Office of Inspector General of Nebraska Child Welfare

ANNUAL REPORT 2019-2020 OVERVIEW

JENNIFER A. CARTER, INSPECTOR GENERAL

Purpose & Jurisdiction

- 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.
- The OIG investigates:
  - Complaints and allegations of wrongdoing by agencies and individuals involved in these systems
  - Deaths and serious injuries of system-involved youth
  - Other critical incidents involving youth in these systems
  - Any other systemic concerns that are raised by the intakes the OIG receives

Annual Report

- The OIG releases an annual report each year which includes:
  - A highlight of current critical issues
  - A summary of the intakes the OIG has received
  - Completed investigations
  - Summaries of other reports that have been completed in that fiscal year

Current Issues

- The FY 19-20 Annual Report highlighted three issues being monitored by the OIG as they potentially influence the current environment within the child welfare and juvenile justice systems.
- Youth Rehabilitation and Treatment Centers
  - YRTC-Geneva crisis and ongoing instability in the YRTC system
- Children & Family Services
  - Caseloads
  - Eastern Service Area – St. Francis Ministries

Youth Rehabilitation and Treatment Centers

- OIG initiated a full investigation into the circumstances that led to the crisis at and closure of YRTC-Geneva.
- Over the course of the last 14 months, the YRTC system has been in a constant state of change and the OIG has been engaged on those issues as they arise, including:
  - Issues regarding the transfer of the female youth to YRTC-Kearney
  - Escapes and assaults
  - Staffing challenges
  - Leadership changes
  - Two different business plans between October and July
  - The transfer of the Chemical Dependency Program from the Hastings Regional Center to Whitehall and the creation of a YRTC in Hastings

Youth Rehabilitation and Treatment Centers

- The OIG recommended that DHHS refrain from implementing any additional major changes to the YRTC system, including the then impending plan to move the JCDP to Lincoln and create a YRTC in Hastings, until the plans were developed and fully vetted with stakeholders and experts in juvenile justice.
- In addition, the OIG encourages DHHS administration to share plans and proposed changes transparently and frequently with community partners, stakeholders and the general public within a reasonable timeframe prior to taking action.

Children & Family Service

- Over the past eight years DHHS has improved their efforts to meet the caseload limits set forth in statute. However, caseload issues continued to trouble the Nebraska Child Welfare system during FY 19-20.
  - FY 19-20 level of caseload compliance statewide is at 80%
  - Down from 92% in FY 18-19
- Eastern Service Area -St. Francis Ministries contributing significantly to decline
  - DHHS is currently engaged in supporting St. Francis Ministries through contract monitoring and monthly leadership meetings.

OIG Intakes & Summary for FY 19-20

- **198 Critical Incidents:** Reports submitted by DHHS, the office of Juvenile Probation;

  Critical Incident would include Death & Serious Injury Notifications

- **179 Complaints:** Issues reported by the general public via phone, email or website form;

- **19 Requests for Information:** Requests made by the public to the OIG;

