Office of

Inspector General of Nebraska Child Welfare

Annual Report

2021-2022

September 15, 2022

The Office of Inspector General of Nebraska Child Welfare thanks and acknowledges the Nebraska Legislature and legislative staff for their continued support, particularly the Executive Board and the Health and Human Services and Judiciary Committees.

Jennifer Carter
Inspector General

Sharen Saf
Assistant Inspector General

Noah Karmann
Assistant Inspector General

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 email, write a letter, or call our toll-free number.

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

Email: OIG@leg.ne.gov

State Capitol
P.O. Box 94604
Lincoln, NE 68509-4604

402-471-4211 or 855-460-6784 (toll free)

Nebraska Abuse and Neglect Hotline
1-800-652-1999

National Suicide Prevention Lifeline
1-800-273-8255

Nebraska Family Helpline
1-888-866-8660

Table of Contents

Message from the Inspector General of Nebraska Child Welfare

The Office of Inspector General of Nebraska Child Welfare (OIG) is honored to present our Annual Report for the Fiscal Year starting on July 1, 2021 and ending June 30, 2022. As an office dedicated to transparency, integrity, and accountability in government, we are grateful for the opportunity to share our work.

This annual report summarizes issues the OIG addressed in Fiscal Year 2021-2022, identifies emerging issues in the child welfare and juvenile justice systems, includes summaries of the investigatory reports completed by the OIG in FY 21-22, and provides updates on the OIG's recommendations and their implementation status since 2015.

In FY 21-22, much of the OIG's focus remained on the child welfare system's Eastern Service Area (ESA) and the contract with Saint Francis Ministries, Inc. for case management services. In late September 2021, the OIG released its special report of investigation regarding the ESA which recommended that the contract with Saint Francis be terminated and the pilot project for privatized case management in the ESA ended. After the December 2021 announcement that the contract would in fact be terminated, the OIG has closely monitored the transition of case management back to the Department of Health and Human Services. We have appreciated the productive communication with and transparency of the Director of the Division of Children and Family Services and her staff during this process.

In addition to monitoring the ESA, the OIG continued to monitor the Youth Rehabilitation and Treatment Centers (YRTC), including the reports that were newly required by the Legislature in FY 21-22. As always, the OIG also monitored a variety of issues through our vetting of over 400 incident reports and complaints. In general, after two years of major system-level challenges in the ESA and at the YRTCs, the child welfare and YRTC systems appear to be more stable than they have been in over two years. However, the absence of crises does not equate to an absence of significant issues.

Several themes have emerged this last fiscal year and these are issues the OIG will continue to monitor and investigate in the year ahead. There has been a significant increase in reports of serious injuries to children in the child welfare system that the OIG is required to investigate. Similarly, there has been a marked increase in incidents and complaints related to cases receiving an Alternative Response (AR). The OIG reviewed 17 AR cases this year, four of which will require an investigation into serious injuries. Last year, the OIG had no AR cases to review. In addition, there have been increasing concerns regarding the availability, stability, and quality of placements for children.

At this time, it is difficult to determine the cause of these identified issues. However, a likely potential factor is the continued toll the pandemic and the stress of the last several years has taken on our families, children, and systems. Stakeholders throughout the system have discussed the increasing need for and challenges accessing the services families need. These are issues that the Legislature, and all of us, must continue to be alert to and mindful of as the consequences of the pandemic linger and continue to reveal themselves.

It is important to note that the stress in the child welfare and juvenile justice systems is felt not just by children and families, but also by the employees working directly with children and families in need. This is difficult, challenging, complex, and often heartbreaking work that was made only more difficult in the last few years. As we note each year, the majority of intakes that the OIG receives are handled

competently by these professionals. We appreciate and acknowledge this hard work. When support for these employees is prioritized, it results in better support for our children and families which benefits all of Nebraska.

The OIG acknowledges that there are challenges in Nebraska's child welfare and juvenile justice systems beyond those mentioned in this report. We will continue to review the issues brought to our attention and we are grateful to those who reach out to share their concerns and to the system partners for their insights and transparency.

I would also like to acknowledge the hard work and professionalism of the OIG staff. We are a small office with a significant mission. After a decade of work, we remain committed to meeting the high standards of Inspector General offices and to fostering and promoting accountability in the Nebraska agencies serving children, youth, and families.

Jennifer A. Carter
Inspector General

About the Office of Inspector General

The Office of Inspector General of Nebraska Child Welfare was created by the Legislature to "[e]stablish a full-time program of investigation and performance review to provide increased accountability and oversight" and assist in improving the child welfare and juvenile justice systems.[1]

Inspectors General have served as an important part of government in the United States since the Revolutionary War. During the war, George Washington was concerned with the training and readiness of the militia, and the Continental Congress wanted accountability for its investment in the militia. To address these concerns, they looked to Europe where Inspectors General had been utilized for over 100 years. The concept was borrowed, and in 1777 the first Inspector General in the United States was appointed with oversight over the militia. Inspectors General have been used extensively in the United States military since that time. In the 1950s, an Inspector General was appointed within the Central Intelligence Agency and in 1978 the Inspector General Act was passed creating an Inspector General in each of 12 federal departments. Today there are 75 Inspectors General at the federal level and over 200 state and local level offices dedicated to government accountability and oversight.

The Office of Inspector General of Nebraska Child Welfare provides accountability for and may conduct investigations involving the following entities:

- Department of Health and Human Services (for both the Division of Children and Family Services regarding child welfare and the Division of Public Health for the licensing of facilities)
- Administrative Office of Probation, Juvenile Services Division
- The Commission on Law Enforcement and Criminal Justice's Juvenile Justice Programs
- Private agencies and service providers in the child welfare and juvenile justice system under state contract
- Licensed child care facilities
- Foster parents
- Juvenile detention and staff secure detention centers

The OIG provides this accountability through investigations, reviews, system monitoring, and recommendations for improvement. Specifically, the OIG is mandated to investigate allegations or incidents of:

1. misconduct, misfeasance, malfeasance, or violations of the statutes or rules and regulations of the Department of Health and Human Services (DHHS), the Administrative Office of Probation, Juvenile Services Division (Juvenile Probation), the Commission on Law Enforcement and Criminal Justice (Crime Commission), or juvenile detention facilities by employees or persons under contract with those agencies and facilities;

[1] Neb. Rev. Stat. §43-4302.

2. deaths and serious injuries[2] of youth (1) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation, (2) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation, or (3) in cases that have had an open investigation for child abuse and neglect in the last 12 months, if the OIG after review determines the death or serious injury did not occur by chance.

The OIG also has the authority to open investigations into systemic issues within the OIG's jurisdiction as they arise based on complaints received or at its discretion to address larger systemic issues identified.

The OIG identifies cases to be investigated through the intake process described in more detail later in this report and through its ongoing monitoring of the system. OIG investigations are focused not just on performance review, but on identifying issues and gaps in the child welfare and juvenile justice systems and the policies and practices that underlie those systems. The OIG's investigations and reviews function as part of the Legislature's oversight of these important state functions. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions regarding system-involved children and youth.

In addition to investigations, the OIG has several additional statutory duties. The OIG reviews and monitors all complaints and incidents related to Alternative Response cases. The office produces an annual report on Juvenile Room Confinement data reported by juvenile residential facilities. The OIG's monitoring of the Youth Rehabilitation and Treatment Centers (YRTCs) includes a review of a variety of data and information that the YRTCs are now required to provide to the OIG. The Inspector General also serves on a variety of committees, commissions, and work groups.

Structurally, the OIG is housed within the Office of Public Counsel, or Ombudsman's office which is part of the Legislative branch. The Inspector General is appointed to a five year term by the Ombudsman with the approval of the Chairs of the Executive Board and Health and Human Services Committee of the Legislature. The OIG also has two full-time Assistant Inspectors General and one half-time Executive Intake Assistant who are all critical to maintaining the significant duties of the OIG.

[2] Serious injury is defined as, "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."

A Decade of Oversight and Accountability

Created in 2012, this year marks the tenth year of operation of the OIG. It seemed an appropriate time to look back at the evolution of the office and its service to the Legislature and to the system involved children of Nebraska over the past decade.

Creation of the Office

The OIG originated as part of several recommendations that came out of Legislative Resolution 37, conducted by the Health and Human Services Committee of the Legislature, which was an extensive and thorough review of Nebraska's attempt to privatize the child welfare system. With the passage of Legislative Bill 821 in 2012, the Inspector General of Nebraska Child Welfare Act[3] was enacted. The Act set out duties for the OIG, including investigating deaths or serious injuries of children and youth in the child welfare and juvenile justice systems.

Growth of the Office

Julie L. Rogers was appointed to serve as the first Inspector General of Nebraska Child Welfare and the OIG was opened in July 2012.

Inspector General Rogers had worked as a deputy public defender in Madison County immediately following law school where she represented children and parents in juvenile court as well as acting as guardian ad litem. She then served as Legal Counsel to the Judiciary Committee at the Nebraska Legislature under then Chairperson Kermit Brashear. She served as a policy analyst for the former Community Corrections Council, and immediately preceding the appointment as Inspector General, worked on Juvenile Services Community Planning Initiatives at the University of Nebraska's Juvenile Justice Institute. Ms. Rogers became a Certified Inspector General through the Association of Inspectors General in 2012.

The OIG was the first ever Inspector General office established in the state of Nebraska. As such, the first year was spent creating an infrastructure for its work, developing operating procedures, working to understand the broad operations and specific details of the complexities that make up child welfare in Nebraska, and implementing processes for inquires, reviews, and investigations. The OIG started receiving complaints as well as incident reports of deaths and serious injuries of youth from DHHS on September 1, 2012. The OIG issued its first investigatory report, *OIG Report of Investigation: Child Death I,* on January 2, 2014.

During Fiscal Year 2014-2015, the OIG staff grew to include an Executive Assistant and an Assistant Inspector General. A second Assistant Inspector General was added during Fiscal Year 2015-2016.

Ms. Rogers became the Ombudsman in early 2020 and Jennifer Carter was appointed as the Inspector General of Child Welfare in August 2020, beginning her tenure in September. Following law school, Ms. Carter was a litigator in New York at Cravath, Swaine & Moore and Sidley Austin LLP, as well as a law clerk for the federal District Court of the District of South Dakota. After moving to Nebraska, Ms. Carter worked as a staff attorney and the Director of the Child Welfare Program at Nebraska Appleseed and as Appleseed's Director of Public Policy. Immediately prior to her appointment as Inspector General, Ms.

[3] Neb. Rev. Stat. §§43-4301 — 43-4331.

Carter served as Legal Counsel to the Health and Human Services Committee of the Legislature where she also worked on issues related to child welfare and juvenile justice. Ms. Carter received her certification as a Certified Inspector General by the Association of Inspectors General in March 2022.

Responsibilities Added to the Office

Over the years, the Legislature has expanded the OIG's duties and jurisdiction. It has also expanded the categories of information that must be provided to the OIG to enhance its ability to monitor and review the system.

2014 – Reviewing Alternative Response

In 2014, shortly after the OIG's creation, the Legislature statutorily mandated that the OIG review complaints and incidents related to cases referred to Alternative Response (AR) and report on those cases annually. Alternative Response was implemented by DHHS as a different approach when responding to certain child welfare cases. It was initiated as a demonstration project and the review by the OIG provided oversight and insight into how this new approach was working.

2016 – Juvenile Room Confinement Report

In 2016, LB 894 was signed into law providing new guidelines related to juvenile room confinement in Nebraska. Facilities in which juveniles reside must provide a quarterly report to the Legislature cataloging each instance in which a youth is involuntarily restricted to a room, cell, or other area alone. As part of the legislation, the OIG was charged with reviewing and analyzing the data reported to the Legislature and issuing a report on its findings annually.

2017 – Tracking Allegations of Sexual Abuse of State Wards

After the 2017 OIG report *Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement*, the Legislature passed LB 1078, which required that all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and juvenile in a residential child-caring agency be reported to the OIG. The following year reports of alleged sexual abuse to the OIG increased 81% as awareness of the issue increased and the provision of LB 1078 went into effect.

2020 - Youth Rehabilitation and Treatment Center Monitoring

In 2020, following the crisis at the YRTC in Geneva, the Legislature established a reporting system with the intent of providing increased accountability and oversight regarding the treatment of juveniles in YRTCs. Nebraska law now requires the Office of Juvenile Services to report to the OIG an array of incidents occurring at any of the three YRTC locations. As part of providing increased accountability and oversight, the Inspector General also visits the facilities regularly.

A Decade of Accomplishments

In the ten years since it was established, the OIG has:

- Received and reviewed over 4,500 intakes including incident reports, complaints, and grievances.
- Issued 41 reports of investigation which incorporated case reviews of over one hundred individual children involved in the child welfare system.

- Made 106 recommendations for improvement to four of the five divisions of the Nebraska Department of Health and Human Services (Behavioral Health, Children and Family Services, Developmental Disabilities, and Public Licensing), two private providers contracted with the Division of Children and Family Services, and the Administrative Office of Probation.
- Positively impacted child welfare policy, procedure, protocol, data collection processes, and workforce development through the completion of OIG recommendations. At the close of the 2021-2022 Fiscal Year, 76 of the 106 OIG recommendations have been completed. Another eight recommendations are currently making progress towards full implementation. For a detailed list of the OIG's recommendations, see page 40 in the OIG Recommendation section of this report.
- Informed senators on key issues as they drafted legislation related to child welfare, including but not limited to, Sudden Unexpected Infant Death education[4], sexual abuse of state wards[5], oversight of Nebraska's YRTCs[6], and the privatization of case management in the Eastern Service Area.[7]

[4] A summary report of *Sudden Unexpected Infant Deaths (SUIDS 2016)* can be found in the OIG Annual Report 2015-2016 at: https://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf.

[5] The full report *Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement (Sexual Abuse 2016)* can be found at: http://oig.legislature.ne.gov/wp-content/uploads/2017/12/OIG-Summary-Report-Child-Sexual-Abuse-1.pdf.

[6] The full report *The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (2021)* can be found at: https://nebraskalegislature.gov/pdf/reports/public_counsel/Geneva_Special_Report_2021.pdf.

[7] The full report *Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services (2021)* can be found at: http://oig.legislature.ne.gov/wp-content/uploads/2021/09/Final-Public-Release-OIG-Report-Eastern-Service-Area-Case-Management.pdf.

Year in Review

This year, the OIG completed a major investigation into the Eastern Service Area privatization contract, continued to monitor the YRTCs, and reviewed hundreds of incidents and complaints some of which required a preliminary investigation into issues that the OIG will continue to monitor. The following are some of the highlights and key issues that arose this year.

Investigation of Saint Francis Ministries and the Eastern Service Area

At the start of FY 21-22, the OIG was completing its investigation into the contract with Saint Francis Ministries, Inc. in the Eastern Service Area (ESA). On September 23, 2021, the OIG publicly released its *Special Report: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services*.[8] In that report, the OIG found that Saint Francis had failed to meet key terms of the contract and that the Eastern Service Area Pilot Project had demonstrated unacceptable risk in the privatization of case management. The OIG recommended that the contract with Saint Francis be terminated and that DHHS end the Pilot Project.

After the release of its investigative report, the OIG continued to monitor Saint Francis's performance under the contract, particularly its progress (or lack thereof) under the Corrective Action Plans. In addition to these issues, Saint Francis's Child Placing Agency license had been placed on disciplinary probation by DHHS's Licensure Unit. Saint Francis had several months to correct the licensing violations but failed to do so before the end of the license period. As a result, on October 1, 2021, the new license period, Saint Francis's Child Placing Agency was issued a probationary license with a stipulation that Saint Francis could not take on any new child welfare cases for case management. DHHS was then required to take on case management of all new cases in the ESA. Staff from DHHS's Resource Development and its Central Office began handling ongoing case management of cases in the ESA in addition to their other responsibilities. On December 1, 2021, Public Licensing determined that Saint Francis had taken all corrective action necessary and issued a full license to it as a Child Placing Agency. DHHS, however, determined that Saint Francis was not in a position to resume case management of new cases, and as a result, DHHS staff continued to manage all ongoing cases in the ESA received after October 1st.

