child Welfare History

Two months prior to the death, law enforcement responded to a domestic violence call. When officers arrived they witnessed the child's mother and father, during a custody exchange. The father was holding the child when the mother hit him. Law enforcement arrested the mother for assaulting the father. Officers noticed a burn on the child's leg, interviewed the mother and her boyfriend about it and opened an

investigation. The mother and her boyfriend said that the child had been burned a few weeks ago when his leg touched a space heater and was treated at a local emergency room. Their stories did not match related to exactly where and when the burn took place. Law enforcement also discovered that there was no electricity in the apartment shared by the couple.

Law enforcement shared their report with the Hotline, and it was accepted for investigation. However, the case was placed on a police hold and DHHS was not allowed to respond or contact the family without law enforcement permission. Two weeks later, a police officer and DHHS went to the apartment where the couple had been living but were unable to make contact with the family. DHHS called the utility company and was informed they no longer had anyone listed as living there. DHHS later learned the landlord had evicted the mother just days prior to the attempted contact. The officer assigned to the case went on vacation following the attempt to contact the family, but kept DHHS on a hold. When he returned, the officer reviewed the medical records for the child's burn, which did not indicate that doctors had concerns about abuse, and confirmed that the mother was being criminally charged for child neglect stemming from the incident during the custody exchange. He then closed his investigation on the child's burn and lifted the hold for DHHS. The intake was now close to thirty days old.

DHHS made contact with the mother, the boyfriend, the child, and the boyfriend's two children from a previous relationship and initially found all the children safe. On a subsequent visit to the home and both the boyfriend and the mother tested positive for marijuana. Based on this, the safety assessment was changed to "conditionally safe" for the child. The case was referred to

a private provider for ongoing case management and safety plan management, while DHHS completed the initial assessment. Sixty days into the case a team meeting with DHHS and the private provider, a safety plan was put in place that required that the mother and biological father use the father's sister (aunt), at times of exchange. The plan specified that the private provider would have weekly contact with the father, his sister, and the mother to check in and be in contact with the DHHS on a weekly basis to address any issues that arose. The process of the private provider overseeing safety plans while DHHS staff complete investigations is no longer used in the DHHS Service Area.

The private provider was not able to contact the mother in the 20 days between the point their case was opened and the child's death, although the caseworker made a number of calls and one stop at the mother's residence. No services were started for the family.

DHHS staff completing the investigation had contact with the family. Two weeks prior to the death, the aunt told DHHS that the mother smelled like marijuana during a drop off, but did not seem to be under the influence. In the week prior to the death, DHHS requested records on the boyfriend from another state and completed a risk assessment interview with the mother and her boyfriend. On the day before the child's injury, DHHS visited the mother and boyfriend after the father and aunt reported concerning bruises and scrapes on the child's face and had a tender shoulder. The mother and boyfriend said the injuries were a result of an accidental fall on the concrete. The father had taken the child to his pediatrician who said he wasn't sure whether the story was accurate or not and advised keeping a close eye on the child.

Records show that during the period of time this case was active, the DHHS staff assigned to the case, had a caseload that was higher than statute allows, between 13 and 15 cases.

15-YEAR-OLD STATE WARD DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

This report summarizes the OIG's investigation into a 15-year-old state ward's death due to acute myeloid leukemia in 2013.

The OIG's investigation into the youth's death included a review of: autopsy report; death certificate; DHHS records available on NFOCUS; court records; and an interview with an administrator involved in the youth's case.

The OIG made no recommendations to DHHS as a result of this investigation.

The 15-year-old state ward had been staying at a nursing home, placed on hospice care for several weeks. At the time of his death, the youth was also diagnosed with: severe congenital neutropenia, a genetic condition present since birth which made him susceptible to infections and leukemia;³⁰ Epstein-Barr virus, which can cause mononucleosis;³¹ staph sepsis (blood

30 "Severe Congenital Neutropenia" Genetics Home Reference, National Institutes of Health. Retrieved from: <https://ghr.nlm.nih.gov/condition/severe-congenital-neutropenia>.

31 "Epstein-Barr Virus and Infectious Mononucleosis" Centers for Disease Control and Prevention. Retrieved from: <https://www.cdc.gov/epstein-barr/about-ebv.html>.

poisoning); attention deficit hyperactivity disorder; and, prenatal methamphetamine exposure.

Child Welfare History

The youth was involved with the child welfare system starting shortly after his birth. A child welfare case was opened due to concerns about the youth's parents, neglecting some of his key needs, including specialized medical care due to his genetic condition, severe congenital neutropenia. The parents had already relinquished rights to two other children.

The youth was first placed in foster care at the age of two. This progressed into a guardianship with his foster parents and the child welfare case was closed.

Ten years later, the foster mother expressed a desire to terminate her guardianship of the youth due to growing behavioral challenges, including sexual acting out with her adopted daughter. The County Attorney filed a no-fault abuse/neglect petition and the court made the youth a state ward, while leaving the guardianship in place.

The youth was admitted to a psychiatric residential treatment facility (PRTF). Less than a month after moving to the PRTF, the youth began to have serious health problems. After being discharged from the PRTF to a hospital, he was diagnosed with leukemia. Plans were made to send the youth out of state for specialized treatment, including a specific type of chemotherapy and bone marrow transplant that was only offered at that hospital. Due to his genetic condition, even with the specialized therapy, doctors estimated his five year survival chances would be no more than 20 percent.

After a brief stay in foster care, the youth traveled to the out of state hospital with his foster mother/guardian. He split his time

between the hospital for treatment and a foster family with whom he had been placed through the Interstate Compact on the Placement of Children. DHHS paid for or reimbursed all of the guardian's travel-related expenses for the trips to the out of state hospital, some of which were court-ordered.