- **7 Grievances:** Copies of grievances made to DHHS and the DHHS findings; and

- **4** Alternative Response Reports

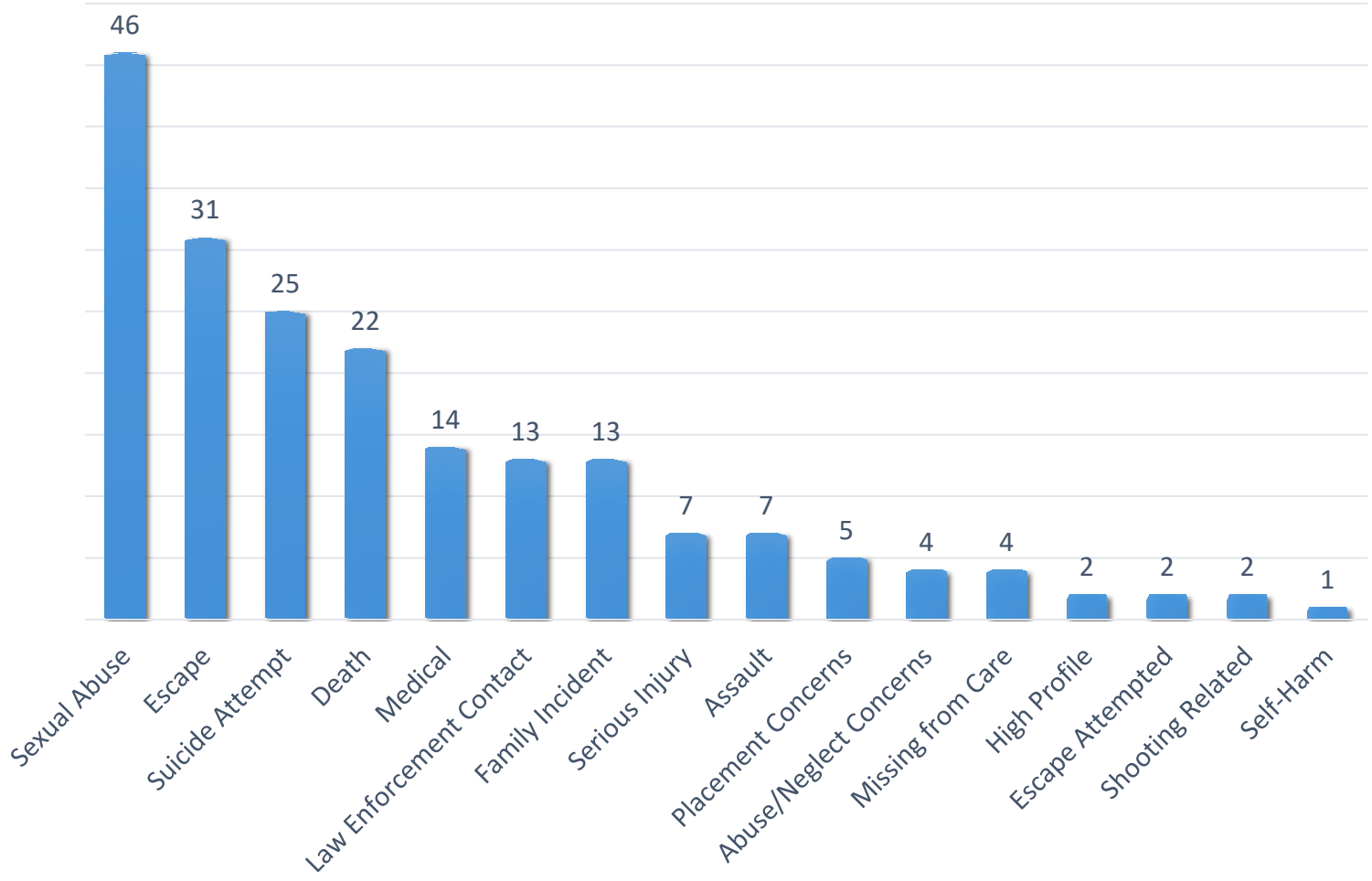
Critical Incidents

160 reported by DHHS;

36 reported by Juvenile Probation; and

2 reported by a Service Provider for DHHS.

Figure 1. Critical Incidents FY 19-20 by Incident Type



Death & Serious Injury

The OIG is required to investigate death and serious injury of system-involved youth who are:

(1) placed in an out of home care;

(2) currently receiving or have received child welfare services from DHHS in the past twelve months;

(3) currently receiving or have received services from the Juvenile Probation in the past twelve months;

(4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months; and,

(5) in a licensed facility.

The OIG is not required to investigate deaths that occurred by chance. Serious injury is defined as, injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.