On December 14, 2021, DHHS and Saint Francis reached an agreement to terminate the contract by June 30, 2022 and return all case management to DHHS. The OIG's monitoring of the ESA then transitioned to focus on the transfer of case management from Saint Francis to DHHS, including the transfer of staff, the transfer of cases, and the communication with and effect on families and the community.

Overall, DHHS implemented a thoughtful and deliberate process for the transition that included an effort to recruit Saint Francis workers to retain staff for cases. There was a process for reviewing cases to triage and prioritize how cases and staff would be transferred from Saint Francis to DHHS. For example, the most complex cases or those without case workers were transferred and addressed first. There was also an effort to transfer staff and cases in such a way that staff could maintain their assigned

[8] A summary is included in Appendix A and the full report can be found at https://nebraskalegislature.gov/pdf/reports/public_counsel/OIG_SaintFrancis_SpecialReport.pdf.

cases to ensure continuity for the families. Each case was staffed by DHHS leadership from around the state prior to transfer and then a deeper review of the cases followed.

The OIG was in regular contact with the CFS Director about the progress of the transition and DHHS was open to receiving feedback about any issues with the transition in the ESA.

Issues did arise as discovered in critical incidents and complaints that the OIG received. The OIG observed a pattern of poor or missing documentation in cases from the ESA under Saint Francis's leadership. In addition, several cases reviewed demonstrated that Saint Francis staff either suffered from a lack of training or misunderstood the rules, regulations, policies, and procedures in Nebraska's child welfare system, making clear that additional training would be necessary for some of the workers transitioning over to DHHS from Saint Francis.

For example, the OIG reviewed a complaint in which the parents alleged they were denied their legal rights during the course of a voluntary case with Saint Francis. The OIG review found that the Saint Francis case worker had misled the family to believe their child was under the control of CFS, similar to being made a ward of the state, even though the family had no current juvenile court involvement. After reviewing the case, the OIG brought it to the attention of CFS Administration who indicated the case had been staffed for transfer to DHHS resulting in the case management errors being appropriately rectified. In addition, case workers moving over to DHHS from Saint Francis would receive training on the management of voluntary cases.

These examples have served to confirm that terminating the contract with Saint Francis and ending the experiment with privatization of case management in Nebraska was the correct choice. As noted later in this report, issues in the ESA remain as it continues to recover from the challenges under the contract with Saint Francis. The OIG will continue to monitor the performance and progress in this service area.

Placement Concerns

In addition to mandatory investigations of deaths and serious injuries, the OIG staff spent a significant amount of time conducting in-depth reviews of systemic issues identified through complaints made to the office. During FY 21-22, three of those reviews revealed concerning facts about placement practices. Assessment of the three complaints discussed below included a complete and thorough document review, subject interviews, and collateral contacts with stakeholders.

The first complaint alleged that children and adolescents were being housed in motel rooms due to a shortage of available foster homes. The complainant indicated that children were frequently being moved from one motel to another, provided only fast food for meals, and that overnight supervision was potentially unsafe as in some cases older teenagers were alone in motel rooms with a single case worker often of the opposite sex. Similarly, the OIG received a second complaint that alleged Saint Francis was moving youth between multiple short term respite providers (sometimes referred to as emergency shelters) as frequently as every day or two until a foster parent could be identified. After reviewing the cases associated with the complaints, the OIG found the facts of the case supported the allegations. The OIG made DHHS administration aware of concerns related to the complaints. The OIG was told that leadership knew of the situations and was looking for alternative solutions.

The OIG also reviewed a complaint in which it was alleged that a suitable foster care provider could not be identified locally, and as a result, a youth was sent hours away to stay with an extended family

member. The move was not documented as a new placement, but rather as respite. As a result, to actually ascertain where the youth was physically located one had to review multiple narratives. In addition, the term respite is typically used to indicate that the youth is away from the current placement, but will return to that same placement, which was not the case here. A member of the OIG team met with DHHS administration to discuss both the mechanics of documenting where a youth is physically located and the apparent practice of referring to a placement as respite. Administration indicated that the issue was two-fold: first, the need for improved case worker understanding of what respite care is and how to appropriately document it and second, the ongoing issue with a shortage of foster care providers.

These complaints highlight how the shortage of traditional foster care placements willing to accept youth into their home is significantly impacting the stability and well-being of system involved youth.

Youth Rehabilitation and Treatment Center Monitoring

After the crisis at the YRTC at Geneva in 2019, the OIG's duties with regard to monitoring the YRTCs were increased and the ability to monitor was enhanced as the result of several significant pieces of Legislation in 2020 related to the YRTC system.

Neb. Rev. Stat. §43-4318(3) now requires the Office of Juvenile Services (OJS), which oversees the YRTCs, to report to the OIG "as soon as reasonably possible" when the following instances occur: assaults, escapes or elopements, attempted suicides or self-harm, property damage not caused by normal wear and tear, the use of mechanical restraints, a significant medical event suffered by a juvenile, and internally substantiated violations of the Prison Rape Elimination Act. The goal of this legislation was to create additional oversight with respect to some of the specific issues and concerns that arose during the crisis at Geneva. The intention was to ensure that issues were caught and addressed before those issues could result in another crisis.

According to that same statutory provision, the OIG and OJS may work in collaboration to clarify the specific parameters of the reporting requirements. After being appointed in late 2020, Inspector General Carter worked with the OJS Administrator and the head of compliance at the YRTCs on the best way to have the information reported to the OIG in a timely manner without creating an unnecessary administrative burden on the YRTC staff and administration. These conversations continue as new situations and issues arise and the OIG appreciates the productive working relationship with the OJS Administrator and his team.

In addition, the OIG monitors the YRTCs through regular visits, communication with the administration and staff of the facilities, and, when appropriate, conversations with the youth. What follows is a summary of the new data and the OIG's observations of the YRTCs generally.

YRTC-Hastings

In the aftermath of the crisis at the YRTC in Geneva, DHHS decided to close the Geneva campus and instead utilize the Hastings Regional Center campus as the YRTC for the female youth. The new buildings utilized for YRTC-Hastings were originally built for the substance youth treatment program for male youth.[9] In early 2021, after spending over 18 months on the YRTC-Kearney campus, the female youth

[9] The substance use treatment program was moved to the Whitehall campus in Lincoln.

were moved to the Hastings campus. The OIG made several visits to Hastings to monitor the transition to this new facility.

Overall the initial transition from YRTC-Kearney went well. In general, the girls reported that they were grateful to be in a space dedicated to their care. However, as noted, the Hasting campus was not built for use as a YRTC. It has been clear since the beginning that the facility will need additional buildings and other changes to serve this population appropriately.[10] The buildings themselves are new and clean. The campus consists of an administration building, a chapel, and three new buildings – a program building which is used as the school and two living units which can accommodate up to 12 girls each.

The youth in the two living units are separated by unit – they are in different classes at school, eat separately, and recreate at different times. This protocol is informed in part by the reality that many of these youth have prior experiences with each other from their neighborhoods at home or prior placements. This can create challenges that have been exacerbated by the design of the campus. For example, the main common areas and windows in each unit face the other unit which allows the girls in different units to see each other through those windows creating an opportunity for the girls to antagonize or communicate with each other. In the fall of 2021, there was an incident during which the behaviors of several girls were escalated in each unit in part because they could view each other's behavior. The incident resulted in several broken windows. The solution to this challenge has been to frost the windows so that the girls cannot communicate with each other. This, however, also results in the girls having only one window at the back of the unit through which they can see the outside. This creates a more institutional setting and may not be trauma informed.

In addition, there is very limited indoor recreation space on campus. For example, the chapel is currently utilized as the gym. While there is a great deal of green space, it is rarely used. More attention should be paid to the needs of this facility to make better use of the ample amount of space on that campus for both indoor and outdoor recreation. The needs of the youth would benefit from more varied and structured recreation time.

There have also been challenges with staff adjusting to working at a YRTC as opposed to the substance youth treatment program. The YRTCs have different protocols and procedures and the youth have different needs. The administration has been transparent about these issues and has continued to work with staff and utilize opportunities for training.

As noted earlier, the OIG receives monthly reports from each facility regarding several types of incidents. For FY 21-22, YRTC-Hastings reported 19 assaults on staff, with an average of three per month although there were several months with no assaults on staff. For the majority of these assaults, there was no resulting injury to the staff, although in three instances basic first aid was required and in one case medical treatment on campus was required. The number of assaults between youth was low, averaging one a month. Regarding property damage above normal wear and tear, the broken windows noted above had to be replaced and reinforced.[11]

[10] It is important to remember that the buildings on the Hastings campus were built for a Psychiatric Residential Treatment Center for treating substance use disorders. It was not built as a secure facility or one that might require management of more difficult or aggressive behaviors.

[11] At this time, the OIG and the YRTCs agreed that the YRTCs would report property damage over $500.

The biggest challenge for Hastings appeared to be self-harm, with an average of two or three incidents a month, including one attempted suicide during the year. In addition, mechanical restraints have been used at least once in eight of the twelve months for the last fiscal year, with mechanical restraints used several times during the fall.

The census at YRTC-Hastings during FY 21-22 has been relatively low averaging anywhere from 11-13 female youth a month and having three months this spring with a census as low as eight. The programs are benefitting from this lower census which allows for a lower staff to youth ratio.

YRTC-Kearney

As with YRTC-Hastings, YRTC-Kearney has also benefitted from a lower census for FY 21-22. At the start of the fiscal year, the census at YRTC-Kearney averaged around 40 youth a month and then, after a dip to a low of 33 youth in December, it has been increasing. During the last quarter of the fiscal year, the census has consistently been over 50.

Regarding the FY 21-22 monthly reports, the YRTC at Kearney had 36 assaults on staff reported with an average of four assaults on staff per month with some months having no staff assaults and two months with a higher than average number of assaults. Twenty-two assaults required some basic first aid and the remainder resulted in no injury to the staff members. Assaults between youth numbered 40 for the year—the highest of any YRTC facility. One assault required medical care off campus and three required medical attention on campus. Additionally, 10 incidents required some first aid and the remaining incidents did not result in any injury. There were fewer incidents of self-harm on the Kearney campus compared to Hastings. However the use of mechanical restraints and the incidents of property damage above $500 was higher at Kearney.

Of note, YRTC-Kearney has reported progress in finding ways to engage the youth in the community, providing a broader range of opportunities and experiences to help the youth prepare for their futures.

YRTC-Lincoln

The YRTC facility at the Lancaster Youth Services Center houses both males and females. The two populations are kept separate. The census at YRTC-Lincoln was relatively low over the course of the fiscal year and for several months there were no male youth residing there. Overall, YRTC-Lincoln reports more regular and consistent use of mechanical restraints compared to the other YRTCs and many instances of self-harm.

For the male youth, there were seven reports of assaults on staff, three requiring medical attention on campus. There were no assaults reported between youth. Mechanical restraints were used at least once a month, and as many as six times in one month. There were also 12 reports of self-harm over the course of the fiscal year.

For the female youth at YRTC-Lincoln, there were eight assaults on staff with only one requiring medical attention on site. There were two reported assaults between youth over the course of the fiscal year. The use of mechanical restraints was fairly consistent occurring at least once a month for 11 of the 12 months with restraints used an average of three to four times per month. There were also 15 reports of self-harm to female youth at the facility.

PREA Allegations

The YRTCs also report allegations of violations of the Prison Rape Elimination Act (PREA). PREA sets strict boundaries around any touching of or between youth. As a result, there are a wide range of PREA allegations that the YRTCs must address from more serious allegations of abuse by staff or more serious allegations of sexual abuse by youth, to more minor incidents of touching between youth. The OIG receives documentation of all the PREA allegations from each facility on a monthly basis. If there is a more serious allegation such as any allegations of staff violations of PREA, the OIG receives notice as soon as possible after those incidents occur.

Of the PREA incidents which were shared monthly with the OIG:

- YRTC-Kearney had 17 reports with 9 being substantiated. All of the substantiated incidents involved inappropriate touching by youth.
- YRTC-Hastings also had 17 reports with 12 being substantiated. All of the substantiated incidents involved inappropriate touching by youth.
- YRTC-Lincoln reported four PREA incidents with three being substantiated. Two of the substantiated incidents involved sexual harassment by youth and one involved indecent exposure by youth.

Education at the YRTC

The contract with the Nebraska Department of Education appears to have been beneficial to the educational programming at the YRTCs. The OIG's monitoring of the YRTCs and conversations with administration indicate that there has been a move away from online credit recovery in favor of classroom instruction. This is more consistent with a traditional educational setting, helping to prepare youth to return to school when released. In addition, efforts are being made at both Kearney and Hastings to provide educational and vocational opportunities for youth who already have their GEDs or have met the requirements to graduate from the YRTC's educational programming. For example, YRTC-Kearney and YRTC-Hastings are working with the local community colleges to provide opportunities for youth to take online classes.

YRTC Five-Year Strategic Planning Advisory Group

The OIG continues to participate in DHHS's advisory group for the YRTC five-year strategic plan. The OIG appreciates and acknowledges the work that has been done to stabilize the YRTC system in the last few years. Our hope and recommendation now is that the strategic planning process will include a more comprehensive and visionary look at what Nebraska needs the YRTCs to be. A strategic plan should include a vision of what the structure of the YRTC system should and could look like. For example, the state needs to determine if it is best to continue with the three YRTCs operating in the state or if a larger number of smaller facilities spread throughout the state would better serve the needs of youth. In addition, the plan should consider the role of the YRTCs in the broader context of our juvenile justice system as a whole. Youth may not be committed to a YRTC until all other community services are exhausted. However, there are gaps in the community service array throughout the state. The YRTCs cannot be effective if they are also required to be the safety net for all other gaps in the system.

Juvenile Room Confinement in Nebraska

Nebraska law requires a wide variety of facilities that serve children and youth to document information every time a child is placed in room confinement – involuntarily restricted to a room, cell, or other area alone – for an hour or longer. Facilities must submit quarterly reports on their use of room confinement to the Nebraska Legislature. The OIG is tasked by statute to review data collected from each facility, assess the use of juvenile room confinement, and report to the Legislature on an annual basis. [12]

Juvenile Room Confinement Data Review & Analysis

Each year, the OIG spends hundreds of hours compiling the Juvenile Room Confinement report, reviewing:

- Quarterly facility room confinement reports submitted to the Legislature and to the OIG;
- Federal and state regulations that govern juvenile facilities' use of room confinement;
- Individual facilities' written policies and procedures for utilizing different forms of room confinement; and,
- Academic research and available reports on the history, impact, and appropriate use of juvenile room confinement, and effective methods for reducing its use.

Part of the challenge of the Juvenile Room Confinement report and what drives the amount of time it requires is that the OIG has to spend time identifying and correcting inaccuracies in the reporting of the data. The OIG cannot accurately assess the use of room confinement in Nebraska without accurate information.

Inaccuracies can include transposed digits, redundancies including multiple reports of the same incident or single individual youth represented by multiple identification numbers, and misspelled names. As an illustration, facilities have reported youth going into room confinement and never coming out. Digits are often transposed resulting, for example, in an entry that a youth was in confinement for nine *days* rather than nine hours. One of the most critical reported data points is the total number of youth being confined within a facility during the fiscal year. In reviewing data for one quarter at one facility, the OIG discovered that the inconsistencies and redundancies in the data resulted in three different totals depending on how the data was sorted.

Resolving each of these issues takes considerable time, discussion, and frequently, multiple recalculations. The work to identify and correct the inaccuracies is beyond the statutory obligations of the OIG. The facilities should be reporting accurate data to the Legislature in the first instance. As discussed below, the OIG is working to clarify and improve the reporting of information for juvenile room confinement through Legislation.

