OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

Report of Investigation

Subject: Death of Two-Year-Old Child Due to Physical Abuse by Parent's Significant Other

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Executive Summary

On February 27, 2021, two-year-old Z.Y.[1] died as a result of serious injuries suffered in his home the day prior. The Office of Inspector General of Nebraska Child Welfare (OIG) was notified of Z.Y.'s death on March 2, 2021, and opened this investigation as mandated by law.

Law enforcement and the Nebraska Department of Health and Human Services' (DHHS) Division of Children and Family Services (CFS) determined that Mr. X, the boyfriend of Z.Y.'s mother, physically abused Z.Y. while his mother, Ms. Y, was briefly away from the home. DHHS conducted two separate child abuse and neglect investigations within the three months before Z.Y.'s death. Mr. X was in a relationship with Z.Y.'s mother during that time, and he was at least occasionally living in or visiting the family's home when Z.Y. was present. Mr. X also contributed to Z.Y.'s care in the month before Z.Y.'s death. However, under DHHS' implementation of its Structured Decision Making (SDM) Model policy and practice, Mr. X was not included as a member of Z.Y.'s household in those investigations or DHHS' safety assessments.

Based on the OIG's review of this case, previous OIG investigations similar to this case, DHHS policy, and both the SDM Model and the SAFE Model, the OIG found that:

1. Current SDM policies and practices do not sufficiently identify or assess all persons in a child's household with regular access to the child who may pose a risk to the child's safety.

The OIG recommends that DHHS:

1. Evaluate and enhance the identification and assessment of all persons with regular access to a child in the child's home.

[1] To maintain confidentiality, the names and identifying information of all children and families in this investigation have been changed.

JURISDICTION

The OIG provides oversight and accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, system monitoring and review, and recommendations for improvement.[2]

The OIG Act[3] mandates that the OIG investigate the death of a child in any case in which the child's family was involved in an investigation with DHHS under the Child Protection and Family Safety Act[4] within the year preceding the death, and the OIG determines the death did not occur by chance.[5]

On March 2, 2021, the OIG received notice from CFS that two-year-old Z.Y. had received severe injuries as the result of physical abuse in his home on February 26, 2021, and died as a result of those injuries on February 27, 2021.

Z.Y. was involved in two other physical-abuse-related intakes accepted for Initial Assessment within 12 months of his death, the most recent of which occurred approximately three weeks before his death.

[2] See Neb. Rev. Stat. §§ 50-1802, 50-1803.
[3] Neb. Rev. Stat. §§ 50-1801 to 50-1821.
[4] Neb. Rev. Stat. §§ 28-710 to 28-727.
[5] See Neb. Rev. Stat. § 50-1806(1)(d).

SCOPE OF OIG INVESTIGATION

This report of the OIG's investigation summarizes the death of Z.Y.; CFS' history with Z.Y.'s family and the handling of Z.Y.'s case before and after his death; information about DHHS' case management models and policies; and the OIG's findings and recommendation as a result of this investigation. The OIG's summary below, and all information that the OIG gathered and reviewed throughout this investigation, comes from the following sources:

- CFS records, including, but not limited to, the Critical Incident Report; Child Abuse and Neglect Intake Worksheets; Case Narratives and Correspondence; and SDM Model Safety and Risk Assessments;
- Juvenile court and criminal trial and appellate court documents;
- An interview with DHHS personnel;
- National research and DHHS literature about the SDM and SAFE Models; and
- Relevant statutes, rules and regulations, and DHHS policy documents in effect at the time of this case, as well as current policies.

Summary of Critical Incident

On February 26, 2021, two-year-old Z.Y. was left at home with his mother's boyfriend, Mr. X, for approximately 45 minutes while his mother, Ms. Y, was buying groceries. When Ms. Y returned to the home, Mr. X tried to prevent her from seeing and touching Z.Y. She nonetheless found Z.Y. undressed down to his diaper with visible abdominal bruising and unable to stand on his own. Mr. X told Ms. Y that she needed to calm down or the same thing would happen to her other child and that if Ms. Y were to call the police, he would make the situation worse than it already was. When Ms. Y attempted to move toward Z.Y., Mr. X pushed her back, dragged Z.Y. to the bedroom closet, and slammed him against the closet wall.

When Ms. Y briefly got away from Mr. X, she called her mother and told her to contact a friend with whom Ms. Y had established a safety plan for contacting law enforcement if Mr. X was being physically abusive. Soon after, Mr. X permitted Ms. Y to make a routine call to a worker at a local nonprofit organization, with whom Ms. Y had also established a similar safety plan. Ms. Y used her safety word on that call, and the organization called law enforcement, who arrived at the home soon after. Law enforcement found Z.Y. lying in the bedroom closet; he was pale, minimally responsive, unable to pick himself up, and covered in bruises. Z.Y. was transported to a hospital, where medical professionals observed severe bruising all over his body, most apparent on his abdomen and face, and indicated that it appeared that he had been beaten. Doctors attempted to treat Z.Y.'s severe abdominal trauma, but his blood was not circulating and he was brain dead. Z.Y. passed away in the early hours of February 27, 2021, his cause of death being lethal damage to his liver from blunt force trauma to the abdomen.

Mr. X was arrested the night of the incident and soon after criminally charged with committing child abuse knowingly and intentionally and resulting in a child's death, as well as terroristic threats. He was found guilty of both felony counts after a jury trial in 2021 and then sentenced to over 70 years' imprisonment. DHHS placed Mr. X on the Nebraska Child Abuse and Neglect Central Registry due to the court's substantiation of the child abuse allegation. Mr. X's criminal convictions were affirmed on appeal in 2023.

