



Office of
Inspector General of Nebraska Child Welfare

ANNUAL REPORT

2020-2021

September 15, 2021

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

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

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

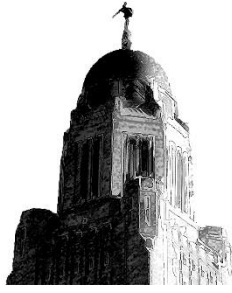
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State Capitol
P.O. Box 94604
Lincoln, NE 68509-4604
402-471-4211 or 855-460-6784

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

National Suicide Prevention Lifeline
1-800-273-8255

Nebraska Family Helpline
1-888-866-8660



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September 15, 2021

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

In accordance with Neb. Rev. Stat. §43-4331, it is my honor to present the Office of Inspector General of Nebraska Child Welfare (OIG) Annual Report for Fiscal Year 2020-2021.

This year the OIG was focused on two major systemic issues: the significant changes within the Youth Rehabilitation and Treatment Center (YRTC) system and the significant challenges with the contract for child welfare case management in the Eastern Service Area. In January 2021, the OIG released its report on what led to the crisis at the YRTC in Geneva, offering six recommendations for system improvement. As discussed in the Annual Report, our office has also been closely monitoring the changes in the YRTC system that followed the crisis, such as the opening of the YRTC in Hastings and the development of a five year strategic plan for the YRTCs. In December 2020, the OIG also opened an investigation into the Eastern Service Area contract to assess the performance and stability of the contract after the substantiated allegations of fraud and financial mismanagement by the leadership of Saint Francis Ministries, Inc. The results of that investigation are forthcoming.

While those are two key issues facing the state, there were, of course, other challenges. COVID had a substantial effect on the child welfare and juvenile justice systems, particularly at the 24 hour residential juvenile facilities. We appreciate the transparency and communication from the Office of Juvenile Services Administrator about the effects of COVID on the facilities and their close work with the local health departments as they navigated this new challenge.

Caseload standards continued to be a test for the child welfare system. We have previously noted the progress that had been made on caseloads in past years. Unfortunately, this year the difficulty in meeting caseload standards was not isolated to the Eastern Service Area but was an issue throughout the state. As noted in this report, new strategies are in place to address the workforce shortage that underpins the caseload issues.

While the work of the OIG necessarily focuses on the most difficult issues and outcomes in the child welfare and juvenile justice systems, we monitor these systems broadly and are always cognizant of the good work being done and the efforts to improve these systems. For example, the Director of

Children and Family Services and her team created a Strategic Transformation Steering Committee for the child welfare system. It is made up of a broad group of dedicated stakeholders that has been meeting at least monthly, with the help of some national partners, to develop a plan to transform and improve the system for children and families. We appreciate being invited to attend these meetings and continue to appreciate the productive working relationship with the Director and her team.

It is important also to note that of the 473 intakes that the OIG received this year, the majority have been handled competently by system professionals. It is a tribute to the dedicated work of the staff in the child welfare and juvenile justice systems who have to handle complex and often heartbreaking cases. We appreciate and acknowledge that hard work, especially this year as the pandemic continued and the systems faced significant change and challenges.

Thank you, as always, for your support of the OIG's mission to provide oversight in our child welfare and juvenile justice systems. We remain committed to fostering and promoting accountability, integrity, and transparency in our governmental agencies serving children, youth, and families.

Sincerely,

A handwritten signature in cursive script that reads "Jennifer A. Carter". The signature is written in black ink and is positioned above the typed name and title.

Jennifer A. Carter
Inspector General

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OVERVIEW OF THE OFFICE

The Office of Inspector General of Nebraska Child Welfare (OIG) provides accountability and oversight for Nebraska's child welfare and juvenile justice systems. Housed within the Nebraska Legislature, the OIG is a subdivision of the Office of Public Counsel (Ombudsman's Office).

Pursuant to the Office of Inspector General of Nebraska Child Welfare Act,¹ the purpose of the OIG is to:

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

The OIG accomplishes this purpose by conducting independent investigations, monitoring and identifying systemic issues, and making recommendations for improvement. Specifically, the OIG investigates allegations or incidents of misconduct, misfeasance, malfeasance, statutory violations, and regulatory violations in the child welfare and juvenile justice systems, including cases in which death, serious injury,² and sexual abuse have occurred.

The OIG oversees and may conduct investigations involving the following entities:

- Department of Health and Human Services (for both the Division of Children and Family Services regarding child welfare and the Division of Public Health for the licensing of child cares)
- Administration of the Office of Probation, Juvenile Division
- The Commission on Law Enforcement and Criminal Justice's Juvenile Justice Programs

¹ Neb. Rev. Stat. § 43-4301 to 43-4332.

² Serious injury is defined as, "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."

- Private agencies and service providers in the child welfare and juvenile justice system under state contract
- Licensed child care facilities
- Foster parents
- Juvenile detention and staff secure detention centers

The focus of the OIG investigations is on issues that affect the entire system – the performance of the executive agencies that operate the systems and the policies and practices that underlie those systems. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions regarding system-involved children and youth.

The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice systems. 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.³ The following report summarizes the work of the OIG from July 1, 2020 to June 30, 2021 and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made between July 1, 2015 and June 30, 2021.

Through the cases it reviews and the committees on which the Inspector General serves, the OIG knows that challenges beyond those mentioned in this report face Nebraska’s child welfare and juvenile justice systems. The OIG looks forward to the work of agencies, committees, public stakeholders, and policy makers to identify and take action to address some of these issues.

³ Neb. Rev. Stat. § 43-4331.

OIG OPERATIONS

The majority of the work done by the OIG is determined by information provided to the office in the form of:

- Incident reports from the Department of Health and Human Services (DHHS) or the Administration of the Office of Probation, Juvenile Division (Juvenile Probation);
- Complaints or reports of information from the public;
- Formal grievances filed with DHHS including DHHS's response to the person filing the grievance; and,
- Reports from the Youth Rehabilitation and Treatment Centers.

Once information has been received it is vetted as part of the intake process for the purpose of determining jurisdiction, identifying systemic issues, and formulating a response or appropriate course of action.

The OIG is also required to collect data and report annually on two narrowly defined subjects related to the child welfare and juvenile justice system – Alternative Response and Juvenile Room Confinement.

Intake Information Received

The OIG receives information – or intakes – in a variety of ways described in more detail below.

Incident Reports

The OIG is required by statute to receive notice of system involved deaths, serious injuries, and allegations of the sexual abuse of state wards in the child welfare system, as well as, juveniles on probation, in a detention facility, and in a residential child-caring agency.⁴ Incident reports are provided by Juvenile Probation, DHHS Divisions of Children and Family Services (CFS), Public Health Licensing, Youth Rehabilitation and Treatment Centers (YTRCs), and private service providers. The reports bring a range of issues to the OIG's attention such as the prevalence of suicide or self-harm, law enforcement contact, assault, concerns regarding placement, abuse or neglect in care, and youth who are missing or unable to be located while in care.

⁴ Neb. Rev. Stat. §43-4318

Complaints

The OIG receives complaints from employees, administrators, foster parents, grandparents, family members, attorneys, parents, and concerned citizens regarding various aspects and issues of the child welfare and juvenile justice systems. Complaints can be lodged with the OIG in person, via an on-line web form, by calling a toll-free number, and by email. The agencies and issues encompassed by complaints made to the OIG are varied and represent all areas and points in the system. If a complaint is received about an area outside of the OIG's jurisdiction, then a referral is made when appropriate.

Reports of Information

Reports of Information cover a wide variety of issues. The primary purpose of such a report is to share information with the OIG that the reporter believes to be important but does not rise to the level of a complaint.

DHHS Grievance Response Reports

Any time someone files a formal grievance with DHHS related to the child welfare system, the original grievance form, including contact information, and the official DHHS response is provided to the OIG for review.

Youth Rehabilitation and Treatment Center Reports

With the August 2020 approval of LB 1144, the Legislature established a reporting system with the intent of providing increased accountability and oversight regarding the treatment of juveniles in Youth Rehabilitation and Treatment Centers (YRTCs).

Nebraska law now requires the Office of Juvenile Services to report to the OIG any of the following instances occurring at a YRTC:

- Assault;
- Escape or elopement;
- Attempted suicide;
- Self-harm by a juvenile;
- Property damage not caused by normal wear and tear;
- Use of mechanical restraints on a juvenile;
- Significant medical event suffered by a juvenile; and,
- Internally substantiated violations of the Prison Rape Elimination Act.

As contemplated by the law, the OIG worked with the Office of Juvenile Services Administrator (OJS Administrator) to clarify the parameters of the reporting requirements and determine the format and frequency of the reporting. As part of providing increased accountability and oversight, the Inspector General also visits the facilities regularly.

Intake Review Process

After receiving information as described above, the OIG assesses every incident report, complaint, information report, and grievance referred to it. Each intake is subject to a preliminary investigation which includes a thorough document review and collateral contacts if necessary for complete vetting. Based on the findings of the preliminary investigation, the OIG then determines if the office holds jurisdiction over the incident, whether or not a full investigation is justified or required by statute, and what additional actions may be appropriate.

One benefit of housing the OIG within the Ombudsman's Office is the ability to coordinate with the Ombudsman's Office to best serve the state. The Ombudsman's Office addresses individual complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office investigates and resolves complaints informally by working with parties involved while promoting accountability in public administration. If, after a preliminary investigation and review, the OIG determines that a complaint does not raise a systemic issue but that the complainant may benefit from the help of the Ombudsman's Office, the OIG can refer that complainant to the Ombudsman.

Additional Responsibilities of the OIG

The OIG has been assigned specific oversight responsibilities by the Legislature that include membership on certain committees, monitoring data, and producing summary reports.

Committee Membership & Participation

The Inspector General participates in several initiatives and attends meetings of groups created to oversee and coordinate efforts to improve the systems serving children and youth in the state's care. Most notably, these include:

- Nebraska Children's Commission (statutory member)
 - Alternative Response Sub-Committee (statutory member)
- Child Death Review Team (statutory member)
- Nebraska Supreme Court Commission on Children in the Courts

- Statewide Juvenile Detention Alternatives Initiative

Legislative Reports

Alternative Response

In 2014 the Legislature statutorily mandated the OIG investigate complaints and incidents of concern related to cases referred to Alternative Response (AR) and report on those investigations annually.⁵

Alternative Response began in October 2014 as a DHHS pilot project implemented in five Nebraska counties. After being expanded to an additional 30 counties in 2016, the program was rolled out state wide in 2018. In 2020, Legislative Bill (LB) 1061 was passed removing the sunset date for the pilot program and adding additional exclusionary criteria for participation in the program.

