Office of the Inspector General of Nebraska Child Welfare

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Offices of Inspectors General

- Government accountability is a fundamental expectation in democratic systems.
- Inspectors General promote:
  - Accountability
  - Transparency
  - Good Government
  - High Performance
- The OIG's goal is to ensure that the child welfare and juvenile justice systems are serving children and families well and are functioning as the Legislature intended.

Association of Inspectors General

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

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

Overview of the OIG of NE Child Welfare

- Created by the Legislature in 2012
  - One of 18 recommendations of a study of child welfare privatization - LR 37 (2011)
  - The OIG of Child Welfare was created to "[e]stablish a full-time program of investigation and performance review to provide increased accountability and oversight" of the child welfare and juvenile justice systems with the purpose of facilitating reform.
- Housed in the legislative branch, within the Ombudsman's office
- Office of Inspector General of Nebraska Child Welfare Act, Neb. Rev. Stat. §§43-4301 – 43-4332.

OIG's Jurisdiction

The OIG 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 and the Division of Public Health)
- Administrative Office of Probation, Juvenile Services Division
- The Crime Commission's Juvenile Justice Programs
- Private agencies and service providers in the child welfare and juvenile justice systems under state contract
- Licensed child care facilities
- Juvenile detention and staff secure detention centers

Duties of the OIG

The OIG provides accountability through investigations, reviews, system monitoring, and recommendations for system improvement.

- Investigate deaths and serious injury to children
- Look into allegations of misconduct and violations of law by individuals and agencies serving children and families
- Monitor data, information, and key system indicators

OIG Operations

- IG is appointed for a five year term by the Ombudsman with approval of the Chair of the Executive Board of the Legislature and the chair of the Health and Human Services Committee.
- The IG must become certified as an IG by the national Association of Inspectors General within two years of their appointment.
- The OIG of Child Welfare has two Assistant Inspectors General who are largely responsible for the investigations. The office also shares an Intake Specialist with the OIG of Corrections.

OIG Operations

- The majority of the OIG's work is determined by information provided to the office in one of four ways.
- Critical Incidents
  - The Department of Health and Human Services, the Juvenile Services Division of the Administrative Office of Probation, and each juvenile detention facility are required to notice the OIG on cases of death and serious injury to youth, as well as all allegations of sexual abuse.
- Complaints
  - The OIG also receives complaints by phone, email, website, walk-ins, and through cases referred from Senators.
- Grievances
- Information

FY 2023-2024 Annual Report

During Fiscal Year 2023-2024 (FY 23-24) starting July 1, 2023 through June 30, 2024, the OIG received 515 total intakes comprised of:

1. 143 Critical Incident Reports;
2. 180 complaints;
3. 90 reports of or requests for information; and,
4. 102 grievances and accompanying findings from DHHS.

OIG Operations

- Intake Process
  - After receiving an intake, the OIG assesses every incident report, complaint, grievance, or information report.
  - The preliminary review includes a thorough document review and collateral contacts if necessary.
  - The OIG then decides if it has jurisdiction over the incident or complaint, whether or not a full investigation is required by statute, and what additional actions may be appropriate.

FY 23-24 Data

Incidents Reported to the OIG	
Reporting Party	Number of Incidents
CFS	120
Public Licensing	17
OIG Discovered	3
Juvenile Probation	3
Total	143

Other Types of Reports Made to the OIG	
Type of Intake	Number Reported
Complaints	180
Reports of Information	90
DHHS Grievances	102
Total	372

Year in Review

- Attorney General's Opinion and Effects
- Review of deaths and serious injuries in the system
- YRTC monitoring
- Sexual Abuse Allegation Monitoring

Deaths and Serious Injuries

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

FY 23-24 Data

OIG Pending Investigations as of End of FY 23-24 (June 30, 2024)	
	Reported by DHHS
Death	10
Serious Injury	24
Total Pending Investigations:	34

- Half of the OIG's mandatory investigations (17) have been added within the last two years.

YRTC Monitoring

- There was an increase in most of the critical indicators reported by the YRTCs.
  - YRTC-Kearney experienced a large increase in assaults on staff and youth. The majority of serious assaults were committed by the same five youth.
  - There was a significant increase in incidents of self-harm at YRTC-Hastings, increasing to 220 from 59 the previous year. Almost all incidents resulted in minor injuries.
  - There was an increase in the use of mechanical restraints across all YRTCs.
- There were also increases in mental health staffing.
- Conducted visits to each facility.

Sexual Abuse Allegations

- DHHS, Juvenile Probation, and juvenile detention facilities are required to notify the OIG of any ***allegations*** of sexual abuse made by state wards and youth on probation.
- In FY 23-24 there was a slight decrease in the number of sexual abuse allegations by state wards.
  - There were 244 allegations of sexual abuse of state wards in FY 23-24, down from 271 in FY 22-23.
  - However, the number of substantiated cases (meaning a court or DHHS found evidence to support the allegations) rose this year to 14 compared to 6 substantiated cases for FY 22-23.

OIG Investigations

- The OIG completed one investigation into the death of a child in a licensed daycare setting.
  - This case involved an accidental asphyxiation due to unsafe sleep.
  - The OIG recommended DHHS revise its regulations to reflect best practices regarding the monitoring of sleeping infants. DHHS accepted that recommendation and reported that regulation changes similar to the OIG's recommendations were already underway

Referrals to the OIG

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

Thank You!

Questions?

Contact our office:

Inspector General of Nebraska Child Welfare

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