Annual Juvenile Room Confinement Report for Fiscal Year 2020-2021 Findings and Recommendations

In the most recent Juvenile Room Confinement report, the OIG found that, overall, Nebraska facilities have made some effort to reduce the number of juvenile room confinement occurrences within their facilities and decrease the duration of incidents, although facilities continue to rely on it as a method of

[12] Neb. Rev. Stat. §83-4,134.01.

behavior management. Better adherence to best practices are still necessary. But, there has been progress as indicated by the data reported.

The OIG made no new recommendations for this fiscal year, as the standards and best practices that lead to a reduction in juvenile room confinement are well known and guidance is available from the experiences of other states in reducing reliance on juvenile room confinement. This has been noted by the OIG in previous reports. Systemic change is not easily accomplished without deliberate actions within facilities. As in the past, the OIG will continue to recommend facility administrators and juvenile justice stakeholders prioritize the need for strategic planning aimed at reducing the use of juvenile room confinement.[13]

Legislation

During the legislative session, the OIG monitors any proposed legislation related to the child welfare and juvenile justice systems. In order to effectively monitor, review, and conduct investigations, the OIG must understand any changes in the responsibilities or duties of DHHS or Juvenile Probation.

Similarly, the OIG must monitor any bills that have a direct effect on the office's duties and responsibilities. This year, the OIG also supported two bills that it requested which directly affected the OIG's work. The first, LB 810 introduced by Senator John Cavanaugh, related to the OIG's duty to analyze and report on the juvenile room confinement data provided to the Legislature by certain juvenile facilities. LB 810 would have improved the data reporting process and provided a more accurate understanding of the use of juvenile room confinement by requiring the documentation of all hours of confinement and requiring the facilities to provide the OIG with an annual summary of key data. LB 810 was advanced to General File from the Judiciary Committee unanimously, but unfortunately did not receive a priority or a place on the consent calendar and ultimately was not considered by the full Legislature.

The OIG, along with the Office of Inspector General of Nebraska's Correctional System, also supported LB 897, introduced by Senator Steve Lathrop, which would have made technical and clarifying changes to the Inspector General Acts. The bill would have clarified or modified some processes such as extending the time period in which the OIG could determine if a complaint would result in a full investigation; clarifying the existing duties in the law to cooperate with the office; and providing DHHS, Juvenile Probation, and other agencies additional time to respond to OIG reports and recommendations. Finally, the bill would have addressed and clarified a barrier the OIG has faced in conducting statutorily mandated investigations of deaths and serious injuries of youth under Juvenile Probation supervision.

The bill was prioritized by the Executive Board of the Legislature. Unfortunately, the Probation Administration objected to the bill and those issues were not resolved in time to allow the bill to be heard by the full Legislature.

[13] The full report can be accessed here: http://oig.legislature.ne.gov/wp-content/uploads/2021/12/JRC-Annual-Report-2021-Final.pdf.

The OIG will continue to monitor and work on legislation that will help the OIG most effectively meet its duties and statutory obligations.

Committee & Commissions

The Inspector General participates in several initiatives and attends meetings of groups created to oversee and coordinate efforts to improve the systems serving children and youth in the state's care. Participation in these committees and commissions provides the Inspector General with a helpful and up-to-date understanding of the challenges in the child welfare and juvenile justice systems, the efforts to address those challenges, and any other changes or system improvements being made. All this information helps the OIG make better and more relevant recommendations in its reports.

Most notably the Inspector General participates in the following groups:

- Nebraska Children's Commission (statutory member)
    - Alternative Response Sub-Committee (statutory member)
- Child Death Review Team (statutory member)
- Nebraska Supreme Court Commission on Children and the Courts
- Commission for the Protection of Children
- Statewide Juvenile Detention Alternatives Initiative
- LB 1173 Work Group

Inspector General and Inspector General Investigator Certifications

The Office of Inspector General of Nebraska Child Welfare Act requires that any person appointed to the position of Inspector General obtain certification as a Certified Inspector General by the Association of Inspectors General (AIG) within two years of appointment. The mission of the AIG is to promote excellence in the Inspector General community by establishing and encouraging adherence to quality standards. The AIG fosters and promotes public accountability and integrity in the prevention, examination, investigation, audit, detection, elimination, and prosecution of fraud, waste and abuse. The AIG has identified six broad areas of core competency for Inspectors General: the Inspector General function, public management issues, ethics, legal issues, investigating fraud, waste, and abuse, and audits, inspections, and reviews. Inspector General Carter successfully attained her certification in March of 2022.

In addition, an Assistant Inspector General at the OIG achieved certification as a Certified Inspector General Investigator from the AIG, marking the first time in the history of the office that the OIG has been served by a Certified Inspector General Investigator. The Certified Inspector General Investigator® program assumes knowledge of investigatory skills, and incorporates seven broad areas of core competency for inspector general investigators: the investigative process, investigative techniques, legal issues, standards for conducting investigations, procurement fraud, ethics in investigations, and working with auditors.

In order to obtain certification the Inspector General and the Assistant Inspector General had to successfully complete the week-long certification programs and pass the certification exam. In order to keep their certification active both must be a member of the AIG and verify the completion of 40 Continuing Professional Education credits every two years.

Looking Ahead

As we look ahead to the next fiscal year, this section will highlight some emerging issues that the OIG will be monitoring.

Increase in Mandatory Investigations of Serious Injury to Children

In the last fiscal year, there has been an increase in reports of serious injuries to children that require an investigation by the OIG – meaning those injuries "did not occur by chance," as delineated in the statute, but rather could have been the result of abuse or neglect. As noted in more detail in sections that follow, in FY 21-22 there were 13 reports of serious injuries to children made to the OIG and ten of those reports will result in a mandatory investigation by the OIG. By contrast, in FY 20-21 only one serious injury out of the eight reported resulted in a mandatory investigation.

Without completing the investigations, it is difficult to draw any conclusions as to why there is an increase. However, one obvious potential factor is the pandemic and the stress on families in the last two and a half years. In conversations with other professionals in Nebraska, several themes have emerged regarding the increasing need for and difficulty accessing mental health care as well as other services. We are only beginning to understand all the long term ramifications of the pandemic. This is a concerning trend that the OIG will continue to monitor along with DHHS and other stakeholders in the system.

Alternative Response Cases and Oversight

Four of the 10 reported cases of serious injury resulting in investigation in the last fiscal year have involved active Alternative Response (AR) cases or cases that had been AR cases within the prior 12 months. Alternative Response is a different approach to handling cases that are called into the Hotline. An AR approach does not require an investigation for abuse or neglect but still includes an assessment of safety and a needs assessment for the family.[14] Alternative Response provides the case worker with additional flexibility to address the family's needs and issues. There are certain types of cases that do not qualify for AR.

The OIG has not previously received reports of serious injuries in cases involving AR which mandated an investigation. At this point in time, there is no clear indication of what might have driven this sudden change. There has been a significant increase in the number of AR cases in the child welfare system overall. Since AR transitioned from a pilot project to full implementation in 2020, its usage has continually increased. In the first year of full implementation, there were 1,582 AR cases throughout the state that made up 10.2% of all reports assessed by the Hotline. In 2021, that number increased to 4,089 AR cases comprising 22.6%—nearly a quarter—of all assessed Hotline reports.[15]

[14] Neb. Rev. Stat. §28-710.

[15] Nebraska Department of Health and Human Services. *Child Abuse and Neglect Annual Report 2021*. https://dhhs.ne.gov/Pages/Children-and-Family-Services-Reports.aspx. (Retrieved on September 12, 2022). In 2021 there were 36,393 reports made to the Hotline, and of those, 18,101 reports were assessed by CFS. The 4,089 AR assessments were 22.6% of the 18,101 total reports assessed—meaning the remaining approximate 78% of assessed reports were traditional response. In 2020, there were 14,981 assessed Hotline reports with 1,528 AR

Given the increasing role of AR in Nebraska's child welfare system, it will be important for the OIG to identify whether these cases reflect a broader systemic issue within AR.

Placement Availability and Stability

The availability of appropriate and stable placements has become an increasing concern in the last couple of years. According to DHHS and other stakeholders, this is a problem child welfare systems are struggling with nationally and may reflect, yet again, another consequence of the pandemic. While placement stability is an ongoing issue in child welfare systems, what has become unusual, and more alarming, is that stakeholders report that even children who historically have been easy to place, including infants, have becoming increasingly challenging to find homes for. Safe and appropriate placements are crucial to the safety and well-being of children. Lack of placements creates pressure to maintain children in placements that might otherwise be considered unsuitable, increasing the risk and the trauma to children in the system's care.

While DHHS and stakeholders in the system are working on this issue, it is one that should be a priority for the Legislature and the state as well.

Staffing and Caseloads

Caseloads and the stability of the child welfare workforce have been consistent issues for DHHS which were made only more challenging as the child welfare system has not been immune from the difficulties in hiring that most employers have faced since the pandemic. This issue continues to be particularly relevant in the ESA as the failure to meet caseloads was a critical failure under the contract with Saint Francis. The struggles with caseloads continued during the transition of case management back to the state and is a lingering issue for DHHS to solve. Every month, DHHS releases a public report listing the percentage of compliance to caseload ratios their staff have in a given service area.[16] During June 2022, total staff compliance to caseload ratios was only 38.6% for the ESA. Comparatively, three of the state's other service areas were in compliance by at least 80% with the Northern Service Area only being in 63.9% compliance. Through the course of vetting and preliminarily reviewing intakes, the OIG repeatedly encountered the issues that arise when a caseworker's caseload is far above the statutory limit. Primarily, a high caseload causes case delays—meaning vital documentation or investigative reports are not completed in a timely manner. For example, the OIG has encountered investigations of alleged child abuse in licensed facilities being delayed by months.

DHHS has been working to address this issue and it appears that the revised contract and pay increase negotiated within the last year has been helpful in hiring. During the months of 2022, the average monthly turnover rate for DHHS caseworkers has reduced to 3.5%.[17] However, the issues present in the ESA will take time to resolve. The issue of how best to measure the workload for case workers will be part of that effort. It is an issue that is being discussed nationally and will be a part of the strategic

cases comprising 10.2% of all assessed intakes. The approximate 12% difference in one year demonstrates that AR is being used to address a significant portion of assessed Hotline reports.

[16] Nebraska Department of Health and Human Services, *Children and Family Services Caseload Status June 2022*. https://dhhs.ne.gov/Pages/CFS-Data-and-Reports.aspx. (Retrieved on September 12, 2022).

[17] Nebraska Department of Health and Human Services. *Children and Family Services Case Manager Turnover 2021-2022.* https://dhhs.ne.gov/Pages/CFS-Data-and-Reports.aspx. (Retrieved on September 12, 2022).

planning resulting from the passage of LB 1173 (discussed below) this past session. A well-trained, professional, and adequate workforce is vital to the safety and well-being of children and families.

LB 1173 Child Welfare Transformation Plan

In the wake of the challenges in the ESA and at the recommendation of the LR 29 Committee which also examined the issues in the ESA, the Legislature passed LB 1173 to structure and support a plan for systemic transformation of the child welfare system. The law requires the creation of a practice and finance model with the assistance of a contracted consultant who is an expert in child welfare system transformation, as well as a work group and a leadership group comprised of representation from all three branches of government.

Many of the issues described throughout this report – placement issues, staffing issues, caseload issues, service array issues – should all be key parts of any discussion regarding transformation of Nebraska's child welfare system.

The OIG is designated as a member of the work group and we look forward to assisting in this important effort.

Challenges with Probation Investigations

According to Nebraska law, the OIG shall investigate:

1. Allegations and incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of the Administrative Office of Probation, Juvenile Services Division by an employee of the juvenile services division, a contractor with the juvenile services division, a private agency, a licensed facility, a foster parent, or any other provider of juvenile services;
2. Death or serious injury in foster homes, private agencies, child care facilities, juvenile detention facilities, staff secure juvenile facilities, and other programs and facilities licensed by or under contract with the DHHS or the juvenile services division if, upon review, the OIG determines the death or serious injury did not occur by chance; and
3. Death or serious injury in any case in which services are provided by the juvenile services division to a child or his or her parents.

Unfortunately, the OIG's ability to provide accountability and conduct investigations and reviews related to juveniles being supervised by Juvenile Probation continues to be compromised. The Probation Administration continues to require a protocol for interviews with its staff that violates the principles and standards of the Association of Inspectors General (through which the Inspector General of child welfare is certified) and the Office of the Inspector General of Nebraska Child Welfare Act. These protocols would compromise the integrity of the investigation. As a result, the OIG is unable to conduct interviews with staff that are necessary to complete these investigations and ensure the OIG has a complete understanding of the facts and Juvenile Probation's policies and protocols. At this time 18 investigations of deaths of youth on Juvenile Probation have not been completed. The OIG had hoped to address this issue through LB 897 in the last legislative session. However, Probation objected to the bill. Other solutions were explored but a resolution was not reached. As a result, even though the Executive Board prioritized the bill, it was not heard.

The OIG recognizes Probation's efforts at self-reflection and quality improvement, such as the extensive effort of the Juvenile Justice System Enhancement-Nebraska currently underway. However, those efforts do not negate the Legislature's considered policy choice to provide for accountability through the OIG. In 2021, there were 1,959 youth under Juvenile Probation's supervision. Since 2017, there have been 18 deaths of youth on Juvenile Probation and at least 190 allegations of sexual assault that the OIG could investigate. Those investigations could provide insights into potential gaps not only in the Juvenile Probation system, but gaps in the broader and overlapping systems of juvenile justice, child welfare, and community services.

The purpose of the Inspector General of Nebraska Child Welfare Act was ultimately to improve the child welfare and juvenile justice systems through independent reviews and investigations. At the time the Inspector General of Child Welfare Act was passed, juveniles on probation received services through DHHS and OJS and were under the OIG's jurisdiction. OIG oversight of youth on Juvenile Probation was always contemplated by the statute and was in fact deliberately maintained by the Legislature in 2013 when the provision of community services to youth on probation was moved from DHHS to Juvenile Probation. The Inspector General of Nebraska Child Welfare Act was amended at that time to reflect this. The OIG hopes the Legislature will work with the OIG and Probation on a solution so that the accountability sought by the Legislature can be realized.

Intake Process

The majority of the work done by the OIG is determined by information provided to the office which the OIG refers to as "intakes." Intakes come in the form of:

- Incident reports from the DHHS or Juvenile Probation;
- Complaints or reports of information from the public;
- Formal grievances filed with DHHS including DHHS's response to the person filing the grievance; and,
- Reports from the YRTCs.

Once information has been received, it is vetted as part of the intake process for the purpose of determining jurisdiction, identifying systemic issues, and formulating a response or appropriate course of action.

The OIG is also required to collect data and report annually on two narrowly defined subjects related to the child welfare and juvenile justice system – Alternative Response and Juvenile Room Confinement.

Information Reported to the OIG

The OIG receives information – or intakes – in a variety of ways described in more detail below.

Incident Reports

The OIG is required by statute to receive notice of system involved deaths and serious injuries of children and youth being served by DHHS or Juvenile Probation or youth residing in a facility or program licensed by DHHS or Probation. In addition, the OIG must receive notice of all allegations of the sexual abuse of state wards in the child welfare system, as well as, juveniles on probation, in a detention facility, and in a residential child-caring agency.[18] Incident reports are provided by Juvenile Probation, DHHS Divisions of Children and Family Services (CFS), Public Health Licensing, YRTCs, and private service providers. The reports bring a range of issues to the OIG's attention such as the prevalence of suicide or self-harm, law enforcement contact, assault, concerns regarding placement, and abuse or neglect in care.

Complaints

The OIG receives complaints from foster parents, grandparents, family members, attorneys, parents, employees, administrators, and concerned citizens regarding various aspects and issues of the child welfare and juvenile justice systems. Complaints can be lodged with the OIG in person, by letter, via an on-line web form, by calling a toll-free number, and by email. The agencies and issues encompassed by complaints made to the OIG are varied and represent all areas and points in the system. If a complaint is received about an area outside of the OIG's jurisdiction, then a referral is made when appropriate.

[18] Neb. Rev. Stat. §43-4318.