AR is a different way to respond to allegations of abuse or neglect. It requires a comprehensive assessment of the child’s safety, the risk of future abuse or neglect, and the family’s strengths and needs. If the family is a candidate for AR, there is no formal investigation or determination of child abuse or neglect and DHHS works with the family to provide the services and support the family needs.⁶ Families that meet any of the exclusionary criteria in the law – including cases involving murder or significant physical abuse, sexual abuse, neglect that requires hospitalization of the child, or a history of termination of parental rights – are not eligible for AR.⁷ AR case are not filed with the court and are not monitored by the court.

Juvenile Room Confinement

In 2016, LB 894 was signed into law providing new guidelines related to juvenile room confinement in Nebraska. Additional guidelines relating to juvenile room confinement specific to a juvenile detention facility, staff secure juvenile facility, facility operated by the Department of Correctional Services, or youth rehabilitation and treatment center operated by the Department of Health and Human Services were added with LB 230 in 2020.⁸

Included in the law are requirements for how data on room confinement is reported and collected. To aid in implementation, the OIG created standard definitions for data collection and reporting

⁵ Neb. Rev. Stat. §28-712.01

⁶ Neb. Rev. Stat. §28-710.

⁷ Neb. Rev. Stat. §28-712.01

⁸ Neb. Rev. Stat. §28-712.02

on room confinement and distributed them to Nebraska’s juvenile facilities in 2016, 2018, and 2020.

The law mandates Nebraska’s juvenile facilities submit reports to the Legislature quarterly. The OIG is charged with reviewing and analyzing the data and issuing a report on its findings annually.⁹

⁹ Neb. Rev. Stat. §83-4,134.01.

FISCAL YEAR 2020-2021 DATA

The following data pertains to the fiscal year of 2020-2021 (FY 20-21) starting July 1, 2020 through June 30, 2021.

Intakes

Total Number of Intakes: 473

* 236 Incident Reports

168 from DHHS Divisions

68 from Juvenile Probation

*182 Complaints

*18 Reports of Information

*37 DHHS Grievances

As explained earlier in this report, the majority of information provided to the OIG comes in the form of incident reports, complaints, reports of information, and grievance reports provided by DHHS. All of that information is entered into an internal case management system as an intake. The intake process is utilized to categorize information for the purpose of vetting, determining jurisdiction, and best course of action. The number of total intakes for this fiscal year remained consistent with last year, showing a slight increase due to more DHHS grievances. Last year the OIG received seven DHHS grievances compared to this fiscal year in which a total of 37 were received.

Reported Deaths & Serious Injuries

30 deaths: 20 from DHHS
 10 from Juvenile Probation

8 serious injuries: 8 from DHHS
 0 from Juvenile Probation

Notices of deaths and serious injuries of system involved youth come to the OIG as incident reports. The deaths and serious injuries listed above are included in the calculation of total intakes and incident reports previously discussed on the page above. Compared to FY 19-20 reports, the total number of reported deaths and serious injuries has remained consistent.

Resulting Mandatory Investigations

Total Number of Mandatory Investigations added in FY 20-21: 6

5 mandatory death investigations: 3 from DHHS
 2 from Juvenile Probation

1 mandatory serious injury investigation from DHHS

The OIG is required to investigate death and serious injury of youth who are: (1) placed in out of home care (2) currently receiving or have received child welfare services from DHHS in the past twelve months (3) currently receiving or have received services from Juvenile Probation in the past twelve months (4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months (5) and youth in a licensed facility. The OIG is not required to investigate deaths that occurred by chance.

During FY 19-20, two deaths were reported that the OIG is required to investigate, both from Juvenile Probation, and there were no reports of death from DHHS that would require an OIG investigation. Similarly, in FY 19-20 there were no reports of serious injury from either DHHS or Juvenile Probation that the OIG is mandated to investigate. By comparison, in FY 20-21, three deaths were reported by DHHS which the OIG will be mandated to investigate and there were two additional deaths reported by Juvenile Probation that the OIG will be mandated to investigate. In addition, there is one serious injury report from DHHS in the last fiscal year that the OIG will be required to investigate.

Overview of Mandatory Investigations added in FY 20-21

Type of Incident	Cause	Age	Type Of Involvement	Time Of Involvement	Reporting Party
Death	Neglect	2	CFS Non-Court	Within 12 Months	DHHS
Death	Abuse	2	CFS Initial Assessment	Current	DHHS
Death	Suicide	16	CFS Initial Assessment	Current	DHHS
Death	Homicide	15	Juvenile Probation	Current	Probation
Death	Suicide	17	Juvenile Probation	Pre-Adjudication	Probation
Serious Injury	Abuse	1	CFS Initial Assessment	Within 12 Months	DHHS

Reported Allegations of Sexual Abuse

After the 2017 OIG report *Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement*, the Legislature passed LB 1078, which required 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. The following year reports of alleged sexual abuse to the OIG increased 81% as awareness of the issue increased and the provision of LB 1078 went into effect. The OIG has continued to monitor reported allegations of sexual abuse with system involved youth and has noted the marked increase, particularly for youth on Juvenile Probation, during FY 20-21. The OIG cannot draw any conclusions as to the cause of the increase at this time, but will continue to observe the trend and assess for systemic issues.

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

Fiscal Year	Total	DHHS	Juvenile Probation
17-18	45	26	19
18-19	41	31	10
19-20	46	15	31
20-21	69	14	55

KEY ISSUES

The following is a brief description of some of the key issues, efforts, and investigations that have arisen in the child welfare and juvenile justice systems in the last year and with which the OIG was actively engaged.

Eastern Service Area Case Management Contract

This year the OIG has spent a significant amount of time on an investigation into the contract for privatized child welfare case management services in the Eastern Service Area (Douglas and Sarpy Counties). In June 2019, the DHHS awarded the case management contract in the Eastern Service Area (ESA) to Saint Francis Community Services of Nebraska, Inc., a wholly owned subsidiary of the Kansas-based Saint Francis Ministries, Inc.

In late 2020, an internal investigation of Saint Francis Ministries, Inc. substantiated allegations of fraud and financial mismanagement by the President and Chief Executive Officer and Chief Operating Officer at Saint Francis Ministries, Inc. As a result, on December 21, 2020, the OIG opened an investigation into the ESA contract with Saint Francis to assess the stability of the contract in light of Saint Francis' financial difficulties and to review the administration, performance, and contract monitoring of the ESA contract. A report from that investigation is forthcoming.

In addition to that work, the OIG testified at the July 9, 2021 hearing of the Legislature's LR 29 Committee which is also looking into the ESA contract. As the OIG testified to before the LR 29 Committee, Saint Francis has faced significant challenges in performance and has been put on seven Corrective Action Plans (CAPs) since the start of the contract. Three of the CAPs have been resolved, although problems persist with court performance and a plan remains in place to address those issues.

Unfortunately, Saint Francis continues to struggle with three other CAPs relating to timeliness of case plans, timeliness of documentation of placement changes, and caseloads. In all three cases, Saint Francis has been out of compliance with these measures for the entirety of the contract. According to the latest Quality Performance Scorecard by DHHS posted on September 7, 2021, while Saint Francis continues on a CAP for monthly face-to-face meetings with youth, it did meet the required goal of over 95% compliance for the first time last month. Finally, Saint Francis has also been out of compliance with its Child Placing Agency license requirements and

its license was placed on disciplinary probation as a result. Saint Francis has until September 30, 2021 to resolve those issues.

Youth Rehabilitation and Treatment Centers

In January 2021, the OIG released its *Special Report of Investigation: The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center*. The Executive Summary can be found on page 18 of this report. That investigation arose out of the crisis at YRTC-Geneva in 2019 and focused on what led to that crisis. There were many significant and swift changes in the YRTC system in the year that followed that crisis. The female youth were moved to YRTC-Kearney which created its own challenges. DHHS then decided to move the substance use treatment program for male youth out of the Hastings Regional Center to the Whitehall facility in Lincoln where it is housed alongside the treatment program for male youth who sexually harm. The newly constructed buildings at the Hastings Regional Center, which were intended for use by the substance use treatment program, were then renovated for use as a new YRTC at Hastings for the female youth. YRTC-Geneva has been permanently closed.

The OIG has remained engaged and monitored all of these changes. Specifically, the OIG, in close collaboration with the Ombudsman's Office, has monitored the opening of the YRTC in Hastings and the transfer of the female youth from YRTC-Kearney to the Hastings facility. The OIG has visited the facility and the youth several times since March and will continue to monitor that facility. The OIG has also visited and monitored YRTC-Kearney as well as the Whitehall and Lincoln facilities.

As part of that work, the OIG has also been monitoring the implementation of the approach and training for which the Missouri Youth Services Institute (MYSI) was contracted. MYSI's approach is to ensure the facilities are structured and secure, but focused on the most effective way to help a youth change his or her behavior. This approach relies on, ideally, a consistent set of staff working with the same group of youth. This allows for a deeper understanding of each individual youth and allows for more effective teamwork and treatment around that youth. The approach requires intensive training, mentoring, and coaching. The training and implementation of the MYSI approach has been hindered by staffing challenges and turnover of staff at the YRTCs. The contract with MYSI has been extended to allow for additional training and coaching with a focus on training managers so that those managers might train front line staff.

In addition, as required by statute, DHHS has prepared a five year strategic plan for the YRTCs. The OIG was part of the planning process and remains on the Advisory Committee.

COVID

As was true with almost all things, COVID presented a significant challenge to the state's 24 hour facilities. The YRTC at Kearney was most affected, in part due to the fact that the majority of the YRTC population - both boys and girls - were residing at YRTC-Kearney until March 2021 when YRTC-Hastings opened.

In the fall of 2020, the administration at YRTC-Kearney had to deal with many positive cases of both staff and youth and faced staffing challenges as staff would be unavailable for periods of time to quarantine. In total, the OIG was aware of 23 youth at YRTC-Kearney who tested positive over the course of several months in late 2020. It was reported to the OIG that most youth were either asymptomatic or dealt with only minor symptoms.

The OJS Administrator kept the OIG apprised of how COVID was affecting the facilities. It has been the OIG's understanding that the OJS Administrator and the Facility Administrators worked closely with the local health departments on protocols regarding testing, quarantine, and visitation. The OJS Administrator also worked with Dr. Donahue, who was a CDC fellow at DHHS at the time, and recently became the acting state epidemiologist. COVID remains a challenge for the facilities and quarantine protocols are still in place for new youth entering a facility.

The child welfare system also felt the effects of COVID as the manner, protocols, and availability of visitations with children had to be adjusted to ensure the health and safety of all involved.

Caseloads

As we have noted in past reports, caseload standards have been a challenge for DHHS since the maximum caseload requirement was passed into law in 2012.¹⁰ Over the past nine years progress has been made and in FY 18-19 DHHS was meeting the caseload standards at an average above 90%. In the OIG's last annual report, however, we noted that the struggles with caseloads in the ESA contributed to a significant decline in overall caseload compliance statewide. Statewide compliance had fallen to 80% from 92% the year before.

