

JULIE L. ROGERS
Inspector General



STATE OF NEBRASKA
OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE
State Capitol, P.O. Box 94604
Lincoln, Nebraska 68509-4604
402-471-4211
Toll Free 855-460-6784
Fax 402-471-4277
oig@leg.ne.gov

September 15, 2019

Dear Governor Ricketts, Justices of the Nebraska Supreme Court, and Members of the Nebraska Legislature:

It is my honor to submit to you the 2019 Annual Report of the Office of Inspector General of Nebraska Child Welfare (OIG). This report provides an account of the OIG's activities over the past fiscal year. We thank the youth, parents, relatives, foster parents, front line staff, supervisors, administrators, private providers, professionals, and others who worked with our office and brought their concerns to our attention. We take their trust in our work most seriously.

Since beginning operations, the OIG has witnessed positive changes to the systems serving Nebraska's children and families. As we begin our 8th year, we continue our work providing accountability related to multiple governmental agencies—in licensed day cares and group homes; those receiving services through the DHHS, those held in juvenile detention; and those at the Youth Rehabilitation and Treatment Centers. Of the 590 cases the OIG received as intakes this year, the majority have been handled competently by system professionals with no major violations of policy or law.

Of the system improvements made in the past year, it is important to highlight one DHHS policy change that is significant. The child abuse and neglect hotline is now required to accept all reports made by medical professionals for investigation (initial assessment) if the identified child is age five or under. We are encouraged that now all such medical professional concerns will be assessed, especially as these children are not yet school age, and a medical professional may be the only ones outside of the family to see and recognize possible child abuse and neglect.

Emerging and Continuing Topics

Amid improvements and changes to the child welfare system, there is still substantial work to do. At present time, there are many efforts underway that, taken all together, provides an uneasiness

permeating across our state regarding the welfare of children. Topics contributing to this unease and discomfort include, but are not limited to:

- The recent increase in serving families through non-court cases instead of court cases;
- Parent and children drug testing protocol change;
- Proposed regulation changes (currently in the formal promulgation process) to expand Alternative Response program eligibility and to related processes;
- The lack of services statewide, including a lack of individualized services for high risk youth with complex needs;
- The federal Family First Prevention Services Act set to be fully implemented in Nebraska starting October 1;
- Whole proposed changes to DHHS child welfare regulations (currently in the formal promulgation process), most of which are stricken in their entirety;
- Ongoing significant facility, staffing, and programming issues with the YRTCs; and
- The Eastern Service Area transition in case management provider occurring until the end of the calendar year and the associated pending litigation.

In addition, on August 16th, DHHS announced the resignation of Children and Family Services Director Matt Wallen, which became effective September 8. Things like pending litigation and changes in CFS leadership could make high-stakes transitions and changes more challenging than under normal circumstances.

Our system will require diligence on the part of all of us as improvements are identified and acted upon. It is critical that continuity of care is maintained for the children and families of the state no matter the outcome of a host of modifications.

Finally, there must be analysis of qualitative measures as whole system changes are made. It is not enough to simply note that Nebraska has fewer state wards, for example. In addition, we need to dig deeper and ask whether children are safer and more stable because of these changes. In every case, we should welcome lessons learned in order to continually adjust and improve. We must insist on great expectations for all of Nebraska's children, youth, and families, no matter their struggles.

As always, I genuinely appreciate your support of transparency, and of the search for truth in government and in the administration of our child welfare and juvenile justice systems. It is a privilege to serve as your Inspector General of Nebraska Child Welfare.

Thank you for your time and attention to this report.

Very sincerely,



Julie L. Rogers

OVERVIEW

The Office of Inspector General of Nebraska Child Welfare (OIG) provides accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, identification of systemic issues, and recommendations for improvement.

Housed within the Nebraska Legislature, the OIG investigates: complaints and allegations of wrongdoing by agencies and individuals involved in these systems; deaths and serious injuries of system-involved children; system-wide looks at concerning topic areas; and other critical incidents related to children involved with the child welfare and juvenile justice system. The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice system. Instead, investigations and reviews function as part of the Legislature's oversight of these important state functions.