BACKGROUND

Structured Decision-Making Model

Since 2012, DHHS has used the Structured Decision Making (SDM) Model for all child welfare case management. The SDM Model provides a framework for how CFS caseworkers assess a family for child safety and the risk of abuse and neglect in the home after a report is made to the Nebraska Child Abuse and Neglect Hotline (Hotline). The SDM Model assists caseworkers with making decisions throughout a case regarding whether and how DHHS will engage with families and whether DHHS will recommend the removal of any child from their home because of a safety concern. The SDM Model used by DHHS consists of several components and assessments that could be used in a case, depending on the reported incident, and each is documented in NFOCUS, DHHS' electronic case management system.

Some of the primary assessments and tools of the SDM Model still used by DHHS include:

1. SDM Household—which documents the people living in a child's household and determines who will be included in all other subsequent assessments and to whom services may potentially be provided;
2. SDM Safety Assessment—used to help caseworkers determine if children are "safe" in their household, "unsafe," or "conditionally safe" with the need for a Safety Plan;
3. SDM Risk Assessment—used to help caseworkers determine if children are at risk of being abused or neglected.

In completing these assessments, DHHS must first determine which persons should be included in the assessment. Any persons included in a child's SDM Household should be included in the safety and risk assessments.[6] A household can consist of many different people and capture numerous types of family dynamics. According to DHHS policy, a household will generally include a "primary caregiver," which is typically a legal parent or other adult in the household who cares for the child the most, or, in other words, cares for the child more than 50% of the time.[7] A household can often include a "secondary caregiver" as well, which can be another adult living in the child's household who, after the primary caregiver, contributes the most to the care of the child.[8] While typically a caregiver is a child's parent or legal custodian, a caregiver under this policy could include any person in a caregiving role and responsible for the child's care for a significant enough amount of time during a particular timeframe. There could

[6] See DHHS-CFS Standard Work Instruction (SWI) 3.4.2 – SDM Households, effective 12/24/20; DHHS-CFS SWI 3.4.3(I)(A) – SDM Safety Assessment, effective 12/24/20; DHHS-CFS SWI 3.4.4(I)(C) – SDM Risk Assessment, effective 12/24/20.
[7] DHHS-CFS SWI 3.4.2.
[8] DHHS-CFS SWI 3.4.2.

thus be multiple caregivers for a child at any given time. Caseworkers must include information in the assessments from such caregivers in the household.

In addition to those who may qualify as a primary or secondary caregiver, DHHS' policies are also clear that any other adult should be a part of the SDM Household and thus included in subsequent safety and risk assessments when that adult (1) "lives in the home," (2) "visits the home regularly and contributes to the care of the children," or (3) "visits the home regularly when the children are also present."[9] For the latter two types of adults, DHHS lists a "significant other" as an example of who should be included in the household.[10]

As with all other child welfare cases over the past 13 years, these basic components and assessments of the SDM Model within DHHS policy were in effect throughout DHHS' cases with Z.Y.'s family.

Safety Assessment & Family Evaluation Model

In the fall of 2024, DHHS publicly announced that it intended to transition from the SDM Model to a child welfare case management model called the Safety Assessment and Family Evaluation (SAFE) Model.[11] DHHS later stated that the transition was "to ensure a cohesive process to inform child welfare intervention."[12] However, in February 2025, DHHS reported that it was pausing the implementation and training of the SAFE Model until further notice.

Created by Action for Child Protection, a national non-profit organization that serves child welfare agencies, the SAFE Model's primary focus is child safety, particularly focusing on children "who may be unsafe based on the presence of uncontrolled danger threats."[13] The SAFE Model attempts to keep "children safe while restoring caregivers to their protective role and responsibility,"[14] and address "inconsistent practice and decision-making by providing a systematic, criteria-based approach for intervening when children are unsafe with their families."[15]

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[9] DHHS-CFS SWI 3.4.2.
[10] DHHS-CFS SWI 3.4.2.
[11] See Holder, Todd, "Safety Assessment and Family Evaluation Model: A Systemic, Change-Based Approach to Public Child Welfare Intervention." *Child Welfare* 99, no. 2 (2021): 103. https://www.jstor.org/stable/48623721 (stating that the SAFE Model has been developed and refined over nearly 40 years in consultation with over 45 public child welfare agencies).
[12] O'Hagan, Kathryn. "Nebraska SAFE Assessment." Nebraska Children's Commission Meeting, October 29, 2024.
[13] See "Practice Model," Action for Child Protection, accessed January 10, 2025, https://action4cp.org/our-services/practice-model/; Holder, Todd, "Safety Assessment and Family Evaluation Model," 103.
[14] Holder, 103.
[15] Holder, 99.

The SAFE Model has two fundamental intervention concepts that serve as the focus for family engagement and the basis for decision-making and determining child safety: (1) impending danger threats, and (2) caregiver protective capacities.[16] Action for Child Protection and DHHS define impending danger threats as dangerous family conditions within a child's residence that represent situations or circumstances, caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions that place a child in a continuous state of danger.[17] There is the related core concept of "present danger," which DHHS has indicated is a more severe type of danger threat requiring a quicker response time from CFS caseworkers than impending danger threats.[18] Action for Child Protection and DHHS define caregiver protective capacities as an individual's behavioral, cognitive, and emotional characteristics and abilities—both personally and as a parent—that are specifically and directly associated with caregiver performance and contribute to the presence or absence of vigilant child protection, influencing safe environments, and impacting the well-being of children.[19] The child welfare agency's decision to open or close a case with a family depends on the presence of these impending or present danger threats to a child and whether the caregiver's protective capacities can mitigate or alleviate those safety threats.[20]

As mentioned, the SDM Model, not the SAFE Model, was used in DHHS' cases with Z.Y.'s family.

