Office of

Inspector General of Nebraska Child Welfare

ANNUAL REPORT

2025-2026

September 15, 2026

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

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

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

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

If you are concerned for the safety and well-being of a child, please contact:

Nebraska Child Abuse and Neglect Hotline
1-800-652-1999 or https://neabusehotline-dhhs.ne.gov/

National Suicide Prevention Lifeline
Call 1-800-273-8255

or text **988** to access a trained crisis counselor
Nebraska Family Helpline
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Message from the Inspector General

The Office of Inspector General of Nebraska Child Welfare (OIG-CW) is honored to present its Annual Report for the fiscal year starting on July 1, 2025, and ending June 30, 2026.

This Annual Report marks the OIG-CW's first year in the new Division of Legislative Oversight, created by the Legislature in 2025, which includes the OIG-CW, the Office of Inspector General of the Nebraska Correctional System, and the Legislative Audit Office. The Legislature also created a new special committee, the Legislative Oversight Committee, to oversee the Division's work. This first year has already demonstrated the benefits of having the mix of OIG and Audit expertise in one division. We have also been grateful to have a committee dedicated to legislative oversight and with which our offices can consult about our work.

In terms of the OIG-CW's work, this last fiscal year was dominated by our investigation into the allegations of sexual abuse of youth by staff at the Youth Rehabilitation and Treatment Center at Kearney. The scale of this investigation required the office to focus almost exclusively on the investigation for close to eight months. I would like to commend the Assistant Inspectors General for their serious, careful, and dedicated effort in this investigation, which involved a very difficult subject matter. I would also like to express our appreciation for the participation and coordination with the Deputy Ombudsman for Institutions who provided invaluable input into the report as well.

This year also challenged our capacity in other ways as we saw a significant increase in the number of death and serious injury investigations the OIG-CW is required to do under statute. The number of pending investigations and the YRTC-Kearney investigation has brought into greater relief the limited capacity of our office compared to the oversight work that needs to be done. With the support of the Legislative Oversight Committee, we are exploring changes to our processes to ensure transparency while also making timely findings and recommendations.

We remain committed to the law and to the principles of accountability, transparency, and good government and will continue to strive for the highest standards in our work.

Jennifer A. Carter
Inspector General

Executive Summary

This Annual Report is a summary of the work completed by the OIG-CW in Fiscal Year (FY) 2025-2026, including any updates on the OIG-CW itself, a summary of issues to which the office devoted time and resources, an analysis of data reported to the OIG-CW from the child welfare and juvenile justice systems related to deaths and serious injuries and sexual abuse allegations, and a summary of the investigations and reports completed by the OIG-CW this fiscal year. For the OIG-CW, this first year in the Division of Legislative Oversight has created meaningful opportunities to collaborate with the Legislative Audit Office and Legislative Oversight Committee. It also produced a significant new working relationship with the Administrative Office of the Courts and Probation, Juvenile Probation Services Division (Juvenile Probation). The OIG-CW has been receiving statutorily required notifications of deaths, serious injuries, and sexual abuse allegations from Juvenile Probation since October 2025 and has included that data in this report.

A significant portion of the OIG-CW's work this year was focused on the Youth Rehabilitation and Treatment Centers (YRTCs). First, the majority of the OIG-CW's resources were directed to an investigation into the allegations of sexual abuse of youth by staff at YRTC-Kearney. That investigation involved 44 allegations made by 37 separate youth against 19 different YRTC-Kearney staff members. After an extensive investigation, the OIG-CW found, among other things, that the culture at YRTC-Kearney normalized inappropriate staff behavior, which the facility failed to sufficiently address, and that although internal compliance investigations at the YRTCs are necessary, they are not sufficient to determine if abuse or neglect of youth has occurred at the YRTCs. The OIG-CW made several recommendations, most importantly, that DHHS should resume conducting abuse and neglect investigations at the YRTCs. The report's findings and recommendations are summarized in this annual report.

Second, the OIG-CW monitored a proposal by the Department of Health and Human Services (DHHS), including proposed legislation, to move two of the YRTCs—specifically moving the male youth at YRTC-Kearney to a correctional facility in Omaha and the female youth at YRTC-Hastings to the YRTC in Kearney. The OIG-CW is continuing to monitor the legislative interim studies to examine these proposed moves.

At the core of the OIG-CW's oversight of the child welfare and juvenile justice systems is the investigations of deaths and serious injuries in those systems. This last year, there was a 63%

decrease in the number of deaths and a 41% decrease in the number of serious injuries reported by DHHS. DHHS reported 10 deaths in FY 2025-2026 compared to 27 in FY 2024-2025. Serious injuries reported by DHHS numbered 16 in FY 2025-2026 compared to 27 the prior fiscal year. Given that this is the first year of reporting from Juvenile Probation, the OIG-CW will not be able to compare the numbers reported by Juvenile Probation until next year's Annual Report. However, it is important to note that Juvenile Probation reported no deaths and 14 serious injuries for FY 2025-2026. Based on a review of these notices from DHHS and Juvenile Probation, the OIG-CW identified 24 new mandatory investigations it must conduct into the deaths and serious injuries of system-involved children.

The OIG-CW was also able to complete two other investigations, which are summarized in this report. In both investigations the OIG-CW found that there were no violations of law, rules, regulations, or policy by DHHS and made no recommendations. One investigation involved the serious injury of a one-year-old child due to physical neglect after the child ingested the mother's medication. The second involved a complaint that questioned the removal of children from the family's home without first implementing a safety plan, among other concerns with how the case was handled.

The OIG-CW continued its monitoring of allegations of sexual abuse of state wards and saw an increase in the number of allegations from the previous year from 293 allegations to 310. This is likely due in part to the allegations related to YRTC-Kearney. Juvenile Probation also reported 16 allegations of sexual abuse.

The OIG-CW also continued its monitoring of data from the YRTCs, which is included for the first time this year in a separately published YRTC Monitoring Report rather than this Annual Report, as well as its monitoring and reports related to child cares and juvenile room confinement. The OIG-CW also conducted in-depth reviews of two incidents at juvenile detention centers, continued to receive and review complaints and information from the public and other government entities, reviewed and summarized any incidents, complaints, and grievances involving Alternative Response as required by law, and updated the status of all its past recommendations to state agencies.

About the Office of Inspector General of Nebraska Child Welfare

The Office of Inspector General of Nebraska Child Welfare (OIG-CW) was created in 2012 by the Nebraska Legislature following a crisis in the child welfare system caused by a troubled attempt to privatize case management.[1] As part of its inherent power of legislative oversight, the Legislature created the OIG-CW to "[e]stablish a full-time program of investigation and oversight of the Nebraska child welfare and juvenile justice systems and assist in the development of legislation related to such systems."[2]

The OIG-CW's ultimate purpose is to foster good government, create transparency and accountability in these critical systems, and ensure that the child welfare and juvenile justice systems are serving children and families as the Legislature intended. The OIG-CW does this through system monitoring and review, conducting investigations into the deaths and serious injuries of children, and making recommendations for improvement. The OIG-CW's work helps the Legislature assess how these systems are functioning and determine if legislative action is necessary to improve these critical systems.

The OIG-CW provides accountability for and may conduct investigations involving:

- Nebraska's child welfare system which is administered by the Department of Health and Human Services (DHHS), specifically the Division of Children and Family Services (CFS);
- Child cares and other facilities that are licensed to serve children and youth in the child welfare system by DHHS' Division of Public Health, Children's Services Licensing (Children's Services Licensing);
- Nebraska's juvenile probation system which is administered by Juvenile Probation;
- Juvenile detention centers and staff secure detention centers; and
- Juvenile Justice Programs administered by the Commission on Law Enforcement and Criminal Justice (Crime Commission).[3]

[1] See LR 37 (2011) Report: Review, Investigation, and Assessment of Child Welfare Reform at https://nebraskalegislature.gov/reports/health.php.
[2] Neb. Rev. Stat. § 50-1802.
[3] See Neb. Rev. Stat. § 50-1806.

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

1. Misconduct, misfeasance,[4] malfeasance,[5] or violations of the statutes or rules and regulations of DHHS, Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities;[6]

2. Deaths and serious injuries of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation, (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation, or (c) in cases that have had an open investigation for child abuse and neglect in the 12 months prior to the death or serious injury.[7] In all these instances, the OIG-CW is required to investigate unless the injury "occurred by chance."

The OIG-CW also receives and assesses complaints from the public and may open an investigation based on those complaints.[8]

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

OIG-CW investigations are focused on whether laws, regulations, and policies were followed by the state agency, as well as identifying issues and gaps in the laws, policies, and procedures in the child welfare and juvenile justice systems. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions.

In addition to investigations and the production of this Annual Report,[9] the OIG-CW has several other duties. The OIG-CW monitors the YRTCs by reviewing data and information that the YRTCs are required to provide, which is now reviewed and analyzed in the OIG-CW YRTC Monitoring Report; [10] monitors allegations of sexual abuse of state wards, juvenile

[4] Misfeasance is defined in Neb. Rev. Stat. § 50-1804(12) as "the improper performance of some act that a person may lawfully do."
[5] Malfeasance is defined in § 50-1804(10) as "a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty."
[6] See § 50-1806(1)(a).
[7] See § 50-1806.
[8] See Neb. Rev. Stat. § 50-1807.
[9] See Neb. Rev. Stat. § 50-1818.
[10] See Neb. Rev. Stat. § 50-1806(3).

probationers, juveniles in a detention facility, and juveniles in a residential child-caring agency;[11] reviews and monitors complaints and incidents related to Alternative Response cases;[12] reviews critical incidents at child cares and Children's Services Licensing's subsequent reviews and compiles that into a Child Care Monitoring Report; and produces an annual report on Juvenile Room Confinement data reported by juvenile facilities.[13] The Inspector General also serves on a variety of committees, commissions, and work groups.

Structurally, the OIG-CW is part of the Division of Legislative Oversight within the Legislature.[14] The Inspector General is appointed to a five-year term by the Director of the Division of Legislative Oversight with the approval of the Chairs of the Legislative Oversight Committee, the Executive Board, and Health and Human Services Committee of the Legislature. The OIG-CW also has two full-time Assistant Inspectors General and one part-time Executive Intake Assistant who are each critical to maintaining the significant duties of the OIG-CW.

[11] See Neb. Rev. Stat. § 50-1806(2)(b).
[12] See § 50-1818; see also Neb. Rev. Stat. § 28-712.01(5).
[13] See Neb. Rev. Stat. § 83-4,134.01(2)(d).
[14] The OIG-CW was previously housed in the Office of Public Counsel (or Ombudsman's Office), but was moved into the newly created Division of Legislative Oversight in 2025 through LB 298. The Office of Inspector General of Nebraska's Correctional System and the Legislative Audit Office are also within this new Division of Legislative Oversight.