¹⁰ Neb. Rev. Stat. §68-1207

Unfortunately, in FY 20-21, compliance with caseload standards has fallen again to 71% statewide. While the ESA continues to have the lowest levels of compliance for ongoing case management, several other service areas have also struggled with caseloads.

DHHS has developed a variety of strategies to address the workforce issues which contribute to the high caseload standards. Leadership at the Division of Children and Family Services is meeting weekly with DHHS's Human Resources to discuss vacancies, applicants, and recruitment efforts. Training for new workers has been shortened and refocused on the caseworkers' particular position – Initial Assessment worker or Ongoing worker – with the goal of allowing the caseworker to start in the field sooner and complete the remainder of the training within three months of the initial phase. DHHS is also working on a draft business plan with the Department of Administrative Services to allow for over-fills which would help maintain caseload standards even when there is turnover in staff.

The OIG will continue to monitor the progress under these new efforts.

Strategic Transformation of Child Welfare System

The Director and team at the Division of Children and Family Services have created a Strategic Transformation Steering Committee for the child welfare system made up of a broad group of stakeholders. This group is being facilitated and supported by Chapin Hall and the Capacity Building Center for States. The goal of this Committee is to guide efforts to transform the child welfare system in Nebraska to improve outcomes for children and families in the system. Meetings are on Monday evenings once or twice a month and began with an assessment and review of the work being done and the resources available throughout the state for families in the child welfare system.

The OIG, while not a member of the Steering Committee, has been invited to attend and participate in these meetings. The committee members are a dedicated group of stakeholders and the effort has been very helpful and informative.

INVESTIGATIONS

As noted, the OIG is required to investigate deaths and serious injuries of system involved youth. In addition, the OIG conducts investigations on broader systemic issues that arise in the child welfare system.

A full investigation, at a minimum, includes:

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

At the conclusion of a full investigation, which can range from several weeks to a few months, the OIG issues an investigative report to the state agency involved. The state agency has the opportunity to review the report and must respond to the recommendations by accepting, rejecting, or requesting a modification of the recommendations. If a private agency is also the subject of the report, that private agency also has an opportunity to review the report and respond to the recommendations.

During FY 20-21 the OIG completed five reports of investigation involving DHHS. These five reports incorporated six death investigations, five serious injury investigations, and one facility investigation with a total of 11 recommendations for systemic improvement.

As noted in more detail below, the OIG was not able to complete any mandatory investigations involving the Administrative Office of Probation.

FY 20-21 JUVENILE PROBATION INVESTIGATIONS

The OIG continues to receive incident reports from the Administrative Office of Probation (AOP) that are prescribed in statute. When required, the OIG requests and the AOP provides the OIG with access to certain records related to critical incidents. However, the OIG is unable to conduct the necessary interviews with staff to properly and fairly complete any investigations. The AOP continues to require a protocol for interviews with its staff that violates the principles and standards of the Association of Inspectors General and the Office of Inspector General of Nebraska Child Welfare Act. As a result, the OIG has not been able to complete the required

investigations, determine if recommendations are necessary, or provide the oversight contemplated by Nebraska law.

FY 20-21 DHHS INVESTIGATIONS

The following sections provide detail on the five DHHS investigations that were completed during FY 20-21. All recommendations made are based on the current state of the Nebraska child welfare system and identified issues that need to be addressed presently. In the cases where no recommendations are made, the incident either revealed no issue about the administration of an agency or the agency had already made systemic changes to address the issues found.

Every effort has been taken to keep the actual identity of the child confidential. The OIG includes details about the case in an effort to be transparent about what was discovered in these investigations and why specific recommendations were made, without compromising the identity of persons involved.

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

PUBLICALLY RELEASED REPORTS

Neb. Rev. Stat §43-4325 provides for the public release of OIG final reports in order to bring awareness to systemic issues that would be in the best interest of the public. During FY 20-21 two of the five reports were released to the public: *Death or Serious Injury Following a Child Abuse Investigation June 2016-June 2019* and *The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center*. These two previously released reports are the first two summaries of investigation below, and can be located on the OIG website at <http://oig.legislature.ne.gov>.

I. DEATH OR SERIOUS INJURY FOLLOWING A CHILD ABUSE INVESTIGATION

JUNE 2016-JUNE 2019

Between June 2016 and June 2019 the OIG received four reports (one death and three serious injuries) from the Department of Health and Human Services (DHHS) involving children who had been the subject of a child abuse or neglect Initial Assessment (also called an investigation) within the 12 months prior to the critical incident.

The report calls attention to trends the OIG found in these four cases, including shortfalls in the investigation and assessments that took place within 12 months prior to the incident where the child was seriously injured or died and systemic issues that impacted how the Initial Assessments were conducted. The OIG observed that when analyzing the IA(s) prior to the critical incidents, the cases shared key similarities. These included: a complex family dynamic that was not recognized; CPS history that was not identified; and, protective parenting capacity that was not corroborated outside of the family unit.

Investigative Findings:

1. Child vulnerabilities were identified, but there is no evidence that they were appropriately taken into consideration throughout the IA investigation.
2. Secondary caregivers were not thoroughly investigated preceding the critical incident.
3. Supervision of the investigation and assessment process prior to the critical incident was insufficient.

OIG Recommendations:

Enhance policy and tools specific to the examination of secondary caregivers in an investigation.

Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregiver substance use is affecting the safety of the child.

Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.

Conduct a work study of Child Protective Services (CPS) Supervisor

II. DETERIORATION AND CLOSURE OF GENEVA

YOUTH REHABILITATION AND TREATMENT CENTER

On August 12, 2019, the Department of Health and Human Services (DHHS) informed the Office of Public Counsel and the OIG about a serious development that arose at YRTC-Geneva. In response to that development, and out of a concern for the safety of the youth, DHHS made plans for changes that would alleviate some of the immediate concerns and dangers, beginning with the reduction of YRTC-Geneva's census. The circumstances ultimately led to the relocation of all of the female youth to the Youth Rehabilitation and Treatment Center at Kearney (YRTC-Kearney) one week later. After learning the details of the crisis situation involving 35 state wards, a formal investigation was initiated to analyze the extent and manner of the deterioration at YRTC-Geneva and to understand how the campus came to deteriorate to such an extent that it required closure.

The investigative report outlined the events leading up to the youth being moved to YRTC-Kearney, describes actions taken in conducting the investigation, gives background on the YRTCs, provides a timeline related to YRTC-Geneva from 2015 to August 2019, presents findings after careful analysis, and makes recommendations for YRTC system improvement.

At the time of the Geneva crisis, 33 out of the 35 youth placed at the facility (94%) had a documented trauma history such as being abused or neglected or both. Fourteen had at some point in their childhood been a ward of the state due to abuse or neglect. All 35 youth were diagnosed with a behavioral disorder, a mental health disorder, or both. Many of the youth also had multiple out-of-home placements including group homes, shelters, detention centers, foster care, and psychiatric residential treatment facilities.

The failures of leadership related to YRTC-Geneva occurred at multiple levels, on multiple fronts, and in ways that were complexly intertwined, with each compounding the consequences of the next. This reflects a failure by leadership to plan, to problem solve, and to dedicate the resources necessary to provide the legally required care for the youth at YRTC-Geneva. The failure of leadership led to management, staffing and training issues, lack of programming and treatment, and the deterioration of the cottages. Each of these elements is required to effectively meet the mission of YRTC-Geneva and the needs of the girls. As a result of these failures, the youth at YRTC-Geneva experienced varying levels of trauma. It was clear after interviewing all the youth, many of them were exposed to or experienced some sort of traumatization or re-traumatization during their commitment at YRTC-Geneva during the crisis.

Investigative Findings:

1. The leadership at the Department of Health and Human Services, Office of Juvenile Services, and at YRTC-Geneva failed to ensure that YRTC-Geneva had the necessary management, staffing, programming, treatment, and facilities to care for the youth in its custody, as evidenced by:

- Key management positions in the administration at YRTC-Geneva were not appropriately staffed or were left vacant;
- Lack of staff and training for staff;
- Failure to provide programming and treatment; and,
- The youth were living in an uninhabitable environment.

2. Youth placed in the care and custody of DHHS for treatment and rehabilitation at YRTC-Geneva were exposed to varying levels of trauma during their commitment to the facility.

OIG Recommendations:

Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.

Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.

Implement a fully digital case management system.

Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.

Implement evidence-based programming consistently throughout the YRTC system.

Implement a trauma-responsive environment across the YRTC system.

III. YOUTH SUICIDE WHILE IN A LICENSED MENTAL HEALTH CENTER – 2015

In August 2018, the OIG received information at a Maternal Child Death and Review Team meeting that a youth had completed suicide at a licensed mental health center in 2015. The OIG is mandated to investigate deaths and serious injuries in facilities licensed by the DHHS-Division of Public Health (Public Health).

This report summarizes the death of a youth while privately placed by his parents in a licensed mental health center and how Public Health conducted its investigation into the death. While the youth had previous involvement with the child welfare system, he was not involved in the child welfare system at the time of his death. The scope of this report, therefore, is focused on the circumstances of the death and the subsequent investigation at a facility licensed by the Division of Public Health.

The youth was admitted to a licensed mental health center in June 2015 based on a history of four suicide attempts beginning in March 2015.

In July 2015, the 16 year-old youth was found in their room at the mental health center; they were non responsive with a bed frame resting on their neck. The next day they were declared clinically brain dead; several days later the youth went into cardiac arrest and was pronounced deceased.

The Abuse and Neglect Hotline (Hotline) received a report regarding the suicide. The Hotline screened the intake as Does Not Meet Definition as there were no allegations of abuse or neglect.

The Department of Health and Human Services-Division of Public Health (Public Health) conducted an investigation regarding the suicide, as the facility was licensed as a Mental Health Center at the time of the death.

Public Health went to the mental health center unannounced and reviewed files of all the youth who were placed at the facility at the time of the incident. They selected 25 cases for further review and then selected 9 cases that had incidents of self-harm or attempts of suicide to integrate into the investigation. Public Health conducted multiple interviews with staff, along with observing the facility.

The mental health center's records indicated that the youth had been in the cafeteria the morning of the suicide. However, the investigation determined that staff did not visually confirm the youth was in the cafeteria. One staff member was in charge of doing checks and believed the second staff member had checked on him. The second staff member handing out meal trays in the cafeteria believed the first staff had checked on him, and thus both staff incorrectly documented

his location based on that mistaken belief. The mental health center did not have roll call prior to each meal. The youth was not under supervision for at least 26 minutes while alone in his room.

In September 2015 Public Health concluded their investigation with one finding, “The facility failed to provide necessary supervision to prevent self-injuries.” Public Health sent the mental health center a letter in December 2015 that required the facility to complete and implement a Statement of Compliance.

On January 2016, the mental health center submitted a Statement of Deficiencies and Plan of Correction to Public Health.