Each year, the OIG is required to publish an Annual Report. The report must provide a summary of the OIG's investigations, including the recommendations it has made and their implementation status.¹ The following summarizes the work of the OIG from July 1, 2018 to June 30, 2019 and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made in prior years.

¹ Neb. Rev. Stat. § 43-4331.

OIG RECOMMENDATION HIGHLIGHTS

An Inspector General's job is to make recommendations. The Office of Inspector General of Nebraska Child Welfare Act² sets forth that the Office of Inspector General (OIG) is to assist in improving operations of Nebraska's child welfare and juvenile justice systems, and that is done through recommendations based on investigations coupled with interviews, case specific document review, and research and analysis. Recommendations by the OIG are made both informally and formally. A full list of recommendations and the status of each, appears at the end of this report.

Recommendations Made in FY 2018-19

The OIG made several formal recommendations during FY 18-19 based on investigations into child deaths and serious injuries. Full summaries of such investigations can be found on page 26.

DHHS *accepted* two formal recommendations. These recommendations were made as part of an investigation of a child death in a foster home:

- Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS, with no timeframes, are lifted.
- Create a policy regarding placement disruption plans with specific reference to where such plans should be located and found on N-FOCUS.

DHHS *rejected* five formal recommendations. These recommendations were made as part of an investigation into infant deaths and serious injuries born to families involved in a CPS case:

- Develop Policy and Procedure for caseworkers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.
- Clarify the definition of "change in circumstance" as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.
- Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.
- Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.
- Implement trauma-informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.

² Neb. Rev. Stat. §§43-4301 – 43-4332.

Recommendations Acted On in FY 2018-19

Statutory Caseload Compliance

Over the years, recommendations made by the OIG relate to caseloads and workloads for frontline child welfare staff. One example of such a formal recommendation is:

- Meet the statutorily required caseload standard for initial assessment and ongoing case management.

Front line professionals have extremely challenging jobs. They are charged with making crucial decisions about children's safety, engaging struggling parents and families, and ensuring youth have access to the care, services, loving and supportive relationships that they need to succeed. Front line workers frequently require those who take on this enormous task to respond to the urgent needs of children and families every day of the week and all hours of the day and night.

A skilled and stable child welfare workforce is key to successful outcomes for children and families and the child welfare system as a whole, especially when more and more is expected of this workforce. This is achieved when front line staff have manageable caseloads and workloads, when they are well-trained and educated, and when turnover is minimized. Increasing the professionalization and stability of the child welfare workforce has received significant attention in Nebraska in recent years from the Legislature, DHHS, and others. Efforts to improve the child welfare workforce through better training, education, recruiting, and retention show promise.

DHHS has been making progress in addressing these recommendations, but the caseload limits set forth in statute have not yet been reached. Efforts by DHHS continue in achieving manageable caseloads and workloads.

DHHS believes they have enough full-time employee positions to meet Child Welfare League of America caseload standards. Turnover has been decreasing with DHHS reporting (July 2019) an average 3% monthly turnover rate. Though caseload numbers are better than in the past (DHHS reported 91.9% statewide in compliance as of July 2019), DHHS continues to be out of compliance with statutorily required caseload standards. A monthly caseload report can be found on their website. DHHS called a working group of internal and external stakeholders to look at the current caseload standards.

A caseload initiative at DHHS is underway. The initiative counts caseloads by the number of children (as opposed to number of families), and it incorporates worker skill level. It is being tested in the field. Based on this initiative, DHHS hopes to propose new statutory language to the caseload requirement in Nebraska law for the 2020 Legislative Session.

Residential Child-Caring Agency Regulations

Several OIG recommendations are related to improving licensed residential child-caring agency regulations. Specifically, the OIG recommended that regulations include requirements on: how medications (including psychotropic medications) are dispensed and monitored; medical record-keeping and documentation; and consents for treatment.