Death & Serious Injury

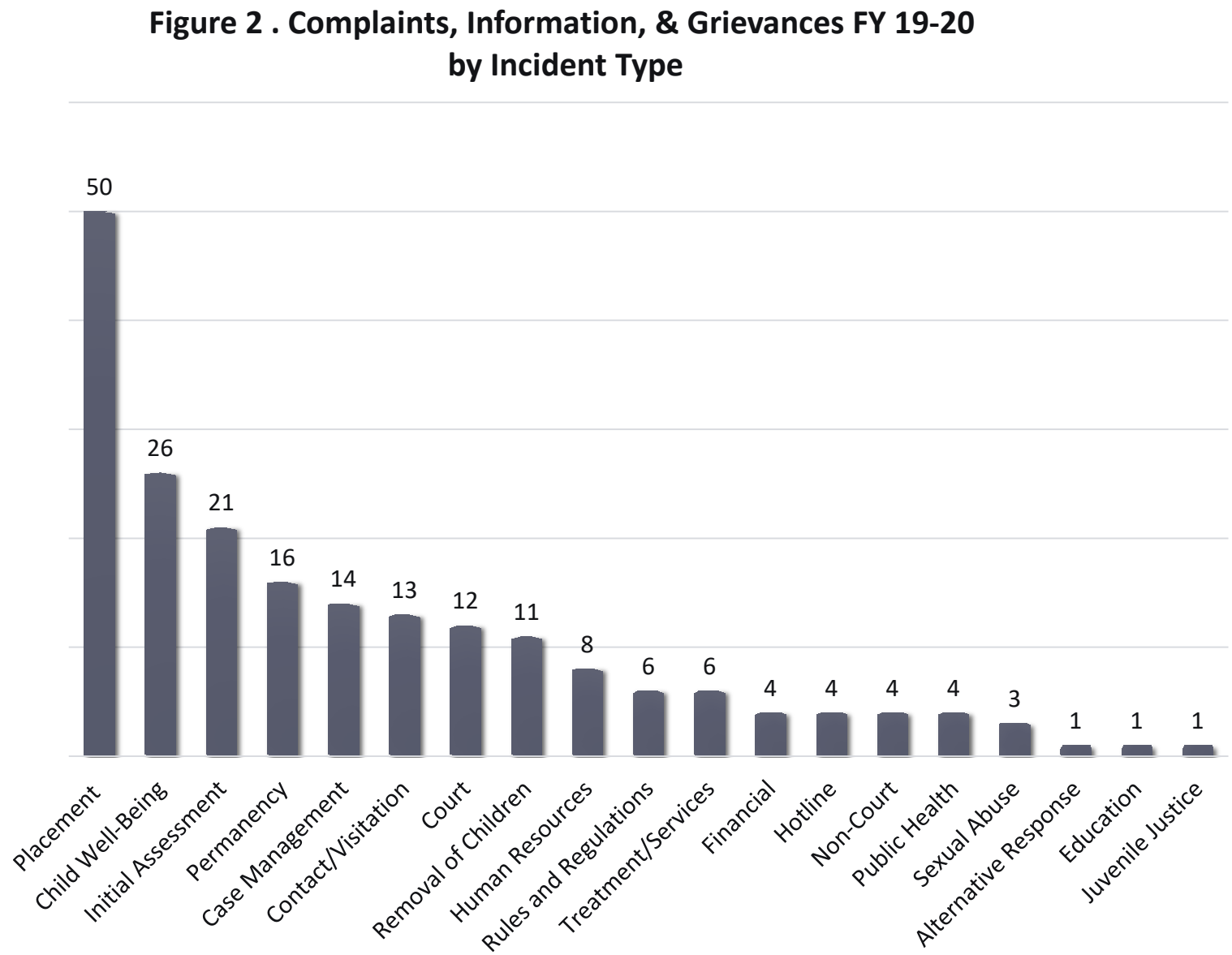
- **22** reported child deaths in FY 19-20.
- **2** had sufficient contact or involvement in the juvenile justice system to merit opening an investigation.
  - Both youth were on juvenile probation when they completed suicide.
- **7** serious injuries reported in FY 19-20**.**
  - The OIG did not open investigations into these critical incidents as they did not have sufficient contact or involvement in the child welfare system.