In February 2018 the mental health center settled a civil lawsuit that was filed by the youth’s parents. The amount of the settlement was not disclosed.

Investigative Findings and OIG Recommendations

The OIG makes no recommendations to DHHS as a result of the investigation. The OIG has taken note of any themes and issues, and they will be tracked in order to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

IV. INFANT DEATHS IN LICENSED FAMILY CHILD CARE HOME MARCH 2016 - SEPTEMBER 2018

Between March 2016 and September 2018 the OIG received four reports of death from DHHS involving infants who were in a licensed Family Child Care Home (child care home) at the time of their death. As a result of these critical incidents, the OIG opened an investigation into how the Department of Health and Human Services — Division of Public Health, Child Care Licensing (Public Health Licensing) operates and performs in their role of regulating and licensing child care homes.

Overview of Child Care Licensing

Facilities that provide childcare have been regulated within the U.S. since the 1920s as a means of ensuring safe, quality child care. Quality child care is important as young children are an exceptionally vulnerable population due to their age and limited visibility within the community. Infants are particularly at risk; they are essentially nonverbal and limited in mobility, making their dependence on caregivers considerably greater in comparison to other age groups. In addition, very young infants are also often invisible, in that they are routinely only seen by family members, health care providers, and child care providers. Licensing practices have been conceived as a means of providing a foundational level of care, rather than a ceiling, of safety and quality. While individual states have developed unique approaches to defining quality child care in conjunction with their own licensing laws and programs, the unified purpose is to create and sustain safe, high quality child care options. Regulations, including the inspection process, creates an additional layer of safety and security for children in child care settings.

Nebraska Public Health Licensing

Public Health Licensing is in charge of processing child care provider applications; granting licenses for child care providers; conducting annual inspections; completing complaint investigations; conducting compliance checks; enforcing regulations; taking action against providers who violate regulations; educating providers; and, providing parents with information regarding child care providers.

A Child Care Inspection Specialist (Inspection Specialist) conducts inspections and investigations of any licensed child care provider. They make sure providers are following regulations and safety codes. If a provider has violated a regulation or is out of compliance, the Inspection Specialist will work with the provider to correct the situation in a timely manner. When necessary, Inspection Specialists have the authority to implement various disciplinary actions against a child care provider. Inspection Specialists are also expected to coordinate with DHHS-

Division of Children and Family Services and/or law enforcement when allegations of abuse/neglect against a child care provider are reported.

Child 1.

In March 2016, a three-month-old was dropped off at the family child care home where he then died. The provider held a child care license issued in 2007.

The license holder of the child care home told local police investigators that after the infant arrived, she fed him a bottle and then placed him in a pack-n-play on his back with one blanket and the bottle. She said that the baby was fussy, so she later turned him on his stomach which seemed to quiet him. The child care provider was in the same room with the infant, watching other children, while he slept. Approximately one hour later, she physically checked him and found him not breathing. She initiated CPR and called 911.

The Nebraska Child Abuse and Neglect Hotline (Hotline) received an intake alleging physical neglect of the infant by the provider. The Hotline accepted the intake for an Out of Home Assessment (OHA). The Division of Children and Family Services and the Division of Public Health conducted a joint investigation of the allegations.

Public Health Licensing completed a Complaint Inspection Report that substantiated multiple regulation violations. The Inspection Specialist informed the provider that she must sign a licensing agreement that would require another individual with her at all times while she is caring for children in her home or voluntarily close her child care home until the abuse/neglect investigation was completed.

The provider refused to sign the licensing agreement. Public Health Licensing filed a Notice of Suspension and Disciplinary Action in May 2016. The result being her license would be suspended until she got the fire marshal's approval for operating a child care in her home, and until that time her license would be on probation for two years with limits on caring for infants for one year.

The provider appealed this decision. The appeal order dated August 2016, found there was enough evidence to indicate the provider failed to comply with the Child Care Licensing Act. The appeal upheld the probation period of two years and the limitation on caring for infants.

The Division of Children and Family Services established that the physical neglect allegations were unfounded based on the autopsy report. The Out of Home Assessment stated, "Even though

we are unable to determine that placing the infant on his stomach somehow lead to his death we must also conclude that he may not have died if he was placed in the crib on his back as policy recommends.” The OHA recommended the Public Licensing revoke the provider’s child care license.

The child care provider voluntarily relinquished her license in December 2016.

Child 2.

In March 2016, a mother brought her 4-month-old son to a child care home which had been licensed since 2008.

The provider reported that she fed the infant and laid him in on his back in a play pen. She checked on him between 30 and 45 minutes later, and saw that he was on his stomach and was not breathing. She handed the infant to another adult in the home (not related to providing child care) and told them to begin CPR while she called 911.

Paramedics arrived shortly after and took over performing CPR before taking him to the hospital, where he was pronounced dead. The parents told sheriff’s deputies that the infant had some recent breathing problems and was receiving nebulizer treatments.

The Hotline received an intake regarding the death. It was accepted for an Out of Home Assessment for the child care home. DHHS reviewed the autopsy results and the Hotline re-screened the intake as does not meet definition, based on the autopsy report stating that the infant died as a result of SUID.

Public Health Licensing was informed that the death was not associated with child abuse/neglect and that there were no allegations of licensing violations, therefore they closed their inquiry and took no further action.

Child 3.

In August 2016, a four-month-old infant was dropped off at the licensed child care home. The child care home had been licensed since 2012.

The infant was laid down for a morning nap, on her back, in a pack-n-play that was equipped with a fitted sheet. The room was on the second floor of the home. The provider reported she remained on the second floor while the infant slept. The provider went to check on the infant

after about 15 minutes, noting that the child was on her stomach sleeping. Twenty minutes later the provider checked on the infant again and found she was not breathing, with part of the fitted sheet around her nose and mouth, and what appeared to be vomit around her mouth and nose. The provider initiated CPR while another worker called 911. The infant was transported to a local hospital, where she was resuscitated and intubated. The infant was then taken to a children's medical center where she went into cardiopulmonary arrest and died.

The Hotline received an intake alleging physical neglect of the infant by the provider. The intake was not accepted due to no indication that the cause of death was due to abuse or neglect.

Public Health Licensing followed up after the death in October 2016. The compliance review stated the provider reported she noticed the pack-n-play sheet was loose and fixed it before leaving the child to nap. The provider was required to submit a statement that all sheets used would be specifically made for pack-n-plays and fit appropriately.

Child 4.

In September, 2018, a two-month-old infant was dropped off at a child care home which had been licensed since 2002.

The infant was cared for by the provider from 10 p.m. on Friday nights until 10 p.m. on Sunday nights, while the mother worked. The provider reported that on early Sunday morning she had placed the infant on her back at 3:45 a.m. in the pack n play, and went to bed. At 7:56 a.m. on Sunday morning, she found the infant face down, stiff, and unresponsive. There were no toys, sheets, or bottles in the pack-n-play. The infant was taken to the hospital and pronounced dead.

The Hotline received an intake alleging physical neglect of the infant by the child care provider. The Hotline screened the intake out as there was no information provided that indicated abuse or neglect had occurred.

Public Health Licensing followed up after the death, finding that the provider had violated regulations while caring for the infant at the time of her death. The provider was required to submit a statement of compliance for each violation.

Investigative Findings:

1. Public Health Licensing does not have regulations or guidelines on how frequent and in what manner to check a sleeping infant.

In Nebraska, child care providers are required to provide adequate and appropriate supervision of the children in their care. “Adequate and appropriate supervision” is defined within Public Licensing regulations as:

1. Knowing the whereabouts and being within sight or sound of all children at all times;
2. Being alert, attentive, and responsive to the needs of all children; and
3. Protecting or removing children from harm.”

The OIG found that in each of the four infant deaths, the licensee self-reported that they “frequently” checked on the sleeping infant. The OIG noted that together, none of the cases demonstrated a consistent time frame or procedure for verifying wellbeing, other than the self-reported frequent checks which ranged from 45 minutes to three hours. In one case the child care provider was engaged with other children in the same room where the infant slept. Another infant was checked on after 45 minutes as his care giver fed other children before checking on him. A third infant was in an overnight child care home and was observed after three hours of sleeping time.

All four family home child care providers were within sound of the infant at the time of death and one being within sight. Family home child care providers are not regulated on how frequently to check on sleeping infants and in what manner to evaluate their well-being. For example, child care providers could be required to check on a sleeping infant every 20 minutes, physically stand near the infant to observe movement from breathing and record the wellbeing check in a logbook.

2. The OIG did not receive notification of all deaths in licensed child care homes occurring between 2016-2018 but a process had been put in place to receive notifications from Public Health Licensing per Neb. Rev. Stat. §43-4318 (2).

Neb. Rev. Stat. §43-4318 (2) requires DHHS to notify the OIG of all cases of death or serious injury of a child in a child care facility or program. Public Health Licensing reported publicly that there were nine deaths occurring in a licensed child care home between 2016 and 2018. The OIG received notification of only four deaths. All nine deaths should have been reported to the OIG. The OIG and Public Health Licensing had a meeting regarding critical incident notification and

criteria. Public Health Licensing will be implementing a new process to assure timely notification of child death within a licensed child care to the OIG.

OIG Recommendations:

Create specific guidelines for how frequently and in what manner sleeping infants should be checked.

The OIG recommends Public Health Licensing create guidelines for child care providers that includes a defined span of time in which a sleeping infant must be checked, and the requirement of a physical observation of the infant to ensure well-being. The establishment of such an infant well-being check protocol would be consistent with current regulations for the bottle feeding, safe sleep and diapering/toileting of infants.

The American Academy of Pediatrics recommends visual checks every 10-15 minutes to assure the infant's head is uncovered, and to assess the infant's breathing and/or color. When a sleeping infant is checked regularly, the child care provider has more opportunities to assess the child's condition, and be better able to make an informed decision about the child's physical needs. For example, a child with a cold, asthma, or other ailment may exhibit signs of discomfort or distress that an alert and attentive care provider could then alleviate.

At least 25 states specifically require, within regulations, regular checks on sleeping infants in child care homes. Fourteen states regulate the visual observation of a sleeping infant; ten of those states specify how frequently the child is observed. Massachusetts requires constant monitoring for children who are younger than six months of age during their first six weeks in a licensed child care setting. Tennessee requires that the sleeping child be physically touched. Colorado requires that a child be observed every 10 minutes, even when a baby monitor is used. Rhode Island requires "in-person checks." Washington expects providers to monitor breathing patterns and check for indicators of illness such as temperature change and irritability. Several states require written documentation of the type and frequency of contact with sleeping infants.

The purpose of regulation is to create safe conditions and to reduce risk. Because infants are helpless, they require greater levels of care and attention; for this reason, the additional well-being check protocol and guidelines should be created.