DHHS had new residential child-caring agency regulations drafted, and the formal promulgation process is now underway. A public hearing on the new regulations was held in August 2019.

Recommendations Completed in FY 2018-19

Several OIG recommendations were **completed** by DHHS:

Improve Home Study Process

- To help ensure quality home studies across the state, DHHS is entering into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts will begin November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.

Provide stronger supports for kinship and relative foster families

- Pre-service online training for foster parents is being offered to relative and kinship placements in order to get more placements licensed. As a foster child's needs are identified, the relative and kinship foster placement will receive specialized training accordingly.

The Nebraska Foster and Adoptive Parent Association provides specialized training, Kinship Connection, across the state. Nebraska received Kinship Navigator funds available through the Family First Prevention Services Act—U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACYF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska's Kinship Navigator program will begin October 1, 2019.

Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.

- DHHS has collected data on high/very-high risk families declining services and has seen a slight increase in the acceptance of services.

DHHS has implemented Safety Organizing Practice (SOP), a family engagement model, over the past 6-12 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement.

Revise regulations to require infant safe sleep training before granting a child care license.

- LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted.

Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.

- Public Health has reported sharing information with both CFS and Probation in a more timely way, and, when possible, conducting joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing. DHHS reports that it shares information on licensing actions and has been coordinating effectively on investigations.

Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.

- LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS has created a new Critical Incident Reporting form accordingly. The form will be utilized statewide by September 2019.

End the practice of screening law enforcement reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.

- DHHS reports that CFS Central Office Administrators and other staff review every "Does Not Meet Definition" screen. DHHS analyzed reasons why intakes were being re-screened and adopted definitions. The CQI team performs qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, are following proper practice and policy.

Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.

- DHHS reports that the Hotline Administrator reviewed the intake process, and QA staff put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed to ensure appropriate use of policy and discretionary overrides. So far this year, of the over 1700 intakes that have been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.

Adhere to policy on out of home assessments and enhance quality assurance

- DHHS has developed new protocols to complete out of home assessments when the child is placed at a DHHS facility.
- DHHS is in the process of developing new policy on out of home assessments for all other placements. The process will engage front line workers who complete these assessments in

creating the new policy. Part of the analysis will focus on how involved Central Office will be in these assessments.

Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation. Review and revise training on child sexual abuse for DHHS staff. Include a component on child sexual abuse prevention in foster and adoptive parent training. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.

- DHHS has contracted with Project Harmony to develop the curriculum for developmentally-appropriate education to prevent sexual abuse and exploitation within the child welfare system. A 3-module training was developed:
 1. Darkness to Light
 2. Sexual Health, Behaviors, and Abuse of Children
 3. Bringing it Home: Managing Sexual Abuse and Behaviors.

Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.

- DHHS has revised contracts with child-placing agencies to better align caregiver and child needs. Specific training for foster parents will be provided based on the specific child's needs. A request for proposals has been developed for resource families. The family's voice and choice is being incorporated into these revisions. Caseworkers are utilizing Safety Organized Practice across the state. Many of these strategies are incorporated into Nebraska's performance improvement plan (PIP).

Strengthen foster care licensing to remove inappropriate and unsuitable homes.

- DHHS has enhanced the application process for foster parenting to better screen foster homes, and DHHS has issued an RFP for home studies in order to improve the process. DHHS has made modifications to regulations, which are presently in the promulgation process, to comply with more stringent foster care, adoptive, and guardianship model licensing standards.

When currently licensed foster parents apply to renew their license, they will have to be in compliance with the new requirements—complete the updated application, home study, compliance checklist, and the like. Those not in compliance with the new regulations will no longer remain as a licensed foster parent.

Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.

- Public Health reports that goal timelines have been developed and implemented. LB 59 was passed into law during the 2019 Legislative Session, which requires that investigatory reports made under the Children's Residential Facilities and Placing Licensure Act be issued 60 days after the determination is made to conduct the investigation, except that the report may be filed within 90 days if an interim report is filed within 60 days.