Reports of Information

Reports of information cover a wide variety of issues, the primary purpose of which is to share information that the reporter believes to be important but does not rise to the level of a complaint.

DHHS Grievance Response Reports

Any time someone files a formal grievance with DHHS related to the child welfare system, the original grievance form and the official DHHS response is provided to the OIG for review.

Youth Rehabilitation and Treatment Center Reports

As noted above, in 2020, the Legislature passed LB 1144, which requires OJS to report to the OIG any of the following instances occurring at a YRTC: assault, escape or elopement, attempted suicide, self-harm by a juvenile, property damage not caused by normal wear and tear, use of mechanical restraints on a juvenile, significant medical event suffered by a juvenile, and internally substantiated violations of the Prison Rape Elimination Act.

Public Information

In addition, the OIG gathers information through the legislative process and the news media. Occasionally, the OIG will discover incidents or information that were not reported to the OIG and in some instances the information discovered should have been reported to the OIG. This public information further informs the OIG on what is happening in Nebraska's child welfare system.

Intake Review Process

After receiving information as described above, the OIG assesses every incident report, complaint, information report, and grievance referred to it. Each intake is subject to a preliminary review which includes a thorough document review, and collateral contacts if necessary, for complete vetting. Based on the findings of the preliminary review, the OIG then determines if the office holds jurisdiction over the incident, whether or not a full investigation is justified or required by statute, and what additional actions may be appropriate.

The OIG will often identify a number of issues in a given incident report or complaint that do not rise to the level of a full investigation. If a critical incident or complaint does not rise to that level, the information discovered is tracked to monitor potential areas of concern.

Working with the Ombudsman

One benefit of housing the OIG within the Ombudsman's Office is the ability to coordinate with the Ombudsman's Office to best serve the state. The Ombudsman's Office addresses complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office investigates and resolves complaints informally by working with parties involved while promoting accountability in public administration. If, after a preliminary review, the OIG determines that a complaint does not rise to the level of an investigation but that the complainant may benefit from the help of the Ombudsman's Office, the OIG can refer that complainant to the Ombudsman. This prevents the complainant from having to repeat the often traumatic circumstances of their complaint.

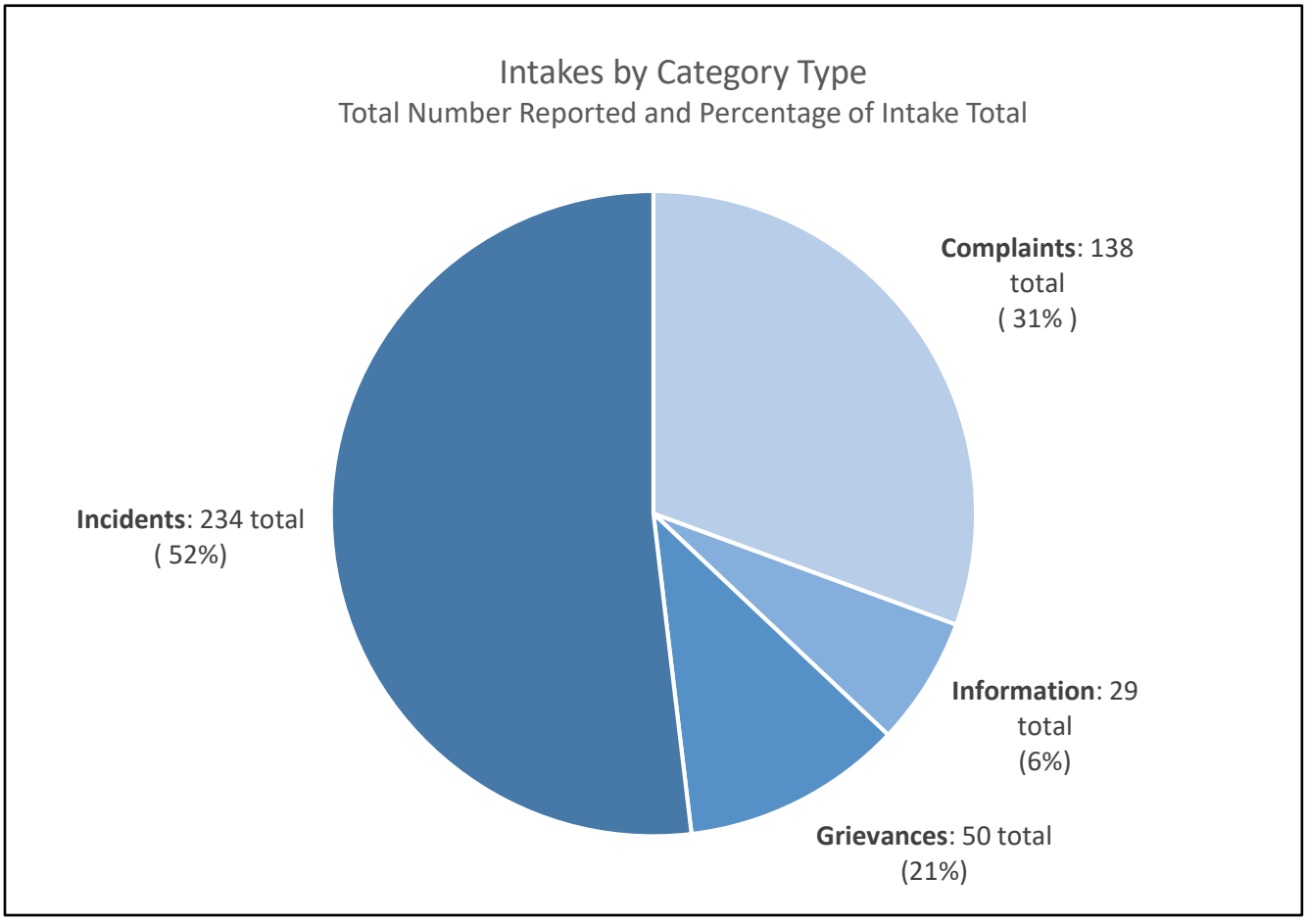
In FY 21-22, the OIG referred many complainants to the Ombudsman's Office and formally forwarded 17 complaints.

Fiscal Year 2021-2022 Data

Intakes

Incidents Reported to the OIG	
Reporting Party	**Number of Incidents**
CFS	61
Public Licensing	101
Private Providers	23
Juvenile Probation	49
Total	234

Other Types of Reports Made to the OIG	
Type of Intake	**Number Reported**
Complaints	138
Reports of Information	29
DHHS Grievances	50
Total	217



Deaths and Serious Injuries

Notices of deaths and serious injuries of system involved youth come to the OIG as incident reports. The deaths and serious injuries listed below are included in the calculation of total intakes and incident reports previously discussed. Compared to FY 20-21, the total number of reported deaths in FY 21-22 was lower and a slightly higher number of serious injuries were reported.

Deaths & Serious Injuries Reported to the OIG FY 20-21 Compared to FY 21-22

FY 20-21	Deaths	Serious Injuries	FY 21-22	Deaths	Serious Injuries
DHHS	20	8	DHHS	11	13
Juvenile Probation	10	0	Juvenile Probation	1	0

It is important to note that reported deaths and serious injuries will include incidents that were not caused by abuse or neglect but may have occurred by chance. As a result, and as noted in the next section, the OIG may not be required to investigate.

Mandatory Investigations

The OIG is required to investigate death and serious injury of youth who are: (1) placed in out of home care; (2) receiving child welfare services from DHHS; (3) receiving services from Juvenile Probation; (4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months; and (5) and youth in a licensed facility. The OIG is not required to investigate deaths that occurred by chance.

As previously noted, this reflects an increase in mandatory investigations of serious injuries. Eight of those serious injuries involved youth under the age of three and four of those youth had been involved with Alternative Response services within 12 months of their serious injury. Additionally, this is the highest number of mandatory investigations to be identified in a fiscal year since 2015.

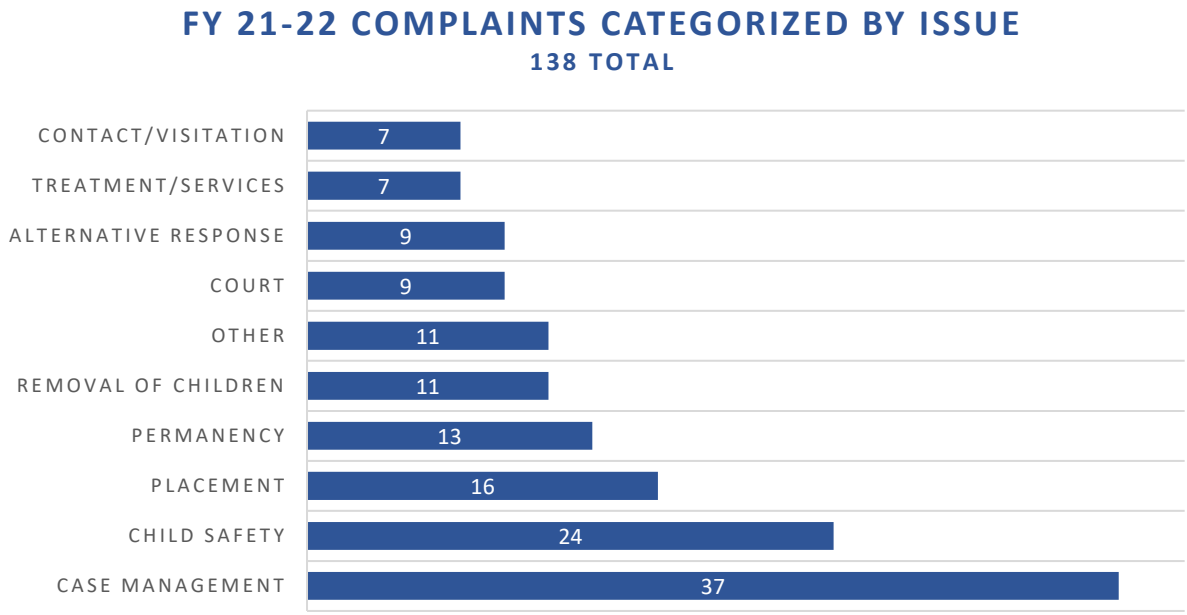
Mandatory Investigations from DHHS: FY 21-22	
Deaths	2
Serious Injury	10

Overview of Mandatory Investigations added in FY 21-22

Mandatory OIG Reports Added in FY 21-22					
Type of Incident	**Cause**	**Age of Child**	**Type Of Involvement**	**Time Of Involvement**	**Reporting Party**
Death	Neglect	Less than 1 year	Licensed Facility	Within 12 Months	DHHS-Public Licensing
Death	Suicide	16 years	Initial Assessment	Current	DHHS
Serious Injury	Abuse	Less than 1 year	CFS-State Ward	Current	DHHS
Serious Injury	Abuse	Less than 1 year	Alternative Response	Within 12 Months	DHHS
Serious Injury	Abuse	Less than 1 year	Initial assessment and Alternative Response	Within 12 Months	DHHS
Serious Injury	Abuse	Less than 1 year	Alternative Response	Within 12 Months	DHHS
Serious Injury	Abuse	Less than 1 year	CFS-State Ward	Current	DHHS
Serious Injury	Abuse	Less than 1 year	Intake at Hotline	Within 12 Months	DHHS
Serious Injury	Abuse	1 year	Alternative Response	Within 12 Months	DHHS
Serious Injury	Abuse	2 years	CFS-State Ward	Current	DHHS
Serious Injury	Abuse	10 years	CFS-State Ward	Current	DHHS
Serious Injury	Shooting	17 years	CFS-State Ward and Juvenile Probation	Current	DHHS

Complaints

While the total number of intakes for FY 21-22 remained consistent with the last few fiscal years, there was an increase in reports of information and grievances, and a decrease in the total number of complaints received by the OIG. This year the OIG received 138[19] complaints compared to FY 20-21 in which 182 complaints were received.



A diverse set of individuals contact the OIG to lodge a complaint which provides the OIG with insights into a wide range of potential issues within the system. The OIG categorizes complaints as a means to understand which concerns are most prevalent for families and individuals involved with Nebraska's child welfare system. The issues reported are by no means all-encompassing of what the totality of families in the system may be experiencing, but they give the OIG a window into potential issues arising in the system. The chart above details the number and overall types of complaints made to the OIG.

The majority of complaints the OIG receives relate to the complainant's frustration with how their case is being managed or their belief that their children should never have been removed from their care. They also may include allegations of errors or unprofessionalism from caseworkers, general confusion on what the role of the state is and its expectations of parents, or that DHHS is not adequately accounting for just how much effort a parent is making.

Additionally, many of the complaints the OIG receives relate to concerns about placement of state wards and their permanency objective. These complaints range from parents raising concerns about the

[19] Several of the complaints made to the OIG touched on more than one issue. For example, a complainant could have complained about case management and their child's placement. This means the numbers in the chart below add up to more than 138. Also, while the OIG receives complaints about the court process, the OIG does not have any jurisdiction over the court process or court decisions. This is explained to complainants when they call.

current foster placement of their child to a relative actively wanting placement of a state ward and being denied placement.

It is important to note that not every complaint is supported by the facts. The OIG receives many complaints that are unsupported and upon further review by the OIG the complaint demonstrates that DHHS appropriately responded to a given situation. In other instances, the concern is supported. In those cases, the OIG decides if the issue reflects a systemic problem requiring further investigation. Also, when appropriate, the OIG will bring key issues discovered through complaints to the attention of DHHS.

Complaints are a critical part of the OIG's work and provide important insights into how the system is working for children and families.

Critical Incidents

A similar number of critical incidents were reported to the OIG in FY 21-22 as compared to FY 20-21. However, there are some key differences in who reported critical incidents to the OIG. DHHS houses several divisions and contracts with a number of private providers all of whom report incidents to the OIG. The OIG has noticed a general decrease in the number of incidents reported by DHHS CFS and an increase in incidents reported from other divisions and private providers.

For example, there has been a consistent increase in incidents reported by Public Licensing. This fiscal year Public Licensing reported 101 critical incidents compared to 58 from last year—a 43% increase. It is very important to note that this increase does not reflect a new or concerning trend in the treatment of children in child cares. In fact, the majority of the critical incidents reported by Public Licensing involve potential regulation violations involving a child rather than physical injury to a child. This reflects, in part, how each division interprets the reporting statute differently. Public Licensing has adopted a broader interpretation of serious injury than CFS, for example, and their transparency and willingness to cooperate with the OIG is appreciated.

Additionally, the OIG has noticed a slight decrease in critical incidents reported by Juvenile Probation with 49 incidents being reported in FY 21-22 compared to 68 from FY 20-21. The vast majority of reports from Juvenile Probation are for allegations of sexual abuse. However, Juvenile Probation is also required to report deaths and serious injuries. The OIG has not received any reports of serious injury to youth on Juvenile Probation for FY 21-22. Probation's statutory obligation to report serious injuries under Neb. Rev. Stat. §43-4318(2)(b) is narrower in scope than the scope of serious injuries the OIG is mandated to investigate. This results in a disconnect between what is reported and what the OIG might be required to investigate. For example, the OIG received a critical incident report from DHHS of a shooting of a youth who was both a state ward and a youth supervised by Juvenile Probation. This youth was shot several miles from their foster home and then walked back to the foster home before being taken to the hospital. Probation did not report this serious injury to the OIG. Given the statutory language and Probation's interpretation of the statute, similar injuries to youth on Juvenile Probation who are not state wards would not be reported to the OIG, despite the OIG's obligation to investigate them under Neb. Rev. Stat. §43-4318(1)(c).

Reported Allegations of Sexual Abuse

Neb. Rev. Stat. §43-4318(2)(b) requires DHHS, juvenile probation, each detention facility, and each staff secure facility to report "all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and a juvenile in a residential child caring agency." It is critical to note that what is reported are **allegations**. More data is required to determine how many of those allegations are substantiated to give a more accurate sense of the degree of the problem.