Year in Review

This section provides an update on changes to the OIG-CW and its work and summarizes some issues to which the office devoted time and resources in FY 2025-2026, in addition to its mandatory duties.

One Year of the Division of Legislative Oversight

The OIG-CW has now been in the new Division of Legislative Oversight for over a year, and the transition has gone well. The Division includes the OIG-CW, the Office of Inspector General of the Correctional System (OIG-CS), and the Legislative Audit Office. The purpose and responsibilities of the Audit Office align well with those of the OIGs. These offices have already begun to leverage each other's expertise to improve the work and efficiency of each office.

The new Division is overseen by the new Legislative Oversight Committee. It has been very helpful to have a committee dedicated to the work of legislative oversight. It is important that the OIGs work with the subject matter committees, such as the Health and Human Services and Judiciary Committees, on issues that arise in the child welfare and juvenile justice systems within their jurisdiction. But the OIG-CW has appreciated the ability to consult with the Legislative Oversight Committee about our work generally, such as our annual work plans, and appreciates having this dedicated avenue for keeping the Legislature informed of our work and any challenges the office may be facing.

In addition, the helpful collaboration with the Ombudsman's Office also continues. As provided for in statute, the Division of Legislative Oversight and the Ombudsman's Office can share confidential information or collaborate on investigations in instances of overlapping jurisdiction. This was particularly crucial during the OIG-CW's investigation into the allegations of sexual abuse at YRTC-Kearney.

Working with Juvenile Probation

Another positive result of LB 298 (2025) over the last year has been the productive working relationship the OIG-CW has developed with Juvenile Probation. In LB 298, the Legislature affirmed its commitment to oversight of the juvenile justice system. In September 2025, the Legislature and the Judicial Branch signed an Information Sharing Agreement. In October, the OIG-CW began receiving the statutorily required notifications of deaths, serious injuries, and sexual abuse allegations from Juvenile Probation. A confidential shared site was created

through which those notifications are sent to the OIG-CW and through which the OIG-CW can make requests for information related to incidents and complaints received.

In addition, the OIG-CW and Juvenile Probation leadership have had very helpful and productive quarterly meetings which provide an opportunity to discuss both how the process is working between the offices and also larger systemic issues facing the juvenile justice system.

OIG-CW Resources and Investigative Reports this Year

The OIG-CW spent the majority of this last fiscal year working on its investigation into the allegations of sexual abuse of youth by staff at YRTC-Kearney. The OIG-CW has a very small staff. In addition to the Inspector General, there are two Assistant Inspectors General, and an Executive Intake Assistant who works for the office part-time. Given the critical nature of the allegations at YRTC-Kearney and the sheer volume of information that had to be reviewed and analyzed, it was necessary to dedicate almost all of our resources to that investigation and report to ensure the review and recommendations were timely.

Despite this, the OIG-CW was able to complete two additional investigations, as well as the Juvenile Room Confinement Report, the Child Care Monitoring Report, and the YRTC Monitoring Report.

However, balancing the thoroughness of investigations with their timeliness so that recommendations remain relevant and impactful is a persistent challenge for offices of Inspectors General. As will be noted later in this report, the OIG-CW has a significant number of pending death and serious injury investigations. The OIG-CW is continuing to determine how to prioritize and complete these pending investigations, while also meeting its other duties and monitoring any other systemic issues that arise within the constraints of our current resources.

Proposed Moves of the Youth Rehabilitation and Treatment Centers

This last year, the OIG-CW was also actively monitoring the proposed moves by DHHS of two of the YRTCs. In January, the OIG-CW was made aware of the Nebraska Department of Correctional Services' (NDCS) plan to repurpose the Nebraska Correctional Youth Facility (NCYF). Under this proposal, NDCS would relocate the NCYF population to other NDCS facilities and then lease the NCYF facility to DHHS to use as a YRTC. DHHS would then move the male population from YRTC-Kearney to NCYF in Omaha, the female population at YRTC-Hastings would move to the YRTC-Kearney facility, and male youth being treated at the substance use

disorder and youth who sexually harm programs at the Whitehall Psychiatric Residential Treatment Facility in Lincoln would move to what is now the YRTC-Hastings facility.

To facilitate these moves, LB 1013 (2026) was introduced, which would amend state statute to allow the YRTC-Kearney facility to be used for female youth. No other legislation related to the moves was proposed, as there is no current requirement in statute that the Legislature approve the repurposing of these existing facilities.

Both the OIG-CW and OIG-CS did not take a position on the moves. But together, in February, both OIGs shared a memorandum with several committee members outlining questions the Legislature might want to consider related to the moves in anticipation of hearings on both LB 1013 and DHHS' agency budget before the Appropriations Committee. The agencies provided the Legislature with responses to the concerns raised in the OIGs' memorandum.

The provisions of LB 1013 and the proposed moves were discussed on the floor of the Legislature, but ultimately LB 1013 was not included in any legislation and was not passed. Instead, two interim studies were introduced—one by Senator Fredrickson, LR 380, and one by Senator Hardin, LR 425—to examine the potential moves of the YRTCs.

DHHS has been clear that there will be no moves of the YRTCs or Whitehall until the completion of the interim studies. NDCS, however, has already moved the population from NCYF. The male youth under age 18 have been moved to a unit in the Reception and Treatment Center in Lincoln. The other incarcerated individuals over age 18 were moved to various NDCS facilities.

NDCS has been helpful in providing information to the OIG-CW about the NCYF facility as the OIG-CW gathers information on the potential effects of moving the YRTC-Kearney population to this new facility. The OIG-CW will continue to monitor the interim studies and any additional plans related to the proposed moves.

Detention Center Incident Reviews

The OIG-CW conducts in-depth reviews of incidents and complaints related to juvenile facilities, which include juvenile detention centers. These reviews are not full investigations but may include a review of videos and incident reports, conversations with facility administrators, and conversations with the youth involved. These deeper reviews are part of the OIG-CW's obligation to monitor juvenile facilities and the treatment of youth, and also provide some insight into the challenges facing these facilities.

This year, the OIG-CW received notice of fewer incidents and complaints at juvenile detention centers. Two of those incidents, however, warranted an in-depth review by the OIG-CW: one at the Douglas County Youth Center (DCYC), and one at the Northeast Nebraska Juvenile Services Center (Madison County Detention).

In the DCYC incident, the OIG-CW was notified in late 2025 that a youth had sustained injuries in a targeted attack by two other youth at the facility. The OIG-CW reviewed documentation and video of the incident, which showed the assault occurring in a living unit while the victim was doing schoolwork. As the victim was being punched, kicked, and hit with objects as they lay on the ground, a facility teacher immediately intervened and attempted to protect them until additional staff arrived soon after and restrained the attacking youth. The OIG-CW spoke with the facility administration about the incident and confirmed that the facility was in compliance with minimum staff-to-youth ratios and that procedures were followed. However, it was clear that having additional staff in the living unit where the assault occurred or more closely nearby might have stopped the assault sooner and provided more immediate assistance and protection to the staff present. The OIG-CW found that the staff and administration handled the situation appropriately overall, and commends the front-line staff for their willingness to intervene and respond to this dangerous situation.

For the Madison County incident, the OIG-CW was notified in early 2026 that a facility staff member was alleged to have engaged in inappropriate conversations with a facility youth, showed the youth sexually suggestive pictures of herself on her smartwatch, and gave the youth her personal phone number. The OIG-CW reviewed documentation and spoke with the facility administration about this incident. During the staff member's unrelated personal leave, facility administration learned that she had also previously distributed her social media information to the facility youth, resulting in her termination. The allegations about the sexual conversations and photos were not made until after her termination, and despite conducting interviews and reviewing camera footage, the facility was unable to substantiate them after the fact. The facility notified all of the appropriate parties of the incident, and the OIG-CW determined that the facility administration demonstrated a commitment to robust internal processes and training to prevent these types of incidents in the future.

The OIG-CW appreciates the cooperation of both detention centers in reviewing these incidents.

Committees and Commissions

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

Most notably, the Inspector General participates in the following groups:

- Nebraska Children's Commission (statutory member)
    - Alternative Response Subcommittee (statutory member)
- Child Death Review Team (statutory member)
    - Reviews deaths as part of the Suicide, Sudden Unexplained Infant Death, and Child Abuse and Neglect Subcommittees
- Nebraska Supreme Court Commission on Children and the Courts
- Governor's Commission for the Protection of Children

Deaths and Serious Injuries

The OIG-CW is required by law to investigate deaths and serious injuries of youth who are: (1) placed in out-of-home care or a licensed facility; (2) receiving child welfare services from DHHS or services from Juvenile Probation; or (3) the subject of a child abuse investigation in the 12 months prior to the death or serious injury.[15] A serious injury for these purposes is defined as "an injury or illness caused by suspected abuse, neglect, maltreatment, self-harm, or assault which requires urgent medical treatment."[16]

DHHS, Juvenile Probation, and other agencies are required to notify the OIG-CW of any deaths or serious injuries of system-involved youth. The OIG-CW receives these notices in the form of critical incident reports. The OIG-CW thoroughly reviews each incident to determine if it is within the OIG-CW's jurisdiction and if the law requires the OIG-CW to conduct a full investigation. The OIG-CW refers to these as "mandatory investigations."

It is important to note that not all of the deaths and serious injuries reported to the OIG-CW are the result of abuse and neglect (for example, some may have been inevitable medical deaths), and not all of the children who died or were injured were known to the system. The abuse that caused the death or serious injury may have been the first incident that brought the family to DHHS' attention. Or, despite active involvement from DHHS or Juvenile Probation, the incident may have been an accident or otherwise occurred by chance not because of any abuse, neglect, or any type of wrongdoing. By statute, the OIG-CW is only required to investigate deaths or serious injuries that "did not occur by chance."[17] As a result, not every death or serious injury reported to the OIG-CW will result in a mandatory investigation.

There was a large overall decrease in deaths and a slight overall decrease in serious injuries reported to the OIG-CW in FY 2025-2026 as compared to the previous fiscal year. This decrease was unexpected, given that the OIG-CW also began receiving incident notifications from Juvenile Probation in this last fiscal year, in addition to the DHHS notifications that the OIG-CW had already been receiving. This year, DHHS reported approximately a third as many deaths and half as many serious injuries as it reported in the previous year. Although the cause of these decreases is unclear, the decrease is still a positive trend.

[15] See Neb. Rev. Stat. § 50-1806.
[16] *Id*.
[17] *Id*.