[16] See Holder, 110.
[17] See Holder, 110; "SAFE Model Core Concepts," SAFE: New Assessment Model, Nebraska Department of Health and Human Services, accessed November 5, 2024.
[18] See "SAFE Model Core Concepts" (defining "present dangers" as immediate, significant, and clearly observable threatening family situations that have just occurred, are actively occurring, or are in the process of continuing to occur, which have or will likely result in serious harm to a child and requires immediate action to protect).
[19] See Holder, 110; "SAFE Model Core Concepts;" O'Hagan, "Nebraska SAFE Assessment."
[20] See Holder, 110–12; "SAFE Model Core Concepts;" O'Hagan, "Nebraska SAFE Assessment."

Summary of Prior System Involvement

CFS Investigation #1

The first CFS involvement with Z.Y.'s family was at the end of December 2020, approximately two months before Z.Y.'s death.[21] The daycare that Z.Y. attended contacted law enforcement and the Nebraska Child Abuse and Neglect Hotline (Hotline) because Z.Y. had arrived with red marks and bruising on his buttocks. Law enforcement observed Z.Y. and initially believed that the marks resembled fingerprints. In speaking with law enforcement, Z.Y.'s mother acknowledged that she did spank Z.Y. but not hard enough to leave marks. She told officers that she was the only person who spanked Z.Y., but there is no DHHS documentation stating that caseworkers ever asked if anyone else lived in the home and cared for Z.Y. She stated that she last spanked Z.Y. with an open hand a few days ago but that she did not believe the spanking left any mark. Law enforcement compared Ms. Y's hands to the mark on Z.Y. and noticed that Ms. Y's fingers were wider than the marks. Because the marks were much smaller than a handprint and too thin to be from Ms. Y's hand, law enforcement did not cite Ms. Y as they could not prove that she caused the marks by spanking Z.Y.

In CFS' investigation, caseworkers spoke with staff at Z.Y.'s daycare, who expressed no concerns with the situation now that law enforcement did not believe Z.Y.'s mother caused the marks. Caseworkers also spoke with W.V., Ms. Y's older daughter; W.V.'s father, Mr. V; and Mr. V's partner as collateral contacts, who collectively suggested that Ms. Y had no pattern of concerning behavior and that they did not believe Z.Y. was in danger. Caseworkers also noted that the family had no prior history of abuse or neglect. The allegation was determined to be unfounded.

In speaking more with Mr. V, caseworkers learned that W.V. primarily lived with him, whereas Z.Y. primarily lived with Ms. Y.[22] Mr. V stated that Z.Y. often came over to play with W.V. Although W.V. stayed at Ms. Y's home on weekends, Mr. V stated that he did not want W.V. to do so because of Ms. Y's boyfriend. No further information regarding what Mr. V meant, nor what the specific concern was with Ms. Y's boyfriend, is included in the CFS records. In addition, the staff at Z.Y.'s daycare told the caseworkers that Ms. Y was often at her boyfriend's apartment. At this point, there is no discussion in the records of Ms. Y mentioning a boyfriend, nor caseworkers asking Ms. Y about the boyfriend or otherwise attempting to learn his identity, history, or whether he ever stayed at Ms. Y and Z.Y.'s home. The records indicate that

[21] There was one previous child abuse and neglect allegation involving Z.Y.'s older sister before Z.Y. was born. That allegation was unfounded by CFS and is not relevant here.
[22] Mr. V was not Z.Y.'s father.

caseworkers and law enforcement did not consider whether the boyfriend had access to Z.Y. or whether he could have caused the marks on Z.Y.

The boyfriend mentioned here was later learned to be Mr. X. As part of Mr. X's criminal proceedings for his role in Z.Y.'s death, Ms. Y stated that she began a casual sexual relationship with Mr. X in August 2020 and discovered in October 2020 that she was pregnant with his child. She also stated that Mr. X moved into her home at some point in January 2021, the same time that the investigation into the marks on Z.Y.'s buttocks was ongoing. It does not appear from the record that caseworkers observed Ms. Y's home in this investigation. On one occasion, caseworkers attempted to visit the home, but Ms. Y was uncooperative and would not let them in.

Caseworkers again visited Z.Y. at his daycare one week after the Hotline report. The mark on Z.Y.'s buttocks was no longer present, and he did not have any other bruises. Z.Y. was happy and healthy. Although Ms. Y previously had issues with consistently bringing Z.Y. to daycare, she was reportedly improving that and engaging more with community services. In the middle of January 2021, a multidisciplinary team[23]—including representatives from CFS, law enforcement, and a child advocacy center, local service provider, and county attorney's office—first met about this case and began discussing how to best monitor the safety and progress of Z.Y.'s family and most effectively coordinate each agency's resources in any future child abuse or neglect investigation. Records of the 1184 team meeting state that after reviewing all of the above information, the team recommended that the case be closed without further action. At the end of January 2021, DHHS then determined that Z.Y. was safe in Ms. Y's care and the final risk assessment level was moderate with a recommendation for case closure.

CFS Investigation #2

Approximately two weeks later, on February 8, 2021, the Hotline received another intake on Z.Y. It was reported that Z.Y. had not been to daycare for a couple of weeks despite being scheduled to come three times a week. When Z.Y. came to the daycare on February 8, daycare staff reportedly observed that there was a cigarette burn on his side, above his hip. The burn was reportedly one and a half to two centimeters wide, circular in shape, and reddish-dark brown colored with scabbing over it. Z.Y. did not appear to be in pain, but because he was mostly nonverbal, he could not disclose anything about the mark. The daycare expressed other concerns to the Hotline, such as that they believed there was physical abuse or domestic violence in Ms. Y's home and an adult male may be living with her, that Ms. Y had told the

[23] See Neb. Rev. Stat. §§ 28-728 to 28-730. These types of multidisciplinary teams, often colloquially referred to as "1184" teams, were created with the passage of Legislative Bill 1184 by the Nebraska Legislature in 1992.

daycare that she was pregnant, and that Ms. Y had told the daycare that she had a black eye without providing any explanation.