Total Reports of Alleged Sexual Abuse by Fiscal Year & Reporting Agency

Fiscal Year	Total	Reported by DHHS	Reported by Juvenile Probation
17-18	45	26	19
18-19	41	31	10
19-20	46	15	31
20-21	69	14	55
21-22	70	21	48

Through the OIG's continued monitoring it noted a consistent increase in reporting from Juvenile Probation and a steady decrease in reporting from DHHS and its affiliated divisions. The OIG corresponded with DHHS on several occasions to understand the decrease in reports and discovered a misunderstanding on how DHHS was interpreting the reporting requirements. This misunderstanding has recently been corrected and since the start of the new fiscal year, DHHS has begun sending the OIG all allegations of sexual abuse of state wards on a monthly basis. Additionally, DHHS sent the last three and a half years of allegations of sexual abuse against state wards. The OIG has not yet been able to analyze this data in order to discern trends or ascertain areas of concern.

Investigation Process

A full investigation by the OIG, at a minimum, includes:

- Comprehensive review of all documents relevant to a case – from agencies, local law enforcement, and others;
- Investigative interviews with key persons and personnel involved in the case;
- Review of relevant Nebraska statutes, and agency rules, regulations, policies, procedures, and protocols; and,
- Additional research on best practices to formulate recommendations.

At the conclusion of a full investigation, the OIG issues an investigative report to the state agency involved. The OIG shares the report with the state agency for its review and the state agency must respond to the recommendations by accepting, rejecting, or requesting a modification of the recommendations. If a private agency is also the subject of the report, that private agency also has an opportunity to review the report and respond to the recommendations.

Open Investigations

In addition to mandatory death and serious injury investigations, the OIG is expected to substantively investigate current key systemic issues affecting Nebraska's child welfare and juvenile justice systems. Investigations can take months to complete as they involve complicated cases and issues necessitating a considerable amount of time and resources for completion. The OIG must continually assess and balance these priorities with the resources available and will have multiple open investigations at any given time.

The OIG's workload fluctuates with the number of mandatory investigations identified each fiscal year. For example, there have been years when only a few mandatory investigations were identified by the OIG. This fiscal year twelve were identified and in years past it has been as high as 26. At the end of FY 21-22, the office has 36 pending mandatory investigations.[20]

The OIG continually strives to meet the highest standards to ensure the office conducts timely yet thorough and accurate investigations.

OIG Pending Investigations as of End of FY 21-22
(June 30, 2022)

	Reported by DHHS	Reported by Juvenile Probation	
Death	6	18	
Serious Injury	12	0	
			Total Pending Investigations: 36

[20] Some of the pending investigations require the completion of criminal investigation and judicial involvement before the OIG is able to obtain relevant information. In some cases this process can take many months to resolve.

FY 21-22 DHHS Investigations

During FY 21-22 the OIG completed two reports of investigation involving DHHS: one serious injury investigation and the OIG's 2021 *Special Report: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services*.

Additionally, the OIG was actively working on several other investigations during FY 21-22 that are pending a final report.

FY 21-22 Juvenile Probation Investigations

As noted above, the OIG's ability to conduct investigations of deaths reported by Juvenile Probation according to the law and Inspector General standards is compromised. The OIG will continue to work on a path forward so that the accountability sought by the Legislature and required by law can be achieved.

Alternative Response Case Reviews

By statute, the OIG Annual Report must include a summary of any case reviewed by the office that included an Alternative Response.[21] Most often AR cases reviewed by the office come in one of three forms—as a complaint made directly to the office, as a DHHS grievance provided to the OIG, or as an incident report related to the death or serious injury of a system involved child. In the case of death or serious injury, the review is twofold: first, a review of the AR case as required by statute, and second, a review to establish if the report meets the criteria for a mandatory investigation. In FY 21-22, the OIG reviewed 17 AR related cases.

As noted previously, AR is a different approach to handling reports that are assessed by the Hotline. The goal is, as stated by DHHS, to meet families where they are by connecting families with local community resources, providing economic resources, and finding solutions for families in times of crisis. Unlike traditional response assessments, AR is not a formal investigation as to whether child abuse or neglect occurred. Safety is still assessed and if a family is found safe, DHHS attempts to provide resources to address the concerns that prompted the Hotline report. After safety is assessed, AR cases are completely voluntary, allowing families to either accept or refuse the services offered by DHHS.

Alternative Response Case Summaries

Complaints Made Directly to the OIG

The complaints received by the OIG involved claims of improper actions by caseworkers, the premature closure of an AR case, and concerns for child safety. It is important to note that while the OIG reviews these complaints, the OIG has not investigated the complaints fully to determine if they are supported or unsupported. Rather, what follows is a summary of the complaints as required by law.

Complaint about Case Worker Actions I

Complainant alleged that an AR worker improperly obtained information from a hair follicle test that was voluntarily agreed to and privately sought by the complainant. CFS was involved due to a parent testing positive for substances as part of conditions for probation. The child was determined to be safe in the care of the parent and the family was referred to community services, which were declined.

Complaint Alleging Improper Case Worker Actions II

Complainant alleged the case worker conducting the AR (based on an elementary aged child defecating on himself at school) inappropriately contacted a community member for collateral information about the child. No safety threats were identified. Community services referrals were recommended and declined by the family.

Complaint Alleging Improper Case Worker Actions III

A caregiver contacted the OIG alleging the family was being investigated by CFS based upon falsified claims and that the CFS case worker was harassing them during the assessment process. The caregiver was the subject of two AR intakes prior to contacting the OIG. The first AR intake reported concerns for the parent's significant mental health issues including delusional behavior such as believing that people were out to get the family and were breaking into their home and smearing blood all over their

[21] Neb. Rev. Stat. § 43-4331.

possessions. CFS assessed the caregiver and while not identifying any immediate safety threats, did note concerns for significant mental health issues by the primary caregiver. Three children in the home reported witnessing the caregiver talk to themselves and make claims that people were breaking into their house to smear blood everywhere, but stated they had never actually observed it to be true. Since the first AR case was opened, CFS has attempted to provide services, but the caregiver has repeatedly refused all services and resisted all attempts for follow up contact by CFS.

Complaint Alleging Improper Case Worker Actions IV

Complainant contacted the OIG with concerns about CFS involvement based on drug use by an adult family member living in the home. The complainant indicated they felt coerced into agreeing to a safety plan that required them to abandon the family member living in the home, but was fearful that if the safety plan was not agreed to children in the home would be removed. The adult family member had recently overdosed while in the presence of the children in the home. CFS found the children conditionally safe with a safety plan in place requiring the adult family member who had overdosed not be allowed back into the home. The family agreed to a voluntary case, however, the county attorney filed a 3a juvenile petition for removal which the court rejected citing a lack of evidence. The court's rejection of the petition ended the family's voluntary case with CFS. Within 12 months of the CFS investigation discussed above, the family was the subject of an AR intake due to a report to the Hotline that the same adult family member who overdosed had a history of sexually abusing minors, and was abusing illegal substances while residing in the home. At the time of the AR no safety threats were identified and the family was offered services which they declined.

Complaint about the Premature Closing of an AR Case

The complainant contacted the OIG due to being dissatisfied that the case worker was closing the AR case and thus ending the services that the complainant was receiving through the open AR case. The case was opened because power to the home was shut off due to non-payment. The case worker did not identify an active safety threat but did identify other economic needs. As a result of the open AR case, the family received gas and grocery vouchers from DHHS and was connected with a local community resource center that provided the family with a year of rental assistance, a support worker, and other benefits.

Complaint Alleging Unsafe Child I

A family member alleged that a child was not safe with her biological parents following an improperly handled AR case that provided the family with baby items, assistance in locating better housing, and community resources. The reporter stated that the child had been left in the care of a family member for several months through a temporary delegation of parental powers. After the closure of the AR case the Hotline accepted an intake for Traditional Response with CFS conducting the Initial Assessment which identified no active safety threats.

Complaint Alleging Unsafe Child II

Reporter expressed concerns that a child was unsafe due to unsanitary living conditions after an AR intake. CFS did not identify a safety threat or observe unsanitary conditions. Because the caregiver was already seeking out community assistance and receiving state resources, the AR case was closed with no further action.

Complaint Alleging Unsafe Child III

The OIG was contacted by the complainant regarding concerns about the safety of a child believed to be in physical danger and suicidal after an AR intake. The complainant alleged that CFS did not adequately evaluate the concerns for physical and emotional abuse. The case worker identified no active safety threats, provided information about services available in the community, and closed the AR case.

Reports of Deaths and Serious Injuries Provided to the OIG by DHHS

Infant Serious Injury Incident I

The OIG received an incident report concerning the serious injury of an infant that required EMS to be called to the infant's home where it was reported that the infant was incredibly thin and struggling to breathe. The infant was involved in a prior AR case within twelve months of the incident. At the time of the AR case, CFS determined the child was safe and the family did not accept services. The OIG found that an investigation into this serious injury is mandated by statute. The final report will be released upon the completion of the investigation and report process.

Infant Serious Injury Incident II

The OIG received an incident report concerning the serious injury of an infant who was thrown against a wall. The infant was involved in an AR three months prior to the incident. As part of the AR, CFS determined the child was safe and the family did not accept services. The OIG determined that the incident met the conditions necessitating a mandatory OIG investigation and report. The final report will be released upon completion of the investigation and report process.

Infant Serious Injury Incident III

The OIG received an incident report concerning the serious injury of an infant who had a brain bleed caused by shaken baby syndrome or head trauma. The infant was involved in an AR several months prior to the incident. As part of the AR, CFS determined the child was safe. CFS recommended community services to the family and closed the AR several months later. The OIG found this incident subject to a mandatory investigation and report. The final report will be released upon the completion of the investigation and report process.

Infant Serious Injury IV

The OIG received an incident report concerning the serious injury of a young child who ingested some opiates requiring several shots of Narcan to be administered. The young child was involved in an AR several months prior to the incident. As part of the AR, CFS determined the child was safe and the family did not accept services. The OIG is conducting an investigation into this incident as mandated by statute. The final report will be released upon the completion of the investigation and report process.

Death of an Infant within a Family with Current AR Services

The OIG received notice of an incident involving an infant who died of Sudden Unexpected Infant Death. The infant's family was involved with an AR case that had been opened a month prior to the infant's passing. The AR case concerned poverty issues affecting the family. CFS found no active safety threats and recommended the family voluntarily work with CFS to receive services. The family was already engaging with available economic services and at the time of the infant's passing, CFS continued the AR case in order to help provide the family grief and community supports in response to their loss. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

Incident Concerning a Youth on Juvenile Probation with AR involvement

The OIG received notice of an incident involving a youth under the supervision of Juvenile Probation who had also been assessed as part of an AR intake in the 12 months prior to the incident. The AR concerned emotional abuse in the family towards the youth. CFS determined that there were no active safety threats and closed the case recommending the family utilize probation services. The OIG determined this incident did not meet criteria for a mandatory investigation under the statute.

Incident at a Licensed Child Care Center Involving a Child with Previous AR

The OIG received notice of an incident involving a child at a licensed child care center who had also been assessed as part of an AR intake in the months prior to the incident. The AR focused on the child's newborn sibling and the substance use of a caregiver. CFS determined there were no active safety threats and did not recommend any other services as the family was already engaging with recommended services. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

DHHS Grievance Responses provided to the OIG by DHHS

DHHS Grievance AR Related Case I

The OIG reviewed a DHHS grievance from a parent undergoing several CFS investigations over the period of a few months including one AR assessment. The parent appeared to be confused on the different types of intakes and why one intake could be screened as a Traditional Response and another as AR. The AR assessment was initiated when a child reported that they were locked in their bedrooms overnight. CFS assessed the home and found it to be in disarray and unsanitary but not to the level of a safety threat. During this period, several other intakes were accepted regarding the family that went to Traditional Response rather than AR. None of these assessments identified a safety threat, but CFS did attempt to work with the family to resolve the concerns regarding the unsanitary living conditions and both the educational and therapeutic service needs for the children.

DHHS Grievance AR Related Case II

The OIG reviewed a grievance from DHHS concerning the actions of caseworker responding to an accepted AR intake. The intake was accepted due to concerns of drug use and unsanitary living conditions. The services offered to the family her through AR were refused.

Appendix A

Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services

Appendix A

Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services

INVESTIGATION & REPORT PROCESS COMPLETED: SEPTEMBER 16, 2021
PUBLICALLY RELEASED: SEPTEMBER 30, 2021

On December 21, 2020, the Office of Inspector General of Nebraska Child Welfare opened an investigation into the contract between the Nebraska Department of Health and Human Services (DHHS) and Saint Francis Community Services of Nebraska, Inc. (Saint Francis) for child welfare case management services in the Eastern Service Area (ESA). The process of investigation and report generation (including providing the agencies named in the report an opportunity to review the report and respond to recommendations) required over nine months of work by the OIG and spanned a period of time included in both the 2020-2021 and 2021-2022 fiscal years.

The investigation generated two recommendations to DHHS, both rejected by DHHS.

The Executive Summary from the publicly released report is summarized below.[22]

In January 2019, DHHS began the procurement process to secure a contract with a private provider for child welfare case management services in the ESA. Saint Francis submitted a bid that was questionably low and potentially inconsistent with state statute regarding caseload ratios. DHHS awarded the contract to Saint Francis in June 2019, began the process of case transfer in October 2019, and full implementation of the contract began in January 2020.

Concerns about Saint Francis' performance under the terms of the contract surfaced early in the process and continued to increase over time. Saint Francis was required by DHHS to submit corrective action plans (CAP) for failing to meet the following contractual requirements: completing case plans within 60 days; documenting placement changes in the State's case management system within 72 hours; meeting the duties and responsibilities with regard to court performance; using E-Verify as part of the hiring process; completing required background checks for employees; meeting caseload ratios as set out in Nebraska statute; and, conducting monthly face to face visits with children and families. Additional issues that raised concerns included Saint Francis' financial stability and the risk to its Child Placing Agency license.

Nebraska had conducted a pilot project for the privatization of child welfare case management services in the ESA for over a decade. Numerous evaluations of the pilot project had been conducted concluding that there has been no measurable improvement in outcomes with the privatization of case management. The difficulties with Saint Francis' performance under the ESA contract brought into stark relief the long-standing challenges and risks inherent in a privatized case management system.

[22] The full report can be accessed on the OIG website at: http://oig.legislature.ne.gov/wp-content/uploads/2021/09/Final-Public-Release-OIG-Report-Eastern-Service-Area-Case-Management.pdf.

As a result of the investigation, the OIG found:

1. Saint Francis has failed to meet key terms of the contract.

2. The Eastern Service Area Pilot Project has demonstrated unacceptable risk in the privatization of case management.

The OIG recommended DHHS take the following actions:

1. DHHS should terminate the current Eastern Service Area contract with Saint Francis.

Saint Francis has not complied with several key terms of the contract for nearly two years and therefore, DHHS should terminate the current contract with Saint Francis.

2. DHHS should end the Eastern Service Area Pilot Project.

The ESA Pilot Project has extended for 12 years and has provided the State with a significant amount of data, all of which suggests that the privatization of case management has not delivered the intended benefits.

The pilot project in the ESA for privatized case management should come to a close with the termination of the contract with Saint Francis and DHHS should look for new ways, outside of privatized case management, to partner with private providers and other stakeholders in the child welfare system to work towards the common goal of protecting children and supporting families.

Appendix B

Serious Injury of a Three-Month-Old Infant during a Voluntary Case

Appendix B

Serious Injury of a Three-Month-Old Infant during a Voluntary Case

INVESTIGATION & REPORT PROCESS COMPLETED: JUNE 14, 2022

The Office of Inspector General of Nebraska Child Welfare Act specifically mandates that the OIG investigate any serious injuries of children whose family is currently provided services by the Department of Health and Human Services (DHHS).[23]

The OIG received a Critical Incident Report from the Department of Health and Human Services Division of Children and Family Services (CFS), indicating Cassia Pallas, age three-months, had sustained a serious head injury as a result of abuse. Two weeks before the serious injury, CFS completed an Initial Assessment of Cassia's mother, Traci Voltz, and Lennox Pallas, Cassia's alleged father. CFS found the children safe but assessed the risk in the home as high. Cassia's mother, Ms. Voltz, agreed to participate in a voluntary case with CFS.[24]

The physical abuse of Cassia Pallas by Mr. Pallas and Ms. Voltz was substantiated by the court in 2021. Additionally, Mr. Pallas was criminally charged and found guilty of committing child abuse resulting in serious bodily injury. Mr. Pallas was sentenced to serve more than fifteen years' incarceration for felony child abuse. Ms. Voltz reunified with all three of her children in 2021.