Complaints, Requests for Information & Grievances

The OIG investigates allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations by:

- DHHS
- Juvenile Services Division (Juvenile Probation);
- The Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) juvenile justice programs;
- Private child welfare agencies and foster parents, licensed child care facilities, and contractors of DHHS and Juvenile Probation; and
- Juvenile detention and staff secure detention facilities.

Complaints, Requests for Information & Grievances



Alternative Response

- The OIG is tasked with reviewing and investigating critical incidents and complaints related to AR. The OIG must report on any AR cases it reviews in its Annual Report.
- The following FY 19-20 critical incidents were reported to the OIG where the family had AR involvement:
  - **1 Critical Incident within 12 months** of AR involvement;
  - **2 Critical Incidents with current AR** involvement; and
  - **1 Complaint with current AR** involvement.
- The OIG conducted a preliminary review of each case, which did not result in a full investigation.

Investigations completed in FY 19-20

Serious Injury of a 7-year-old due to Abuse and Neglect within 12 months of Family Involvement in a Non-Court Case

Investigation into the serious injury of a seven-year-old boy, “Ben”, due to abuse and neglect by his parents. The family was DHHS-involved eight months prior to the critical incident due to the family participating in a non-court case.

The OIG made several recommendations in response to this investigation.

Serious Injury of a 5-month-old within One Year of DHHS Services

Investigation into the serious injury of five-month-old “Ethan” due to physical abuse perpetrated by his biological father. The infant’s mother was party to an open Children and Family Services (CFS) case five months prior to the serious injury of the infant. The case included the mother and her two older children.

No system-wide recommendations were made as a result of this investigation.

Juvenile Room Confinement FY 18-19 Synopsis

For FY 2018-19 the OIG received room confinement reports from 32 individual facilities comprised of five different types of juvenile facilities in Nebraska—correctional institutions, youth rehabilitation and treatment centers, detention centers, mental health and substance abuse treatment centers, and residential child-caring agencies.

FINDINGS

- *Over the past three years, limited changes have been made to decrease reliance on juvenile room confinement as a management tool among the facilities that report;*
- *Subjective interpretations of the current statute have resulted in inconsistent reporting;*
- *The Jail Standards Board at the Nebraska Crime Commission and the Department of Health and Human Services-Division of Public Health have not revised their regulations to incorporate statutes related to juvenile room confinement.*

RECOMMENDATION TO THE LEGISLATURE

IMPLEMENT LEGISLATION THAT REQUIRES THE FOLLOWING:

- *All facilities adhere to best practices to reduce reliance on juvenile room confinement;*
- *Clarification of current legislative provisions related to juvenile room confinement; and*
- *Extension of the Crime Commission and Department of Health and Human Services-Division of Public Health responsibilities related to juvenile room confinement to include, at a minimum, on-site verification and standardized data collection and content.*

OIG Recommendations 2016-2020

- Reports of investigation issued by the OIG contain recommendations for systemic reform and/or case-specific action.
- The OIG's annual report is required by Neb. Rev. Stat. § 43-4331 to detail recommendations and the status of implementation of recommendations.
- The OIG has made a total of 93 recommendations to date.
- A detailed list including the current status of each recommendation can be found in the FY 19-20 Annual Report.
- All OIG Annual Reports can be found at http://oig.legislature.ne.gov/.

OIG Contact Information

Anyone may file a complaint with the OIG regarding concerns about specific children and cases or broad misconduct in the child welfare and juvenile justice systems. The information provided is confidential as is the identity of the reporting party. A complaint may be filed online or you may call, email, or write a letter.

Website:
http://oig.legislature.ne.gov/

Email: OIG@leg.ne.gov

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P.O. Box 94604
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Nebraska Abuse and Neglect Hotline
1-800-652-1999

National Suicide Prevention Lifeline
1-800-273-8255

Nebraska Family Helpline
1-888-866-8660