Responding law enforcement officers assessed Z.Y. at the daycare and believed the mark was a burn. An officer then contacted Z.Y.'s mother over the phone. Ms. Y was aware of the mark but only stated that she noticed it a couple of days ago and that it was a scab that Z.Y. picked at. According to DHHS documentation, during that phone call, the officer believed that someone present with Ms. Y was coaching her as she answered questions. The officer told CFS caseworkers that they knew that Ms. Y was in a relationship with Mr. X, which was concerning. There is no documentation that the caseworkers ever sought an explanation about what law enforcement's concern was with Mr. X.

Officers and caseworkers visited Z.Y. and Ms. Y at their home on February 10. They did not believe the mark was a cigarette burn because it was larger than the size of a cigarette. Ms. Y could not explain the mark, except that it could have come from an incident where Z.Y. bumped into an oven. A caseworker and Ms. Y took Z.Y. to the nearby children's hospital, where an APRN diagnosed the mark as impetigo—a type of bacterial skin infection—rather than a burn. The APRN found other impetigo marks on Z.Y.'s head as well.

The caseworker noted that Z.Y. appeared happy and healthy at the home visit and observed no other marks or injuries. Ms. Y stated that she did not need any services from DHHS and that she had adequate support. Ms. Y told the caseworker that Mr. X would watch Z.Y. at her home whenever Z.Y. did not go to daycare and that Mr. X last watched Z.Y. two weeks prior when Z.Y. stayed home sick for a full week. Ms. Y reported that she and Mr. X got along well, that Mr. X did not do any physical punishment because Z.Y. was not his child, and that he only used time out when discipline was necessary. Ms. Y stated that when she and Mr. X disagreed, it was only ever a small argument and never went past that. It does not appear that caseworkers inquired into how often Mr. X lived in the home and had access to Z.Y. CFS records lack any mention of caseworkers gathering information to determine if Mr. X could have qualified as a part of the family's household as a caregiver under the SDM Model.

The caseworker also spoke with Ms. Y's mother, who was present during the home visit. She stated that she had no concerns about Mr. X and that Ms. Y was on bed rest until she and Mr. X's baby was expected to be born in June 2021. The following day, the caseworker visited Z.Y.'s sister W.V. at her father's home as a collateral contact. W.V. said that she enjoyed Ms. Y's home and did not know about any injuries on Z.Y. She also stated that she did not know if Ms. Y and Mr. X ever fought or had any injuries. She further claimed that Mr. X and Ms. Y never hurt her when she visited them.

Based on all of this information, DHHS determined that there was no safety threat to Z.Y. DHHS found him safe in Ms. Y's care on February 11, 2021. DHHS contracted with CEDARS Youth Services (CEDARS) to provide non-court involved family support and visitation services to Ms. Y and Z.Y. beginning on February 12. CFS records also mention that Ms. Y began working with Blue Valley Community Action (BVCA) around this time for their expectant mothers' program.

A week after Z.Y. was found safe by DHHS, another 1184 multidisciplinary team meeting occurred, where the February 8 Hotline intake and CFS' subsequent investigation were discussed. In the records from that meeting, it is stated that when caseworkers visited the apartment building where Ms. Y and Z.Y. lived, CFS had additional concerns about the family's situation after speaking with people around the building. The records lack detail about those concerns. Further, the 1184 team meeting records state that although Ms. Y had not answered the door to her home when caseworkers visited, on one occasion, Mr. X was at the home, and he answered the door and gave caseworkers permission to look through the home. The records do not mention whether Z.Y. was there with Mr. X at that time. The team meeting records also say that Mr. X was facing criminal charges at that time for shooting someone.

There remained an open investigation into this February 8 intake, and the related risk assessment had yet to be completed at the time of Z.Y.'s death. Caseworkers were reportedly assessing the situation with law enforcement and working on establishing a family social worker to assist Ms. Y. CFS' next planned contact with the family was to occur the following month.

Contact with Family Days Before Z.Y.'s Death

On February 24, 2021, Ms. Y brought Z.Y. to daycare with marks above his eye that Ms. Y claimed Z.Y. received when he fell down stairs at their home. The daycare was concerned about the injury and contacted BVCA, who was still providing services to Ms. Y. BVCA then contacted CFS, who agreed to check in with Ms. Y and Z.Y. about the concern.

CFS caseworkers and a staff member from CEDARS visited Z.Y. at the daycare. CEDARS was still providing family support services at this time and working with Ms. Y on her parenting skills and the concern of domestic violence by Mr. X. The caseworkers and CEDARS worker agreed that the mark appeared to be rugburn consistent with falling on carpet stairs and did not have any further concern after seeing the marks. Nonetheless, the caseworkers and the CEDARS worker visited Ms. Y at her home that same day. Ms. Y explained how Z.Y. fell off balance on the stairs and received the injury. The caseworkers determined that Ms. Y's story matched the injury.

While at the home, Ms. Y proceeded to tell the caseworkers that Mr. X was controlling, monitored her phone, did not allow her much freedom, and that he did get physical and yell at her, but never Z.Y. She assured the caseworkers that if Mr. X ever were to touch Z.Y. she would

call the police. She stated that Mr. X mainly grabbed her arms when he was angry, but that she shielded Z.Y. from this and that Mr. X did not hit her. She further disclosed that Mr. X was currently dealing with some legal troubles and in the middle of court proceedings. According to court documents, Mr. X had pending felony assault and firearm-related charges during this time for an incident that occurred a year prior. Mr. X was later convicted in that case.

The caseworkers then discussed a safety plan with Ms. Y should she ever be in danger from Mr. X. Specifically, Ms. Y was to tell the caseworkers or workers at CEDARS the code word that she was having a "fantastic" day or that things were going "fantastic" if she was in danger, and they would immediately send her help. Ms. Y stated that she had a good support system and that Z.Y. would continue to attend daycare each day. Despite the information learned about Mr. X, the caseworkers concluded that they did not identify any safety threats at that time and that the visit with Ms. Y was simply a follow up on the concerns provided by BVCA.