A summary of the investigation into the serious injury of Cassia Pallas is provided below.

Ms. Voltz is the biological mother of three children: Colleen Carlton, Yara Pallas, and Cassia Pallas. Ms. Voltz was in a relationship with Lennox Pallas at the time of the serious injury of Cassia. Mr. Pallas is the biological father of Yara Pallas and was the presumed biological father of Cassia Pallas at the time of her serious injury.

Traci Voltz was involved as a child with CFS due to physical abuse and neglect. Ms. Voltz came into care when she and her brother were repeatedly physically abused by their biological mother. Ms. Voltz was again the subject of abuse, when a relative foster parent physically abused her.

Lennox Pallas was also system involved as a child. His history includes becoming a state ward at two years of age, being adopted at the age of five, having multiple placements during his adolescent years, and experiencing physical abuse after being adopted.

Ms. Voltz first became involved with DHHS as a parent when Colleen was an infant. Ms. Voltz declined to participate in a voluntary case, and the case was closed without services.

Three years later an intake on the Pallas-Voltz family was accepted due to concerns for physical abuse by Mr. Pallas. The children were found safe in the care of Ms. Voltz with the probability of future abuse or neglect as very high. Additionally, the assessment noted that Ms. Voltz had been involved in multiple

[23] Neb. Rev. Stat. §43-4318 (1) (c).
[24] The names of all involved parties have been changed to protect their identities.

domestic violence incidents with Lennox Pallas in the past year, but none of the incidents were in the presence of the children. The assessment documented Mr. Pallas's criminal history, which included domestic assault, possession of controlled substances, burglary, terroristic threats, and property damage. The assessment also noted that Ms. Voltz stated she was having a "very difficult time" parenting Colleen. Ms. Voltz agreed to accept services. The case was active for approximately five months.

Two years after the voluntary case the Hotline accepted a second intake on the Voltz- Pallas family due to allegations of domestic violence. The parents reported to the caseworker that Mr. Pallas did not live with Ms. Voltz and her three children, clarifying that he was in the home a significant amount of time caring for the children while Ms. Voltz worked. Both parents denied the physical altercation and framed it as an argument over several issues, including a rumor that Mr. Pallas was not the biological father of Cassia Pallas. The caseworker documented that Mr. Pallas stated he threw and broke several items during the argument but denied throwing anything directly at Ms. Voltz. During the visit at the family home, Colleen denied seeing the fight and reported to the caseworker that Mr. Pallas told her to answer "no" to all the case worker's questions. The caseworker later interviewed Colleen at school, without Ms. Voltz or Mr. Pallas present. Colleen again reported that she did not see the altercation as she was in her room holding her baby sister.

The children were found safe in the care of Ms. Voltz, with a high risk of future maltreatment. The caseworker documented lingering concerns that a domestic violence incident had occurred and was witnessed by the children. After discussing the high-risk score with the caseworker, both parents initially indicated they were willing to accept services voluntarily. Mr. Pallas would later decline participation. After several delays, the ongoing caseworker scheduled the first in-person contact with the family for the same day as the critical incident.

Findings

1. After reviewing CFS records and the documentation contained in N-FOCUS, CFS Protection and Safety Procedures and Memorandums, the Standard Work Instructions (SWI) documents, and reviewing all the required Structure Decision Making© (SDM) assessments, the OIG finds that there was no violation of statute, rules and regulations, or policies and protocols in DHHS's handling of this case.
2. The OIG also finds that this case involved multiple complex and challenging issues that can be difficult to assess including:
    - two parents with a significant history of abuse and neglect as children;
    - a history of domestic violence between the couple; and
    - a secondary caregiver, Mr. Pallas, who was responsible for the life-threatening injuries to the child.

These complex factors are not fully factored into the analytics of a tool like SDM. Rather, in such cases the system must rely on a caseworker's level of understanding of the effect these issues might have on the safety and risk to a child.

Recommendations

The OIG is tasked with making recommendations for system improvement in investigation reports.[25] The OIG has previously made recommendations related to the complex issues noted above.

For example, the OIG has recommended that DHHS have an independent entity conduct a validation study of the SDM in Nebraska, and it is the OIG's understanding that a validation study is underway.[26] The OIG has also recommended additional training for Initial Assessment (IA) workers, including refresher trainings,[27] and the specialization of the IA workforce.[28] DHHS accepted and has taken action on these recommendations.

Finally, the OIG has examined the issue of secondary caregivers in abuse and neglect cases in two prior reports in 2016 and 2021 and most recently recommended that DHHS enhance the policies and tools specific to the examination of secondary caregivers in an investigation.[29] The OIG strongly encourages DHHS to continue to work to address this challenge.

While the outcome of this case may not have been avoided, it highlights the importance of continued training for staff and a regular review of the effectiveness of the policies and procedures meant to address the issues present in this case.

Given the policies, procedures, and standard work instructions already in place and considering the recommendations the OIG has previously made, the OIG makes no new recommendations to DHHS based on this investigation.

The OIG will continue to take note of any themes and systemic issues raised by this investigation to be tracked and considered as topics for further investigations if necessary and appropriate.

[25] Neb. Rev. Stat. §43-4327.
[26] *Investigation Summary: Death and Serious Injury Following a Child Maltreatment Investigation* (contained in OIG Annual Report 2016, p. 49): https://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf.
[27] *Investigation Summary: Serious Injury of a Child after 11 Reports of Alleged Physical Abuse* (contained in OIG Annual Report 2016, p. 29).
[28] *Investigation Summary: Death and Serious Injury Following a Child Maltreatment Investigation* (contained in OIG Annual Report 2016, p. 48).
[29] *Report of Investigation: Death or Serious Injury Following a Child Abuse Investigation June 2016-June2019*, (August 7, 2020, p. 16): https://nebraskalegislature.gov/pdf/reports/public_counsel/Final_IA_Report_9-20.pdf.

Appendix C
OIG Recommendation Updates

Appendix C

OIG Recommendation Updates

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 following table contains a summary of all recommendations made by the OIG in its investigative reports ordered from Incomplete to Complete and grouped by agency involvement. The recommendations are numbered based on the year and order the recommendation appeared in an annual report. For example, the first recommendation appearing in the 2015 Annual Report is numbered 15-01.

Each recommendation is noted to be either accepted or rejected by the agency[30], based on an official response to the investigation.

Accepted: The agency accepted the recommendations as part of the original investigation.

Rejected: The agency rejected the recommendation as part of the original investigation.

Based on information provided by the subject agency the OIG then assigns an implementation status. The definitions of each status are:

Incomplete: The agency has not taken relevant action to address the recommendation.

No Further Action: The agency has taken some relevant action to address the recommendation, but has no plans to take additional necessary action to address the recommendation.

Progress: The agency has taken relevant action to address the recommendation and has plans to take additional necessary action to address the recommendation.

Complete: The agency has taken all relevant and necessary action to address the recommendation.

The OIG monitors shifts to established policy/procedure as well as changes in implementation status of previously completed recommendations. Recommendations with a revised status will be denoted with the status being CAPITALIZED and **bold**.

[30] In cases where the subject agency requested modification to the recommendation and the OIG agreed, the recommendation is categorized as accepted. When the requested modification was denied by the OIG, the recommendation is categorized as rejected.

OIG Recommendation Status – INCOMPLETE

Administrative Office of Probation Division of Juvenile Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-24	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Incomplete
Recommendation: Adopt policy on documentation and record keeping. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
16-25	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Incomplete
Recommendation: Increase internal quality assurance efforts at the state level. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
17-02	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
17-03	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Implement guidelines on when it is appropriate to use specific types of alternatives to detention. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						

Administrative Office of Probation – Incomplete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-04	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
17-05	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
17-07	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						
17-08	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Incomplete
Recommendation: Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website.						

OIG Recommendation Status – INCOMPLETE

DHHS Division of Public Health- Licensing

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-16	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Rejected	Incomplete
Recommendation: Ensure adequate staffing for residential-child caring agency licensing operations.						
Update: No relevant action taken to address the recommendation.						

OIG Recommendation Status – NO FURTHER ACTION

Administrative Office of Probation Division of Juvenile Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-22	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	**NO FURTHER ACTION**
Recommendation: Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD). **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website. **OIG Note:** As noted in previous reports, Probation provides the Nebraska Developmental Disabilities Access Guide to Probation Officers. To date the OIG has not been made aware of any changes to the situation in which Probation is unable to locate a suitable training vendor and plans to coordinate with DHHS to accomplish training; there are no policies yet created, and the OIG is unaware of any action to create a policy.						
17-06	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	**NO FURTHER ACTION**
Recommendation: Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities. **Update:** The OIG sent a letter requesting a status update on this recommendation from the Administrative Office of Probation for FY 21-22. Probation responded with no update. In the past Probation Administrator Deb Minardi has invited the OIG to review numerous published reports available on their website. **OIG Note:** Probation has created this form. It is unknown whether the form has been approved and implemented.						

OIG Recommendation Status – NO FURTHER ACTION

DHHS Division of Children & Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-07	2014-2015	Child Death III	DHHS	CFS	Accepted	No Further Action
Recommendation: Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline. **Update:** In the fall of 2015, the League of Municipalities distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. **OIG Note:** No training for other frequent reporters – schools, medical professionals, etc. has been produced or made easily available.						
16-04	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	No Further Action
Recommendation: Further define process for utilizing child advocacy centers by Initial Assessment. **Update:** After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers, DHHS decided not to update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. **OIG Note:** DHHS indicated they did not believe the burden for referral should be on DHHS staff alone. DHHS issued a revised memo on use of CACs, Protection and Safety Procedure #23-2017, however, none of the OIG's suggestions were incorporated.						
16-09	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	No Further Action
Recommendation: Take steps toward greater Initial Assessment workforce specialization and experience. **Update:** DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts of the state. DHHS has enhanced training for workers assigned to Initial Assessment, held internal discussions about additional CFS paygrades, adjustments to team composition such as end-to-end teams and allowing IA partnering caseloads between two workers.						

DHHS Division of Children & Family Services – No Further Action continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-05	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	No Further Action
Recommendation: Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement. **Update:** DHHS has created a new finding, Law Enforcement Refusal, which indicates that law enforcement is choosing to not investigate the allegation. In these cases, DHHS is not investigating the allegations either. This change in Hotline protocol has been implemented statewide. Staff at the Hotline continue to reach out to law enforcement. The Hotline Administrator has met with law enforcement across the state about the importance of communicating these investigatory conclusions with the Hotline.						
18-06	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	No Further Action
Recommendation: Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone. **Update:** DHHS reports that this is already occurring, based on assessments and referrals that take place at the Hotline. Hotline staff will connect families to other hotlines and the CACs when appropriate. DHHS has implemented a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. All referrals through the FAST program are documented on NFOCUS.						

DHHS Division of Children & Family Services – No Further Action continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
20-01	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	No Further Action

Recommendation: Create a policy or training to address when the alleged perpetrator or involved caregiver(s) of the named child victim has extensive and/or specific knowledge of the Nebraska child welfare system.

Update: A series of Lunch and Learn sessions were held for CFS supervisors and administrators to discuss cases that involve child welfare savvy individuals. Training centered on the skill level of a worker who should be assigned to such cases, and the use of supervisor consultations for quality oversight. A training session of the Case Staffing Model was conducted which focused on the supervisor's role in facilitating case staffing. A Standard Work Instruction was developed for Hotline reports involving DHHS employees.

OIG Note: To date the training has not involved workers or specific actions a caseworker might take in these situations. Training and policy should be provided at the worker level, and should address child welfare savvy individuals who are not current DHHS employees.

20-04	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Rejected	No Further Action

Recommendation: Change DHHS policy to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case no less than 60 days after opening.

Update: DHHS created a Standard Work Instruction, "Mandatory Consultation Points" which clarifies that a consultation point is required when there continues to be an active safety threat in a non-court case, no less than 60 days after opening. Workers are required to document their consultation regarding any staffing with the County Attorney regarding a non-court case with an active safety threat which has been open less than 60 days. A new Quality Assurance Review was implemented in July 2020 to determine adherence to this policy change. The review looks at active non-court cases with a duration of less than 60 days and an identified safety threat. This new review will be conducted bi-annually. At least 100 cases will be selected for review each review period. A report with review results and recommendations will be posted on the internally and shared with Administrators, supervisors and staff, within the month following the completion of the reviews.

OIG Note: DHHS has indicated there are no plans to further address this recommendation. The OIG does not agree that when applied to non-court cases, consultations should only occur when there is an active safety threat.

DHHS Division of Children & Family Services – No Further Action continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-01	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	No Further Action

Recommendation: Enhance policy and tools specific to the examination of secondary caregivers in an investigation.

Update: DHHS created a Standard Work Instruction for Initial Assessment which directs workers to include information from the secondary caregiver, if a secondary caregiver is identified, in the Risk Assessment narrative. The Standard Work Instruction also added language regarding the non-custodial parent when there are no allegations. Additionally, a micro-training was developed to help workers be able to correctly identify households along with primary and secondary caregivers.

OIG Note: These efforts 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.

OIG Recommendation Status – PROGRESS

DHHS Division of Behavioral Health- Youth Facilities/OJS

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-07	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	Progress
Recommendation: Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health. **Update:** DHHS has this recommendation as one of their initiatives for the DHHS Youth Facilities 5 year strategic plan; it is scheduled to be looked at in Year 4. Additionally, currently this recommendation is being discussed and looked at by the YRTC workgroup as part of the legislative juvenile subcommittee.						
21-06	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	**PROGRESS**
Recommendation: Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS. **Update:** DHHS has internally clarified the chain of command as it relates to the OJS Administrator's roll in supervising the YRTC System. **OIG Note:** The purpose of the recommendation was also to clarify for the public where within DHHS the YRTCs are located and who is responsible for administering them. While the updated organizational chart (including the OJS administrator position) is currently available on the DHHS website the entirety of the YTRC system is not anywhere within the chart. For this reason the OIG has reclassified this recommendation from complete to progress.						

OIG Recommendation Status – PROGRESS

DHHS Division of Children & Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-01	2014-2015	Child Death I	DHHS	CFS	Accepted	**PROGRESS**
Recommendation: Adopt federally mandated mental & behavioral health policies. **Update:** Central Service Area is piloting the use of a trauma screen tool. The SDM tool that houses the FSNA is currently being reviewed for fidelity. It is unclear at this time, if that will impact the continued use of that tool.						
16-08	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Progress
Recommendation: Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards. **Update:** The Workforce Development team continues to assess the workforce needs for each program area under Protection & Safety to determine the staffing levels needed based on trend analysis for each service area.						
16-10	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	**PROGRESS**
Recommendation: Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument. **Update:** Evident Change (formerly National Council on Crime and Delinquency) submitted their final report on Nebraska's fidelity to the SDM model for the Intake Assessment, Safety Assessment and Risk Assessment, including the results of a Risk Validation study. Evident Change worked with a group of local internal and external stakeholders to review proposed modifications to the risk assessment to improve the accuracy, equity, distribution. Another stakeholder group will met at the end of June to align policies and procedures with the risk model that was selected. **OIG NOTE:** The OIG anticipates reclassifying this recommendation as complete once the report is provided to this office for review.						

