OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE
SUMMARY OF ANNUAL REPORT
FISCAL YEAR 2023-2024

There was an increase in the number of child deaths reported to the OIG.

- 21 child deaths were reported to the OIG in FY 23-24 compared to 11 in FY 22-23.
- 7 of those deaths involved co-sleeping or unsafe sleep.
- 8 others were the result of medical issues or accidents.
- 3 deaths were caused by abuse or neglect but the family was not known to DHHS before the death.
- 3 deaths will be investigated by the OIG because the child was either being served by the system or in a facility licensed by DHHS.

There was an increase in the number of serious injuries to children reported to the OIG.

- 27 serious injuries of children were reported to the OIG in FY 23-24 compared to 15 in FY 22-23.
- 7 of the serious injuries were caused by suspected abuse and neglect but the family was not known to DHHS before the injury.
- 11 serious injuries were not the result of abuse or neglect.
- 8 serious injuries will be investigated by the OIG because the child was either being served by the child welfare system or in a facility licensed by DHHS.

There was an increase in most of the critical indicators reported by the YRTCs.

- YRTC-Kearney experienced a large increase in assaults on staff and youth. The majority of serious assaults were committed by the same five youth.
- There was a significant increase in incidents of self-harm at YRTC-Hastings, increasing to 220 from 59 the previous year. Almost all incidents resulted in minor injuries.
- There was an increase in the use of mechanical restraints across all YRTCs.

There was a slight decrease in the number of sexual abuse allegations by state wards.

- There were 244 allegations of sexual abuse of state wards in FY 23-24, down from 271 in FY 22-23.
- It is important to note that these are **allegations**, not the number of substantiated cases.
- However, the number of substantiated cases (meaning a court or DHHS found evidence to support the allegations) also rose this year to 14 compared to 6 substantiated cases for FY 22-23.

The OIG completed one investigation into the death of a child in a licensed daycare setting.

- The OIG recommended DHHS revise its regulations to reflect best practices regarding the monitoring of sleeping infants. DHHS accepted that recommendation and reported that regulation changes similar to the OIG's recommendations were already underway.

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

- DHHS announced it will move from the Structured Decision Making (SDM) model used to assess families for abuse and neglect to a different model called the Safety Assessment Family Evaluation (SAFE) model.
- DHHS will also end its contract with UNL's Center for Children, Families, and the Law for new caseworker training, opting to bring this training in-house.