However, the CEDARS staff member who accompanied the caseworkers to the visit with Ms. Y on February 24 again visited Ms. Y the next day, but without the CFS caseworkers, to follow up on Ms. Y's safety plan to ensure that she, her unborn child, and Z.Y. were all safe from Mr. X. At that visit with Ms. Y on February 25, Ms. Y provided more details about Mr. X's abuse.

Ms. Y told the CEDARS worker that the abuse was not that bad and that she sent Z.Y. to his room whenever it happened. Ms. Y stated that she was more concerned about Z.Y.'s safety than herself or her unborn child. Ms. Y said that she had tried to leave Mr. X in the past but was too scared to because Mr. X said that if she did, he would "smash Z.Y.['s] skull in" and told her that she "better hope the police come before he is done with Z.Y. or he will be dead."

Ms. Y stated that she knew DHHS would have to intervene if she did not keep Z.Y. safe. Ms. Y informed the worker that she had the same "fantastic" safety word in place with a friend and that they had a plan where if the situation with Mr. X ever got too bad, Ms. Y would give the friend the safety word and the friend would contact Ms. Y's mother who worked in law enforcement. But if Mr. X ever hit Z.Y., Ms. Y stated she would contact law enforcement immediately. The CEDARS worker talked with Ms. Y about establishing a better plan, which included allowing Z.Y. to stay with Ms. Y's mother if things ever became unsafe for him, changing the code on the door of the building to keep Mr. X out, and, if Mr. X were being abusive, locking Z.Y. inside his bedroom while waiting for police to arrive. The CEDARS worker ultimately told Ms. Y that the Hope Crisis Center would be better suited to help Ms. Y formulate a plan to safely end her relationship with Mr. X. Ms. Y assured the worker that she would go to the Center the next day with a friend.

There is no documentation showing that the CEDARS worker notified CFS caseworkers about the additional information that Ms. Y disclosed on February 25 about the threats that Mr. X had

previously made towards Z.Y.'s life, nor of Ms. Y's plan to leave Mr. X. Neither was a report made to the Hotline regarding Mr. X's physical abuse and neglect towards Ms. Y and Z.Y. DHHS was not aware of this information that Ms. Y shared with CEDARS until after Z.Y.'s death.

The next day, on February 26, 2021, while Mr. X was at work, Ms. Y and her friend went to the local law enforcement office to seek help about getting out of her relationship with Mr. X. It is unclear if they also went to the Hope Crisis Center as planned. After Mr. X got off work, he and Ms. Y picked up Z.Y. from daycare before returning home. Mr. X offered to change Z.Y.'s diaper and look after him while Ms. Y and W.V. went to the store to buy groceries. Upon Ms. Y and W.V.'s return 45 minutes later, they found Z.Y. severely injured. Z.Y. died as a result of those injuries shortly after.

After Z.Y.'s Death

Mr. X was quickly determined to be the perpetrator of the physical abuse towards Z.Y. and consequently arrested and criminally charged. In the safety and risk assessments of Z.Y.'s sister W.V. completed after Z.Y.'s death, it was noted that there was no known history of child abuse or neglect in the family, no safety concerns whenever caseworkers observed Z.Y. and visited with Ms. Y at her home, nor any concerns expressed by W.V. about Ms. Y or Mr. X. The assessments also mention that Ms. Y had previously reported that Mr. X had never harmed Z.Y. and that she had no reason to believe that he would harm him. DHHS concluded the incident happened without Ms. Y's knowledge while she was at the grocery store.

Despite the indications that Mr. X was physically abusive towards Ms. Y before Z.Y.'s death, Ms. Y denied any domestic violence in the home when speaking with caseworkers following Z.Y.'s death. There were never any reports of domestic violence between Mr. X and Ms. Y made to law enforcement.

Ms. Y maintained that she did not know why Mr. X hurt Z.Y. But at Mr. X's criminal trial for his role in Z.Y.'s death, Ms. Y testified that Mr. X was often irritated with Z.Y.'s crying, would yell at him, and occasionally pushed and threatened him.

OIG Investigative Findings

1. **Current SDM policies and practices do not sufficiently identify or assess all persons in a child's household with regular access to the child who may pose a risk to the child's safety.**

As the OIG has noted in two previous reports in 2016 and 2020, DHHS policy and practice can focus too narrowly on assessing a child's primary or secondary caregivers, while failing to fully assess those in the child's household with regular access to the child who may pose a safety threat to that child. With those previous reports, in addition to the death in this report, the OIG has now investigated 15 cases where children have died or were seriously injured by persons who may not qualify as a caregiver under the SDM Model, but would likely qualify at some point as a member of the child's household under the SDM Model because of how often they were in the child's home and cared for the child. These cases are examples of a systemic issue of DHHS policy and practice not sufficiently identifying or assessing all members of a child's household when DHHS investigates allegations of abuse or neglect.

In the OIG's 2016 investigation into 10 death and serious injury cases following child abuse investigations by DHHS,[24] the OIG found that in most of those cases, a male parent, caretaker, or unrelated partner to a primary caregiver was responsible for the abuse. Relatedly, in all but one of those cases, the offending parent or caretaker was not listed as the child's primary caregiver. The OIG found that those offending parents or caretakers did not have their history or risk factors thoroughly analyzed by DHHS and that the SDM Model placed more emphasis on primary caregivers in the assessment process. In some of those cases, the OIG found that, as here, the male offender went unidentified because they were not properly assessed or DHHS never made contact with them because they were not identified as a part of the child's household. The OIG also found that those male offenders were rarely identified and contacted by caseworkers as collateral sources of information.