A number of times during the youth's care, there was confusion between medical providers and DHHS staff about who needed to consent for specific treatment or what the approach to life support would be. For example, once the youth was in the out of state hospital, frontline DHHS staff learned they had to work with the state medical director in decisions consenting to chemotherapy, surgery, and advanced directives. However, no coordination had been done ahead of time.

The youth returned to the home of his guardian after 10 months of treatment was found to be mostly unsuccessful. Some treatments continued at a local hospital. Once treatment stopped the youth was placed on hospice, after a DHHS Central Office Team, the guardian, and legal parties to the case were consulted. A do not resuscitate order was signed by the court as well.

In the lead up to the youth's death, DHHS staff and local service area administrators visited the youth and arranged special events and recognition for him, including throwing out the first pitch at a baseball game. The administrator interviewed shared that this case was extremely hard on the staff and others, and that, in retrospect, after the youth's death many staff, supervisors, and even administrators had been grieving, but that formal supports could have been better put in place for the team in the related Service Area.

16-YEAR-OLD JUVENILE PROBATIONER DEATH INVESTIGATION SUMMARY

Cause of Death: Homicide

The following report summarizes the OIG's investigation into a 16-year-old's death due to homicide in 2016. At the time of his death, the youth was under juvenile probation supervision.

The OIG investigation included a review of: autopsy report; police report summary; Probation records available through its electronic case management system, N-PACS; court records; social media accounts used by the youth; and media reports related to the youth's death.

The OIG made no recommendations to Probation as a result of this investigation.

Law enforcement responding to a shooting found the 16-year-old youth injured, and he was immediately transported to a local hospital where he was briefly treated with surgery and resuscitation, and then pronounced dead. The autopsy found the youth's cause of death to be three gunshot wounds to the torso that had caused extensive damage to his major organs. The youth was shot while waiting at a bus stop with his friend, who was reportedly waiting to go to work.

Youth's Juvenile Probation History

At the time of the youth's death, he was under juvenile probation supervision. The youth was initially offered diversion upon coming to the attention of the juvenile justice system, but was not able to successfully complete the program. New charges were filed on the youth thirty days later. That same month, he was transported to a local emergency room by law enforcement after a violent confrontation at home. The youth was then expelled from his high school after threatening staff and was

transferred to a new high school. Once he was transferred, the youth no longer attended school.

The youth was adjudicated on his first charge, and a predisposition investigation (PDI) was ordered. A Youth Level of Service/Case Management Inventory (YLS/CMI) was conducted on the youth, which Probation indicated his score put him at a moderate high risk to reoffend. The youth tested positive for marijuana and reported frequent use during his PDI interview. The completed PDI recommended that the youth complete a chemical dependency evaluation, an anger management class, attend school regularly, complete thirty hours of community service, write an apology letter, and participate in a pro-social activity or part-time employment. The youth was placed on indefinite probation and a co-occurring evaluation and random weekly drug tests, among other conditions, were ordered. The youth's case was transferred to an ongoing probation officer. Months later the case was transferred to another probation officer.

The youth completed a co-occurring evaluation which diagnosed him with severe cannabis use disorder, conduct disorder, and persistent depressive disorder. The evaluation recommended individual therapy at least twice a week due to the severity of the youth's diagnoses, a psychiatric referral for evaluation and possible medication management, and enrollment in a mentoring program.

Four months later the court modified the youth's disposition to include: six months of Probation supervision; completion of a psychiatric evaluation, completion of dual

diagnosis treatment, and the youth refrain from aggressive behavior in his home and community.

During the youth's term of probation, he was cited for shoplifting, disorderly conduct and also expelled from his second high school for a fight on campus. The youth did not regularly attend school before his expulsion. After his expulsion, he was not enrolled in school until about a week before his death.

The youth continued to use marijuana throughout his time on Probation. Violent and aggressive confrontations with his mother and other family members continued as well. The youth bounced between his mother's home, grandmother's home, and unknown locations. Probation issued a

number of vouchers for therapy, psychiatric services, and transportation to those appointments. However, the family either struggled to schedule the appointments or ensure that the youth attended.

Due to non-compliance, Probation issued a number of sanctions to the youth, including being reprimanded and counseled by his probation officer, receiving additional community service, and increased supervision. As part of sanctions, Probation authorized both tracker and evening reporting services.

According to Probation records, a few weeks before the youth's death, probation officers were preparing to staff the youth's case to consider whether to file a request for a motion to revoke probation.

18-YEAR-OLD JUVENILE PROBATIONER DEATH INVESTIGATION SUMMARY

Cause of Death: Medical

The following report summarizes the OIG's investigation into an 18-year-old's death due to excited delirium syndrome. Excited delirium syndrome is a state of mania, often induced by drug abuse, which can lead to cardiorespiratory collapse.³² At the time of death, the youth was under Probation supervision.

The OIG investigation into the youth's death included a review of: autopsy report; death certificate; police reports; Probation records available through its electronic case management system, NPACS; and court records.

The OIG made no formal recommendations to Probation as a result of this investigation.

Law enforcement were dispatched to an office building to investigate a report of a down party outside an entrance. Officers found a female body and determined that she had been deceased at the location for a few days. Law enforcement later identified the body as that of the 18-year-old youth.