Table 1. ***Reported Deaths & Serious Injuries***

	DHHS Deaths	DHHS Serious Injuries	Juvenile Probation Deaths	Juvenile Probation Serious Injuries	Dually Adjudicated Deaths	Dually Adjudicated Serious Injuries[18]
FY 23-24	21	27	-	-	-	-
FY 24-25	27	27	-	-	-	-
FY 25-26	10	14	0	12	0	2

Deaths and Serious Injuries in the Child Welfare System

In FY 2025-2026, DHHS reported 10 deaths of children and youth to the OIG-CW, a significant decrease compared to the 27 deaths reported in FY 2024-2025, and 21 reported in FY 2023-2024. Of the 10 deaths reported, only one warrants a mandatory investigation by the OIG-CW. Of the remaining nine deaths that do not require a mandatory investigation:

- Five of the deaths involved unsafe sleep.
- Two of the deaths were the result of medical issues.
- One of the deaths was caused by neglect but the child's family was not known to DHHS before the death.
- One of the deaths occurred out of state and the cause of death could not be determined.

The 10 deaths occurred in approximate even distribution across DHHS' five Service Areas. The most notable change was that there were two deaths in the Eastern Service Area (ESA), which consists of Douglas and Sarpy County, compared to 15 in the ESA in the previous year. Two of the 10 deaths occurred out of state. The eight reported in-state deaths occurred in seven different counties.

[18] When a youth is both under the care and custody of the child welfare system (DHHS) and the supervision of the juvenile justice system (Juvenile Probation), the youth is referred to as being "dually adjudicated." As reflected in Table 1, the OIG-CW received notice from both DHHS and Juvenile Probation of two serious injuries involving dually adjudicated youth in FY 2025-2026.

DHHS also reported significantly fewer serious injuries in this last fiscal year than it did in the previous two fiscal years. DHHS reported 16 serious injuries in FY 2025-2026, compared to the 27 serious injuries reported in both FY 2024-2025 and FY 2023-2024. In two of those cases, the youth was dually adjudicated, so the OIG-CW received a notification of the injury from Juvenile Probation as well. Of the 16 serious injuries reported by DHHS this last fiscal year, 14 warrant a mandatory investigation by the OIG-CW. Two of those mandatory investigations involve the dually adjudicated youth. The OIG-CW determined that the other two serious injuries reported by DHHS are not mandatory investigations under Nebraska law because one occurred by chance, and the other was caused by neglect but the child's family was not known to DHHS before the serious injury.

These serious injuries predominantly occurred in the ESA (11 of the 16 total DHHS serious injuries) with nine of the injuries occurred in Douglas County. The 16 serious injuries occurred in five different counties.

Unsafe Sleeping Deaths

In the past two Annual Reports, the OIG-CW noted a concerning trend of an increase in reported deaths of infants attributed to unsafe sleeping conditions. In both FY 2024-2025 and FY 2023-2024, DHHS reported seven unsafe sleeping deaths, and several of each involved alcohol and co-sleeping. DHHS has actively worked to implement policies and practices that address with families the dangers of unsafe sleeping conditions for infants. In this last fiscal year, DHHS reported slightly fewer unsafe sleeping deaths with five such incidents, and only one of which involved alcohol and co-sleeping conditions.

Deaths and Serious Injuries in the Juvenile Probation System

Again, the OIG-CW started receiving incident notifications from Juvenile Probation in October 2025, during the second quarter of the OIG-CW's fiscal year, after an Information Sharing Agreement between the OIG-CW and Juvenile Probation was signed in September 2025. Juvenile Probation reported no deaths to the OIG-CW during the three quarters of the year following the Agreement.

Juvenile Probation did report 14 serious injuries to the OIG-CW in that time. The OIG-CW will not be able to compare these numbers to another reporting period until next year's Annual Report. As mentioned, two of those cases involved a dually adjudicated youth, and DHHS

provided a notice to the OIG-CW as well. Of those 14 serious injuries, 11 warrant a mandatory investigation by the OIG-CW, including the two dually adjudicated youth. The OIG-CW determined that the other three serious injuries reported by Juvenile Probation are not mandatory investigations because they occurred by chance.

In six of the serious injuries, the injured youth was being supervised in Probation District 3J (incidents occurred in Lancaster and Otoe County and at an out-of-state placement). Another six injured youth were being supervised in Probation District 4J (incidents occurred in Douglas and Sarpy County), one youth was being supervised in Probation District 6 (incident in Dodge County), and another was being supervised in Probation District 12 (incident in Scotts Bluff County).

Self-Harm and Attempted Suicide Serious Injuries

The data received by the OIG-CW in FY 2025-2026 also showed an increase in self-harm and attempted suicide serious injuries. This increase in the data reported, however, is likely due to changes in the reporting requirements, and the OIG-CW cannot determine if there was an actual increase in the number of incidents of self-harm or attempted suicides. In 2025, LB 298 added "self-harm" to the definition of a serious injury for purposes of the OIG-CW Act. Accordingly, the OIG-CW now receives and must investigate certain injuries or illnesses caused by self-harm requiring urgent medical treatment.[19] DHHS and Juvenile Probation collectively reported over two dozen incidents of self-harm or attempted suicide to the OIG-CW in this last fiscal year, but only eight of those were qualifying serious injuries under the OIG-CW Act.

Pending Mandatory Investigations

Taken together, the OIG-CW added 24 new mandatory investigations in FY 2025-2026, which is nearly half of the total number of open OIG-CW investigations as of the date of this report. With these additions, the OIG-CW now has 51 pending mandatory death or serious injury investigations, each involving children served by DHHS or Juvenile Probation. Forty-one of those pending mandatory investigations (approximately 80%) have been added since 2024. The OIG-CW's ability to conduct that many investigations remains challenging, given the OIG-CW's staff size and resources, and especially now that the office is receiving increased incident notifications from Juvenile Probation and self-harm related serious injuries. As previously noted, balancing the thoroughness and timeliness of investigations is a constant challenge for

[19] See § 50-1806(11).

Inspector General work. The OIG-CW, with the support of the Legislative Oversight Committee, is looking at changes to some of its processes to ensure that each case can be reviewed to provide the necessary transparency while also ensuring relevant and timely recommendations are made.

As will be highlighted later in the summaries of the OIG-CW's reports of investigation completed in FY 2025-2026, since last year's Annual Report, the OIG-CW completed two mandatory investigations. One of those investigations reviewed the serious injury of a child involved with DHHS. The other investigation involved the allegations of sexual abuse of youth by staff at YRTC-Kearney, which was added and also completed within this last fiscal year.[20] Despite the many different cases included within that investigation, for purposes here, the OIG-CW considered the investigation as a singular mandatory investigation that was completed.

In addition, the OIG-CW determined in the last fiscal year that four other cases involving the serious injuries of four youth previously included as pending mandatory investigations were, based on new information and evidence, no longer mandatory investigations and were thus closed without a full investigation. The OIG-CW also completed one investigation into a complaint that the office received. Table 2 below details the breakdown of the OIG-CW pending mandatory investigations.

[20] Although the OIG-CW's mandatory investigations are traditionally of reported deaths and serious injuries, as is referenced earlier in this report, Neb. Rev. Stat. § 50-1806(1)(a) of the OIG-CW Act also requires the OIG-CW to investigate "[a]llegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of . . . The department by an employee of . . . the department." It is under this mandate that the OIG-CW investigated the 44 youth allegations of sexual abuse against 19 different YRTC-Kearney staff members.

Table 2. ***Pending Mandatory OIG-CW Investigations***

	Pending Before FY 25-26	Added in FY 25-26	Completed or Resolved in FY 25-26	Current Pending Total
Deaths	9	1	0	10
Serious Injuries	23	23	5	41
Allegations of child welfare provider misconduct / law violations, etc.	0	1	1 (of 44 allegations)	0
Total Pending Mandatory Investigations				**51**

Additional details about the deaths and serious injuries reported by DHHS in FY 2025-2026 that the OIG-CW determined require mandatory investigations are provided in Table 3a below.

Table 3a. ***Mandatory OIG-CW Investigations Added in FY 25-26 (DHHS-Reported)***

Report Type	Cause	Age of Child	Reporting Agency
Serious Injury	Neglect	Less than 1 yr.	DHHS-CFS
Serious Injury	Attempted Suicide	18 yrs.	DHHS-CFS
Serious Injury	Self-Harm	15 yrs.	DHHS-CFS
Serious Injury	Attempted Suicide / Self-Harm	15 yrs.	DHHS-CFS
Serious Injury	Attempted Suicide	15 yrs.	DHHS-CFS

Table 3a. *Mandatory OIG-CW Investigations Added in FY 25-26 (DHHS-Reported)*			
Report Type	**Cause**	**Age of Child**	**Reporting Agency**
Serious Injury	Neglect	6 yrs.	DHHS-CFS
Serious Injury	Shooting	14 yrs.	*DHHS-CFS & Juvenile Probation
Serious Injury	Neglect	Less than 1 yr.	DHHS-CFS
Serious Injury	Abuse	1 yr.	DHHS-CFS
Serious Injury	Self-Harm	16 yrs.	DHHS-CFS
Serious Injury	Attempted Suicide	17 yrs.	*DHHS-CFS & Juvenile Probation
Serious Injury	Abuse	1 yr.	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	DHHS-CFS
Serious Injury	Self-Harm	16 yrs.	DHHS-CFS
Death	Abuse	Less than 1 yr.	DHHS-CFS

Additional details about the serious injuries reported by Juvenile Probation in FY 2025-2026 that the OIG-CW determined require mandatory investigations are provided in Table 3b below.

Table 3b. ***Mandatory OIG-CW Investigations Added in FY 25-26 (Juvenile Probation-Reported)***

Report Type	Cause	Age of Child	Reporting Agency
Serious Injury	Stabbing	17 yrs.	Juvenile Probation
Serious Injury	Stabbing	17 yrs.	Juvenile Probation
Serious Injury	Shooting	16 yrs.	Juvenile Probation
Serious Injury	Shooting	14 yrs.	*Juvenile Probation & DHHS-CFS
Serious Injury	Assault	16 yrs.	Juvenile Probation
Serious Injury	Attempted Suicide	17 yrs.	Juvenile Probation
Serious Injury	Shooting	18 yrs.	Juvenile Probation
Serious Injury	Stabbing	17 yrs.	Juvenile Probation
Serious Injury	Attempted Suicide	17 yrs.	*Juvenile Probation & DHHS-CFS
Serious Injury	Assault	16 yrs.	Juvenile Probation

Table 3b. ***Mandatory OIG-CW Investigations Added in FY 25-26 (Juvenile Probation-Reported)***

Report Type	Cause	Age of Child	Reporting Agency
Serious Injury	Shooting	16 yrs.	Juvenile Probation

Sexual Abuse Data Monitoring

The OIG-CW is tasked with monitoring sexual abuse allegations in the child welfare and juvenile justice systems. Nebraska law requires DHHS, Juvenile Probation, juvenile detention facilities, and staff secure facilities to report to the OIG-CW "all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and a juvenile in a residential child caring agency."[21] It is critical to note that the required reports to the OIG-CW are **allegations**—meaning an accusation of sexual abuse has been reported, but an appropriate CFS assessment or law enforcement investigation to determine if the allegations can be substantiated has yet to occur.