In the OIG's 2020 investigation into four death and serious injury cases following child abuse investigations by DHHS,[25] the OIG similarly found that the secondary caregivers in those cases were not thoroughly investigated preceding the critical incident involving the child and that information regarding the secondary caregivers was not gathered with as much tenacity as with primary caregivers. Specifically, the OIG found that secondary caregivers were superficially considered in DHHS' investigation, resulting in inadequate safety and risk assessments. In most

[24] Office of Inspector General of Nebraska Child Welfare, *Death and Serious Injury Following Child Abuse Investigations October 2013–June 2015*. March 17, 2016.
[25] Office of Inspector General of Nebraska Child Welfare, *Death or Serious Injury Following a Child Abuse Investigation June 2016–June 2019*. August 7, 2020. https://nebraskalegislature.gov/pdf/reports/public_counsel/Final_IA_Report_9-20.pdf.

of the cases, as here, those persons who caused the children's death or serious injury had been occasionally present in the home during the investigation before the critical incident. In those investigations, caseworkers were less assertive in contacting that offender, obtaining information about them and their role within the family, and incorporating information about them into case documentation. The OIG's investigative report also discussed that DHHS' definitions of a caregiver and sole focus on which persons qualify as a caregiver so that they are included in the SDM assessments can be misguided, as there could be persons who qualify as a member of a child's household and fit the functions, but not the definition, of a caregiver—for example, a primary caregiver's boyfriend or girlfriend who lives in the home and interacts with the child, other relatives who care for the child, or other unrelated persons that the family relies on to care for the child on a routine basis.

DHHS' current policy and guidance regarding the makeup of SDM Households does, in principle, capture persons who may not always qualify as a caregiver but still have regular access to the child in the household. According to DHHS policy, a household will typically include a primary caregiver—those who are legal parents or who do at least 51% of the caregiving—and will also often include a secondary caregiver —those who, after the primary caregiver, contribute the most to the care of the child. DHHS' policies are also clear that *any* other adult who lives in the home, "visits the home regularly and contributes to the care of the children," or "visits the home regularly when the children are also present," should be part of the SDM Household as well. DHHS policy on SDM Households specifically includes "significant others" as an example of other adults who should be included in a household. The plain language of the policy is focused not just on caregivers but those with regular access to the child. Indeed, the SDM Household guidance also notes that when more than one family is living in a household, adults that "*have access* to children in both families" should be assessed as one household.[26] Since policy states that all SDM Assessments are completed on the members of a child's household, members of that household, beyond the caregivers, should be included in the subsequent safety and risk assessments. The tools used for safety and risk assessments, however, only focus on primary caregivers and secondary caregivers.

In its response to this OIG report, DHHS stated that DHHS policy and SDM tools required a person to "provide 50% of the care and reside in the home" in order to be considered part of the household.[27] In further discussions with DHHS regarding their response to the report, DHHS explained that while a household may be determined as required under the policy, the focus of any assessment would be on the caregivers that reside in the home. Other persons that reside in the home may also be part of the assessment, if they have any information about the child

[26] See DHHS-CFS SWI 3.4.2 (emphasis added).
[27] DHHS Formal Response and Clarification, August 1, 2025, attached in the Appendix.

and circumstances surrounding the allegations reported to DHHS. However, as noted, there is nothing in the plain language of the SDM policy that requires someone to reside in the home to be considered a member of the household. There is also nothing in written policy that limits SDM households to caregivers for an assessment.

DHHS's practical application of the SDM policies are more limiting in terms of the persons assessed than the written policies.

Given DHHS' interpretation of policy, Mr. X was not documented in the assessments in the first or second intake. With regard to the first intake, DHHS may not have had the information necessary to determine that Mr. X was part of the household, although more questions might have been asked. While he was not explicitly named, Mr. X's existence was first made known to CFS at the time of the first Hotline intake involving Z.Y., in December 2020. The CFS records state that when caseworkers were investigating the cause of the alleged marks on Z.Y.'s buttocks in that intake and speaking with W.V. and Mr. V, Mr. V told the caseworkers that he did not want W.V. to go to Ms. Y's home whenever Ms. Y's boyfriend was there. Z.Y.'s daycare also told CFS that Ms. Y had a boyfriend and that she was often at his apartment. At that point, Mr. X might have been considered a collateral contact.[28] But the CFS records do not include any follow-up from caseworkers about the boyfriend mentioned and what the specific concern about him was. It does not appear that anyone from DHHS asked about the boyfriend or attempted to learn or gather any information about him.

At the time of the second intake, Mr. X was clearly part of the household under the terms of the written policy, and perhaps even under DHHS' practice. Mr. X was explicitly named in the February 2021 intake that alleged the burn mark on Z.Y. The intake also alleged that Mr. X may have given Ms. Y a black eye from physical abuse, that Ms. Y was pregnant, and that Mr. X was living in her home. During the initial contact with the family, law enforcement told CFS that they knew Ms. Y was in a relationship with Mr. X, which was concerning to them. At the home visit during the initial assessment, Ms. Y disclosed to caseworkers that Mr. X watched Z.Y. every time that Z.Y. did not go to daycare, which was quite often according to Z.Y.'s daycare, and that he had in fact recently watched Z.Y. for a full week while Z.Y. was sick.

DHHS has stated that Mr. X was not a caregiver because he did not provide 50% of the care and did not reside in the home. As a result, Mr. X was not included in the safety assessment documentation completed several days after the February 2021 intake. This, however, requires

[28] After a Hotline intake is accepted for initial assessment by DHHS, DHHS policy requires caseworkers to contact, interview, and gather information from various "collaterals," who are persons who may have information about the circumstances surrounding the allegation made to the Hotline. These people include, in part, the alleged victim, the alleged perpetrator, and "other adults in the home." DHHS-CFS Standard Work Instruction (SWI) 3.4(I)(H)(1) – Initial Assessment v.3, effective 12/24/20.

a very narrow reading of the SDM Household policy. Mr. X was identified as a potential perpetrator of physical abuse in the Hotline allegations, was alleged to live in the home, and Ms. Y stated that Mr. X regularly cared for Z.Y. Under the plain language of the SDM Household definition, Mr. X would qualify as part of the household. According to DHHS, a safety assessment is conducted to "assess whether a household presents imminent danger of serious harm to any child."[29] There is nothing in DHHS' documentation to indicate that the imminent danger that Mr. X may have posed as a member of the household and an alleged perpetrator was assessed or considered. The OIG recognizes that allegations of domestic violence may affect CFS' decision to contact an alleged abuser. But at the time of the safety assessment, Ms. Y had denied that any domestic violence was occurring.

