# 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.

# 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. §§50-1801 – 50-1821.

# OIG's Jurisdiction

The OIG-CW provides accountability for and may conduct investigations involving:

- Nebraska's child welfare system which is administered by the Department of Health and Human Services (DHHS), specifically the Division of Children and Family Services (CFS);
- Child cares and other facilities that are licensed to serve children and youth in the child welfare system by DHHS' Division of Public Health, Children's Services Licensing (Children's Services Licensing);
- Nebraska's juvenile probation system which is administered by the Administrative Office of Probation, Juvenile Services Division (Juvenile Probation);
- Juvenile detention and staff secure detention centers;
- Juvenile Justice Programs administered by the Commission on Law Enforcement and Criminal Justice (Crime Commission); and
- Private agencies and service providers in the child welfare and juvenile justice systems under state contract.

# 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 and youth
  - (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation;
  - (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation; and
  - (c) in cases that have had an open investigation for child abuse or neglect in the 12 months prior to the death or serious injury.
- Review and investigate 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 Director of the Division of Legislative Oversight with approval of the Chair of the Legislative Oversight Committee, the Chair of the Health and Human Services Committee, the Chair of the Judiciary Committee, and the Chair of the Executive Board of the Legislature.
- 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
  - DHHS, Juvenile 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

# 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 staff discussion.
  - 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 2024-2025 Annual Report

During Fiscal Year 2024-2025 (FY 24-25) starting July 1, 2024 through June 30, 2025, the OIG received 445 total intakes comprised of:

1. 96 Critical Incident Reports;
2. 161 complaints;
3. 91 reports of or requests for information; and,
4. 97 grievances and accompanying findings from DHHS.

# FY 24-25 Data

| Incidents Reported to the OIG | |
|---|---|
| **Reporting Party** | Number of Incidents |
| **CFS** | 70 |
| **Children's Services Licensing** | 25 |
| **OIG Discovered** | 1 |
| **Juvenile Probation** | 0 |
| **Total** | 96 |

| Other Types of Reports Made to the OIG | |
|---|---|
| **Type of Intake** | Number Reported |
| **Complaints** | 161 |
| **Reports of Information** | 91 |
| **DHHS Grievances** | 97 |
| **Total** | 349 |

# Deaths and Serious Injuries

- 27 child deaths were reported to the OIG in FY 24-25.
  - 27 child deaths were reported to the OIG in FY 24-25 compared to 21 in FY 23-24
  - 7 of those deaths involved co-sleeping or unsafe sleep.
  - 7 others were the result of medical issues or accidents.
  - 2 deaths were caused by abuse or neglect but the family was not known to DHHS before the death.
  - **4 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.
  - 11 of the serious injuries were caused by suspected abuse and neglect but the family was not known to DHHS before the injury.
  - 6 serious injuries were not the result of abuse or neglect.
  - **6 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 24-25 (June 30, 2025) | |
|---|---|
| | Reported by DHHS |
| **Death** | 9 |
| **Serious Injury** | 23 |
| **Total Pending Investigations:** | 32 |

- Twenty-seven of the OIG's mandatory investigations have been added within the last three years.

# Year in Review

- LB 298 and Creation of Division of Legislative Oversight
- DHHS Letters of Agreement Complaint
- Review of Assaults on Staff and Uses of Force at Juvenile Facilities
- Youth Committed to the Lincoln Regional Center
- Monitoring of changes to DHHS services and policies
- YRTC monitoring
- Sexual Abuse Allegation Monitoring

# YRTC Monitoring

- YRTCs are required to report to us when the following incidents occur: assaults, escapes or elopements, an attempted suicide, self-harm by a juvenile, property damage, use of mechanical restraints, significant medical events suffered by a youth, and internally substantiated PREA violations.
  - Some information is received in critical incident reports and some in monthly data and reporting
- The YRTCs saw an increase in their census while other data reported remained fairly consistent to last fiscal year.
  - YRTC-Kearney saw a significant increase in their census with an average monthly census of 76 up from 62. But at the time of the writing of the report into this first quarter, the YRTC-Kearney census had consistently been near or over 100 youth.
  - There was still a concerning number of youth-on-staff assaults, although YRTC-Kearney actually saw a reduction.
  - There were no reports of attempted suicide for the second consecutive year.
- Conducted visits to each facility.

# Sexual Abuse Allegation Monitoring

- 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 24-25 there was an increase in the number of sexual abuse allegations by state wards reported by DHHS.
  - There were 293 allegations of sexual abuse of state wards in FY 24-25, up from 244 in FY 23-24.
  - 77 allegations were investigated by CFS with five substantiated, 52 unfounded, and 11 pending criminal court action.
- Juvenile Probation did not report any allegations to the OIG in FY 24-25. But the OIG has recently begun receiving notifications from Juvenile Probation again and should have data available next fiscal year.
- The OIG has also not received notification of any allegations from juvenile detention centers.

# OIG Investigations

- The OIG completed three investigative reports into the deaths and serious injuries of 11 children.
  - One report included nine deaths and serious injuries in cases that received an Alternative Response.
    - The OIG found Alternative Response was often used for high and very high-risk families and made two recommendations regarding the use of Alternative Response, including improvements in data tracking and evaluation of family engagement strategies.
  - In the investigation of the death of a two-year-old due to abuse by the mother's significant other, the OIG again recommended that DHHS evaluate and enhance the identification and assessment of all persons with regular access to a child in a child's home.

# Other OIG Reports

- Child Care Monitoring Report
- Juvenile Room Confinement Report

# Referrals to the OIG

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

# Thank You!

# Questions?

Contact our office:

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