V. SERIOUS INJURY OF A CHILD WHILE IN A LICENSED FAMILY CHILD CARE HOME – 2017

During 2017 the OIG received two reports rising to the level of serious injury from the Public Health Licensing Unit, a division of the Department of Health and Human Services (DHHS) involving children who were in a licensed Family Child Care Home (child care home) at the time of their injury. This report summarized the serious injuries of two children while in two different child care homes.

Child 1.

A three year old nearly drowned in 2017, at a child care home. After outdoor play, a headcount revealed that she was missing. She was located in the duck pond after a brief search. The duck pond was in a fenced-in area, but the gate to the pasture and pond had been left open. The toddler was resuscitated and taken to a local hospital. She was later flown to a different regional hospital. She eventually returned to neurological baseline and was released.

The child care home had been subject to a six month licensing agreement that expired less than a week before the serious injury of the toddler. During the six month period the provider was required to add her son as a child care staff member/substitute and obtain written permission to transport children. Prior to this, the provider had been allowing her 17-year-old son to take children to school despite the fact that he was not listed as a staff member and had not completed a mandated background check.

After the serious injury, the family child care home was placed on Probation for one year, from November, 2017 through November, 2018. The child care provider was required to renew an expired CPR/First Aid Certification, and in addition to the current fencing around the pond, a fenced-in play area had to be installed; until installment was verified by the department, no child could be left unsupervised out-of-doors.

Child 2.

In 2017, an infant was seen for his 2-month pediatric checkup. At the time his head measurement was in the 24th percentile. 60 days later, at his 4-month checkup it was noted that his head measurement was now in the 99th percentile. An ultrasound indicated fluid and blood between the infant's brain and skull. After being admitted to a regional hospital, the infant was found to have a bilateral subdural hematomas as well as benign enlargement of subarachnoid spaces (BESS). Physicians believed the injury had occurred within the previous two months.

The Hotline accepted the intake alleging the physical abuse of the infant by the child care provider. The local police department initiated a criminal investigation. Public Health Licensing informed the provider she was not allowed to have contact with any children during the investigation unless another adult was present in the child care home.

The local police interviewed the provider, about the infant's injury. The child care provider gave conflicting statements about how the injury occurred. Later she stated that, she was angry and "may have" thrown or dropped the infant into the pack n play indicating that her actions may or may not have caused the injury. The children present in the home at the time of the injury were too young to be interviewed.

The Division of Children and Family Services agency substantiated the physical abuse allegations and the child care provider was placed on the Nebraska Child Abuse Central Registry. Public Health Licensing filed a Notice of Revocation, and her license was revoked.

This child care provider was issued a child care license in 2009 and has a history of concerning events occurring while she was providing child care in her home.

In 2011, a five month old infant stopped breathing and died while in the child care home. The cause of death was listed as "severe blunt force trauma to chest and abdomen" based on information that the baby was incorrectly given CPR by the provider's husband. It is unknown why the baby initially stopped breathing. There was no Hotline intake associated with this death.

In 2015, a one year old toddler stopped breathing about an hour after being dropped him off at the child care home. The provider's husband again performed CPR while waiting for the ambulance. Physicians at the local hospital determined that the child had two hematomas, a subarachnoid hemorrhage, and a swollen mark on his face. Doctors at a regional hospital found a retinal hemorrhage, and reported that the toddler had suffered at least three seizures. A doctor who specializes in child abuse, believed that there had been at least two separate incidences of abusive head trauma.

The Child Abuse and Neglect Hotline (Hotline) accepted an intake alleging physical abuse of the toddler while in the child care home. The allegations of physical abuse were substantiated by the Division of Children and Family Services without the identification a perpetrator.

The Public Health Licensing Unit completed a complaint investigation regarding the serious injury in conjunction with an annual inspection of the child care home. The child care provider was cited for being in violation of the requirement to notify Public Health Licensing of an incident and allowing her husband to perform CPR on the child when he was not certified.

During the 2017 serious injury investigation, a doctor certified in child abuse pediatrician, reviewed the autopsy of the 2011 death that occurred in the provider's home. The doctor expressed disagreement with the original pathologist's assessment that CPR given to the infant prior to death caused the fatal injuries. The doctor believed that CPR (incorrectly performed or not) could not have caused the injuries.

The local police sent information regarding the serious injury and the two prior deaths to the local county attorney; those documents were forwarded to the Nebraska Attorney General for review. As of the date of this report, there has been no legal actions taken against the child care provider.

Investigative Findings and OIG Recommendations

The OIG made no recommendations to DHHS as a result of the investigations into these cases. The OIG has taken note of any themes and issues, and they will be tracked in order to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

REQUIRED LEGISLATIVE REPORTS

FY 20-21 Report on Alternative Response Case Reviews

Alternative Response (AR) was implemented by DHHS to change the way the system responds to some child welfare and neglect intakes. The OIG is tasked with reviewing and investigating intakes related to AR. The OIG must report on any AR cases it reviews in its Annual Report.

The OIG did not receive any incident reports, complaints, or reports of information related to AR during FY 20-21.

FY 19-20 Report Summary on Juvenile Room Confinement

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 then report quarterly on their use of room confinement to the Nebraska Legislature. As directed by Nebraska statute, the OIG is charged with preparing an annual report on the use of juvenile room confinement.¹¹

For the fiscal year 2019-2020, the OIG received room confinement reports from 22 individual facilities comprised of five different types of juvenile facilities in Nebraska—correctional institutions, youth rehabilitation and treatment centers, detention centers, mental health and substance abuse treatment centers, and residential child-caring agencies.

It should be noted that due to the COVID-19 pandemic, the OIG expected to see facilities reporting periods of juvenile room confinement in the fourth quarter of the fiscal year due to medical quarantine. Four facility reports included incidents due to medical quarantine. The remaining facility reports did not indicate incidents of juvenile room confinement due to medical quarantine in the early days of the pandemic. As a result, the OIG cannot determine if some facilities did not report any incidents of medical quarantine during the pandemic because there truly was no need for a medical quarantine during that time or if the absence of medical quarantine was the result of the facility's own sickbed policies and the facility's interpretation of the law as not requiring such reporting.

¹¹ Neb. Rev. Stat. §83-4,134.01.

There are currently at least 16 different definitions of confinement in the Nebraska Administrative Code that would fall under “juvenile room confinement,” or would be inclusive of juvenile room confinement practices. This is in addition to other language in facility and agency policies that may result in the practice of juvenile room confinement.

Nebraska has adopted juvenile room confinement definitions as well as documentation and reporting requirements designed to “provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility.” It is important to note that room confinement is not prohibited by Nebraska law. Rather, as a means of monitoring its practice and use, the law requires the documentation and reporting of each time juvenile room confinement is used for a period of one hour or more.

Nebraska facilities that report the use of juvenile room confinement have made an effort to reduce the number of occurrences within their facilities and decrease the duration of incidents. While this shows some progress, the OIG has found that some facilities continued to rely on it, and there has been limited success by some of these facilities in the coordinated implementation of recommended best practices. The OIG also noted that in very limited cases, some facilities have focused on producing favorable data more so than facilitating the necessary culture shift by, for example, making adjustments to wording in facility policy or procedure documents to reflect a shift away from the use of juvenile room confinement, when in reality there has been only a slight modification to the actual practice within the facility.

Best practices, derived from established national standards, strive to minimize the use of juvenile room confinement and the potential consequences that include:

- Increased risk of self-harm and suicidal ideation;
- Greater anxiety, depression, sleep disturbances, paranoia, and aggression;
- Exacerbation of the on-set of pre-existing mental illness and trauma symptoms; and,
- Increased risk of cardiovascular related health problems.¹²

Best practices dictate that the use of youth room confinement should be:

- Used as a last resort;
- Time-limited;

¹² Haney, C. (2001). The Psychological Impact of Incarceration on Post-prison Adjustment. In *Prison to Home: The Effect of Incarceration and Reentry on Children, Families, and Communities*. Retrieved from <http://aspe.hhs.gov/basic-report/psychological-impact-incarceration> on October 24, 2018.

- Closely Monitored;
- Youth should have access to their own belongings; and,
- Confinement or isolation should not be used when a youth is potentially suicidal.

In general, successful efforts to reduce room confinement focus on changing facility culture by way of staff training and education initiatives, as well as changes in facility approaches to behavior management. Nationally there are examples of facilities implementing positive behavioral management techniques and therapeutic models to replace older models that were ineffective or that heavily relied on room confinement.¹³ A number of reports and case studies have also highlighted the benefit of outside technical assistance to help facilities reduce the use of room confinement.¹⁴

Those facilities that have successfully reduced room confinement have had to implement significant and ongoing changes to facility culture, policy, and practice to find new and different ways to respond to youth behavior and safety concerns.

Even with decades of research, national standards, organizational best practices, and legislative action, the task of implementation and changing facility culture falls to the individual facilities. Doing so requires commitment to the process, which can be complex and multifaceted, with a clearly articulated plan. The process can be time-consuming, staff-intensive, and bring to surface uncomfortable situations and difficult decisions. However, in light of the risks and ill effects to youth, staff and facility safety in general, the required commitment, resources and time are worth the investment.

The role of juvenile room confinement and associated best practices within Nebraska facilities is continuing to develop.

Findings

As a result of the inquiry and data analysis undertaken for the 2019-2020 Juvenile Room Confinement in Nebraska Annual Report, the OIG found the following:

¹³ Delaney, K. R. (2006). Evidence Base for Practice: Reduction of Restraint and Seclusion Use during Child and Adolescent Psychiatric Inpatient Treatment. *Worldviews on Evidence-Based Nursing* 3(1).19–30.

¹⁴ Council of Juvenile Correctional Administrators. “Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation [Toolkit].” and, LeBel, et. al. (2012).

1. Juvenile room confinement data submitted to the OIG cannot be used to conclusively monitor the actual use of the practice in Nebraska facilities due to subjectivity, non-standardized information, lack of independent verification of data, and reporting format discrepancies.

The OIG can only report on the data it receives from facilities which is limited by differing interpretations of the definition of room confinement, differing interpretations of the reporting requirements, and different reporting methods. As a result, the data does not provide conclusive evidence of how juvenile room confinement is utilized in individual facilities, or if facilities are in alignment with legislative intent. Noted improvements or deterioration in statistical measures may not indicate an actual change in confinement and caution should be used when comparing room confinement data among facilities and from year to year.

2. There is no clear administrative enforcement mechanism for either the reporting requirements or the new juvenile room confinement standards set forth in Legislative Bill 230.

While the intent of the law is clear, what is not clear is how compliance with the new mandate will be enforced. The OIG gathers and reports data that is generally more quantitative, relying on the discretion of the facility to provide contextual information on room confinement to help the Legislature monitor its use. But there is no oversight agency responsible for the qualitative monitoring of juvenile room confinement practices within these facilities' or compliance with the room confinement standards, and no agency is currently authorized to enforce these standards or implement any disciplinary or corrective action for any violations or non-compliance.