The youth had been reported missing by her parents. The police investigation into her death found that the youth had been using alcohol and drugs throughout the time she was missing. A friend of the youth's told law enforcement she had picked her up at a bar on the evening before her death, and she was intoxicated. The friend then dropped the youth off at an apartment where the youth bought and used drugs. The apartment was

³² Mash, Deborah C. "Excited Delirium and Sudden Death: A Syndromal Disorder at the Extreme End of the Neuropsychiatric Continuum." *Frontiers in Physiology* 7

(2016): 435. *PMC*. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5061757/> .

across the street from the building where the youth's body was found.

The autopsy listed the youth's cause of death as excited delirium syndrome. Methamphetamine toxicity and hyperthermia were cited as possible secondary causes or contributors. The toxicology report showed that the youth tested positive for amphetamines, alcohol, THC, and stimulants from tobacco products and caffeine at death.

Youth's Juvenile Probation History

The youth had been involved with the juvenile justice system for over a year. Although she originally participated in a diversion program, she failed to abstain from using substances, attend her required intensive outpatient therapy (IOP), and comply with tracker requirements. The youth went missing from home numerous times, tested positive for marijuana, and was hospitalized with a .35 blood alcohol level while on diversion. Diversion was ended due to non-compliance

A juvenile petition related to the youth's charges were filed, the case was adjudicated, and Probation was ordered to complete a predisposition investigation (PDI) and arrange an additional chemical dependency evaluation. The youth continued to run from home, use substances, and miss appointments for PDI interviews and the evaluation. When the youth failed to appear at her disposition hearing, a warrant was issued.

A month after the warrant was issued, the youth was found in a hotel room with two adult males and large quantities of alcohol. She was initially detained and then transferred to a shelter, while a PDI and co-occurring evaluation were completed. The co-occurring evaluation recommended Level I outpatient therapy and a psychiatric evaluation for the youth. In the final PDI,

Probation requested the court to order the youth to participate in Level I Outpatient Therapy. Probation reported that after the youth took the Youth Level of Service/Case Management Inventory (YLS/CMI), it put her at a moderate high risk to reoffend.

The youth was placed on Probation for six months, returned home with electronic monitoring, and was ordered to attend outpatient therapy and complete a psychiatric evaluation. Probation removed the monitor 60 days later and replaced it with a simple curfew. After a brief period, Probation began the process of putting tracking services in place as the youth had still not begun therapy. However, the youth went missing from home the next day. When she was found, she again tested positive for cocaine and THC. Probation then placed the youth on electronic monitoring. Within a month the youth cut her electronic monitor off and went missing again. She was located several days later at her place of employment and was subsequently detained at a detention center. She again tested positive for marijuana and THC. The youth later admitted that she was using cocaine daily, and had spent over \$1400 in savings, all the wages from her job, and hundreds of dollars stolen from her parents, on her drug use. A motion to revoke probation was filed.

At a detention hearing, the court ordered a new chemical dependency evaluation and placement at a shelter. The updated evaluation completed by a third service provider recommended residential treatment for substance use. The youth's probation was revoked, and she was placed on probation indefinitely. The youth was ordered to be placed in a Level III Residential Treatment Center. About a month later, the youth was admitted to a substance use residential treatment center.

Upon admission, treatment center staff diagnosed the youth with severe alcohol and

cannabis use disorder, moderate stimulant disorder, and depression. The youth reportedly struggled in treatment and had thoughts of running away almost daily. About 2 months after starting treatment, the youth ran from the treatment program, stole from a local business, used substances, and attempted to steal her parents' car. The youth returned to the residential treatment center voluntarily the next day after her mother convinced her that it was preferable to detention.

Two weeks later, the treatment center gave notice that they intended to discharge the youth as she was not participating in treatment. The center went on to recommend she be admitted to a different residential program.

After the youth's discharge from the treatment center, Probation recommended unsuccessful termination from Probation to

the court. The youth had graduated from high school, was taking classes at a community college, and looking for a job at the time. At a hearing two months before her death, the court placed the youth home with electronic monitoring (EM) or tracker services and a requirement to attend IOP, and ordered Probation to apply to residential treatment.

Probation removed EM as the youth had been testing clean since being placed at home and had two jobs. A few weeks before her death, Probation visited the youth at home and she tested negative for substances. However, as her therapy was beginning, she again went missing with intermittent contact with Probation and her parents in the days leading up to her death, although the probation officer and tracker did searches for the youth and reached out by text message.

STATUS OF OIG RECOMMENDATIONS

Reports of investigation issued by the OIG contains recommendations for systemic reform and/or case-specific action. The OIG's annual report is required by Neb. Rev. Stat. § 43-4331 to detail recommendations and the status of implementation of recommendations.

The table below contains a summary of all recommendations made by the OIG in its investigative reports. The recommendations are numbered based on the year and order the recommendation appeared in an annual report. For example, the first recommendation appearing in the 2015 Annual Report is numbered 15-01.

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

Rejected: The agency rejected the recommendation as part of the original investigation.

Incomplete: The agency has not taken relevant action to address the recommendation.

No Further Action: The agency has taken relevant action to address the recommendation, but has no plans to take additional necessary action to address the recommendation.

Progress: The agency has taken relevant action to address the recommendation and has plans to take additional necessary action to address the recommendation.

Complete: The agency has taken all relevant and necessary action to address the recommendation.

Of the OIG's recommendations:

- DHHS took action on several. From FY 2016-2017 to FY 2017-2018:
 - 2 went from Incomplete to Complete,
 - 8 recommendations went from Progress to Complete,
 - 1 went from Incomplete to Progress, and
 - 1 went from Incomplete to No Further Action.

- Of the 18 new recommendations made to DHHS pursuant to the Sexual Abuse Report:
 - 2 are Complete,
 - 12 show Progress,
 - 2 remain Incomplete, and
 - 2 remain Rejected with no action.