DHHS Reporting

In FY 2025-2026, DHHS reported 310 allegations of sexual abuse of state wards. This was an increase from 293 in the previous fiscal year. The 310 allegations of sexual abuse involved 214 individual state wards. The sexual abuse allegations were distributed across DHHS service areas in proportion to the populations in those service areas, except the Central Service Area, which saw an increase in both of the last two years. Most of this year's increase—both overall and in the Central Service Area—can be accounted for by the 44 allegations of sexual abuse at YRTC-Kearney.

Table 4. ***Total Reports of Alleged Sexual Abuse by Fiscal Year & Reporting Agency***

Fiscal Year	Total	Reported by DHHS	Reported by Juvenile Probation
22-23	311	271	40
23-24	247	244	3
24-25	293	293	0
25-26	325	310	15

Table 5. ***Sexual Abuse Allegation Reports by CFS Service Area***

Service Area	Total
Central	70
Eastern	137
Northern	34
Southeast	57
Western	12

Previously, when the OIG-CW had access to DHHS' electronic case management system, NFOCUS, it was able to conduct a high-level review of DHHS' handling of the reported sexual abuse allegations. Unfortunately, that level of review would be more time-consuming and

[21] Neb. Rev. Stat. § 50-1806(2)(b).

labor-intensive for both DHHS and the OIG-CW under the current process, which would require the OIG-CW to request the case file for all 310 allegations. As a result, the OIG-CW is limited to analyzing the numerical data.

The OIG-CW does, however, request information to determine whether the allegation was investigated by either DHHS or law enforcement. When CFS receives a sexual abuse allegation through the Nebraska Child Abuse and Neglect Hotline (Hotline) it can be handled in different ways: (1) it can be screened as requiring no further assessment because the allegations either did not meet the definition of abuse and neglect, or were already assessed as part of an existing case; (2) it can be accepted by CFS to assess the family for safety and risk in conjunction with law enforcement evaluating for criminal wrong doing; and (3) it can be referred to law enforcement without CFS involvement, commonly known as a "law enforcement only" intake.[22]

Of the 310 total sexual abuse allegations reported to the Hotline, 82 of the allegations were accepted for assessment by CFS and 156 allegations were referred to the appropriate law enforcement agency as law enforcement only. The remaining allegations did not meet criteria for acceptance, were screened as being information that was additional to another report, or the same allegations were reported by multiple reporters. This means that approximately 77% of intakes were either investigated by CFS or referred to law enforcement for a possible criminal investigation.

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

Of the 82 allegations investigated by CFS thus far, one was substantiated by a court, two were substantiated by DHHS, and three are awaiting outcomes from court proceedings. This is about

[22] As the OIG-CW currently understands the Law Enforcement Only intake process, the Hotline refers allegations to law enforcement when the information suggests: the involved family or perpetrator resided in another state, but the incident occurred in Nebraska; the alleged victim is currently 19 years of age or older but was a child at the time of the alleged sexual abuse; or the alleged perpetrator is not a family member of the child's household and no longer has access to the child. All intakes alleging child abuse or neglect that are assigned for law enforcement investigation only do not include direct CFS involvement.

the same number of substantiated cases as in FY 2024-2025, in which there were five substantiated cases of sexual abuse at the time of that Annual Report.

DHHS found that 71 of the allegations were unfounded, and four do not have an outcome entered. One allegation was against a minor younger than 12 and was not substantiated.

Table 6. ***Results of Allegations Accepted for CFS Assessment***

Result	FY 23-24	FY 24-25	FY 25-26
Unfounded	66	52	71
Court Substantiated	6	2	1
Agency Substantiated	8	3	2
Court Pending	7	11	3
Other	4	8	1
Outcome Not Entered	3	1	4

The 156 allegations accepted as law enforcement only represented a marked increase in the number of law enforcement referrals—26 more than the previous fiscal year. This was likely due to the influx of intakes received regarding sexual abuse allegations involving youth at YRTC-Kearney.

At the time DHHS reported the data to the OIG-CW, results of only 10 of the law enforcement only intakes were entered into CFS' system—eight were not accepted for investigation, one was court substantiated, and one was entered as court pending. The low number of outcomes entered could be due to the law enforcement investigation not being completed or DHHS not yet entering outcomes of law enforcement investigations into its system.

In addition to the monthly data, DHHS also provided six critical incident reports in relation to certain sexual abuse allegations in FY 2025-2026. The OIG-CW did request case file information for these reported allegations. Of those six, five alleged that sexual abuse occurred in a foster home, and one alleged sexual abuse by staff occurred in a group home setting. The age range of the youth involved in these intakes was as follows: three were between the ages of 13 and 18, one was 4 years old, and two were 12 years old.

Of the six critical incidents, one of the allegation findings is court pending due to an arrest being made and a criminal case working its way through the court system. One allegation is court substantiated, as the perpetrator has been convicted. One investigation found the foster home to be unsuitable. Two investigations found two foster homes were suitable, and one allegation was unfounded.

It should be noted that the YRTCs also send critical incidents when there are sexual abuse allegations that are considered PREA violations. The sexual abuse allegations of youth by staff at YRTC-Kearney are included in the 310 total allegations reported in this section.

Juvenile Probation Reporting

Juvenile Probation began reporting sexual abuse allegations to the OIG-CW in October 2025. These reports are called Juvenile Incident Reports (JIR). The data in this section will not include any allegations that pertain to Juvenile Probation youth placed at YRTC-Kearney, as those have been counted in the total number of allegations reported by DHHS, and are therefore not counted again in the number of sexual abuse allegations reported by Juvenile Probation.

Apart from the YRTC-Kearney allegations, there were 15 JIRs regarding sexual abuse allegations received from Juvenile Probation in FY 2025-2026. Five of these alleged inappropriate behavior by staff at congregate care facilities, two alleged sexual abuse by youth at congregate care facilities, six were alleged to have occurred in the community, one allegedly occurred in the family home, and one was said to have occurred in a foster home.

Three of these allegations were investigated by DHHS and were all unfounded. Two were not investigated by DHHS due to not meeting the definition for acceptance of an intake, and they were also not investigated by law enforcement since no criminal conduct was alleged. Six are being investigated by law enforcement, with charges pending in two of those cases. In three cases, the placement facility terminated the involved staff member for inappropriate boundaries with youth. One incident occurred at a facility outside of Nebraska and was unfounded by the facility.

The table below shows how these incidents reported by Juvenile Probation were spread out across the state.

Table 7. *Sexual Abuse Allegation Reports by Juvenile Probation District*	**FY 25-26**
District 1 - Beatrice Area	1
District 2 - Bellevue/Plattsmouth Area	1
District 3J - Lincoln Area	1
District 4J - Omaha Area	2
District 6 - Fremont Area	1
District 7 - Norfolk Area	2
District 8 - O'Neill Area	1
District 9 - Grand Island/Kearney Area	4
District 11 - North Platte Area	1
District 12 - Gering Area	1

Incidents, Complaints, and Grievances

Intake Process

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

The OIG-CW refers to the information it receives as "intakes." Intakes come in the form of notifications of incidents or reports from agencies, grievances filed with DHHS, including DHHS' response to the individual filing the grievance, and from complaints or reports of information made by members of the public.

After receiving information as described above, the OIG-CW assesses every incident report, complaint, information report, and grievance referred to it. Each intake is subject to a preliminary review, which includes a thorough document review and collateral contacts, if necessary, for complete vetting. Based on the findings of the preliminary review, the OIG-CW then determines if the office has jurisdiction over the intake, whether a full investigation is justified or required by statute, and what additional actions may be appropriate. Although a complaint or incident may not result in an investigation, it can assist the OIG-CW in identifying concerning trends or systemic issues that not only may need to be investigated by the OIG-CW but also brought to the attention of the agencies responsible or to the Legislature for legislative change.

Fiscal Year 2025-2026 Intakes

This last fiscal year, the OIG-CW received a total of 549 intakes, a marked increase from the 445 intakes received in the previous year. This increase appeared to be primarily due to the many incidents that the OIG-CW received regarding the allegations of sexual abuse at YRTC-Kearney, as well as Juvenile Probation resuming its process of notifying the OIG-CW of incidents under the law. The breakdown of information received is presented in the figures below.

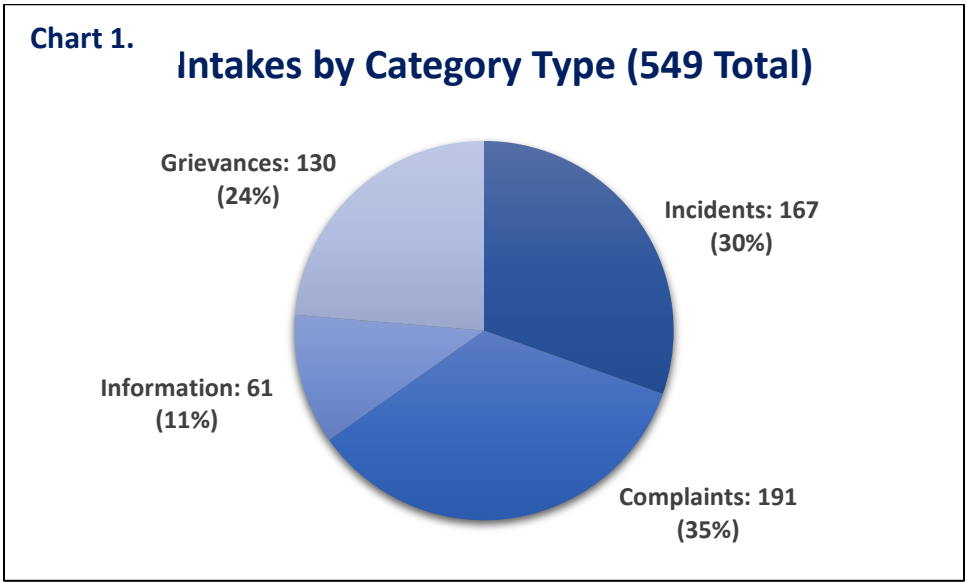
Table 8. *Incidents Reported to the OIG-CW FY 25-26*

Reporting Agency	Number Reported
DHHS-CFS	83
Juvenile Probation	37
DHHS-Children's Services Licensing	24
DHHS-CFS *and* Juvenile Probation	23
OIG-CW Discovered	0
Total	**167**

Table 9. *Other Types of Reports Made to the OIG-CW FY 25-26*

Type of Intake	Number Reported
Complaints	191
Reports of Information	61
DHHS Reported CFS Grievances	130
Total	**382**

Chart 1.