OIG Recommendations

In conjunction with the 2019-2020 findings, the recommendations made in 2019-2020 for the reduction on reliance of juvenile room confinement are the following:

- *Examine oversight and enforcement mechanisms for juvenile room confinement reporting.*
- *Examine juvenile room confinement enforcement mechanisms for provisions within Legislative Bill 230.*
- *Require facilities to create formal facility juvenile room confinement reduction plans to be submitted to the Legislature and monitored through the Jail Standards Board, Public Health, Office of Juvenile Services, Department of Corrections, and the OI*

OIG RECOMMENDATIONS UPDATE

Reports of investigation issued by the OIG contain 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 following table contains a summary of all recommendations made by the OIG in its investigative reports ordered from Incomplete to Complete and grouped by agency involvement. 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 noted to be either accepted or rejected by the agency¹⁵, based on an official response to the investigation.

- **Accepted:** The agency accepted the recommendations as part of the original investigation.
- **Rejected:** The agency rejected the recommendation as part of the original investigation.

Based on information provided by the subject agency the OIG then assigns an implementation status. The definitions of each status are:

- **Incomplete:** The agency has not taken relevant action to address the recommendation.
- **No Further Action:** The agency has taken some relevant action to address the recommendation, but has no plans to take additional necessary action to 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.

The OIG monitors shifts to established policy/procedure as well as changes in implementation status of previously completed recommendations. Recommendations with revised status will be noted.

¹⁵ In cases where the subject agency requested modification to the recommendation and the OIG agreed, the recommendation is categorized as accepted. When the requested modification was denied by the OIG, the recommendation is categorized as rejected.

OIG Recommendations – Status Incomplete

ADMINISTRATIVE OFFICE OF PROBATION

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-24	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Incomplete
<p>Recommendation: Adopt policy on documentation and record keeping.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						
16-25	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Incomplete
<p>Recommendation: Increase internal quality assurance efforts at the state level.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						
17-02	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-03	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Implement guidelines on when it is appropriate to use specific types of alternatives to detention.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						
17-04	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						
17-05	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-07	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						
17-08	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
<p>Recommendation: Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.</p> <p>FY Update: No update provided. Probation Administrator Deb Minardi invited the OIG to review numerous published reports available on their website.</p>						

DHHS DIVISION OF PUBLIC HEALTH (LICENSING)

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-16	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Rejected	Incomplete
<p>Recommendation: Ensure adequate staffing for residential-child caring agency licensing operations.</p>						
<p>FY Update: No relevant action taken to address the recommendation.</p>						

OIG Recommendations – Status: No Further Action

DHHS DIVISION OF CHILDREN & FAMILY SERVICES

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-01	2014-2015	Child Death I	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Adopt federally mandated mental & behavioral health policies.</p> <p>FY Update: In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017. DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.</p>						
15-07	2014-2015	Child Death III	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.</p> <p>FY Update: In the fall of 2015, the League of Municipalities distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. No training for other frequent reporters – schools, medical professionals, etc. has been produced or made easily available.</p>						
16-04	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Further define process for utilizing child advocacy centers by Initial Assessment.</p> <p>FY Update: After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers, DHHS decided not to update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. DHHS indicated they did not believe the burden for referral should be on DHHS staff alone. DHHS issued a revised memo on use of CACs, Protection and Safety Procedure #23-2017, however, none of the OIG’s suggestions were incorporated.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-09	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Take steps toward greater Initial Assessment workforce specialization and experience.</p> <p>FY Update: 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, held internal discussions about additional CFS paygrades, adjustments to team composition such as end-to-end teams and allowing IA partnering caseloads between two workers.</p>						
16-10	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Contract with an independent entity to perform a validation study of Nebraska’s SDM Risk Assessment instrument.</p> <p>FY Update: DHHS contracted with the National Council on Crime and Delinquency to conduct independent case reads on SDM safety and risk assessments. 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>						
16-20	2015-2016	Suicides of State Wards	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible.</p> <p>FY Update: In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017. DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-05	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.</p> <p>FY Update: DHHS has created a new finding, Law Enforcement Refusal, which indicates that law enforcement is choosing to not investigate the allegation. In these cases, DHHS is not investigating the allegations either. This change in Hotline protocol has been implemented statewide. Staff at the Hotline continue to reach out to law enforcement. The Hotline Administrator has met with law enforcement across the state about the importance of communicating these investigatory conclusions with the Hotline.</p>						
18-06	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	No Further Action
<p>Recommendation: Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.</p> <p>FY 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 has implemented a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. All referrals through the FAST program are documented on NFOCUS.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
20-01	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Create a policy or training to address when the alleged perpetrator or involved caregiver(s) of the named child victim has extensive and/or specific knowledge of the Nebraska child welfare system.</p> <p>FY Update: A series of Lunch and Learn sessions were held for CFS supervisors and administrators to discuss cases that involve child welfare savvy individuals. Training centered on the skill level of a worker who should be assigned to such cases, and the use of supervisor consultations for quality oversight. A training session of the Case Staffing Model was conducted which focused on the supervisor's role in facilitating case staffing. A Standard Work Instruction was developed for Hotline reports involving DHHS employees. However, the training has not involved workers or specific actions a caseworker might take in these situations. Training and policy should be provided at the worker level, and should address child welfare savvy individuals who are not current DHHS employees.</p>						

20-04	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Rejected	No Further Action
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Recommendation: Change DHHS policy to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case no less than 60 days after opening.

FY Update: DHHS created a Standard Work Instruction, "Mandatory Consultation Points" which clarifies that a consultation point is required when there continues to be an active safety threat in a non-court case, no less than 60 days after opening. Workers are required to document their consultation regarding any staffing with the County Attorney regarding a non-court case with an active safety threat which has been open less than 60 days. A new Quality Assurance Review was implemented in July 2020 to determine adherence to this policy change. The review looks at active non-court cases with a duration of >60 days and an identified safety threat. This new review will be conducted bi-annually. At least 100 cases will be selected for review each review period. A report with review results and recommendations will be posted on the internally and shared with Administrators, supervisors and staff, within the month following the completion of the reviews. DHHS has indicated there are no plans to further address this recommendation. The OIG does not agree that when applied to non-court cases, consultations should only occur when there is an active safety threat.

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-01	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	No Further Action
<p>Recommendation: Enhance policy and tools specific to the examination of secondary caregivers in an investigation.</p> <p>FY Update: DHHS created a Standard Work Instruction for Initial Assessment which directs workers to include information from the secondary caregiver, if a secondary caregiver is identified, in the Risk Assessment narrative. The Standard Work Instruction also added language regarding the non-custodial parent when there are no allegations. Additionally, a micro-training was developed to help workers be able to correctly identify households along with primary and secondary caregivers. These efforts did not include enhancing policy and tools specific to the examination of secondary caregivers during an investigation. Substantive policy and tools that assist workers in the assessment of secondary caregivers has not yet been added to the investigative process.</p>						

OIG Recommendations – Status: Progress

ADMINISTRATIVE OFFICE OF PROBATION

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-22	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Progress
<p>Recommendation: Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).</p> <p>FY Update: 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.</p>						
17-06	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Progress

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

FY Update: Probation has created this form. It is unknown whether the form has been approved and implemented.

DHHS DIVISION OF BEHAVIORAL HEALTH (DHHS YOUTH FACILITIES/OJS)

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-07	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
<p>Recommendation: Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.</p> <p>FY Update: As part of the YRTC 5 Year Strategic Plan licensing options are being considered.</p>						
21-08	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
<p>Recommendation: Implement a fully digital case management system.</p> <p>FY Update: DHHS currently utilizes the Avatar system for digital case management. The system also allows for a structured data sets and analytics that are used for reporting and to improve operations. Avatar is now used across all DHHS residential facilities. Modifications and enhancements for added value are under review.</p>						
21-09	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
<p>Recommendation: Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.</p> <p>FY Update: Human Resources and the YRTCs are currently engaged in discussions of the entry level roles and their descriptors. DHHS, through its consultative relationship with MYSI (Missouri Youth Services Institute), is reviewing the roles and responsibilities of positions within the care continuum.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-10	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
<p>Recommendation: Implement evidenced-based programming consistently throughout the YRTC system.</p> <p>FY Update: DHHS states that this is already in place through the use of Cognitive Behavioral Therapies, Rational Emotive Therapy, and Motivational Interviewing, to early adoption of trauma informed care in 2014, to the more recent implementation of the MYSI model of care. Additional clinical supervision roles have been added to the care continuum to allow for more direct clinical participation and oversight of the youth care process.</p>						
21-11	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
<p>Recommendation: Implement a Trauma-Responsive environment across the YRTC system.</p> <p>FY Update: DHHS states that implementing the trauma informed care system training and utilization began in 2014 and is now a standard component of the care that is provided to youth in the YRTC system. The staff are trained and receive refreshed training on how to maintain a trauma responsive environment of care. In addition, in December of 2019 the YRTCs began including an additional resource called Trauma Affect Regulations: Guide for Education and Therapy (TARGET). During the past fiscal year all LMHP staff were given additional trauma training.</p>						

DHHS DIVISION OF CHILDREN & FAMILIES SERVICES

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-08	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Progress
<p>Recommendation: Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.</p> <p>FY Update: The Initial Assessment workforce has averaged at a rate of about 84% compliance with caseload standards for FY 20-21. DHHS is addressing the lack of compliance with the law by focusing on filling open positions. There are weekly meetings between CFS leadership and HR to discuss vacancies, applicants, offer letters, as well as, recruitment efforts to fill all vacancies. Once a position is filled the New Worker Training has been shortened to allow for IA workers to start in the field after six weeks of training and ongoing workers to start after nine weeks; the remaining training modules are completed within three months of the initial training phase.</p>						
18-10	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Progress
<p>Recommendation: Meet the statutorily required caseload standard for initial assessment and ongoing case management.</p> <p>FY Update: DHHS reports indicate that during FY 20-21, the average of caseload conformity for Initial Assessment and Ongoing was 71%. While DHHS continues to be out of compliance with statutorily required caseload standards, the agency has implemented efforts to fill current vacancies (see Recommendation 16-08 above). Once all available positions have been filled, a business plan proposal will be submitted to the Department of Administrative Services that would allow for the over filling of positions thus addressing the potential turnover of field workers.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-02	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Progress
<p>Recommendation: Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregiver substance use is affecting the safety of the child.</p> <p>FY Update: DHHS has requested drug testing information from other states and is conducting a cross walk of that information to better assess practices across the country. DHHS Central Office staff have met with staff from the Division of Behavioral Health to elicit guidance and expertise regarding the use of drug testing. CFS also purchased Drug ID posters and 2020 Street Drug ID Desk Reference Guides for every CFS Lead Worker, Supervisor and Administrator.</p>						