- Probation Administration has taken action on at least 3 recommendations:
 - 1 is Complete, and
 - 2 show Progress.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
15-01. Adopt federally mandated mental & behavioral health policies.	DHHS - CFS	<p>No Further Action</p> <p>In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017.</p> <p>DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.</p>
15-02. Expand training on mental and behavioral health.	DHHS - CFS	<p>Complete</p> <p>DHHS has added in-service training on these topics, and added suicide prevention training to topics covered in New Worker Training. In July 2017, an updated mental health desk aid was made available to all staff.</p>
15-03. Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications	DHHS- CFS	<p>Complete</p> <p>DHHS updated its N-FOCUS system in March 2015 to allow for easy record keeping on medications, health care appointments, and medical conditions. Information entered is now reviewed by administration and at Continuous Quality Improvement (CQI) meetings.</p>
15-04. Improve Home Study Process	DHHS-CFS	<p>Progress</p> <p>An updated draft home study template and draft quality assurance tool were developed in 2017 and are being reviewed internally. DHHS reports that an RFP will be issued in Fall 2018 to complete home studies DHHS staff, after which the contractor and DHHS will complete home studies which will help ensure consistency and quality across the state.</p>
15-05. Provide stronger supports for kinship and	DHHS-CFS	<p>Progress</p>

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
relative foster families		<p>Significant changes to how kinship and relative foster homes are supported are currently underway. In 2017, DHHS was planning to hire and train 14 kinship specialists placed in offices across the state to help support kinship homes instead of private providers. This change was to ensure support even though budget cuts prevented contracting for these services. However, DHHS reallocated the 14 positions to caseworker, or CFSS, positions.</p> <p>DHHS has solicited stakeholder feedback and created a working group to tackle this issue, including identifying barriers to training and licensing kinship homes. CFS Director requested the Children's Commission review the issue. Project Harmony has proposed training for kinship and relative families. DHHS has contracted with the Nebraska Foster and Adoptive Parent Association to provide specialized training, Kinship Connection, across the state. The "Caring for Our Own" Curriculum is being explored.</p> <p>The Family First Prevention Services Act was enacted in February 2018, and the first opportunity to receive title IV-E funding through U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACYF) under the new Act is to develop, enhance, or evaluate kinship navigator programs. DHHS has applied for Kinship Navigator funds through ACYF. The funds become available October 1, 2018.</p>
15-06. Ensure "Absence of Maltreatment in Foster Care" is as accurate as possible	DHHS-CFS	<p>Complete</p> <p>Since May 2016, DHHS has listed the number of maltreatment cases that have been "court pending" between 8 and 12 months in its CQI reports.</p> <p>This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.</p>
15-07. Develop and provide training to frequent reporters and law enforcement on	DHHS-CFS	<p>No Further Action</p> <p>In the fall of 2015, the League of Municipalities</p>

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
Child Abuse and Neglect Hotline.		distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. No training for other frequent reporters – schools, medical professionals, etc. has been produced or made easily available.
15-08. Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.	DHHS-CFS	Complete In February 2016, DHHS adopted Protection and Safety Procedure #5-2016 , "The use of Photographs from Intake through Case Closure."
15-09. Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.	DHHS-CFS	Complete DHHS is currently developing a quarterly report to review information captured by N-FOCUS to develop outreach strategies in immigrant communities. Substantive collaboration between DHHS and Bring Up Nebraska has been developed as means of furthering strategies to collect consistent, statewide data, provide funding, and prioritize culturally appropriate and competent prevention service delivery. In May 2018, DHHS partnered with the Nebraska Coalition to End Sexual and Domestic Violence and funded a Community Engagement Coordinator position to collaborate with local and tribal domestic violence programs and community based organizations to address family violence issues in racial and ethnic minority populations and underserved populations.
15-10. Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.	DHHS-CFS	Complete On July 1, 2017, DHHS's "Secure Transportation" service definition for transport to and from YRTC's became effective.
15-11. Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.	DHHS-CFS	Complete In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTC's.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place. OJS is currently planning for the next round of PREA audits.
15-12. Provide increased guidance for culture change at YRTC-Geneva	DHHS-CFS	<p>Complete</p> <p>In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs.</p> <p>Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists.</p>
15-13. Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva	DHHS-CFS	<p>Complete</p> <p>In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics.</p> <p>YRTC-Geneva made changes to OM 115.17.5 in August 2015 to clarify facility specific policy and procedure. Work to standardize policies and procedures at both YRTCs is ongoing.</p>
15-14. Clarify Hotline policy and procedure when receiving a report of sexual assault	DHHS-CFS	<p>Complete</p> <p>The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency. The OIG reviewed intakes about YRTC-Geneva for the 2016-17 fiscal year and identified only one error.</p>
16-01. Implement training on the medical aspects of child abuse.	DHHS-CFS	<p>Complete</p> <p>CCFL consulted with Dr. Bleicher as a medical expert for curricula review in August and September 2017. The following recommendations were made:</p> <ul style="list-style-type: none"> • Spiral fractures in toddlers and young