DHHS Division of Children & Family Services – Progress continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-20	2015-2016	Suicides of State Wards	DHHS	CFS	Accepted	PROGRESS
Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible. **Update:** FY Update: Central Service Area is piloting the use of a trauma screen tool. The SDM tool that houses the FSNA is currently being reviewed for fidelity. Unclear at this time, if that will impact the continued use of that tool. In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017.						
18-10	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Progress
Recommendation: Meet the statutorily required caseload standard for initial assessment and ongoing case management. **Update:** CFS continues to explore opportunities and strategies to reduce caseworker turnover to include participating in national workgroups and convenings as this workforce shortage is not specific to Nebraska. CFS reports that caseload compliance can only be achieved when they are fully staffed; however, their Workforce Development team is also assessing if they have enough FTE's to handle the workload trends currently being experienced.						
21-02	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Progress
Recommendation: Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregiver substance use is affecting the safety of the child. **Update:** Central Office has submitted a draft drug testing policy that includes the use of an assessment tool by a CFSS.						

OIG Recommendation Status – PROGRESS

DHHS Division of Public Health-Licensing

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-05	2020-2021	Infant Death in Licensed Family Child Care Homes March 2016-Septemeber 2018	DHHS	Public Health-Licensing	Accepted	**PROGRESS**

Recommendation: Create specific guidelines for how frequently and in what manner sleeping infants should be checked.

Update: Draft regulations were revised based on the Office of Inspector General recommendations and presented at the 2nd hearing for NAC 391 Chapters 1 and 2 on 5/18/21. The proposed infant sleep checks and where infants should sleep in a Family Child Care Home were strongly opposed. On 9/3/21 the regulations were not approved and terminated by the Secretary of State. Children's Services Licensing will continue to work with stakeholders to clarify, gain feedback and adjust as appropriate the proposed change in infant sleep checks and where infants should sleep in a Family Child Care Home.

OIG Note: As part of FY 20-21 the OIG classified this recommendation as complete based on the revised regulations. Due to developments during FY 21-22, the OIG has reclassified this recommendation from complete to progress. The OIG appreciates that Public Health attempted the promulgation of regulations based on this recommendation, but notes the recommendation was to create guidelines which are now even more critical due to the lack of regulations. As the report illuminated how frequently and in what manner sleeping infants are checked was directly attributed to the death and serious injury of infants.

16-19	2015-2016	Sudden Unexpected Infant Deaths	DHHS	Public Health-Licensing	Accepted	**PROGRESS**

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

Update: LB 717 was signed by the Governor on April 11, 2018, statutorily requiring training before a daycare license is granted. 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. Proposed child care regulations including this requirement were prepared by Public Health and went to hearing in August and September 2021. The regulations were not approved and terminated by the Secretary of State for 391 NAC Chapters 1-5.

OIG Note: This requirement is codified in the law but not included in regulations. The OIG noted this recommendation as complete in FY 20-21, due to this update the recommendation has been reclassified as progress. The OIG encouraged Public Licensing to continue efforts to modify regulations.

OIG Recommendation Status – COMPLETE

Administrative Office of Probation Division of Juvenile Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-09	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Complete
Recommendation: Assess whether Probation has the authority to monitor alternatives to detention. **Update:** Probation implemented a Predisposition Supervision Policy in September 2017 clarifying the circumstances under which predisposition, court-ordered supervision may occur.						
17-01	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Probation did not Accept or Reject	Complete
Recommendation: Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing. **Update:** Probation approved a Predisposition Supervision Policy in September 2017. The policy sets forth the circumstances under which predisposition, court-ordered probation supervision may occur.						
16-23	2015-2016	Death of Youth Served by Probation & DHHS	Administrative Office of Probation	Juvenile Services	Rejected	Complete
Recommendation: Adopt policy on child welfare referrals and joint case management. **Update:** Probation released a policy regarding this subject. Probation has been training probation officers and DHHS caseworkers across the state with DHHS on the new joint case management policy.						

OIG Recommendation Status – Complete

DHHS Division of Behavioral Health [Youth Facilities/OJS]

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-11	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	**COMPLETE**
Recommendation: Implement a Trauma-Responsive environment across the YRTC system. **Update:** There are a variety of evidence-based programs and practices used at each center to help support clinical programming that is trauma responsive and trauma informed. All staff receive an annual Trauma Informed Care training, with clinical staff receiving additional training for their work in therapy sessions. Keeping youth and staff safe and secure is our primary concern throughout the course of every day. A large percentage of youth committed have experienced trauma in their life. Trauma is addressed individually and in group therapy sessions with licensed professionals. Youth who express to staff that they are struggling with their trauma, are immediately assessed by mental health staff to talk through their thoughts and develop coping skills and develop a safety plan if necessary. **OIG Note:** The OIG confirmed that all staff, including support staff such as secretaries and janitors, receive the annual training referenced above.						
21-10	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	**COMPLETE**
Recommendation: Implement evidenced-based programming consistently throughout the YRTC system. **Update:** Evidence-based educational and therapeutic intervention is provided weekly through Trauma Affect Regulation Guide for Educational and Therapy (TARGET) by licensed mental health practitioners or Clinical Psychologist. TARGET is designed to prevent and treat traumatic stress disorders. VOICES is a female gender-specific program of self-discovery and empowerment for girls, used at the Hastings facility formal groups are provided two times a week for youth. Moral Reconation Therapy continues weekly, this group focuses on moral reasoning. In addition youth are offered individual and family therapy, to focus on mental health and substance use issues. Therapists and the Clinical Psychologist use Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Dialectical Behavioral Therapy (DBT) interventions with youth, all of which are evidence-based. Aggression Replacement Training is utilized at the Kearney program to help youth learn alternatives to aggression, manage impulses, and decrease antisocial behaviors. Love Notes is an evidence based relationship program utilized at the Lincoln facility to help youth build skills to maintain healthy relationships of all types, they learn to recognize the signs of an unhealthy relationship and set boundaries. **OIG NOTE:** The nature of providing programing is challenging as it requires an ongoing commitment. The OIG will continue to monitor the programing being utilized within the YRTC system.						

DHHS Division of Behavioral Health [Youth Facilities/OJS] - Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
21-09	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	**COMPLETE**
Recommendation: Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels. **Update:** YRTCs are currently maintaining a 1:4 ratio in addition to including the ratio in the DHHS Youth Facilities 5 year strategic plan. **OIG Note:** The OIG will continue to monitor compliance with the 1:4 ratio.						
21-08	2020-2021	The Deterioration & Closure of Geneva Youth Rehabilitation and Treatment Center	DHHS	Behavioral Health- DHHS Youth Facilities	Accepted	**COMPLETE**
Recommendation: Implement a fully digital case management system. **Update:** Beginning in January 2022, the centers began transferring documentation of treatment from paper format to full utilization of the electronic record system myAVATAR, which is used throughout the DHHS facilities for a variety of services. This system holds documentation of each youth's treatment, progress and behavior from the time of admission to discharge. Other systems utilized to access a variety of data include the Nebraska Data Exchange Network or "NDEN", Nebraska Criminal Justice Information System "NCJIS" and NFOCUS. The utilization of the fully digital case management system has allowed for the seamless sharing of information between centers when youth transfer facilities.						
16-33	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
Recommendation: Digitalize Records at YRTC-Kearney. **Update:** Beginning in January 2022, the centers began transferring documentation of treatment from paper format to full utilization of the electronic record system myAVATAR, which is used throughout the DHHS facilities for a variety of services. This system holds documentation of each youth's treatment, progress and behavior from the time of admission to discharge.						

DHHS Division of Behavioral Health [Youth Facilities/OJS] – Completed continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-32	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health-Youth Facilities	Accepted	Complete
Recommendation: Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney. **Update:** DHHS examined staffing at YRTC-Kearney, and calculated how many staff it needed to comply with PREA. Additional staff for YRTC-Kearney were included in the 2016 DHHS budget request and funded by the Legislature in 2017. DHHS reports that recruitment of staff at YRTC-Kearney has significantly improved.						
16-31	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health-Youth Facilities	Accepted	Complete
Recommendation: Develop Continuous Quality Improvement Process at YRTCs Led by Central Office. **Update:** The YRTCs now employ a Clinical Program Director who oversees the mental health services and clinical programming for the YRTC facilities and monitors data related to mental health critical incidents, and provides guidance and oversight to mental health staff at the youth facilities. A child and adolescent psychiatrist oversees the medical and mental health services provided at all youth facilities. The Clinical Director and Psychiatrist work collaboratively with the OJS administrator and facility administrators to ensure quality health and mental health services are provided with fidelity and meet the needs of every youth.						
16-30	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health-Youth Facilities	Accepted	Complete
Recommendation: Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5 **Update:** At this time, no youth are housed permanently in the Dickson unit, youth. Youth are able to utilize Dickson for self-directed or staff directed cool offs, and will return to their housing units after a short period of time. Staff in Dickson will offer time to process through the issues of the youth, and contact other professionals (nursing, mental health) as necessary. If a youth has a significant behavior, which poses a high risk to themselves or others, they may do a "reintegration plan" where they share time between Dickson and their regular housing unit. Reintegration plans are set for 14 days or less.						

DHHS Division of Behavioral Health [Youth Facilities/OJS] – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-29	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney	DHHS	Behavioral Health- Youth Facilities	Rejected	Complete
Recommendation: Make the OJS Administrator a Full-time Position. **Update:** An active full time OJS Administrator is reflected on the Division of Behavioral Health's organization chart. The position is a direct report to DHHS Facilities Chief Operating Officer.						
15-13	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
Recommendation: Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva. **Update:** In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics. YRTC-Geneva made changes to OM 115.17.5 in August 2015 to clarify facility specific policy and procedure. Work to standardize policies and procedures at both YRTCs is ongoing. **OIG Note:** YRTC-Geneva is no longer operational, the program has been relocated to Hastings						
15-12	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
Recommendation: Provide increased guidance for culture change at YRTC-Geneva. **Update:** In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs. Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists. **OIG Note:** YRTC-Geneva is no longer operational, the program has been relocated to Hastings.						
15-11	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
Recommendation: Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva. **Update:** In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs. In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place.						

DHHS Division of Behavioral Health [Youth Facilities/OJS] – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-10	2014-2015	General Investigation I	DHHS	Behavioral Health- Youth Facilities	Accepted	Complete
Recommendation: Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.						
Update: On July 1, 2017, DHHS's "Secure Transportation" service definition for transport to and from YRTCs became effective.						

