Office of the Inspector General of Nebraska Child Welfare

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Overview of the OIG

- Created by the Legislature in 2012
  - One of 18 recommendations of a study of child welfare privatization - LR 37 (2011)
    - "...to enhance accountability and facilitate reform in the child welfare system."
  - Oversight of DHHS employees and contractors
- Housed in the legislative branch, within the Ombudsman's office
- Jurisdiction expanded in 2015 to include juvenile justice agencies and contractors:
  - Juvenile Probation
  - Nebraska Commission on Law Enforcement and Criminal Justice
  - Juvenile Detention
  - Juvenile Diversion

Role of the OIG

- Conduct confidential, independent investigations and reviews of child welfare and juvenile justice operations
  - Investigate deaths and serious injury to children
  - Look into allegations of misconduct and violations of law by individuals and agencies serving children and families
  - Identify systemic issues and needed policy changes
  - Assist in improving agency and system operations and outcomes

Association of Inspectors General

Values

- Honesty
- Integrity
- Trustworthiness
- Independence
- Confidentiality
- Promoting:
  - Accountability
  - Transparency
  - Good Government
  - High Performance

"...The public expects OIGs to hold government official accountable...and to prevent, detect, identify, expose and eliminate fraud, ...illegal acts and abuse. This public expectation is best served by inspectors general when they follow the basic principles of integrity, objectivity, independence, confidentiality, professionalism, competence, courage, trust, honesty, fairness, forthrightness, public accountability and respect..."

-- Statement of Principles for Offices of Inspector General, Association of Inspectors General

OIG Operations

- Critical Incident Reviews
- Complaint Reviews
- Investigations
- Reports
  - Individual Investigations
  - Annual Report
  - Juvenile Room Confinement

In FY 2015-2016, the OIG received 577 cases:

- 385 critical incidents (22 deaths, 20 serious injuries)
- 155 complaints
- 24 reports or requests for information
- 13 grievance reports from DHHS

OIG Operations, FY 15-16

- The OIG completed:
  - Investigations into 22 deaths or serious injuries of system-involved children and 4 deaths in licensed child care facilities;
    - Serious Injury after 11 Reports of Physical Abuse
    - Death or Serious Injury after a Child Maltreatment Investigation (11 children)
    - Sudden Unexpected Infant Deaths (11 children)
    - Suicides of State Wards (2 children)
    - Death of Youth Jointly Served by DHHS & Probation
  - An investigation into deteriorating conditions and violations of law at YRTC-Kearney

OIG Operations, FY 15-16

- The OIG issued 30 recommendations – 26 to DHHS, 4 to Probation – related to:
  - Caseload and Workload for Caseworkers and Other Staff
  - Strengthening the Workforce – Specialization and Training
  - Coordination between Agencies Serving Children
  - Enhancements to Internal and External Performance Monitoring

Investigation:
Serious Injury After 11 Reports of Physical Abuse

Case Scenario: A 4-year-old, whose family had recently agreed to participate in a voluntary child welfare case, was admitted to the hospital with a skull fracture and bruising all over his body.

The subsequent investigation revealed that his father was responsible and had repeatedly physically abused him. In the six months before the injury, the Hotline had received 11 reports of alleged physical abuse of the 4-year-old by his father, five of which were investigated by DHHS, law enforcement, or both.

The OIG's Investigation Found:

- The Hotline made errors that either delayed or prevented injuries from being assessed.
- Medical information was repeatedly misinterpreted by DHHS and law enforcement, leading them to dismiss the child's recurring injuries.
- Investigations into the possible abuse were flawed. Key evidence was not gathered, including photographs of the child's injuries. Interviews were not appropriately conducted.
- DHHS staff did not fully rely on their assessment tool to guide decisions about child safety.
- A slow transition to ongoing case management meant that even though a case was open when the child's serious injury occurred, no supports or services were being provided to the family.

Recommendations:
Serious Injury After 11 Reports of Physical Abuse

Based on the findings in its investigation, the OIG recommended:

- Implement training on the medical aspects of child abuse.
- Adopt policy on photographing injuries during Initial Assessment.
- Develop additional, specialized training for Initial Assessment staff.
- Further define process for utilizing child advocacy centers by Initial Assessment.
- Update and provide additional detail on response priority definitions at the Hotline.
- Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.
- Expand quality assurance and continuous quality improvement (CQI) at the Hotline.