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		<p>children are often activity related but the same fracture in the arms (especially infants) are highly suspicious of abuse. References made to spiral fractures need to be clarified (revision meeting scheduled for 12.05.17)</p> <ul style="list-style-type: none"> • Incorporate the article Bruising Characteristics Discriminating Physical – help to distinguish accidental from abusive injuries (revision meeting scheduled for 12.05.17). <p>02/02/18 This training was created and trained for the first time with the 1117 training group.</p>
16-02. Adopt policy on photographing injuries during Initial Assessment.	DHHS-CFS	<p>Complete</p> <p>In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."</p>
16-03. Develop additional training for Initial Assessment staff.	DHHS-CFS	<p>Complete</p> <p>CCFL updated its New Worker Training in 2016 to include a more intensive focus on family engagement. Caseworker in-service training on Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, Human Trafficking, Advanced Testifying, and Engaging Families in Safety and Risk Assessments have been developed and are being offered around the state.</p>
16-04. Further define process for utilizing child advocacy centers by Initial Assessment.	DHHS-CFS	<p>No Further Action</p> <p>After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers, DHHS decided not to update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. DHHS indicated they did not believe the burden for referral should be on DHHS staff alone.</p> <p>DHHS issued a revised memo on use of CACs, Protection and Safety Procedure #23-2017, however, none of the OIG's suggestions were incorporated.</p>

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
16-05. Update and provide additional detail on response priority definitions.	DHHS-CFS	<p>Complete</p> <p>DHHS updated its intake manual in August 2017 in Protection and Safety Update #26-2017. The updated manual provides clarification on priority response time definitions involving injuries to children under age six.</p>
16-06. Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.	DHHS-CFS	<p>No Further Action</p> <p>In September 2016, new guidelines for supervisory review of intakes (calls to the Hotline) went into effect, reducing the percentage Supervisors had to review and extending the timeframe for them to complete reviews. However, these changes were implemented without an analysis of supervisory staffing and a review of all of their responsibilities. In 2017, DHHS added a supervisor position at the Hotline and refocused supervisors on reviewing accepted reports. CFOMs were also transferred to the Hotline and now review screened out reports.</p>
16-07. Expand quality assurance and continuous quality improvement (CQI) at the Hotline.	DHHS-CFS	<p>Complete</p> <p>As part of their quality assurance efforts, DHHS is reviewing additional Hotline calls related to physical abuse allegations of children under 7 on a quarterly basis.</p>
16-08. Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.	DHHS-CFS	<p>Progress</p> <p>DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts of the state. DHHS has enhanced training for workers assigned to Initial Assessment. Internal discussions about additional CFS paygrades continue. The Southeast Service Area has adopted end to end teams. In other parts of the state, IA is moving to partnering caseloads between two workers.</p>
16-09. Take steps toward greater Initial Assessment workforce specialization and experience.	DHHS -CFS	<p>No Further Action</p> <p>DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts</p>

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		of the state. DHHS has enhanced training for workers assigned to Initial Assessment. Internal discussions about additional CFS paygrades continue. The Southeast Service Area has adopted end to end teams. In other parts of the state, IA is moving to partnering caseloads between two workers.
16-10. Contract with an independent entity to perform a validation study of Nebraska’s SDM Risk Assessment instrument.	DHHS-CFS	<p>No Further Action</p> <p>DHHS contracted with the National Council on Crime and Delinquency to conduct independent case reads on SDM safety and risk assessments. The results of the case reads were fairly positive.</p> <p>However, this was not a validation study. There is still no research demonstrating whether Nebraska’s SDM tool is accurately predicting risk or not and whether adjustments to the tool may need to be made.</p>
16-11. Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials.	DHHS – Public Health	<p>Complete</p> <p>The Child Safety Collaborative Innovation & Improvement Network (CoIIN), housed at Public Health, was instrumental in creating the Nebraska Safe Babies Campaign, which includes the Nebraska Abusive Head Trauma/Shaken Baby Syndrome Prevention Education Hospital Campaign. As part of that campaign, new abusive head trauma prevention materials were produced, including “1, 2, 3 Don’t Shake Me” and “Babies Cry. Make Your CRYing Plan”</p>
16-12. Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts.	DHHS-CFS	<p>Complete</p> <p>In April 2016, CFS Central Office distributed an “Under 2” packet, in English and Spanish, designed with input from the Division of Public Health, to field staff. Information about pediatric abusive head trauma is included in the packet. CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.</p>
16-13. Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload	DHHS-CFS	<p>Complete</p> <p>DHHS added a supervisor position to the Hotline and placed 3 CFOM positions at the Hotline to review</p>

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
and ongoing training and supervision.		screened out reports to ensure appropriate screening decisions occurred. Supervisors review all screened out reports and listen in on calls. A new process has been set up so that quality assurance staff review accepted intakes that the field wants re-screened. Hotline processes have been reviewed through the Lean Six Sigma process to improve performance. An additional staff member was also added to the Hotline to take calls. If an intake is not accepted for initial assessment, all referrals are now tracked. All CFSS trainees will begin to shadow at the Hotline.
16-14. Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.	DHHS-CFS	Complete DHHS has developed a monthly report on CWLA caseload compliance, including initial assessment and mixed caseloads. An overall report is posted publicly on their website detailing months January 2018 through June 2018. DHHS plans to update it monthly.
16-15. Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.	DHHS-CFS	Progress DHHS has collected data on high/very-high risk families declining services. DHHS is implementing Safety Organizing Practice (SOP), a family engagement model, in the next 6 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement. In the first 5 months of 2018, compared to 2017, DHHS increased the ratio of cases served through ongoing case management by 4% when the intake closed with a "High" or "Very High" risk level.
16-16. Restructure the Children's Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds	DHHS-CFS	Complete DHHS has developed a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
are spent to ensure they are addressing systemic gaps in child abuse investigations.		The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.
16-17. Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.	DHHS-CFS Private Agency: Nebraska Families Collaborative (NFC)	Complete In August 2017, DHHS adopted Protection and Safety Procedure #28-2017, "Mandatory Monthly Visits With Children, Parents & Out of Home Care Providers," which includes the Nebraska Safe Sleep Environment Checklist developed by Public Health and policy for workers regarding safe sleep. NFC updated the monthly Walkthrough Checklist, adding prompts to address children ages 0-5 sleeping location, the condition of the room/bed etc.
16-18. Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.	DHHS-CFS Private Agency: Nebraska Families Collaborative	Complete DHHS training adopted for staff, under 2 packets. NFC has incorporated Safe Sleeping into New Worker Training and a webinar has been created that is mandatory for all permanency staff. The training includes information on items that should/shouldn't be in the crib, co-sleeping, blankets, infant sleepwear, etc. This training will be completed annually by all permanency staff. NFC has attached Safe Sleep Guidelines to ages 0-5 Walkthrough Packet that is to be reviewed and/or given to the caregiver at each walkthrough when assessing non-agency/kinship homes.
16-19. Revise regulations to require infant safe sleep training before granting a child care license.	DHHS- Public Health	Complete LB 717 was signed by the Governor on April 11, 2018, requiring training before a license is granted. Public Health is working with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted. Printed information regarding safe sleep,