The 1184 team meeting records also state that Mr. X permitted caseworkers to enter the home on at least one occasion, that caseworkers had concerns about the family after speaking with neighbors, and that it was known that Mr. X had pending criminal charges against him for shooting someone. Once again, however, Mr. X was not even considered as a collateral contact.

The timing of events in this case – when information was received and when Z.Y. was determined to be safe – may also have played a role in whether Mr. X was included in the assessments. At the time DHHS gathered information during the second intake about the care that Mr. X provided to Z.Y., the injury was quickly determined not to be the result of abuse and Z.Y. was found safe. DHHS also had two statements from Ms. Y's mother and daughter that Mr. X was not a concern to them. DHHS did provide services to the family, contracting with CEDARS to address the concern that there was domestic violence in the home and that Mr. X may have been physically abusing Ms. Y. Ms. Y was also beginning to work with Blue Valley Community Action.

A few weeks later when a new concern from the day care arose, DHHS and CEDARS visited again with Ms. Y, and at that time learned more details about the domestic violence in the home. Additional safety planning was done and Ms. Y was directed to additional resources for help. The direct threat against Z.Y. was not known until CEDARS visited Ms. Y again the day before the incident and it is not clear that DHHS was aware of that information before Z.Y.'s death.

While Mr. X was not included in the household under DHHS' current practice, this case is yet another example of the need to ensure that DHHS' policies and practices subject persons like Mr. X to a sufficient level of scrutiny when DHHS is identifying members of a family's household and when DHHS is investigating and assessing child abuse and neglect. While the roles of primary and secondary caregivers are key, more robust attention should be paid to the threats

[29] DHHS-CFS SWI 3.4.3(I)(A) – SDM Safety Assessment, effective 12/24/20.

that may come from other adults in the household who do not meet DHHS' definition of a caregiver but still have regular access to the child or regularly contribute to the child's care.

DHHS' interpretation and implementation of the SDM policies explain why Mr. X was not assessed in this case. But, as noted, the language of the SDM Household policy could have included Mr. X as a significant other who visits the house regularly while the child is present. The written policy is broad enough to capture those who might pose a threat to a child other than the primary or secondary caregivers. However, DHHS' interpretation and implementation of those policies in practice is much narrower, limiting the ability to robustly assess the threats that persons other than the primary and secondary caregiver may pose to a child. The implementation and practice of that written policy should ensure that significant others, like Mr. X, are part of the household and safety and risk assessments.

As noted, DHHS is considering a move to the SAFE Model. The SAFE Model's framework appears to consider the broader circumstances and individuals who threaten a child's safety—including adults in a child's household who may not necessarily meet the definition of a caregiver. The SAFE Model's intensive focus on pending and impending danger threats in a child's home and a caregivers' protective capacities has the potential to properly identify, contact, and assess not only secondary caregivers, but other adults in a child's household who often function as the child's caregiver by regularly contributing to the child's care and visit the child's home when the child is present.

RECOMMENDATIONS

The OIG is tasked with making recommendations in its investigative reports for systemic reform.[30] The OIG has previously made recommendations to improve the SDM Model and the assessment of secondary caregivers in a CFS investigation.

In the OIG's 2016 report discussed above, the OIG recommended that DHHS "[c]ontract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument."[31] DHHS accepted that recommendation and began that validation study in fiscal year (FY) 19–20. The validation study was completed in FY 22–23.

In the OIG's 2020 report discussed above, the OIG recommended that DHHS "[e]nhance policy and tools specific to the examination of secondary caregivers in an investigation."[32] DHHS accepted that recommendation and created a new Standard Work Instruction policy for the Initial Assessment process which "direct[ed] workers to include information from the secondary caregiver, if a secondary caregiver is identified, in the Risk Assessment narrative" and "added language regarding the non-custodial parent when there are no allegations."[33] DHHS also developed a micro-training to help caseworkers correctly identify members of the SDM Households along with primary and secondary caregivers.

These changes to policy and procedure in response to the OIG's recommendations would have been in effect at the time of Z.Y.'s case. However, DHHS acknowledged to the OIG that its response to the 2020 recommendation "did not include enhancing policy and tools specific to the examination of secondary caregivers during an investigation. Substantive policy and tools that assist workers in the assessment of secondary caregivers has not yet been added to the investigative process."[34]

Then, in DHHS' FY 23–24 update on the status of the OIG's 2020 recommendation, it stated, in part, that it would be moving away from the SDM Model and that the new SAFE Model that

[30] See Neb. Rev. Stat. § 50-1814(1).
[31] See Office of Inspector General of Nebraska Child Welfare, *Investigation Summary: Death and Serious Injury Following a Child Maltreatment Investigation* (contained in *OIG Annual Report FY 15–16*, 49): https://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf.
[32] See Office of Inspector General of Nebraska Child Welfare, *Investigation Summary: Death or Serious Injury Following a Child Abuse Investigation June 2016–June 2019* (contained in *OIG Annual Report FY 20–21*, 17): https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20210915-164210.pdf.
[33] Office of Inspector General of Nebraska Child Welfare, *OIG Annual Report FY 20–21*, 44.
[34] Office of Inspector General of Nebraska Child Welfare, *OIG Annual Report FY 20–21*, 44.

was in development "allows for the assessment of all caregivers in the home weighted equally."[35]

This equal assessment of all caregivers that DHHS claims the SAFE Model allows for would have been another positive step in assessing the safety risks to children. However, the problem of DHHS not properly identifying the members of a family's household and assessing perpetrators of child abuse or neglect and other adults in a child's home who do not qualify as the child's "caregiver" could persist under the SAFE Model as well.