The 167 incidents reported to the OIG-CW in FY 2025-2026 were almost twice as many as the 96 incidents reported to the OIG-CW in the previous year. The number of incidents from DHHS' Division of Public Health, Children's Services Licensing, as well as the CFS incidents where Juvenile Probation is not also involved with the youth, were similar to the previous year.

In addition to incidents, the OIG-CW also saw a slight increase in other types of reports made to the office in FY 2025-2026, with 382 combined complaints, reports of information, and DHHS-reported grievances. In FY 2024-2025, there were 349 such combined reports. In particular, the OIG-CW received 30 more complaints and 33 more grievances, but 30 fewer reports of information than in the previous year.

Incidents

One of the critical ways the OIG-CW receives information throughout the year is through reports from DHHS (including CFS, Children's Services Licensing, and the YRTCs) and Juvenile Probation. As noted above, these come in the form of incident reports typically involving the deaths and serious injuries of children or reports of sexual abuse allegations. But the OIG-CW also receives critical incidents that are not related to these categories. For example, this last fiscal year, the OIG-CW was notified of other YRTC critical incidents, child care incidents, as well as Safe Haven incidents, high-profile incidents, incidents where youth ran away and were missing from care, and more.

Approximately one-third of all incidents reported to the OIG-CW in FY 2025-2026 concerned the allegations of sexual abuse of youth by staff at YRTC-Kearney. These incidents were reported by both DHHS and Juvenile Probation and are included in the total number of incidents that the OIG-CW received from each. Further, both DHHS and Juvenile Probation reported other incidents at the YRTCs, including other sexual abuse allegations not included in the OIG-CW's YRTC-Kearney investigation, and all of those incidents are included in the total number of incidents that the OIG-CW received as well. All YRTC incidents are monitored and, starting this year, will be generally captured in a YRTC Monitoring Report published annually by the OIG-CW.

In addition, Children's Services Licensing provides incident reports related to suspected abuse and neglect of children in licensed child care facilities. In FY 2025-2026, the OIG-CW received 24 incident reports from Children's Services Licensing, which was nearly identical to the 25 reports it received in FY 2024-2025. These incidents are monitored and reported in a Child Care Monitoring Report annually, which the OIG-CW began two fiscal years ago and which will be summarized later in this report.

Complaints

The OIG-CW also receives complaints from a wide variety of individuals, including parents, foster parents, other family members, attorneys, employees, and concerned persons regarding

various aspects and issues of the child welfare and juvenile justice systems. This diverse set of individuals provides the OIG-CW with insights into a wide range of potential issues within the system.

For FY 2025-2026, the OIG-CW received slightly more complaints than it did in FY 2024-2025. The OIG-CW received 191 complaints this fiscal year, compared to 161 the previous year.

Individuals who contact the OIG-CW raise many kinds of concerns. Most often, complainants allege issues with how a case is being managed by DHHS, citing delays in receiving services and maintaining contact with caseworkers and involved parties. Specifically, in FY 2025-2026, the OIG-CW once again received many complaints regarding the actions of DHHS caseworkers, the suitability of a placement that DHHS moved a child to, DHHS' decisions in removing children from their homes, or DHHS not accepting an allegation of abuse or neglect made to the Hotline and, therefore, not investigating. In fact, approximately 80% of all complaints in this last fiscal year were at least partially regarding specific DHHS caseworker conduct. Approximately 60% of all complaints concerned the placement of a child, and approximately 35% of all complaints involved DHHS' Hotline determinations. The next most common types of complaints and grievances that the OIG-CW reviewed last fiscal year involved DHHS case management issues in the ESA, issues with relative and kinship foster homes, issues with CFS' implementation and monitoring of safety plans, and issues with DHHS not arranging or paying for services.

The OIG-CW thoroughly reviews each complaint through interviews with complainants and a review of documentation. The majority of the time, the OIG-CW's review concludes that the complaint demonstrates that the state agency or facility that the complaint is about appropriately responded to a given situation. However, if a complaint, or a series of complaints, demonstrates a systemic issue, the OIG-CW can decide to conduct a deeper review or open an investigation.

In addition, the OIG-CW continued to receive a high number of complaints in FY 2025-2026 regarding issues that the OIG-CW lacks jurisdiction over, especially complaints against various aspects of the judicial system and ongoing court cases. These complaints often involved court orders and proceedings or law enforcement actions, which, again, are outside of the jurisdiction of the OIG-CW. The OIG-CW encouraged these complainants to continue working with their attorneys and proceeding with the judicial process, and, when appropriate, referred the complainants to offices with the authority to review such issues.

Often, a more thorough review of a complaint is not possible. Due to the OIG-CW's lack of access to DHHS' NFOCUS system, the OIG-CW must reveal the names of the children involved in the case that was the subject of the complaint to request information from DHHS. While the OIG-CW maintains the confidentiality of complainants, complainants are sometimes concerned about a perceived risk of retaliation in a child welfare case even if only the child's name is provided to DHHS, thereby alerting the agency that a complaint was made about that particular case. As a result, it is more difficult for the OIG-CW to request information relevant to the complaints and conduct a more complete review.

Working with the Ombudsman

In other cases, the OIG-CW receives complaints about an individual case which do not reveal broader problems with the child welfare system. In these cases, the OIG-CW tries to provide assistance by referring the complainant to a more appropriate entity to handle that concern. Most often, the OIG-CW will refer individual concerns to the Ombudsman's Office. The Ombudsman's Office addresses complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office can investigate and resolve complaints informally by working with the parties involved while promoting accountability in public administration. If, after a preliminary review, the OIG-CW determines that a complaint does not rise to the level of an investigation but that the complainant may benefit from the help of the Ombudsman's Office, or if the complaint is directed against a state government entity outside of the child welfare and juvenile justice systems, the OIG-CW can refer the complaint to the Ombudsman's Office. In total, the OIG-CW referred 47 complaints to the Ombudsman's Office in FY 2025-2026. This is somewhat comparable, but fewer than both the 63 complaints referred to the Ombudsman's Office in the previous year and the 60 referred in FY 2023-2024.

While the Legislature moved the OIG-CW out of the Ombudsman's division and into the Division of Legislative Oversight in 2025, the law still allows for the OIG-CW to refer complaints to the Ombudsman's Office, and both offices still regularly communicate to share information and collaborate when appropriate regarding the complaints and issues presented to each office.

In addition to the Ombudsman's Office, the OIG-CW also occasionally refers complainants to DHHS' Division of Public Health, particularly Children's Services Licensing, as well as to DHHS

generally if the complainant has questions or concerns regarding general or economic government assistance, and other entities.

Complaints Referred to Juvenile Probation

If the OIG-CW receives a complaint about Juvenile Probation, after reviewing the complaint, the OIG-CW may refer the complainant to contact Juvenile Probation directly with their concern. Specifically, the OIG-CW may refer the complainant to contact the Chief Probation Officer of whichever probation district the complaint is about, or by contacting members of the Juvenile Probation administration. This last fiscal year, the OIG-CW received very few complaints about Juvenile Probation, but those that it did receive primarily regarded specific juvenile probation officer conduct. While maintaining the confidentiality of the complainant, the OIG-CW shared the general details about these complaints with Juvenile Probation in its quarterly meetings.

Complaints Referred to the Hotline

In FY 2025-2026, the OIG-CW continued to receive complaints and information regarding current concerns for a child's safety, which need to be provided to the Hotline. In response, the OIG-CW immediately asks the person to contact the Hotline and directs them to the Hotline's phone number and reporting website, and then the OIG-CW, as a statutorily named mandatory reporter, makes a report to the Hotline as well.

In FY 2025-2026, 37, or 11.5% of all complaints and reports of information received by the OIG-CW, were referred to the Hotline. This is a substantial decrease from FY 2024-2025, when 67, or 26.6% of all complaints and reports of information received by the OIG-CW, were referred to the Hotline. The OIG-CW appreciates the continued communication with DHHS this last year about the best process to pass along such information to the Hotline.

Grievances

Neb. Rev. Stat. § 81-603 requires DHHS to provide the OIG-CW with grievances the Department receives and "the determination of any action to be taken by the department." In FY 2025-2026, the OIG-CW received 130 grievances from DHHS, an increase from the 97 in the previous year. The grievance process is open to families who are currently involved with CFS, either in an Initial Assessment or Ongoing Services Case. It is most often used when they may be unable to resolve case issues with their caseworker or supervisor. The grievance is submitted through an online form, and a review is completed by DHHS staff by speaking with the reporting party, the case team, and reviewing case files. DHHS provides the OIG-CW with both the initial grievance

form and its response letter detailing what was found through its review. The OIG-CW reviews these grievances to determine if there are broader systemic issues that become apparent across the grievances that would require a more extensive investigation.

In the overwhelming majority of the grievances reviewed by the OIG-CW in FY 2025-2026, the primary concerns raised by families were, like the previous year, regarding the actions of DHHS caseworkers or the decisions of DHHS and a juvenile court in removing a child from their home, the child's new placement, and various other court matters.

Alternative Response Oversight and Case Summaries

Alternative Response (AR) is an approach used by DHHS and in many other states that allows those working in the child welfare system to engage with families in a less adversarial, more collaborative way and to respond to less severe allegations of child abuse or neglect without a traditional investigation. Instead, AR allows children to stay in their homes and offers families voluntary services and community support to enhance their ability to keep the children safe. AR was intended to improve outcomes for Nebraska families and lower the number of children being removed from their homes and formally entering the child welfare system. To proceed as an AR case, the children must be found to be safe. AR was intended to serve families at a lower risk of future maltreatment.

The use of AR in child welfare cases throughout the state has fluctuated through the years. The number of AR cases has risen significantly since 2020 after AR transitioned from a pilot project to full implementation. In 2025, DHHS reported that AR cases comprised approximately 29% of all child abuse and neglect reports assessed by the Hotline, a slight increase from the 27% in 2024.[23]

By statute, the OIG-CW's Annual Report must include a summary of any case reviewed by the office that includes AR.[24] AR cases reviewed by the OIG-CW typically take the form of either (1) a complaint made directly to the OIG-CW regarding an AR case, (2) an incident report related to the death or serious injury of a system-involved child in an AR case, or (3) a DHHS grievance related to an AR case. In the case of a death or serious injury, the review is twofold: first, a review of the AR case as required by statute, and second, a review to determine if the report meets the criteria for a mandatory investigation by the OIG-CW. The OIG-CW will conduct a full investigation into those deaths and serious injuries determined to be mandatory investigations.