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		sudden infant death, and abusive head trauma prevention will be given out at orientations until the online training has been developed. A workgroup from DHHS and Nebraska Department of Education has been formed to begin work on the online training.
16-20. Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible	DHHS-CFS	No Further Action See Recommendation 15-01
16-21. Enhance efforts to reduce caseworker turnover.	DHHS-CFS	Complete DHHS has made changes to job recruitment strategies, revisions to New Worker Training to make it more accessible and less travel-intensive to complete. In July 2017, DHHS implemented a supervisor training program to better ensure caseworkers are supported.
16-26. Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.	DHHS-CFS	Complete DHHS has issued Administrative Memo 1-2018, Crossover Youth Practice Model, and, with Probation, presented the Statewide Crossover Youth Initiative Training to all case managers and juvenile probation officers.
16-27. Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.	DHHS-CFS DHHS- Developmental Disabilities	Complete Both CFS and DD participate in the Cross Divisions Solution Team. In 2017, DD helped provide information and feedback on CFS New Worker Training and developed a PowerPoint on available services for CFS staff.
16-28. Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system	DHHS - Developmental Disabilities	Complete DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTC's for service eligibility.
16-29. Make the OJS Administrator a Full-time Position	DHHS-CFS	Complete Trevor Spiegel is the current OJS Administrator.
16-30. Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5	DHHS-CFS	Complete In 2016, DHHS ended the full-time care program in Dickson. Currently, youth can live in Dickson for a short period of time if they have had struggles in their living unit. Each youth in Dickson has a Reintegration Plan that must be developed where the youth begins participating in normal activities as soon as they are able (example - school, group meetings). YRTC-Kearney reports that youth have not stayed in Dickson for longer than three to four weeks. These changes have not been codified in policy.
16-31. Develop Continuous Quality Improvement Process at YRTC's Led by Central Office	DHHS-CFS	Complete In 2017, DHHS Central Office began putting together monthly data reports on Performance-based Standards at the YRTC's. They include information on assaults, confinements, escapes, injury, restraints, misconduct, property incidents, suicidal behavior, youth seen for medical treatment, and staff-to-resident ratio.
16-32. Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney	DHHS-CFS	Complete DHHS examined staffing at YRTC-Kearney, and calculated how many staff it needed to comply with PREA. Additional staff for YRTC-Kearney were included in the 2016 DHHS budget request and funded by the Legislature in 2017. DHHS reports that recruitment of staff at YRTC-Kearney has significantly improved.
16-33. Digitalize Records at YRTC-Kearney	DHHS-CFS	Complete In January 2017, the YRTC's began loading information on incident reports into an online portal, Salesforce. The system is now fully operational and allows

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		facilities to review records of individual incidents as well as track specific incidents, including escapes, use of force, restraints, and seclusion.
17-10. Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.	Private Agency: Owens Educational Services, Inc.	Complete Owens now requires staff to contact & stay in communication with mental health professionals when a release is signed.
17-11. Implement training on suicide warning signs and prevention in youth.	Private Agency: Owens Educational Services, Inc.	Complete In April 2017, an LIMHP, PLADC Mental Health Practitioner trained staff company-wide on QPR (Question. Persuade. Refer.) Training for suicide prevention. This curriculum was also added to New Hire Training.
17-12. Promulgate rules and regulations related to the Children’s Residential Facilities and Placing Licensure Act as soon as possible.	DHHS- Public Health	Incomplete DHHS has developed a draft set of regulations with stakeholder input. These regulations have been submitted to DHHS Legal for final review before being sent for approval to set for public hearing. They have not been sent to the Secretary of State. It is unknown when this will occur. Updating these regulations have been designated as priority for the Licensure Unit.
17-13. Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.	DHHS- Public Health	Incomplete DHHS has included standards on dispensing medication in the draft regulations that have been sent to DHHS Legal, but have not yet been sent to the Secretary of State nor set for public hearing. See 17-12.
17-14. Adopt clear requirements on medical record-keeping and documentation in regulations.	DHHS- Public Health	Incomplete DHHS draft regulations include record keeping requirements for medications and specify that facilities must adopt policies on medical record-keeping. These regulations have not been sent to the Secretary of State. See 17-12.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
17-15. Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.	DHHS- Public Health	Incomplete DHHS draft regulations specify that facilities must adopt policies obtaining consent for medical treatment. These regulations have not been sent to the Secretary of State. See 17-12. DHHS is also planning to develop additional guidance for facilities on how to comply with regulations, while not adding requirements to regulations themselves.
17-16. Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.	DHHS- Public Health	Complete Public Health has committed to sharing information with both CFS and Probation, and, when possible conducting joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing. DHHS reports that it shares information on licensing actions and has been coordinating on investigations.
18-01. Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS’s child welfare and juvenile justice programs.	DHHS-CFS	Progress LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS is currently developing an implementation plan.
18-02. End the practice of screening law enforcement reports as “Does Not Meet Definition” when the allegation continues to meet DHHS’s definition of child sexual abuse.	DHHS-CFS	Incomplete DHHS reports that the Hotline Administrator and other staff are reviewing reasons why intakes are being re-screened and adopting definitions. The CQI team has begun to perform qualitative reviews to determine whether sexual abuse allegation intakes are following proper practice and policy. So far, the sample is very small. In a quarterly review conducted May 2018, out of 407 intakes alleging sexual abuse, 11 were reviewed by the CQI team. 2 of the 11 were rescreened to Does Not Meet Definition, and in both cases, the CQI reviewer agreed. No questions in the CQI analysis have to do with whether the sexual abuse allegation meets DHHS’s definition of child sexual abuse, whether the rescreen to Does Not Meet Definition is based on practice or policy, and whether the practice of rescreening, if still