Based on the findings in this investigation, the OIG makes the following recommendation:

1. **Evaluate and enhance the identification and assessment of all persons with regular access to a child in the child's home.**

Regardless of the child welfare case management model used by DHHS moving forward, the OIG recommends that DHHS evaluate and enhance DHHS policy and practice regarding the identification of the members of a child's household and the assessment of those persons in the safety and risk assessment tools.

The OIG has identified—in this case and over a dozen others like it in its 2016 and 2020 investigations—instances in which a secondary caregiver, a caregiver's significant other, or another adult in the child's household who regularly visits the home when the child is present or contributes to the care of the child, is not being sufficiently included in the household and thus not investigated or assessed as a safety threat to the child. As noted, the current SDM guidance regarding who should be part of the SDM Household should be sufficient, if followed in practice, to capture those persons with regular access to the child in the home. DHHS should enhance the training and guidance around SDM Households to ensure that caseworkers are identifying all members of a household, including persons who regularly visit the home when the children are present.

Similarly, DHHS should also evaluate and enhance its safety and risk assessment tools to ensure that they do not focus too narrowly on primary and secondary caregivers to the exclusion of other persons identified to be in the household with access to the children.

This recommendation should be considered in the current context of the SDM Model or any other model, such as the SAFE model, that DHHS might utilize. DHHS noted, in its response to the OIG's request for updates on the implementation of past OIG recommendations, that the

[35] Office of Inspector General of Nebraska Child Welfare, *OIG Annual Report FY 23–24*, Appendix, https://nebraskalegislature.gov/FloorDocs/108/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20240916-120055.pdf.

SAFE Model would allow for the assessment of all persons and caregivers in the home through the Model's core concepts regarding child safety, such as assessing present and impending dangers and assessing and enhancing caregivers' protective capacities.

As this case and the numerous others in the OIG's 2016 and 2020 investigations demonstrate, persons who are not a child's legal parent, primary or secondary caregiver, but nonetheless have access to the child in the home are often an unrecognized danger to the child. The OIG recommends that DHHS ensure such persons are appropriately assessed as it moves forward with either the SDM Model, SAFE Model, or any other model.

APPENDIX

DHHS' August 1, 2025 Memorandum: Formal Response and Clarification to the OIG Report

OIG's August 28, 2025 Letter to DHHS in response to DHHS" August 1st Memorandum

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

To: Jennifer Carter, Inspector General
From: Dr. Bish, Director of Children and Family Service, Department of Health and Human Services
Date: August 1, 2025
Re: "Report of Investigation"

DHHS Formal Response and Clarification:

Page 1, Recommendation #1:
"DHHS failed to identify [redacted] *as a member of the* [redacted] *family's household under the SDM Model, and* [redacted] *should have been included in the safety assessment completed after the second intake involving* [redacted]*."*

DHHS Response:
DHHS disagrees with the statement "DHHS failed to identify [redacted] as a member of the [redacted] family's household under the SDM Model." According to DHHS policy and SDM tool, a person must provide 50% of care and reside in the home to be considered a household member. Because [redacted] did not provide 50% of care and he had his own residence, he was not considered a household member. Additionally, this case was reviewed several times prior to the child's death with the 1184 team, county attorney, and law enforcement. Information about DHHS policy and the reviews by outside entities was provided during an interview with the OIG on November 19, 2024 with DHHS-CFS Deputy Stolz and DHHS-CFS Legal Counsel Remus.

JENNIFER A. CARTER
Inspector General

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August 28, 2025

Dr. Alyssa Bish
Director, Children and Family Services
Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Dear Dr. Bish,

Thank you for your August 1, 2025 memorandum detailing DHHS' Formal Response and Clarifications regarding the OIG's Investigative Report, "Death of a Two-Year-Old Due to Physical Abuse by Parent's Significant Other." I am writing to follow up on your response and make clear what if any changes the OIG has made in the final report.

In the response, DHHS stated that it disagreed with the OIG's finding that DHHS had failed to identify the perpetrator – who was the mother's boyfriend – as part of the family's household under the Structured Decision Making (SDM) Model for purposes of assessing the family. The memo explains that DHHS requires a person to "provide 50% of care and reside in the home to be considered a household member." DHHS' position was further clarified in our WebEx conversation on August 18, 2025.

Given the clear language of the written SDM Household policy, the OIG stands by its determination that the perpetrator in this case should have been identified as a member of the household under the plain language of the policy. There is no residency requirement in the written policy and it specifically notes that significant others who visit the house frequently when the children are present should be considered part of the household.

However, given that DHHS' implementation and practice of the SDM Household policy is different and narrower than the written policy, it is understandable that the perpetrator in this case would not have been included in the household under DHHS' practice. As a result, the OIG reconsidered its finding that DHHS had failed to identify the perpetrator as part of the household. The report has been edited to remove that finding.

The second finding that current SDM policies and practices do not sufficiently identify or assess all persons in a child's household with regular access to the child who may pose a risk to the child's safety remains, as does the OIG's recommendation.

With regard to DHHS' note in the response that this case was reviewed by the 1184 Team, county attorney, and law enforcement, the OIG has added that fact as well as information from those reviews in both the background section and the finding.

Once again, we appreciate DHHS' feedback and the conversation clarifying the policy implementation.

With these changes, the report is considered to be final. We plan to share a public version (without confidential information) with the Legislative Oversight Committee. DHHS' response will be included with any confidential information redacted. In addition, as required by law, a summary of the report will be included in the annual report in September.

As always, we welcome any questions and are always happy to meet if that would be helpful.

Sincerely,

Jennifer A. Carter