Summary of AR Incidents

Child Death I

The OIG-CW received notice from DHHS that a seven-month-old child passed away at home. The cause of death was not immediately clear, but the responding law enforcement officer

[23] See Nebraska Department of Health and Human Services. *Child Abuse and Neglect Annual Report* 2025. https://dhhs.ne.gov/Pages/CFS-Data-and-Reports.aspx#docaccess-b7b362450bd18cb2b0a1a7e2d35a3d7f (Retrieved September 4, 2026).
[24] See Neb. Rev. Stat. § 50-1818; see also Neb. Rev. Stat. § 28-712.01(5).

observed the home to be extremely unsanitary and unsafe for children. The child's family had been involved in a prior intake accepted as AR a year prior, before the child was born. In that intake, the concerns were with the cleanliness of the home as well as the mother leaving the deceased child's siblings unattended. The child's cause of death was later determined to be Sudden Infant Death Syndrome, with unsafe sleeping conditions as a factor. It was learned that the child had been left unsupervised on a couch cushion near one of the child's young siblings for at least 30 minutes, and then discovered partially face-down on the couch, deceased. The OIG-CW determined that this incident did not meet the criteria for a mandatory investigation under the law.

Child Death II

The OIG-CW received notice from DHHS that a different seven-month-old child passed away in another state due to unknown causes. DHHS and subsequently the OIG-CW had been notified of the death due to the family's prior history with DHHS. The family had been involved in a prior intake accepted as AR four months before the death. In that intake, the concern was that the infant had special needs and issues with feeding, and had lost significant weight in the past week, but the family did not show up to a scheduled medical appointment for the child. Days after that intake, the family moved out of state, so the AR case was closed. As such, the OIG-CW determined that it lacked jurisdiction over the child's death and this incident did not meet the criteria for a mandatory investigation under the law.

Child Serious Injury I

The OIG-CW received notice from DHHS and Juvenile Probation that a 14-year-old child had been seriously injured after being shot. The child was being actively supervised by Juvenile Probation and a part of an open AR case with DHHS at that time. There were two intakes accepted as AR on this child before the serious injury. One was 10 months before the serious injury, and the concern was for educational neglect due to the child's lack of school attendance. The other was a month before the serious injury, and there, the concern was that the child was not following the rules set by Juvenile Probation and that their mother was not enforcing those rules either, allowing for the child to be on the streets without any supervision. The OIG-CW found that this incident was subject to a mandatory investigation and report. The final report will be released after the investigation and report process is completed.

Child Serious Injury II

The OIG-CW received notice from DHHS of a six-month-old child who had been seriously injured after physical abuse from the child's father. The child had been taken to the hospital due to difficulty breathing, and after assessment, it was discovered that the child had bruising all over their body and numerous broken ribs in various stages of healing. After forensic interviews with the child's siblings, it was determined that the child's father had hit and pushed down on the child's torso. The child's family had a previous intake accepted as AR one month before this incident. In that intake, it was reported that one of the child's older siblings had attempted suicide, but the mother would not take them to the hospital. The AR case was closed shortly later, however, after it was determined that the sibling was not suicidal and had not intended to hurt themself, and that the mother's response to the sibling's behaviors was appropriate. The OIG-CW found that the serious injury incident was subject to a mandatory investigation and report. The final report will be released after the investigation and report process is completed.

Child Attempted Suicide

The OIG-CW received notice from DHHS that a 17-year-old child had attempted suicide by overdosing on alcohol and medication. The child apparently had a history of known struggles with mental health and had called the suicide hotline after fearing they had overdosed on medications. The child was hospitalized and given mental health assessments, but otherwise had no injury, and there were no medical concerns. The child's family had a previous intake accepted as AR one month before this incident. In that intake, it was reported that the child's mother had recently provided mind-altering mushrooms to the child. Due to a lack of a qualifying serious injury, the OIG-CW determined that this incident did not meet the criteria for a mandatory investigation under the law.

Child Injury

The OIG-CW received notice from DHHS of a one-year-old child who was found in a ditch by the side of the road. The child was dehydrated, dirty, covered in insect bites and abrasions, but otherwise not seriously injured. The child's family had been involved in two previous intakes accepted as AR before this incident, one involving the child's siblings before the child was born, and one three months before the incident. In both of those intakes, the concerns regarded conditions of the home. In both cases, the concern was not severe enough to warrant a safety issue, and the children were found safe. Both AR cases were closed after the family declined

services. Due to a lack of a qualifying serious injury, the OIG-CW determined that this incident did not meet the criteria for a mandatory investigation under the law.

Summary of AR Complaints and Grievances

Complaint to OIG-CW About Child's Well-Being Should Family Not Cooperate in AR Case

The complainant stated that they were aware of a young child whose special medical needs were not being properly managed by the child's mother, who had significant mental health issues of her own. The complainant stated that they frequently call the Hotline to report that the mother fails to meet the basic medical needs of the child, and that the child's regular school attendance had been an issue with the family for several years, often because of the child not having their necessary medical equipment with them at school. The family was also reportedly homeless. The complainant communicated that the family was actively receiving services from DHHS through an open AR case. The complainant stated that they believed appropriate steps were being taken to address these issues with the family, but was concerned that, due to AR case participation being voluntary, should the child's mother decide to stop cooperating with the AR case, the child would be harmed and not get the help they needed. The complainant wanted the OIG-CW to be aware of this perspective of what they believed to be a systemic issue with AR. The OIG-CW determined that no further action was needed regarding this specific complaint, but added the topics within it to the issues that the OIG-CW continuously monitors and may revisit if necessary and appropriate.

DHHS Grievance About Poor Caseworker Communication in AR Case

The OIG-CW received a grievance from DHHS where an individual was complaining that the DHHS caseworker assigned to their active AR case was not communicating with them and not returning their texts, calls, or emails, and that DHHS had spoken to their children at the children's school without properly notifying them. The individual wanted the AR case to be closed and for the caseworker and her supervisor to be reprimanded. DHHS responded to that grievance stating that the department had attempted to contact the individual numerous times since the AR case had been opened, both by phone and at the individual's residence, but could not reach them. DHHS then provided a phone number and email address for the individual to get in contact with DHHS.

DHHS Grievance About Caseworker Not Following Policy in AR Investigation

The OIG-CW received a grievance from DHHS where an individual was complaining that a DHHS caseworker arrived with law enforcement to their child's school in response to a call received with concerns about the child. The individual was concerned that the caseworker never contacted the child's parents to get permission to speak to the child and never provided paperwork to the family or had the family sign documentation about receiving information about AR, as DHHS policies require. The complainant stated that they had spoken to the caseworker's supervisor with these concerns and that the supervisor said she would go over training with the caseworker to remind them of their obligations in these situations. The complainant stated that they were submitting the grievance to have their concerns documented and to request that DHHS lift the hold it placed on the family's license to be foster parents in response to the AR intake. DHHS responded to the grievance acknowledging that the caseworker had deviated from the expectations related to the AR process by not notifying the parents about talking to the child nor by providing the AR-related paperwork. DHHS confirmed that the caseworker's supervisor met with the caseworker and refreshed them on the AR-related expectations and that the AR case would soon be closed, and that the hold placed on the family's foster license had been lifted.

DHHS Grievance About Caseworker Not Taking Action to Address Child Safety Concern and Changing AR Case to TR

The OIG-CW received a grievance from DHHS in which an individual was complaining that the DHHS caseworker assigned to the family's open AR case knew that the father of the complainant's children had recently physically abused and neglected the children on a couple of occasions in the shared family home, but did not take appropriate steps to keep the children safe. The complainant stated that they called the Hotline and law enforcement about the concerns and requested that, due to these safety concerns with the children's father, DHHS change the AR case to a TR case to better protect the children. DHHS responded by explaining the AR and TR case process and that DHHS screens and investigates every allegation of child abuse and neglect made to the Hotline. DHHS confirmed that the Hotline had been called about the complainant's specific safety concerns, and that DHHS had conducted a safety assessment of the children's home but found the children safe. DHHS noted that the complainant and the caseworker at issue had developed and agreed to a family plan in the AR case to best identify

services and supports to strengthen the family's ability to keep the children safe moving forward.

Investigations, Reports, and Recommendations

Nebraska law requires the OIG-CW to summarize any investigations from the last year in its Annual Report and to provide an update on the status of implementation of any OIG-CW recommendations.

Process of OIG-CW Investigations

A full investigation by the OIG-CW includes:

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

After a full investigation, the OIG-CW issues an investigative report and shares the report with the state agency for review.[25] The state agency may respond by accepting, rejecting, or requesting a modification of the recommendations and the agency may also make any factual corrections if necessary.[26] A private agency that is also the subject of the report similarly has an opportunity to review the report and respond to the recommendations.[27]

Provided below are the summaries of all reports completed by the OIG-CW in FY 2025-2026.

[25] Neb. Rev. Stat. § 50-1815(1).
[26] *Id*.
[27] § 50-1815(2).

Summaries of OIG-CW Investigative Reports

Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney[28]

The OIG-CW was notified of 44 different sexual-abuse-related allegations made by 37 separate youth against 19 different staff members at the Youth Rehabilitation and Treatment Center at Kearney (YRTC-Kearney) occurring between March 2025 and March 2026. The allegations ranged from more severe allegations of staff abuse of youth, including sexual abuse, assault, touching, or harassment, to less severe allegations of staff violations of appropriate and professional boundaries with youth. Within those 44 allegations were over 200 specific claims of a variety of improper conduct by staff. These allegations implicated violations of the Prison Rape Elimination Act (PREA), Nebraska state law, and Nebraska Department of Health and Human Services (DHHS) policies regarding appropriate and professional boundaries between staff and youth.

As of the date of the report, the status of the 44 allegations was:

- Four staff members had been criminally charged with sexual abuse of protected individuals, one of whom was also charged with additional felonies.
- Three other allegations had been substantiated by the Office of Juvenile Services' (OJS) Compliance Department (Compliance) at YRTC-Kearney.
- Nine allegations were unfounded or unsubstantiated by Compliance and the Nebraska State Patrol's (NSP) investigations into those allegations were also closed.
- The remainder of the allegations, which include the majority, had been unsubstantiated or unfounded by Compliance.

