OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE
SUMMARY OF ANNUAL REPORT
FISCAL YEAR 2024-2025

There was a slight increase in the number of child deaths reported to the OIG.

- 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.
- 7 others were either the result of causes unknown or abuse and neglect but were not mandated for investigation by the OIG.
- 4 deaths are mandated to be investigated by the OIG under the law.

There was no change in the number of serious injuries to children reported to the OIG.

- 27 serious injuries to children were reported to the OIG in FY 24-25 – the same as reported 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 are mandated to be investigated by the OIG under the law.

The YRTCs saw an increase in their census while other data reported remained fairly consistent.

- There was a significant increase in the amount of youth served at YRTC-Kearney at any given time in FY 24-25 as compared to FY 23-24.
- There was still a concerning number of youth-on-staff assaults within YRTCs in FY 24-25.
- There were no reports of attempted suicide within the YRTCs for the second consecutive year.

There was an increase in the number of sexual abuse allegations by state wards.

- There were 293 allegations of sexual abuse of state wards in FY 24-25, up from 244 in FY 23-24.
- It is important to note that these are **allegations**, not the number of substantiated cases.
- 77 allegations were investigated by CFS with five substantiated, 52 unfounded, and 11 pending criminal court action.

The OIG completed three investigative reports into the deaths and serious injuries of 11 children.

- In one report 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.

Significant decisions were made by DHHS about child welfare policy and practice.

- DHHS announced its transition to the SAFE Model for assessing safety and risk was on hold and it will continue utilizing Structured Decision Making for assessments.
- DHHS announced it will bring all support of relative and kinship homes in-house instead of contracting the support of some relative and kinship homes out to child placing agencies.