OIG Recommendations – Status: Completed

ADMINISTRATIVE OFFICE OF PROBATION

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-09	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Complete
<p>Recommendation: Assess whether Probation has the authority to monitor alternatives to detention.</p> <p>FY Update: Probation implemented a Predisposition Supervision Policy in September 2017 clarifying the circumstances under which predisposition, court-ordered supervision may occur.</p>						
17-01	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Complete
<p>Recommendation: Adopt statewide policy or protocol on what a probation officer’s role is between assigning an alternative to detention and a court hearing.</p> <p>FY Update: Probation approved a Predisposition Supervision Policy in September 2017. The policy sets forth the circumstances under which predisposition, court-ordered probation supervision may occur.</p>						
16-23	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Complete
<p>Recommendation: Adopt policy on child welfare referrals and joint case management.</p> <p>FY Update: Probation released a policy regarding this subject. Probation has been training probation officers and DHHS caseworkers across the state with DHHS on the new joint case management policy.</p>						

DHHS DIVISION OF BEHAVIORAL HEALTH (DHHS YOUTH FACILITIES/OJS)

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-06	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Complete
<p>Recommendation: Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.</p> <p>FY Update: The Office of Juvenile Services (OJS) provides supervision to all of the 24/7 youth facilities: Whitehall, YRTC-Kearney, YRTC-Geneva, the Lincoln youth facility and the Hastings youth facility. Whitehall is licensed as a Psychiatric Residential Treatment Facility (PRTF) and falls under the Behavioral Health (BH) division. The Youth Rehabilitation and Treatment Center facilities, plus the Lincoln and Hastings facilities, fall under the Children and Family Services (CFS) division. In order to provide programming structure, staffing support and operational consistency, the Chief Operating Officer (COO) provides direct supervision to the OJS administrator. The COO works in collaboration with the Director of Children and Family Services and the Director of Behavioral Health. An updated organizational chart, including the OJS administrator position, is currently available on the DHHS website.</p>						
16-33	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Digitalize Records at YRTC-Kearney.</p> <p>FY Update: In January 2017, the YRTCs began loading information on incident reports into an online portal, Salesforce. The system is now fully operational and allows facilities to review records of individual incidents as well as track specific incidents, including escapes, use of force, restraints, and seclusion.</p>						
16-32	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney.</p> <p>FY Update: 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.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-31	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Develop Continuous Quality Improvement Process at YRTC's Led by Central Office.</p> <p>FY Update: 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.</p>						
16-30	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5</p> <p>FY Update: 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 reported that youth have not stayed in Dickson for longer than three to four weeks. These changes have not been codified in policy.</p>						
16-29	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Rejected	Complete
<p>Recommendation: Make the OJS Administrator a Full-time Position.</p> <p>FY Update: An active full time OJS Administrator is reflected on the Division of Behavioral Health's organization chart. The position is a direct report to DHHS Facilities Chief Operating Officer.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-13	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva.</p> <p>FY Update: In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics. YRTC-Geneva made changes to OM 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>						
15-12	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Provide increased guidance for culture change at YRTC-Geneva.</p> <p>FY Update: In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs. Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists.</p>						
15-11	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.</p> <p>FY Update: In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs. In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place. OJS is currently planning for the next round of PREA audits. Both YRTCs underwent a PREA Audit in the fall of 2018. The final PREA Audit reports were released on November 18, 2018 which found compliance with PREA standards at each facility.</p>						
15-10	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
<p>Recommendation: Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.</p> <p>FY Update: On July 1, 2017, DHHS's "Secure Transportation" service definition for transport to and from YRTCs became effective.</p>						

DHHS DIVISION OF CHILDREN & FAMILY SERVICES

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-04	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Complete
<p>Recommendation: Conduct a work study of Child Protective Services (CPS) Supervisors.</p> <p>FY Update: DHHS Administration held individual town hall style meetings within each service area which included receiving feedback from supervisors, and continues to assess the current supervisor culture with quarterly and bi-monthly meetings. CFS is also working on training and leadership development for supervisors.</p>						
21-03	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Complete
<p>Recommendation: Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.</p> <p>FY Update: Protection and Safety now has a landing page with a collection of community resource links from across the state. The public page is organized by subject and service area. An email was sent to staff about the landing page and where community referrals should be documented in NFOCUS. Workers can access information about the page in an Initial Assessment Narrative Guide in the CFSS Standard Work Instruction Resource Library. DHHS indicated that workers are having conversations with parents about the information source and how to utilize it.</p>						
20-05	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	Complete
<p>Recommendation: Develop specific non-court evaluation criteria to help caseworkers and supervisors determine when a non-court case should be referred to the multi-disciplinary (1184) team and/or county attorney for review, and require formal training for supervisors to ensure they can assist caseworkers in making referral decisions.</p> <p>FY Update: DHHS created a Standard Work Instruction "Ongoing Case Management" which includes direction regarding the case management of non-court cases. It states the worker and their supervisor will collaborate to determine if a referral for the LB 1184 for review and/or a referral to the County Attorney's office is necessary. DHHS created a Standard Work Instruction, "1184 Team Meetings" to provide guidance to staff regarding when, how and what types of cases are to be referred for 1184 team review. It also includes a flowchart to follow regarding referrals and a template to be used when making a referral and attending 1184 team meetings.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
20-03	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	Complete
<p>Recommendation: Create a handout/brochure to be provided to the family at the time the non-court case is offered.</p> <p>FY Update: A brochure has been created for families who are participating in a non-court case and is waiting on final draft approval and printing. The brochure will be stored within CFS offices for CFS staff to disseminate to the families who are involved in a non-court case. The brochures were printed and provided to CFS offices in September 2020. Local offices will be responsible for printing additional copies as needed.</p>						
20-02	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Rejected	Complete
<p>Recommendation: Create non-court case policy establishing that participating in a non-court Case requires the following: Parents sign a release of information for all related medical/mental health providers specific to obtaining collateral information and assessing progress on case plan goals, Parents allow contact between the worker and their children, without caregivers present, and Parents must formally agree to participate in recommended services.</p> <p>FY Update: DHHS rescinded Protection and Safety Procedure #34-2016. DHHS created Standard Work Instruction, "Ongoing Case Management" that includes the case management of "non-court" cases when there is an active safety threat and/or the risk level is determined to be "high" or "very high". Parents/caregivers will be required to sign a Release of Information form for all related medical/mental health providers for the purpose of gathering collateral information and assessing progress on the case plan/foster care prevention plan goals; allow contact between the worker and the child(ren), without the caregivers present, and; must formally agree to participate in the recommended services. Record of this formal agreement will be documented within the Foster Care Prevention Plan.</p>						
19-07	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
<p>Recommendation: Implement trauma informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.</p> <p>FY Update: DHHS engaged in a partnership with the Quality Improvement Center for Workforce Development (QIC-WD) to identify interventions that focus on addressing Secondary Traumatic Stress (STS) among CFSS and supervisors. DHHS has implemented the CFS Strong program which includes curricula to address on-going and acute traumatic events with Resilience Alliance , Peer Support, and Restoring Resiliency Response sessions.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-06	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
<p>Recommendation: Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.</p> <p>FY Update: SDM micro-learning units have been developed by CCFL Trainers while the training is directly provided to workers by supervisors. DHHS reported that Micro-learning units are delivered monthly, however, the monthly units may not always be specific SDM training.</p>						
19-05	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
<p>Recommendation: Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.</p> <p>FY Update: DHHS created Standard Work Instruction, “Mandatory Consultation Points”, in July 2020 which clarifies the required consultation when a parent has voluntarily relinquished their parental rights as well as direction to staff to conduct a mandatory consultation with their supervisor when a CFS case closes due to reunification with the non-custodial parent. DHHS also created Standard Work Instruction “Non-Custodial Parents Identification and Engagement” in July 2020 specifically outlines the required steps to be taken prior to case closure with a non-custodial parent, which includes staffing the closure with the CFS Supervisor.</p>						
19-04	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
<p>Recommendation: Clarify the definition of “change in circumstance” as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.</p> <p>FY Update: DHHS created Standard Work Instruction, “Initial Assessment” that includes language specific to the birth of baby in July 2020. The language states that additional safety assessments are required when there is a change in family conditions including when a new baby is born. The response time is set as a priority 2, unless a more immediate response is required.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-03	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
<p>Recommendation: Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.</p> <p>FY Update: DHHS developed two Quick Tips for system involved Pregnancy and Newborns and sent them to all CFS Specialists, Supervisors, Lead Workers, and Administrators. Assessing Pregnancy and Newborns includes what the worker should do and information that should be shared when they have information that a system involved parent or teen is pregnant. Pregnancy or Newborn Planning provides information on discussion and planning that needs to occur with the family, their safety networks, GAL, CASA, and Tribal Representative when there is a pending or new birth to ensure the safety of the newborn and any children in the home or who there is a plan to reunify. A Standard Work Instruction became effective in August 2020 that provides guidance for workers regarding a contract between DHHS and Nebraska Children's Home Society for Options Education. This service provides parents or parents to be, with information and education about the different permanency options and legal ways to achieve permanency for their child. A family can be referred for this service at any time while they are system involved. Standard Work Instructions were updated to include guidance on Safety Assessments and Safety Plans when a new baby is born.</p>						
19-02	2018-2019	Death of a 14-month-old State Ward	DHHS	CFS	Accepted	Complete
<p>Recommendation: Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.</p> <p>FY Update: DHHS created Standard Work Instruction, "Participating in a Case Staffing with Managed Care Organizations" that addresses the assessment and well-being needs of youth in care in conjunction with placement, services and support needs. DHHS created Standard Work Instruction, "Foster Home Placement Disruption and Foster Home Hold and Review Process" to specify where to document and locate placement disruption plans within NFOCUS.</p>						
19-01	2018-2019	Death of a 14-month-old State Ward	DHHS	CFS	Accepted	Complete
<p>Recommendation: Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.</p> <p>FY Update: DHHS created Standard Work Instruction, "Foster Home Placement Disruption and Foster Home Hold and Review Process", that outlines the process for workers in the field. The new procedure was finalized in August 2020.</p>						
18-15	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	Complete
<p>Recommendation: Include a component on child sexual abuse prevention in foster and adoptive parent training.</p> <p>FY Update: The training that Project Harmony is implementing will also be utilized in foster and adoptive parent training. See 18-11 below for specifics.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-14	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Strengthen foster care licensing to remove inappropriate and unsuitable homes.</p> <p>FY Update: DHHS enhanced the application process for foster parenting to better screen foster homes, and DHHS issued an RFP for home studies in order to improve the process. DHHS made modifications to regulations, which are presently in the promulgation process, to comply with more stringent foster care, adoptive, and guardianship model licensing standards. When currently licensed foster parents apply to renew their license, they will have to be in compliance with the new requirements—complete the updated application, home study, compliance checklist, and the like. Those not in compliance with the new regulations no longer remain as a licensed foster parent.</p>						
18-13	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.</p> <p>FY Update: DHHS has revised contracts with child-placing agencies to better align caregiver and child needs. Specific training for foster parents will be provided based on the specific child’s needs. A request for proposals has been developed for resource families. The family’s voice and choice is being incorporated into these revisions. Caseworkers are utilizing Safety Organized Practice across the state. Many of these strategies are incorporated into Nebraska’s performance improvement plan (PIP).</p>						
18-12	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Review and revise training on child sexual abuse for DHHS staff.</p> <p>FY Update: DHHS has contracted with Project Harmony to implement the training. See 18-11.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-11	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.</p> <p>FY Update: DHHS contracted with Project Harmony to develop the curriculum for developmentally-appropriate education to prevent sexual abuse and exploitation within the child welfare system. A 3-module training was developed:</p> <p>1. Darkness to Light 2. Sexual Health, Behaviors, and Abuse of Children 3. Bringing it Home: Managing Sexual Abuse and Behaviors.</p>						
18-09	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.</p> <p>FY Update: 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 had been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked. FY 19-20: DHHS has rescinded Program Memo #33-2017 and created a Standard Work Instruction, "Monitoring of Law Enforcement Only Intakes by Hotline" effective December 2019.</p>						
18-08	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Adhere to policy on out of home assessments and enhance quality assurance.</p> <p>FY Update: DHHS has created Standard Work Instruction "DHHS Facility Investigations" that details how investigations will be completed for facilities managed by DHHS effective October 2019. DHHS has an Out of Home Assessment policy for facilities that are not managed by DHHS effective November 2017. DHHS also created a Standard Work Instruction, "Facility Assessments-Out of Home Assessment Team" effective August 2020. DHHS plans to implement a QA process for out of home assessments.</p>						
18-07	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.</p> <p>FY Update: 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.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-04	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.</p> <p>FY Update: DHHS contracted with Project Harmony to create three modules related to preventing and educating about the sexual abuse of children.</p>						
18-03	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.</p> <p>FY Update: DHHS reports that the Hotline Administrator reviewed the intake process, and QA staff 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. At the time of completion over 1700 intakes that had been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.</p>						
18-02	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
<p>Recommendation: End the practice of screening law enforcement reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.</p> <p>FY Update: At the time of completion DHHS reported that CFS Central Office Administrators and other staff review every "Does Not Meet Definition" screen. DHHS analyzed reasons why intakes were being re-screened and adopted definitions. The CQI team was performing qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, were following proper practice and policy.</p>						
18-01	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	Complete
<p>Recommendation: Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.</p> <p>FY Update: LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS has created a new Critical Incident Reporting form accordingly. The form will be utilized statewide by September 2019.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-26	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS	Accepted	Complete
<p>Recommendation: Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.</p> <p>FY Update: 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. FY 19-20: DHHS has rescinded Protection and Safety Procedure #1-2018 and created a Standard Work Instruction on "Crossover Youth Practice Model" effective November 12, 2019.</p>						
16-21	2015-2016	Suicides of State Wards	DHHS	CFS	Accepted	Complete
<p>Recommendation: Enhance efforts to reduce caseworker turnover.</p> <p>FY Update: At the time of completion DHHS 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 initiated a supervisor training program to better ensure caseworkers are supported.</p>						
16-16	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Restructure the Children's Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.</p> <p>FY Update: DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017. The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.</p>						
16-15	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.</p> <p>FY Update: DHHS has collected data on high/very-high risk families declining services and has seen a slight increase in the acceptance of services. DHHS has implemented Safety Organizing Practice (SOP), a family engagement model, over the past 6-12 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement. DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017. The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-14	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.</p> <p>FY Update: 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 and updated monthly.</p>						
16-13	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.</p> <p>FY Update: DHHS added a supervisor position to the Hotline and placed 3 CFOM positions at the Hotline to review 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.</p>						
16-12	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts.</p> <p>FY Update: 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>						
16-07	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Expand quality assurance and continuous quality improvement (CQI) at the Hotline.</p> <p>FY Update: At the time of completion quality assurance efforts included DHHS reviewing additional Hotline calls related to physical abuse allegations of children under 7 on a quarterly basis.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-06	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.</p> <p>FY Update: 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>						
16-05	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Update and provide additional detail on response priority definitions.</p> <p>FY Update: 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. FY 19-20: DHHS updated the intake manual in October 2019.</p>						
16-03	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Develop additional training for Initial Assessment staff.</p> <p>FY Update: 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>						
16-02	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Adopt policy on photographing injuries during Initial Assessment.</p> <p>FY Update: In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-01	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
<p>Recommendation: Implement training on the medical aspects of child abuse.</p> <p>FY Update:CCFL consulted with Dr. Bleicher as a medical expert for curricula review in August and September 2017. The following recommendations were made: • Spiral fractures in toddlers and young 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) • Incorporate the article Bruising Characteristics Discriminating Physical – help to distinguish accidental from abusive injuries (revision meeting scheduled for 12.05.17). 02/02/18 This training was created and trained for the first time with the November 2017 training group.</p>						
15-14	2014-2015	General Investigation I	DHHS	CFS	Accepted	Complete
<p>Recommendation: Clarify Hotline policy and procedure when receiving a report of sexual assault.</p> <p>FY Update: The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency.</p>						
15-09	2014-2015	Child Death III	DHHS	CFS	Accepted	Complete
<p>Recommendation: Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.</p> <p>FY Update: DHHS developed 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.</p>						
15-08	2014-2015	Child Death III	DHHS	CFS	Accepted	Complete
<p>Recommendation: Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.</p> <p>FY Update: In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."</p>						
15-06	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
<p>Recommendation: Ensure "Absence of Maltreatment in Foster Care" is as accurate as possible.</p> <p>FY Update: Since May 2016, DHHS has listed the number of maltreatment cases that have been "court pending" between 8 and 12 months in its CQI reports. This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-05	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
<p>Recommendation: Provide stronger supports for kinship and relative foster families.</p> <p>FY Update: Pre-service foster parent online training is offered to relative and kinship placements in order to get more of such placements licensed. As a foster child's needs are identified, the relative and kinship foster placement will receive specialized training accordingly. The Nebraska Foster and Adoptive Parent Association provides specialized training, Kinship Connection, across the state. Nebraska received Kinship Navigator funds available through the Family First Prevention Services Act—U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACYF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska's Kinship Navigator program began October 1, 2019.</p>						
15-04	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
<p>Recommendation: Improve Home Study Process.</p> <p>FY Update: To help ensure quality home studies across the state, DHHS entered into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts began November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.</p>						
15-03	2014-2015	Child Death I	DHHS	CFS	Accepted	Complete
<p>Recommendation: Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications.</p> <p>FY Update: DHHS updated its N-FOCUS system in March 2015 to allow for easy record keeping on medications, health care appointments, and medical conditions. At the time of completion, information entered was reviewed by administration and at Continuous Quality Improvement (CQI) meetings.</p>						
15-02	2014-2015	Child Death I	DHHS	CFS	Accepted	Complete
<p>Recommendation: Expand training on mental and behavioral health.</p> <p>FY Update: DHHS 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>						