Despite the investigation including allegations of staff sexual abuse of youth from March 2025 through March 2026, the OIG-CW did not receive notice of any allegations until August 2025, and it was not until late September and early October 2025 that the OIG-CW and Ombudsman's Office, which investigates complaints of any juvenile committed to the YRTCs, were notified of several other allegations. On October 17, 2025, the OIG-CW notified DHHS that it was opening an investigation into the sexual abuse allegations at YRTC-Kearney. The Ombudsman's Office

[28] Office of Inspector General of Nebraska Child Welfare, *Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney.* July 27, 2026. https://nebraskalegislature.gov/pdf/reports/oig_childwelfare/OIG-CW%20Report,%20YRTC-K%20Sexual%20Abuse%20Investigation%20PUBLIC%20FINAL%20(with%20Appendices%207.28.26).pdf.

participated in the investigation as well, as the law allows for the offices to coordinate on investigations in circumstances of overlapping jurisdiction.

The report includes a detailed summary of four of the most serious allegations involving three separate youth (one youth alleged abuse by two different staff members) and a composite summary discussing and analyzing the other 40 allegations. The report also includes a summary of the legal framework for sexual abuse allegations of youth in a facility; background on the YRTCs' purpose, structure, staff roles, and internal compliance process; and an explanation of abuse and neglect investigations conducted by DHHS.

The most common type of allegation, which arose approximately 50 times, involved allegations that staff made inappropriate statements to youth, including flirtatious comments and sexually suggestive or explicit conversation, shared intimate details of their personal lives, and expressed a desire to have sexual contact or relationships with the youth. The next most common allegation was that staff inappropriately touched youth, most commonly by touching a youth's legs and thighs, but it was also alleged that staff would press their buttocks or breasts against youth in a way that might appear to be inadvertent, but the youth believed to have been deliberate. Many allegations also involved staff giving the youth their personal phone numbers. In at least 15 instances, youth were in possession of the personal phone numbers of staff. No conclusion was ever reached on how the youth obtained the phone numbers. Other specifics of the myriad of allegations are detailed within the report.

As a result of the investigation, the OIG-CW made the following findings:

1. **The culture at YRTC-Kearney normalized inappropriate staff behavior, which the facility failed to sufficiently address.**

2. **Internal compliance investigations are necessary, but they are not sufficient to determine if abuse or neglect has occurred at the YRTCs.**

3. **Without abuse and neglect investigations at the YRTCs, staff who abuse youth may not be placed on the Nebraska Child Abuse and Neglect Central Registry and can continue to work with youth elsewhere.**

4. **There were numerous issues and limitations with Compliance's reviews and investigations into the sexual abuse allegations at YRTC-Kearney.**

5. **The OIG-CW was not notified of the initial incidents in March and April 2025 as a result of Compliance's determination that those incidents were not PREA violations, which placed them outside the required notifications under the law.**

The OIG-CW made the following recommendations as a result of the investigation:

1. **DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made.**

2. **DHHS and YRTC-Kearney should address the culture problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth**.

3. **DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report.**

4. **The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth.**

Serious Injury of Child After Ingesting Parent's Medication in the Home

On November 24, 2020, the OIG-CW received notice from DHHS that a 21-month-old child had received a serious injury on that same date after ingesting a near-fatal dosage of methadone that the child's mother had been prescribed to treat the mother's drug addiction. The child was found unconscious by the parents and hospitalized, but survived. The child had ingested the medication without the parents' knowledge, and the medication had not been properly secured in the home.

The child's family had no active CFS case at the time of the serious injury, but the child's mother had an extensive prior history with DHHS spanning eight years, many Hotline intakes—seven of which were within 12 months of the serious injury—three juvenile court cases, and numerous CFS assessments. This history was almost entirely related to the mother's drug use, specifically methamphetamine use and abuse of opioids and prescription medications. Many of the allegations involving the mother's drug use were not accepted for assessment, could not be verified, or were unfounded. Other allegations were addressed by therapy, treatment, medication, and other community services.

Based on the OIG-CW's review of the information and documentation gathered in the investigation, the OIG-CW found the following:

1. **The OIG-CW found no violations of statute, rules, or regulations, and identified no significant systemic issues in this investigation.**

The OIG-CW's review of DHHS' conduct in its interactions with the family leading up to the child's serious injury, and in the serious injury incident itself, reflected no violations of applicable laws, rules, or regulations, nor revealed any significant systemic issues that DHHS or the Legislature needs to address.

In each of the intakes where the information indicated that the children may have been unsafe due to the mother's drug use, DHHS investigated the allegations, conducted assessments of the home, and made decisions regarding the children's safety, including in some cases removing the children from their parents' custody. After each incident that led to the children's removal and throughout the juvenile court cases that followed, DHHS stayed actively involved with the family and partnered with the community to provide many court-ordered services, most aimed at treating the mother. Throughout that process, DHHS adhered to all governing authorities, remained engaged with the family, provided ongoing assessments and services, and

coordinated with the juvenile court, the county attorney, and community providers to ensure the mother had the opportunity to receive treatment.

Although the mother went through several periods of treatment and relapse, she complied with what the juvenile court and DHHS required of her in each case and achieved reunification with her children. As of the date of the OIG-CW's report, the mother had not had any known relapses with illicit substances, and the family had remained together without CFS intervention for several years.

The OIG-CW did not find that DHHS could have been expected to prevent the child's injury from ingesting their mother's methadone. The mother was lawfully prescribed the medication and authorized to possess it and take it each day in her home. There was no information in DHHS' documentation before the injury suggesting that the medication was not regularly secured.

The OIG-CW's report noted that DHHS has recently adopted updated policies and protocols that strengthen its ability to monitor and address a caregiver's substance use and recovery, including requiring caseworkers to engage in relapse planning with the caregiver's treatment provider. The OIG-CW found that DHHS views caregiver substance use as an issue that needs to be managed clinically through treatment and support, rather than punishment alone. The OIG-CW concluded that DHHS should continue to evaluate whether additional policies are needed to keep Nebraska youth safe from exposure to illicit substances and from family members who have drug addictions or who have potentially dangerous medications to treat drug addictions in the home.

Based on its finding, the OIG-CW made no recommendations as a result of the investigation. The OIG-CW took note of the child welfare themes reflected in the case, which will be tracked to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

Complaint Regarding Out-of-Home Case with DHHS from 2024–2026

The OIG-CW received a complaint regarding DHHS' handling of an out-of-home case. Specifically, the complainant identified concerns regarding whether or not reasonable efforts were provided prior to the removal of the children from the parental home and the conduct of professionals at the time of the removal. Additional concerns surrounded visitation throughout the case, the conduct of mental health professionals, concerns with the Guardian ad Litem (GAL), and centered around the removal and return of the children to the parental home. The complainant felt that the parents were not given enough opportunity to address the abuse in the home before the children were placed in foster care. The identified safety issue in the home was the sexual abuse of the 5-year-old child by their teenaged sibling.

The OIG-CW found the following:

1. **The OIG-CW found that there was no misfeasance, malfeasance, or misconduct in DHHS' handling of the case.**

In this specific case, the parents admitted to knowing about no less than five instances of abuse between the siblings occurring in the home. While the parents felt that they were doing enough to address this issue, it was clear that these attempts had not worked. In addition, these parents were licensed foster parents and were trained to report any instances of abuse to the Hotline. They failed to do so when it came to their own children, believing they could address the concerns themselves. The younger child, however, remained subject to abuse by the older sibling. The DHHS determination that the children were not safe to remain in the home was supported by the evidence. Law enforcement made the decision to remove the children from the home based on the totality of the evidence, and DHHS was required to place the children into care. In addition, all concerns with services provided by DHHS, including visitation, were brought before the court, which ultimately decided what to order DHHS to provide. DHHS followed all of these orders.

2. **There were many issues raised within the complaint that are outside of the OIG-CW's jurisdiction.**

The issues raised within the complaint regarding the GAL, the court, and the mental health professionals are outside of the jurisdiction of the OIG-CW, and the complainant was referred to other entities for these concerns. The complainant additionally was concerned about an

increase in termination of parental rights filings in York County, which does not pertain to this specific case and will be looked at as relevant to the work of the OIG-CW.

The OIG-CW made no recommendations to DHHS as a result of this investigation. The OIG-CW has taken note of any themes and issues present in this complaint, which will be tracked to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

Summaries of OIG-CW Monitoring Reports

Youth Rehabilitation and Treatment Center Monitoring

YRTCs are facilities operated by DHHS' Office of Juvenile Services (OJS)[29] that provide programming and services to rehabilitate and treat youth in Nebraska's juvenile justice system.[30] There are three YRTCs in Nebraska—YRTC-Kearney, which serves male youth; YRTC-Hastings, which serves female youth; and YRTC-Lincoln, which serves both male and female youth.

In 2020, the Legislature enacted a law to provide increased accountability and oversight regarding the YRTCs. Neb. Rev. Stat. § 50-1806(3)(a) requires OJS to report to the OIG-CW as soon as reasonably possible after any of the following incidents occur at a YRTC: an assault; an escape or elopement; an attempted suicide; self-harm by a juvenile; property damage not caused by normal wear and tear; the use of mechanical restraints on a juvenile; a significant medical event suffered by a juvenile; and internally substantiated violations of the Prison Rape Elimination Act (PREA).[31]

Beginning this year, the OIG-CW's detailed reporting and analysis of the annual YRTC data will be published annually as a separate "YRTC Monitoring Report" due to the large volume and complexity of the data, rather than included within this Annual Report. The separate YRTC Monitoring Report for FY 2025-2026 is currently available on the Legislature's website and will continue to be published there in future years.[32] Below, however, is a summary of the data.

The YRTC data reported to the OIG-CW for this last fiscal year reflected a continuation of the trends observed in the previous year. The most prevalent issues remained elevated facility censuses, relatively high rates of assaults, uses of mechanical restraints, and incidents of youth self-harm. Consistent with that previous year, however, almost all data categories reported by the YRTCs in FY 2025-2026 showed either a decrease (including assaults and uses of mechanical restraints) or no significant increase, and most categories saw improvement or no incidents at all. The three exceptions were incidents of youth self-harm, elopements and attempted

[29] OJS is within DHHS' Division of Child and Family Services.
[30] Neb. Rev. Stat. § 83-102(1).
[31] 34 U.S.C. § 30301 et seq.
[32] Office of Inspector General of Nebraska Child Welfare, *Report of Monitoring: Youth Rehabilitation and Treatment Center Data, Fiscal Year 2025-2026.* September 15, 2026. https://nebraskalegislature.gov/pdf/reports/oig_childwelfare/YRTC%20Monitoring%20Report%20FY%2025-26%20(FINAL).pdf.

escapes, and PREA allegations (but not substantiated allegations), which all saw increases compared to the previous year, however slight.