OIG Recommendation Status – COMPLETE

DHHS Division of Children & Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
22-01	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS	CFS	Rejected	Complete
Recommendation: DHHS should terminate the current Eastern Service Area contract with Saint Francis. **Update:** In December 2021 DHHS terminated the Saint Francis Ministries contract effective June 30, 2022.						
22-02	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS	CFS	Rejected	Complete
Recommendation: DHHS should end the Eastern Service Area Pilot Project. **Update:** Legislative Bill 1173 in conjunction with amendment 1959 removed all pilot project language from statute, thus ending the Eastern Service Area Pilot Project.						
21-04	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Complete
Recommendation: Conduct a work study of Child Protective Services (CPS) Supervisors. **Update:** DHHS Administration held individual town hall style meetings within each service area which included receiving feedback from supervisors, and continues to assess the current supervisor culture with quarterly and bi-monthly meetings. CFS is also working on training and leadership development for supervisors.						
21-03	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019	DHHS	CFS	Accepted	Complete
Recommendation: Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided. **Update:** Protection and Safety now has a landing page with a collection of community resource links from across the state. The public page is organized by subject and service area. An email was sent to staff about the landing page and where community referrals should be documented in NFOCUS.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
20-05	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	Complete
Recommendation: Develop specific non-court evaluation criteria to help caseworkers and supervisors determine when a non-court case should be referred to the multi-disciplinary (1184) team and/or county attorney for review, and require formal training for supervisors to ensure they can assist caseworkers in making referral decisions. **Update:** DHHS created a Standard Work Instruction "Ongoing Case Management" which includes direction regarding the case management of non-court cases. It states the worker and their supervisor will collaborate to determine if a referral for the LB 1184 for review and/or a referral to the County Attorney's office is necessary. DHHS created a Standard Work Instruction, "1184 Team Meetings" to provide guidance to staff regarding when, how and what types of cases are to be referred for 1184 team review. It also includes a flowchart to follow regarding referrals and a template to be used when making a referral and attending 1184 team meetings.						
20-03	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Accepted	Complete
Recommendation: Create a handout/brochure to be provided to the family at the time the non-court case is offered. **Update:** A brochure has been created for families who are participating in a non-court case and is waiting on final draft approval and printing. The brochure will be stored within CFS offices for CFS staff to disseminate to the families who are involved in a non-court case. The brochures were printed and provided to CFS offices in September 2020. Local offices will be responsible for printing additional copies as needed.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
20-02	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	CFS	Rejected	Complete
Recommendation: Create non-court case policy establishing that participating in a non-court Case requires the following: Parents sign a release of information for all related medical/mental health providers specific to obtaining collateral information and assessing progress on case plan goals, Parents allow contact between the worker and their children, without caregivers present, and Parents must formally agree to participate in recommended services. **Update:** DHHS rescinded Protection and Safety Procedure #34-2016. DHHS created Standard Work Instruction, "Ongoing Case Management" that includes the case management of "non-court" cases when there is an active safety threat and/or the risk level is determined to be "high" or "very high". Parents/caregivers will be required to sign a Release of Information form for all related medical/mental health providers for the purpose of gathering collateral information and assessing progress on the case plan/foster care prevention plan goals; allow contact between the worker and the child(ren), without the caregivers present, and; must formally agree to participate in the recommended services. Record of this formal agreement will be documented within the Foster Care Prevention Plan.						
19-07	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
Recommendation: 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. **Update:** DHHS engaged in a partnership with the Quality Improvement Center for Workforce Development (QIC-WD) to identify interventions that focus on addressing Secondary Traumatic Stress (STS) among CFSS and supervisors. DHHS has implemented the CFS Strong program which includes curricula to address on-going and acute traumatic events with Resilience Alliance, Peer Support, and Restoring Resiliency Response sessions. CFS is exploring contractual options to ensure that this RRR process remains in place post-pilot and can also be available to all staff across the state to include Hotline.						
19-06	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
Recommendation: Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months. **Update:** SDM micro-learning units have been developed by CCFL Trainers while the training is directly provided to workers by supervisors. DHHS reported that Micro-learning units are delivered monthly, however, the monthly units may not always be specific SDM training.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-05	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
Recommendation: 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.						
Update: DHHS created Standard Work Instruction, "Mandatory Consultation Points", in July 2020 which clarifies the required consultation when a parent has voluntarily relinquished their parental rights as well as direction to staff to conduct a mandatory consultation with their supervisor when a CFS case closes due to reunification with the non-custodial parent. DHHS also created Standard Work Instruction "Non-Custodial Parents Identification and Engagement" in July 2020 specifically outlines the required steps to be taken prior to case closure with a non-custodial parent, which includes staffing the closure with the CFS Supervisor.						
19-04	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
Recommendation: 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.						
Update: DHHS created Standard Work Instruction, "Initial Assessment" that includes language specific to the birth of baby in July 2020. The language states that additional safety assessments are required when there is a change in family conditions including when a new baby is born. The response time is set as a priority 2, unless a more immediate response is required.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
19-03	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury	DHHS	CFS	Rejected	Complete
Recommendation: Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.						
Update: DHHS developed two Quick Tips for system involved Pregnancy and Newborns and sent them to all CFS Specialists, Supervisors, Lead Workers, and Administrators. Assessing Pregnancy and Newborns includes what the worker should do and information that should be shared when they have information that a system involved parent or teen is pregnant. Pregnancy or Newborn Planning provides information on discussion and planning that needs to occur with the family, their safety networks, GAL, CASA, and Tribal Representative when there is a pending or new birth to ensure the safety of the newborn and any children in the home or who there is a plan to reunify. A Standard Work Instruction became effective in August 2020 that provides guidance for workers regarding a contract between DHHS and Nebraska Children's Home Society for Options Education. This service provides parents or parents to be, with information and education about the different permanency options and legal ways to achieve permanency for their child. A family can be referred for this service at any time while they are system involved. Standard Work Instructions were updated to include guidance on Safety Assessments and Safety Plans when a new baby is born. A Young Adult Pregnant and Parenting one page resource was developed and provided to CFS workers, and community stakeholders to hand out to parents when they work with families. The resource guide provides information and contact information for services and supports.						
19-02	2018-2019	Death of a 14-month-old State Ward	DHHS	CFS	Accepted	Complete
Recommendation: Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.						
Update: DHHS created Standard Work Instruction, “Participating in a Case Staffing with Managed Care Organizations” that addresses the assessment and well-being needs of youth in care in conjunction with placement, services and support needs. DHHS created Standard Work Instruction, “Foster Home Placement Disruption and Foster Home Hold and Review Process” to specify where to document and locate placement disruption plans within NFOCUS.						
19-01	2018-2019	Death of a 14-month-old State Ward	DHHS	CFS	Accepted	Complete
Recommendation: Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.						
Update: DHHS created Standard Work Instruction, “Foster Home Placement Disruption and Foster Home Hold and Review Process”, that outlines the process for workers in the field. The new procedure was finalized in August 2020.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-15	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	Complete
Recommendation: Include a component on child sexual abuse prevention in foster and adoptive parent training. **Update:** The training that Project Harmony is implementing will also be utilized in foster and adoptive parent training. See 18-11 below for specifics.						
18-14	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Strengthen foster care licensing to remove inappropriate and unsuitable homes. **Update:** DHHS enhanced the application process for foster parenting to better screen foster homes, and DHHS issued an RFP for home studies in order to improve the process. DHHS 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 no longer remain as a licensed foster parent. 395 NAC 3 finalized and became effective in July 2020, revised forms continue to be utilized.						
18-13	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements. **Update:** 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). Quality assurance review continue to be conducted on a quarterly basis for youth placed in out of home care with intakes received involving sexual abuse allegations.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-12	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Review and revise training on child sexual abuse for DHHS staff. **Update:** DHHS has contracted with Project Harmony to implement the training. See 18-11.						
18-11	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation. **Update:** DHHS 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.						
18-09	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Review, modify, and enforce process for gathering information and making findings in law enforcement only cases. **Update:** DHHS has transferred the responsibility for entering findings to the Hotline for investigations conducted by law enforcement only. (Program Memo #33-2017). In May 2018, Hotline staff began addressing the backlog of law enforcement cases where no findings had been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked. FY 19-20: DHHS has rescinded Program Memo #33-2017 and created a Standard Work Instruction, "Monitoring of Law Enforcement Only Intakes by Hotline" effective December 2019.						
18-08	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Adhere to policy on out of home assessments and enhance quality assurance. **Update:** DHHS has created Standard Work Instruction "DHHS Facility Investigations" that details how investigations will be completed for facilities managed by DHHS effective October 2019. DHHS has an Out of Home Assessment policy for facilities that are not managed by DHHS effective November 2017. DHHS also created a Standard Work Instruction, "Facility Assessments-Out of Home Assessment Team" effective August 2020.DHHS plans to implement a QA process for out of home assessments. Quality assurance reviews of Out of Home Assessments were implemented in 2021 and continue to be conducted on a quarterly basis.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-07	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.						
Update: DHHS reports that a curriculum has been developed on the preponderance of the evidence standard. Trainings for all supervisors occurred across the state beginning in April 2018.						
18-04	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.						
Update: DHHS contracted with Project Harmony to create three modules related to preventing and educating about the sexual abuse of children.						
18-03	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: 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.						
Update: 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. At the time of completion over 1700 intakes that had been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.						
18-02	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Accepted	Complete
Recommendation: 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.						
Update: At the time of completion DHHS reported 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 was performing qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, were following proper practice and policy. Quality assurance reviews continue to be conducted on a quarterly basis to determine if intake decisions followed the proper intake practice and policy expectations. The case review sample includes intakes with sexual abuse allegations that were screened as "Does Not Meet Definition" or "Law Enforcement Only".						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-01	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	CFS	Rejected	Complete
Recommendation: 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. **Update:** 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. During FY 21-22 CFS met with OIG to evaluate a more efficient process to ensure that this information is provided. A draft data report was provided to OIG and approved for implementation.						
16-26	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS	Accepted	Complete
Recommendation: Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system. **Update:** DHHS has issued Administrative Memo 1-2018, Crossover Youth Practice Model, and, with Probation, presented the Statewide Crossover Youth Initiative Training to all case managers and juvenile probation officers. FY 19-20: DHHS has rescinded Protection and Safety Procedure #1-2018 and created a Standard Work Instruction on "Crossover Youth Practice Model" effective November 12, 2019. There are local Crossover Management meetings that meet twice a year to discuss data and progress which is separate from crossover staffings which occur for each case. The statewide advisory groups convenes to discuss statewide opportunities for improvement and growth.						
16-21	2015-2016	Suicides of State Wards	DHHS	CFS	Accepted	Complete
Recommendation: Enhance efforts to reduce caseworker turnover. **Update:** At the time of completion DHHS made changes to job recruitment strategies, revisions to New Worker Training to make it more accessible and less travel-intensive to complete. In July 2017, DHHS initiated a supervisor training program to better ensure caseworkers are supported. CFS continues to explore opportunities and strategies to reduce caseworker turnover to include participating in national workgroups and convenings as this workforce shortage is not specific to Nebraska.						
16-16	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: 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. **Update:** CJA continues to have a working Multidisciplinary Team Subcommittee and CJA is a standing agenda item on the Quarterly meeting for the Commission for the Protection of Children. CJA funds can only be utilized for projects associated with the Three Year Assessment which is developed by the Commission. A Proposal process has been developed to ensure that DHHS and the Commission both support the use of funds.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-15	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement. **Update:** 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. DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017. The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.						
16-14	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis. **Update:** DHHS has developed a monthly report on CWLA caseload compliance, including initial assessment and mixed caseloads. An overall report is posted publicly on their website and updated monthly.						
16-13	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision. **Update:** The Workforce Development team continues to assess the workforce needs for each program area under Protection & Safety to include the Abuse Hotline and a request has been submitted in Biennium Budget request for additional Hotline staff and supervisors given the continued uptick in intakes being received for both APS and CPS.						
16-12	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts. **Update:** In April 2016, CFS Central Office distributed an “Under 2” packet, in English and Spanish, designed with input from the Division of Public Health, to field staff. Information about pediatric abusive head trauma is included in the packet. CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-07	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Expand quality assurance and continuous quality improvement (CQI) at the Hotline.						
Update: Quality assurance reviews continue to be conducted on a quarterly basis to determine if intake decisions followed the proper intake practice and policy expectations. The case review sample continues to include a number of intakes with physical abuse allegations involving children under age 7.						
16-06	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.						
Update: The Workforce Development team continues to assess the workforce needs for each program area under Protection & Safety to include the Abuse Hotline and a request has been submitted in Biennium Budget request for additional Hotline staff and supervisors given the continued uptick in intakes being received for both APS and CPS.						
16-05	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Update and provide additional detail on response priority definitions.						
Update: CFS is in the process of assessing and deploying changes to Priority Response Timeframes - there will only be P1's and P2's - P3's will be sunset as they will be P2. The communication and roll-out is still being reviewed. DHHS updated its intake manual in August 2017 in Protection and Safety Update #26-2017. The updated manual provides clarification on priority response time definitions involving injuries to children under age six. FY 19-20: DHHS updated the intake manual in October 2019.						
16-03	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Develop additional training for Initial Assessment staff.						
Update: CCFL updated its New Worker Training in 2016 to include a more intensive focus on family engagement. Caseworker in-service training on Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, Human Trafficking, Advanced Testifying, and Engaging Families in Safety and Risk Assessments have been developed and are being offered around the state. CFS and CCFL host quarterly meetings to review feedback from training to develop ways to enhance. CFS is also identifying ways to enhance field training by way of Lead Workers and other internal staff.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-02	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Adopt policy on photographing injuries during Initial Assessment. **Update:** In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."						
16-01	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	CFS	Accepted	Complete
Recommendation: Implement training on the medical aspects of child abuse. **Update:** CCFL consulted with Dr. Bleicher as a medical expert for curricula review in August and September 2017. The following recommendations were made: • Spiral fractures in toddlers and young children are often activity related but the same fracture in the arms (especially infants) are highly suspicious of abuse. References made to spiral fractures need to be clarified (revision meeting scheduled for 12.05.17). Incorporate the article Bruising Characteristics Discriminating Physical – help to distinguish accidental from abusive injuries (revision meeting scheduled for 12.05.17). 02/02/18 This training was created and trained for the first time with the November 2017 training group.						
15-14	2014-2015	General Investigation I	DHHS	CFS	Accepted	Complete
Recommendation: Clarify Hotline policy and procedure when receiving a report of sexual assault. **Update:** The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency.						
15-09	2014-2015	Child Death III	DHHS	CFS	Accepted	Complete
Recommendation: Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities. **Update:** DHHS continues to fund a Community Engagement Coordinator position, as well as a Youth Engagement Coordinator position with the Nebraska Coalition to End Sexual and Domestic Violence to collaborate with local and tribal domestic violence programs and community based organizations to address family violence issues in racial and ethnic minority populations and underserved populations. The Community Engagement Coordinator mobilizes communities to create social change around sexual and domestic violence and intersecting oppression, while providing training and capacity-building assistance to member programs and other organizations on topics related to anti-oppression; diversity and access; community engagement; collaboration; and related topics. In addition, to the Community Engagement the Coalition funds a Youth Engagement Coordinator that works in tandem with the Community Engagement Coordinator to plan, coordinate, and manage the youth engagement activities. The goal of this position is to engage the voices of youth from the ages of 13 – 18 years old who are often marginalized in school and the community.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-08	2014-2015	Child Death III	DHHS	CFS	Accepted	Complete
Recommendation: Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.						
Update: In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."						
15-06	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
Recommendation: Ensure "Absence of Maltreatment in Foster Care" is as accurate as possible.						
Update: Since May 2016, DHHS has listed the number of maltreatment cases that have been "court pending" between 8 and 12 months in its CQI reports. This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.						
15-05	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
Recommendation: Provide stronger supports for kinship and relative foster families.						
Update: Pre-service foster parent online training is offered to relative and kinship placements in order to get more of such 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 (ACF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska's Kinship Navigator program began October 1, 2019.						
15-04	2014-2015	Child Death II	DHHS	CFS	Accepted	Complete
Recommendation: Improve Home Study Process.						
Update: To help ensure quality home studies across the state, DHHS entered into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts began November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.						
15-03	2014-2015	Child Death I	DHHS	CFS	Accepted	Complete
Recommendation: Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications.						
Update: Updates were made on N-FOCUS and CFS generates reports with the child's medications. CFS reviews reports and case staffing are utilized to address/discuss child's medical needs, services and medication management. Additionally, quality assurance case reviews are conducted on a quarterly basis to monitor the assessment of needs and services to address the child's physical, mental and behavioral health. The reviews includes a review of oversight of the child's prescription medications including psychotropic medications.						

DHHS Division of Children & Family Services – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
15-02	2014-2015	Child Death I	DHHS	CFS	Accepted	Complete

Recommendation: Expand training on mental and behavioral health.

Update: DHHS added in-service training on these topics, and added suicide prevention training to topics covered in New Worker Training. In July 2017, an updated mental health desk aid was made available to all staff.

OIG Recommendations Status – COMPLETE

DHHS Divisions of Children & Family Services and Developmental Disabilities

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-28	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS & DD	Accepted	Complete
Recommendation: Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system.						
Update: DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTCs for service eligibility.						
16-27	2015-2016	Death of Youth Served by Probation & DHHS	DHHS	CFS & DD	Accepted	Complete
Recommendation: Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.						
Update: At the time of completion both CFS and DD participated in the Cross Divisions Solution Team. In 2017, DD helped provide information and feedback on CFS New Worker Training and developed a PowerPoint on available services for CFS staff. In April 2022, CFS and DD collaborated to develop a one-pager for both DD and CFS staff regarding their roles for ensuring youth who may be eligible for DD services have applied. In addition, the one-pager outlines what services are available to youth who are DD-Eligible and waiting for wavier funding; those who are on the comprehensive waiver funding includes links to helpful resources.						

OIG Recommendation Status – COMPLETE

DHHS Division of Children & Family Services and contracted Private Agency

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-11	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Owens Educational Services, Inc.	Accepted	Complete
Recommendation: Implement training on suicide warning signs and prevention in youth.						
Update: In April 2017, an LIMHP, PLADC Mental Health Practitioner trained staff company-wide on QPR (Question. Persuade. Refer.) Training for suicide prevention. This curriculum was also added to New Hire Training.						
17-10	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Private Agency	Owens Educational Services, Inc.	Accepted	Complete
Recommendation: Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.						
Update: Owens now requires staff to contact & stay in communication with mental health professionals when a release is signed.						

OIG Recommendations Status – COMPLETE

DHHS Division of Children & Family Services and Private Agency

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
16-18	2015-2016	Sudden Unexpected Infant Deaths	DHHS & Private Agency	CFS & Nebraska Families Collaborative (PromiseShip)	Accepted	Complete
Recommendation: Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep. **Update:** In 2016, DHHS incorporated infant safe sleep into New Worker Training. An "Under Two Packet" with information about safe sleep was created with assistance from the Division of Public Health. This is distributed to all families and caregivers of children under two. In 2016, NFC incorporated Safe Sleeping into New Worker Training and a webinar has been created that is mandatory for all permanency staff. The training includes information on items that should/shouldn't be in the crib, co-sleeping, blankets, infant sleepwear, etc. This training will be completed annually by all permanency staff. NFC has attached Safe Sleep Guidelines to ages 0-5 Walkthrough Packet that is to be reviewed and/or given to the caregiver at each walkthrough when assessing non-agency/kinship homes. In April 2022, a review of the Under Two Packet occurred to ensure all brochures and information were current. The 1-2- ABCs of Safe Sleep brochure remains current. The National Institute of Health (NIH) updated their Safe Sleep Environment brochure and this version was included in the Under Two Packet in May 2022. These brochures are available in both English and Spanish.						
16-17	2015-2016	Sudden Unexpected Infant Deaths	DHHS & Private Agency	CFS & Nebraska Families Collaborative (PromiseShip)	Accepted	Complete
Recommendation: Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases. **Update:** In August 2017, DHHS adopted Protection and Safety Procedure #28-2017, "Mandatory Monthly Visits With Children, Parents & Out of Home Care Providers," which includes the Nebraska Safe Sleep Environment Checklist developed by Public Health and policy for workers regarding safe sleep. FY 19-20: DHHS has rescinded Protection and Safety Procedure #28-2017 and created a Standard Work Instruction on "Mandatory Monthly Visits with Children, Parents, & Out of Home Care Providers" effective April 23, 2020. NFC updated the monthly Walkthrough Checklist, adding prompts to address children ages 0-5 sleeping location, the condition of the room/bed etc.						

OIG Recommendation Status – COMPLETE

DHHS Division of Public Health-Licensing

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
18-18	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies. **Update:** 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.						
18-17	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: 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. **Update:** 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. Children's Services Licensing has an internal policy and procedure in place, a tracking mechanism to support investigative efforts and a licensing action guide.						
17-16	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies. **Update:** Coordination continues with CFS and Probation. Investigation conversations are formally conducted at joint meetings regarding the specified licensee. Children's Services Licensing shares completed investigations with CFS and Probation when applicable.						
17-15	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations. **Update:** 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.						

DHHS Division of Public Health Licensing – Complete continued

Number	Annual Report	Report Name	Agency	Division	Agency Response	Status
17-14	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Adopt clear requirements on medical record-keeping and documentation in regulations. **Update:** 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.						
17-13	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies. **Update:** 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.						
17-12	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible. **Update:** 391 NAC Chapter 7 Residential Child Caring Agency and 391 NAC Chapter 8 Child Placing Agency regulations became effective March 2021.						
16-11	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Public Health-Licensing	Accepted	Complete
Recommendation: Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials. **Update:** Current and proposed child care licensing regulations include pediatric abusive head trauma training through the "Safe with You" training series. This training is required in all licensed child care programs.						