DHHS accepted all recommendations.

Investigation:
Death and Serious Injury Following Child Maltreatment Investigations

Case Scenario: Between July 2013 and June 2015, 2 deaths and 9 serious injuries following a child maltreatment investigation were reported to the OIG.

After each of the DHHS investigations (also called Initial Assessments), no case was opened to offer ongoing services to the families. In all of the cases, the injuries were caused by abuse or neglect. The OIG examined each case and also identified trends and larger issues.

Findings:
Death and Serious Injury Following Child Maltreatment Investigations

The OIG's Investigation Found:

- Children age 3 and under were the victims in every case. The OIG found specific challenges which limited the effectiveness of Initial Assessments with very young children.
- Physical abuse by the child's father or mother's male partner was the cause of injury in the majority of cases. Assessment of the perpetrators was often limited before the death or serious injury.
- Half of the families scored as high risk for future abuse or neglect by DHHS. However, even those that scored as moderate risk had significant risk factors for abuse and neglect present.
- Most children injured lived in rural communities, which impacted Initial Assessment practice and families' access to resources.
- In half of the cases, the Hotline received an additional call between the Initial Assessment closing and the death or serious injury. Errors were made that limited DHHS' ability to appropriately screen calls.
- Every investigation conducted before a death or serious injury involved law enforcement, medical professionals, or both. Poor coordination with or poor practice by these entities contributed to bad outcomes in many cases.
- Initial Assessment policy and procedure were not consistently followed. Required documentation was not gathered and interviews with key collateral contacts did not occur.
- Initial Assessment and mixed caseloads do not comply with state law. High caseloads negatively impact the ability to do thorough, quality work and follow DHHS policy.

Recommendations: Death and Serious Injury Following Child Maltreatment Investigations

Based on the findings in its investigation, the OIG recommended:

- Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.
- Take steps toward greater Initial Assessment workforce specialization and experience.
- Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.
- Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials distributed by the Division of Public Health.
- Increase the capacity for the CFS workforce to participate in pediatric abusive head trauma prevention efforts.
- Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.
- Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.
- Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.
- Restructure the Children's Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.

DHHS accepted all recommendations.

Investigation: Deteriorating Conditions at YRTC-Kearney

Case Scenario: During the 2015-16 fiscal year, the OIG experienced a more than 300 percent increase in complaints and critical incidents related to the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K), Nebraska's residential facility for boys in the juvenile justice system.

The investigation focused on the administrative oversight and decision-making that allowed a deterioration of conditions and violations of state law at YRTC-K to go unchecked while the facility was without a full-time administrator.

Findings:
Deteriorating Conditions at YRTC-Kearney

The OIG's Investigation Found:

- Key data measures significantly worsened while YRTC-K was without a full-time administrator;
- The decision to remove the prior facility administrator was made hastily and under outside pressure, without adequate consideration for the impact it might have on the youth and facility;
- There was no appropriate plan in place for how YRTC-K would operate under interim administration;
- The Office of Juvenile Services (OJS) Administrator was not able to fulfill job duties related to YRTC-K, leaving the facility without appropriate oversight;
- Central Office administrators were unaware of the specifics of programs and planning at YRTC-K that were unlawful and producing negative outcomes for youth; and
- Youth at YRTC-K, especially those living fulltime in the Dickson Unit, were continually subject to conditions that were not compliant with Nebraska law.

Recommendations:
Deteriorating Conditions at YRTC-Kearney

Based on the findings in its investigation, the OIG recommended:

- Make the OJS Administrator a Full-time Position
- Close or Appropriately Restructure Full-time Secure Care Program in Dickson, D5
- Develop Continuous Quality Improvement Process Led by Central Office
- Develop and implement a comprehensive Strategic Staffing Plan at YRTC-K
- Digitalize Records

DHHS accepted 4 of 5 recommendations.

Referrals to the OIG

- Walk-Ins or Appointments
- Email: OIG@leg.ne.gov
- Online complaint form: oig.legislature.ne.gov
- Phone: 402-471-4211 or 855-460-6784

Thank You!

Questions?

Contact our office:

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