In addition to the data monitoring and analysis, the OIG-CW generally visits each YRTC facility and communicates with the facilities' administration, staff, and committed youth when appropriate. In FY 2025-2026, the OIG-CW only made two visits to YRTC-Kearney for general purposes, which is less than it typically does each year, due to a lack of capacity given the office's focus on the large investigation into the many allegations of sexual abuse at YRTC-Kearney for the majority of the year. Further, the OIG-CW's collaboration with the Ombudsman's Office, particularly the Deputy Ombudsman for Institutions who more frequently visits and communicates with the administration and youth at state facilities like the YRTCs, helps to keep the OIG-CW informed of any updates and current issues regarding the YRTCs and the care of the youth committed there. This last fiscal year, the OIG-CW relied more heavily on the Ombudsman's Office contact with the YRTCs than normal. The OIG-CW plans to resume its visits to the YRTCs this fiscal year.

Child Care Monitoring Report

Beginning with the 2023-2024 fiscal year, the OIG-CW completed a Report of Monitoring regarding critical incidents in licensed child cares that were reported to the OIG-CW by the DHHS Division of Public Licensing, Children's Services Licensing. Statute mandates that the OIG-CW investigate any death or serious injury of a child in a child care facility when the office determines that the death or injury did not occur by chance. The majority of the child care deaths and serious injuries reported to the OIG-CW do not require a full investigation. The OIG-CW, however, still conducts an in-depth review. This report summarizes the OIG-CW's review and monitoring of child injuries and accidental deaths in licensed child cares reported to the OIG-CW during FY 2024-2025 which was completed on October 30, 2025.[33] The report does not include any incidents that warrant further investigation under statute. The report is completed annually.

Throughout FY 2024-2025, Children's Services Licensing reported a total of 23 serious injuries and deaths to the OIG-CW that occurred within licensed child care homes and facilities. The incidents ranged from serious injuries such as broken bones, hematomas, and nursemaid's elbow, to less severe injuries such as bruises, scratches, and rug burns. Sexual abuse allegations were also investigated. In two instances, a child was left alone in a daycare van for a short time after being transported, with no resulting injuries. There was also one death that was determined to be due to illness. The incidents reported to the OIG-CW occurred in both licensed child care homes and licensed child care centers.

One of these 23 incidents is not included in this report, as the serious injury was a bite from a bat that was not investigated by Children's Services Licensing or Children and Family Services (CFS) due to occurring entirely by chance. Of the remaining 22, CFS accepted 21 for assessment, with one not meeting the definition for an investigation. Of those 21 investigated by CFS through an Out of Home Assessment (OHA), 11 were determined to be unfounded for child abuse or neglect. Two investigations were agency substantiated, as it was found that the child care provider was at fault for the injury to the child. Four investigations were listed as court pending due to legal charges being filed against a child care provider or a staff member at a

[33] A summary of the 2024-2025 Child Care Monitoring Report, with all confidential and identifying information removed, and DHHS' response to the report, can be accessed on the Legislature's website, here: https://nebraskalegislature.gov/pdf/reports/oversight/child_care_monitoring_report_2024-2025.pdf.

child care center. There were four OHAs, that did not have a finding listed within the reviewed OHA.

Children's Services Licensing investigated all 22 incidents included in the monitoring report. Fourteen cases were substantiated as being out of compliance with licensing regulations and required corrective action from the child care.

The OIG-CW conducted an in-depth review of all of the incidents reported to the OIG-CW in FY 2024-2025 by reviewing: the investigation documents provided by DHHS, including the intake and OHA completed by CFS and the Complaint Review completed by Children's Services Licensing; all prior investigations completed by Children's Services Licensing posted to its public website; and any provided law enforcement reports. Relevant statutes, policies, and regulations were reviewed as well.

Findings

The majority of the investigations by CFS were thorough and detailed, particularly when documenting what was said in interviews and the events of the day of the incidents. A few OHAs were noted to be less thorough due to a lack of details, information being copied and pasted into different sections of the OHA, and the need for further explanation of the finding. In four OHAs completed, there was no finding at all.

As for Children's Services Licensing, many investigations were thorough and detailed, though there were a few with very little detail about the interviews and investigation. In most investigations, the scope not only pertained to the complaint being investigated, but while visiting the child care, the investigator reviewed for any and all violations of regulations present, noting these in their review document. The specific regulations being reviewed for compliance and all regulations noted to be violated are clearly identified within CSL's complaint review form. It was also noted that licensed child cares are being regularly monitored through unannounced semi-annual visits from licensing staff.

The OIG-CW-CW also noted that it often takes many months for the OIG-CW to receive the Children's Services Licensing written investigations after the date of the reported incident. Children's Services Licensing investigations can also be delayed because of a law enforcement investigation into the incident. However, in a review of Children's Services Licensing policies, there does not appear to be a timeframe in which these written investigations are expected to

be completed. In contrast, CFS requires that OHAs be completed within 60 days of the intake, with a few exceptions.

The OIG-CW commends CFS and CSL for working together on the reviewed investigations, which allowed for the parties involved to only be interviewed once and information to be shared freely. This collaboration is a great way to preserve government resources and decrease stress and trauma to children.

The OIG-CW had no formal recommendations regarding the investigative processes within CFS and Children's Services Licensing. While not all investigations reviewed in FY 2024-2025 were exemplary, the OIG-CW's overall review determined that the work is being done well and collaboratively within DHHS. The OIG-CW would suggest that CSL review the timeframes in which investigations are being completed to determine if there is any room for improvement.

Juvenile Room Confinement Report

In 2016, the Legislature enacted juvenile room confinement statutes to "establish a system of investigation and performance review in order to provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility."[34] As part of that, certain juvenile facilities are required to document each incident where a juvenile is involuntarily placed alone in a room or area for a cumulative period one hour or longer during a 24-hour period.[35] The facilities are required to submit quarterly reports to the Legislature detailing the data about those juvenile room confinement incidents.[36] The OIG-CW is then required to review that data to assess the use of room confinement for juveniles at each facility and to submit an annual report of its findings to the Legislature.[37]

The OIG-CW's most recent Juvenile Room Confinement report was released in February 2026 and analyzed the room confinement data submitted by facilities in Fiscal Year 2024-2025.[38] After review of that data, the OIG-CW made the following findings:

1. Overall, the use of juvenile room confinement in Nebraska remained high compared to past years, with the number of confinement hours and the number of confinement incidents the highest they have ever been.
2. Despite the increase in total confinement hours and incidents, most individual incidents were generally shorter in duration for the second consecutive year, which indicates better compliance with best practices.
3. Juvenile room confinement was primarily used for safety and security reasons and there were significantly fewer administrative reasons for confinement than in the previous year, which aligns with best practices.
4. Enhanced internal and external oversight of room confinement at the juvenile facilities and more consistent and standardized juvenile room confinement statutory interpretations and practices continue to be needed.

[34] Neb. Rev. Stat. § 83-4,134.01(1).
[35] See Neb. Rev. Stat. § 83-4,125(4); § 83-4,134.01(2)(a).
[36] § 83-4,134.01(2)(c)
[37] See § 83-4,134.01(2)(e).
[38] The full 2024-2025 report can be accessed on the Legislature's website, here: https://nebraskalegislature.gov/pdf/reports/oversight/2025_juvenile_room_confinement_annual_report.pdf.

Based on those findings, the OIG-CW made the following recommendations to the Legislature and the juvenile facilities:

1. The Jail Standards Board, Nebraska Department of Correctional Services, and DHHS' Office of Juvenile Services should collaborate to establish a standardized and consistent interpretation of current juvenile room confinement statutes and practices across all juvenile facilities.
2. Each juvenile facility should have internal staff dedicated to juvenile room confinement oversight, data analysis, and improving and reducing confinement practices.
3. The Legislative Audit Office should conduct a performance audit of the juvenile facilities regarding the practice of juvenile room confinement to independently verify reported room confinement data and practices and assess facilities' compliance with the Nebraska juvenile room confinement statutes.
4. Juvenile facilities should be required to report room confinement data in a format that the Division of Legislative Oversight, particularly the OIG-CW and Legislative Audit Office, determines is necessary for its review.
5. To better comply with best practices, juvenile facilities should conduct multidisciplinary reviews, including an urgent mental health evaluation, of every youth who has been confined for 24 consecutive hours.

OIG-CW Recommendations Status Update

Reports of OIG-CW investigations contain recommendations for systemic reform. The OIG-CW's Annual Report is required to describe those recommendations and the status of their implementation.[39]

The updates to the recommendations provided by DHHS-CFS in 2026 mainly state that past recommendations have been resolved. DHHS provided more specific updates for the following:

1. In regards to a 2023 recommendation that DHHS should develop a comprehensive health care management plan for state wards, DHHS stated that they fully internalized support of all relative and kinship foster homes in 2026 and continue to partner with Medicaid MCOs on best ways to serve youth and coordinate services.
2. In regards to the two recommendations from the 2025 report on Alternative Response, DHHS reported that they continue to work with their NFOCUS team on ways to pull and track data. Additionally, CFS tracks if a family chooses to engage in AR services and for those families who do engage, they measure timeliness before the next intake. The goal is to have no interaction with the system for one year after services are provided.
3. The 2025 recommendation to evaluate and enhance the identification and assessment of all persons with regular access to a child in their home prompted the response from DHHS that CFS continues to ensure high standards for interacting with families and asking routine questions to understand who is part of the family ecosystem.

The OIG-CW appreciates these steps but would note that, particularly with regard to medical case plans and the inclusion of significant others with regular access to the children in CFS' safety assessments, the actions taken by DHHS do not directly respond to or address the OIG-CW's recommendation. The OIG-CW will continue to work with DHHS to gain more clarity on their responses.

DHHS-YRTC recommendation updates stated that the recommendations are all resolved, with the exception of the four new recommendations from the OIG-CW report on YRTC-Kearney. Those recommendations are included earlier in this Annual Report. Their initial response to these recommendations is noted in the status update tracking tool, found on the Legislature's website, as noted below. DHHS-Public Health recommendation updates state that there were

[39] See Neb. Reb. Stat. § 50-1818.

no changes in the past fiscal year, noting that regulations were updated in 2021 and that all five chapters of child care regulations were re-opened for revisions in July 2026.

The OIG-CW has made 122 total recommendations in the past 15 years. A full list of the OIG-CW recommendations and status updates from DHHS over the years can now be found on the Legislature's website at http://nebraskalegislature.gov/divisions/oig-recommendations.php.

Office of

Inspector General of Nebraska Child Welfare

ANNUAL REPORT

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

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