

# OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE SUMMARY OF ANNUAL REPORT FISCAL YEAR 2024-2025

# There was a slight increase in the number of child deaths reported to the OIG.

- 27 child deaths were reported to the OIG in FY 24-25 compared to 21 in FY 23-24.
- 7 of those deaths involved co-sleeping or unsafe sleep.
- 7 others were the result of medical issues or accidents.
- 2 deaths were caused by abuse or neglect but the family was not known to DHHS before the death.
- 7 others were either the result of causes unknown or abuse and neglect but were not mandated for investigation by the OIG.
- 4 deaths are mandated to be investigated by the OIG under the law.

# There was no change in the number of serious injuries to children reported to the OIG.

- 27 serious injuries to children were reported to the OIG in FY 24-25 the same as reported in FY 23-24.
- 11 of the serious injuries were caused by suspected abuse and neglect but the family was not known to DHHS before the injury.
- 6 serious injuries were not the result of abuse or neglect.
- 6 serious injuries are mandated to be investigated by the OIG under the law.

# The YRTCs saw an increase in their census while other data reported remained fairly consistent.

- There was a significant increase in the amount of youth served at YRTC-Kearney at any given time in FY 24-25 as compared to FY 23-24.
- There was still a concerning number of youth-on-staff assaults within YRTCs in FY 24-25.
- There were no reports of attempted suicide within the YRTCs for the second consecutive year.

# There was an increase in the number of sexual abuse allegations by state wards.

- There were 293 allegations of sexual abuse of state wards in FY 24-25, up from 244 in FY 23-24.
- It is important to note that these are **allegations**, <u>not</u> the number of substantiated cases.
- 77 allegations were investigated by CFS with five substantiated, 52 unfounded, and 11 pending criminal court action.

# The OIG completed three investigative reports into the deaths and serious injuries of 11 children.

- In one report the OIG found Alternative Response was often used for high and very high-risk families and made two recommendations regarding the use of Alternative Response, including improvements in data tracking and evaluation of family engagement strategies.
- In the investigation of the death of a two-year-old due to abuse by the mother's significant other, the OIG again recommended that DHHS evaluate and enhance the identification and assessment of all persons with regular access to a child in a child's home.

# Significant decisions were made by DHHS about child welfare policy and practice.

- DHHS announced its transition to the SAFE Model for assessing safety and risk was on hold and it will continue utilizing Structured Decision Making for assessments.
- DHHS announced it will bring all support of relative and kinship homes in-house instead of contracting the support of some relative and kinship homes out to child placing agencies.