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
		meeting the definition, is acceptable.
18-03. Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.	DHHS-CFS	Incomplete DHHS reports that the Hotline Administrator is reviewing the intake process. QA staff have put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed to ensure appropriate use of policy and discretionary overrides. So far, the sample is very small. For example, in a quarterly review conducted May 2018, out of 407 intakes alleging sexual abuse, 11 were reviewed by the CQI team. An override was used in 3 of the 11 cases, and in the 3 cases, the reviewer agreed with the closing status.
18-04. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.	DHHS-CFS	Progress DHHS has begun working with CCFL on revisions for training all CFSS staff.
18-05. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.	DHHS-CFS	Progress DHHS has created a new finding: Law Enforcement Refusal, which indicates that law enforcement is not choosing to investigate the allegation. This change in Hotline protocol has been piloted in the Eastern Service Area and will be rolled out to the rest of the state on September 1. Staff at the Hotline will continue to reach out to law enforcement.
18-06. Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.	DHHS-CFS	Rejected DHHS reports that this is already occurring, based on assessments and referrals that take place at the Hotline. Hotline staff will connect families to other hotlines and the CACs when appropriate. DHHS is rolling out a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. Any referral will be documented on NFOCUS.
18-07. Provide additional	DHHS-CFS	Complete

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.		DHHS reports that a curriculum has been developed on the preponderance of the evidence standard. Trainings for all supervisors occurred across the state beginning in April 2018.
18-08. Adhere to policy on out of home assessments and enhance quality assurance	DHHS-CFS	Progress DHHS is relooking at the policy on out of home assessments, including engaging front-line workers who complete these assessments in creating any new policy. Part of the analysis will focus on how involved Central Office will be in these assessments. Once the policy is redone, an implementation process will be developed and acted on.
18-09. Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.	DHHS-CFS	Complete DHHS has transferred the responsibility for entering findings to the Hotline for investigations conducted by law enforcement only. (Program Memo #33-2017). In May 2018, Hotline staff began addressing the backlog of law enforcement cases where no findings have been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked.
18-10. Meet the statutorily required caseload standard for initial assessment and ongoing case management.	DHHS-CFS	Progress DHHS has repurposed 24 positions to CFS specialist positions. DHHS believes they have enough FTE to meet CWLA caseload, including a 10% vacancy rate. DHHS is exploring a teaming approach to cases. Turnover is decreasing. Though caseload numbers are better than ever (DHHS reported 93% in compliance as of August 2018), DHHS continues to be out of compliance with statutorily required caseload standards. A monthly caseload report can be found on their website. CFS has called a working group of internal and external stakeholders to look at the current caseload standards and come up with an improved way to measure caseloads for all caseworkers.

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
18-11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.	DHHS-CFS	Progress DHHS is exploring language to add to foster parenting/child-placing agency contracts on this topic. DHHS administrators have had several meetings with Project Harmony and other stakeholders to look for input. For consistency sake, similar language will also be included in caseworker training.
18-12. Review and revise training on child sexual abuse for DHHS staff.	DHHS-CFS	Progress DHHS has begun working with CCFL and with Project Harmony on revisions. Nothing has been formally implemented.
18-13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.	DHHS-CFS	Progress DHHS is revising contracts and looking at provisions on the use of respite, revisions to training requirements, disruptions in placement. DHHS is also working on better aligning caregiver and child needs. Many of these strategies are incorporated into the PIP.
18-14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.	DHHS-CFS	Progress DHHS is changing the application process for foster parenting and issuing an RFP for home studies. DHHS has considered modifications to regulations to limit foster parents whose license has been revoked from re-applying within a certain timeframe. These changes are expected to roll out October 2018.
18-15. Include a component on child sexual abuse prevention in foster and adoptive parent training	DHHS-CFS	Progress Foster parent training and guidance is being revisited and modifications are being made to contracts. DHHS has reached out to Project Harmony and other stakeholders for input.
18-16. Ensure adequate	DHHS-	Rejected

OIG Recommendation	Agency or Agencies Responsible	Implementation Status
staffing for residential-child caring agency licensing operations	Public Health	DHHS noted in the LB 1079 (2018) fiscal note that an additional staff person would be required to meet a 30 day investigation timeline for uncomplicated cases.
18-17. Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.	DHHS- Public Health	<p>Progress</p> <p>Public Health reports that goal timelines have been developed and implemented the following:</p> <ul style="list-style-type: none"> - review within 5 days to determine whether to investigate; - finalized report within 30 days; and - a 90 day timeline for CFS/LE involved reports. <p>For 2018, there have been 12 investigations initiated all within 3 days of receipt of complaint. 6 are complete, 6 pending. 7 complaints were screened out.</p>
18-18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.	DHHS- Public Health	<p>Progress</p> <p>Public Health reports reviewing PREA regulations and incorporating some into draft regulations submitted to DHHS legal, which will then be sent to PRO. Unclear on how long it will take before a hearing is scheduled.</p>

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

August 20, 2018

Ellen Fabian Brokofsky
Probation Administrator
1445 K Street, State Capitol, Room #1209
Lincoln, NE 68508

Dear Ms. Brokofsky:

The Office of Inspector General of Nebraska Child Welfare (OIG) is in the process of compiling its Annual Report which is due from our office on September 15. Neb. Rev. Stat. §43-4331 requires the OIG, in the annual report, to detail recommendations made in investigative reports and their implementation status.