DHHS DIVISIONS OF CHILDREN & FAMILY SERVICES AND DEVELOPMENTAL DISABILITIES

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-28	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS & DD	Accepted	Complete
<p>Recommendation: Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system.</p> <p>FY Update: DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTCs for service eligibility.</p>						
16-27	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS & DD	Accepted	Complete
<p>Recommendation: Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.</p> <p>FY Update: At the time of completion both CFS and DD participated 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.</p>						

DHHS DIVISION OF CHILDREN & FAMILY SERVICES AND PRIVATE AGENCY

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-18	2015-2016	Sudden Unexpected Infant Deaths	DHHS & Private Agency	CFS & Nebraska Families Collaborative (PromiseShip)	Accepted	Complete
<p>Recommendation: Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.</p> <p>FY Update: In 2016, DHHS incorporated infant safe sleep into New Worker Training. An “Under Two Packet” with information about safe sleep was created with assistance from the Division of Public Health. This is distributed to all families and caregivers of children under two. In 2016, NFC incorporated Safe 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.</p>						
16-17	2015-2016	Sudden Unexpected Infant Deaths	DHHS & Private Agency	CFS & Nebraska Families Collaborative (PromiseShip)	Accepted	Complete
<p>Recommendation: Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.</p> <p>FY Update: 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. FY 19-20: DHHS has rescinded Protection and Safety Procedure #28-2017 and created a Standard Work Instruction on “Mandatory Monthly Visits with Children, Parents, & Out of Home Care Providers” effective April 23, 2020. NFC updated the monthly Walkthrough Checklist, adding prompts to address children ages 0-5 sleeping location, the condition of the room/bed etc.</p>						

DHHS DIVISION OF CHILDREN & FAMILY SERVICES CONTRACTED PRIVATE AGENCY

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-11	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Owens Educational Services, Inc.	Accepted	Complete
<p>Recommendation: Implement training on suicide warning signs and prevention in youth.</p> <p>FY Update: 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.</p>						
17-10	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Owens Educational Services, Inc.	Accepted	Complete
<p>Recommendation: Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.</p> <p>FY Update: Owens now requires staff to contact & stay in communication with mental health professionals when a release is signed.</p>						

DHHS DIVISION OF PUBLIC HEALTH (LICENSING)

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-05	2020-2021	Infant Death in Licensed Family Child Care Homes March 2016-Septemeber 2018	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Create specific guidelines for how frequently and in what manner sleeping infants should be checked.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021. 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
18-18	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
18-17	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.</p> <p>FY Update: LB 59 was passed into law during the 2019 Legislative Session, which requires that investigatory reports made under the Children’s Residential Facilities and Placing Licensure Act be issued 60 days after the determination is made to conduct the investigation, except that the report may be filed within 90 days if an interim report is filed within 60 days. Children's Services Licensing has an internal policy and procedure in place, a tracking mechanism to support investigative efforts and a licensing action guide.</p>						
17-16	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.</p> <p>FY Update: Public Health has reported sharing information with both CFS and Probation in a more timely way, 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 effectively on investigations.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-15	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
17-14	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Adopt clear requirements on medical record-keeping and documentation in regulations.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
17-13	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
17-12	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Promulgate rules and regulations related to the Children’s Residential Facilities and Placing Licensure Act as soon as possible.</p> <p>FY Update: 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.</p>						
16-19	2015-2016	Sudden Unexpected Infant Deaths	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Revise regulations to require infant safe sleep training before granting a child care license.</p> <p>FY Update: LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted. Regulations regarding the change are being formally promulgated. Public Health worked 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. Proposed child care regulations will include this requirement.</p>						

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-11	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Public Health-Licensing	Accepted	Complete
<p>Recommendation: Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials.</p> <p>FY Update: Current and proposed child care licensing regulations include pediatric abusive head trauma training through the "Safe with You" training series. This training is required in all licensed child care programs.</p>						