Although Probation has not formally accepted any of the OIG recommendations, the OIG is committed to providing updates on all of the improvement you have made specific to these areas. To that end, we are requesting the OIG is provided information on what action, if any, Probation has taken on the recommendations. The present day *draft* of the status of probation recommendations is attached. Please provide any information related to these recommendations by **Friday, August 31**.

Please do not hesitate to let me know if you or members of your team have any questions or concerns about the updates. I look forward to highlighting the progress Probation is making regarding these recommendations in our annual report.

Respectfully,


Julie L. Rogers

Attachment

OIG Recommendations to Probation	Implementation Status
16-22. Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD)	Progress Probation provides the Nebraska Developmental Disabilities Access Guide to Probation Officers; to date Probation has been unable to locate a suitable training vendor and plans to coordinate with DHHS to accomplish training; there are no policies yet created, and the OIG is unaware of any action to create a policy.
16-23. Adopt policy on child welfare referrals and joint case management.	Complete Probation has policy released regarding this subject. Probation has been training probation officers and DHHS caseworkers across the state with DHHS on the new joint case management policy.
16-24. Adopt policy on documentation and record keeping.	Rejected
16-25. Increase internal quality assurance efforts at the state level.	Rejected
17-01. Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.	Incomplete
17-02. Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.	Incomplete
17-03. Implement guidelines on when it is appropriate to use specific types of alternatives to detention.	Incomplete
17-04. Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.	Incomplete
17-05. Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.	Incomplete

OIG Recommendations to Probation	Implementation Status
17-06. Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.	Progress Probation has created this form. It is unknown whether the form has been approved and implemented.
17-07. Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.	Incomplete
17-08. Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.	Incomplete
17-09. Assess whether Probation has the authority to monitor alternatives to detention.	Incomplete

Corey R. Steel
State Court Administrator



Ellen Fabian Brokofsky
State Probation Administrator

August 30, 2018

Julie Rogers
Inspector General
State Capitol, P.O. Box 94604
Lincoln NE 68509-4604

Re: OIG Annual Report for 2017-2018

Dear Ms. Rogers:

This correspondence is in response to your August 20, 2018 letter to me regarding the duty of the Office of Inspector General to provide an annual report pursuant to Neb. Rev. Stat. § 43-4331. The Clerk's Office received this correspondence on August 28, 2018 and forwarded it to me unopened. I note that there has not been an investigative report involving Probation completed by your office since the publication of your last annual report on September 12, 2017, and thus there are no new reports or recommendations to summarize.

Although I did not accept any of the recommendations from previous reports, Probation Administration took the reports, findings, and recommendations very seriously. As stated in your 2017 Annual Report, "[i]mplementation of OIG recommendations is voluntary; the OIG Act does not require agencies to accept OIG recommendations or take action in response to issues identified in OIG investigations." Nonetheless, the recommendations are included in Probation's ongoing evaluation of its evidence-based practices and policies. In addition, the recommendations are beneficial in evaluating judicial branch education and training targeted to Probation system employees.

Probation's ongoing evaluation of its evidence-based practices and juvenile justice reform efforts are addressed, in part, on the Supreme Court's website, with several web links which will provide insight into some of the Juvenile Services Division initiatives and projects aimed at improving the provision of services within the juvenile justice system. For example, the following web addresses may be of value in gauging the efficacy of Probation's programs and services aimed at Nebraska youth.

Julie Rogers
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August 30, 2018

Juvenile Services Division at <https://supremecourt.nebraska.gov/probation/juvenile>
Annual Statistical Report of Juvenile Justice System, 2017 at
<https://supremecourt.nebraska.gov/sites/default/files/jjssar.pdf>

Specific Reports on Probation's Juvenile Justice Reform (including statistical charts)
[https://supremecourt.nebraska.gov/forms-
publications?field_publication_report_type_tid=2794&=Apply](https://supremecourt.nebraska.gov/forms-publications?field_publication_report_type_tid=2794&=Apply)

2018 Action Plan Update to November 2015 Council of State Governments Report
https://supremecourt.nebraska.gov/sites/default/files/Probation/juvenile/Action_Plan_Updated_2018.pdf

Biannual Supreme Court Strategic Agenda
<https://supremecourt.nebraska.gov/sites/default/files/2017-2019-strategic-agenda.pdf>

All of the information cited above reflects Probation's commitment to improving the lives of Nebraska juveniles which are placed under our supervision by the courts, highlights the progress we have made, and our commitment to future improvements within the Probation system.

Please direct all correspondence to the Clerk of the Supreme Court for accurate receipt and documentation. I will not respond to emails but will respond to correspondence addressed to me and delivered to the Clerk of the Supreme Court. If you have confidentiality concerns, please seal the envelope and mark "Confidential" on the outside.

Sincerely,



Ellen Fabian Brokofsky
Probation Administrator

EFB/sb