OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

Report of Investigation

Deaths and Serious Injuries of Children After an Alternative Response Assessment

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Executive Summary

Between 2021 and 2024, the Office of Inspector General of Nebraska Child Welfare (OIG) received notices from the Nebraska Department of Health and Human Services' (DHHS) Division of Children and Family Services regarding nine children in Nebraska, six of whom were seriously injured and three of whom had died, after the acceptance of an Alternative Response (AR) intake within the previous 12 months. AR was initially introduced by the Nebraska Legislature as a pilot project in 2014, and implemented by the Legislature as a permanent program in 2020. There were no deaths or serious injuries of children related to an AR case reported to the OIG until 2021. The nine cases that are the subject of this investigative report include all the deaths and serious injuries related to an AR case of which the OIG has been notified.

AR is defined as "a comprehensive assessment of (i) child safety, (ii) the risk of future child abuse or neglect, (iii) family strengths and needs, and (iv) the provision of or referral for necessary services and support."[1] It is an approach used by DHHS and in many other states that allows those working in the child welfare system to engage with families in a less adversarial, more collaborative way and to respond to less severe allegations of child abuse or neglect without a traditional investigation. Once it is assigned to AR, the children must be found to be safe by DHHS, meaning there is no immediate safety threat to the child, for the case to proceed as an AR case. After the child's safety is assessed, the risk of future abuse and neglect is assessed along with the family's strengths and needs. AR then offers families voluntary services and community support to enhance their ability to keep the children safely in their homes. AR was intended to improve outcomes for Nebraska families and lower the number of children being removed from their homes and formally entering the child welfare system.

This investigative report includes an explanation of AR in Nebraska's child welfare system, a history of AR's implementation and changes over time, a summary of the critical incidents and analysis of any commonalities between the cases, and a review and analysis of data related to the use of AR. In addition to reviewing the specific critical incidents, the report is focused on

[1] Neb. Rev. Stat. § 28-710(a)

how AR is implemented in Nebraska and how well and whether AR is meeting the Legislature's stated goals for this approach to child welfare cases.

It is important to note that, DHHS' assignment of each case to AR followed the law and regulations. However, as a result of this investigation and broader review of AR, the OIG found:

1. Alternative Response is not being used solely in cases with a low or moderate risk of abuse and neglect but is used as often for high and very high risk families.

2. Since AR is voluntary and families assessed at high or very high risk of future maltreatment may refuse services, family engagement is critical to mitigating the risk to the children in those families.

3. DHHS' limited review of a family's history and previous risk determinations when assigning cases to Alternative Response can create a gap and a challenge in serving some families.

4. Additional data points are necessary to evaluate the effectiveness of Alternative Response.

5. There were errors in the completion of Structured Decision Making (SDM) prevention assessments when determining future risk scores.

The OIG recommends that DHHS:

1. Enhance the tracking system for Alternative Response to better analyze outcomes in Alternative Response cases.

2. Develop a system for evaluating the effectiveness of family engagement within Alternative Response.

JURISDICTION

The OIG provides oversight and accountability for Nebraska child welfare and juvenile justice systems through independent investigations, system monitoring and review, and recommendations for improvement.[2]

The OIG Act[3] mandates that the OIG investigate any deaths or serious injuries of children whose families are currently provided services or were the subject of an investigation or assessment by DHHS within the previous 12 months.[4]

From 2021–2024, the OIG received notices from DHHS' Division of Children and Family Services (CFS) regarding nine children in Nebraska, six of whom experienced a serious injury and three of whom had died, following the acceptance of an Alternative Response intake within the previous 12 months.[5] The notices received were as follows:

1. On November 22, 2021, seven-month-old AB suffered a significant skull fracture in her home less than four months after an Alternative Response Assessment was completed for her family.
2. On January 3, 2022, three-month-old CD suffered severe neglect resulting in malnutrition and severe illness three months after an Alternative Response Assessment was completed for his family.
3. On February 7, 2022, five-month-old EF suffered a brain bleed three months after an Alternative Response Assessment was completed for his family.
4. On March 11, 2022, nine-month-old GH suffered multiple fractures four months after an Alternative Response Assessment was completed for her family.
5. On May 11, 2022, one-year-old IJ ingested some type of opioid, requiring multiple doses of Narcan to be administered, three months after an Alternative Response Assessment was completed for his family.

[2] See Neb. Rev. Stat. § 50-1802 and § 50-1803.
[3] Neb. Rev. Stat. §§ 50-1801 – 50-1821.
[4] See Neb. Rev. Stat. § 50-1806 (1)(c) and (d).
[5] To maintain confidentiality, the names and identifying information of the children and families have been changed.

6. On October 23, 2022, three-month-old KL died at home due to unsafe sleeping conditions while receiving services through an Alternative Response case.
7. On April 12, 2023, two-month-old MN died after suffering physical abuse in his home two months after an Alternative Response Assessment was completed for his family.
8. On May 30, 2023, five-month-old OP died at home as a result of unsafe sleeping conditions while receiving services through an Alternative Response case.
9. On March 17, 2024, three-year-old QR suffered medical neglect due to his family's failure to seek medical care 11 months after an Alternative Response Assessment was completed for his family.

Scope of OIG Investigation

This report of the OIG's investigation includes a summary of the deaths and serious injuries of the nine identified children, the CFS assessment of each injury or death, the AR assessments within the previous 12 months, any services offered or provided to each child's family through AR, and a review of AR utilization and effectiveness. During the course of the investigation, the OIG gathered information from the following sources:

- DHHS-CFS records;
- An interview with a DHHS Deputy Director regarding AR policy;
- Review of relevant statutes and the history of AR implementation in Nebraska;
- DHHS Standard Work Instructions (SWI), Standard Operating Procedures (SOP), and other DHHS policy and directive documents;
- Data regarding AR provided by DHHS; and
- Relevant research regarding the history of AR nationally and in Nebraska.

BACKGROUND

Each time that allegations of child abuse or neglect are received by the Nebraska Child Abuse and Neglect Hotline (Hotline), the information is screened to determine if it warrants acceptance—meaning the allegation will be assessed by CFS.[6] If the Hotline determines that the intake should be accepted, a decision then needs to be made as to whether the allegation should proceed through a "Traditional Response" or an "Alternative Response."

Traditional Response in the Child Welfare System

A Traditional Response (TR) case begins with the CFS worker assessing the safety of the children identified in the intake. Contact is made with the identified child victims first, followed by contact with the child's parents. CFS' assessment of the child's safety must be done in either 24 hours or five days, depending on the priority assigned to the intake. If CFS finds the children are unsafe, CFS can work with the family to implement a safety plan in the home, implement a safety plan where the children temporarily leave the home, or work with local law enforcement to have the children legally removed from the home. The case can be referred to a county attorney's office to file a petition of abuse and neglect. The petition can be filed whether children remain in the home or not. The courts have the authority to require that the family participate in certain services and address specific issues in order for the children to safely return to or remain in the home.

Importantly, a TR intake also results in a finding of whether abuse or neglect occurred. That finding is determined by the court in a court-involved case, or DHHS can substantiate that abuse and neglect occurred in cases that are not before the court. The Nebraska Child Abuse and Neglect Central Registry (Central Registry) is a statewide database that maintains records of all reports of child abuse or neglect that are substantiated by the court or DHHS.[7] The Central Registry helps prevent future harm by identifying individuals with a history of child abuse to potential employers, schools, or volunteer organizations. The identified caregiver that

[6] The SDM Intake Screening Policy and Procedures Manual is used to ensure consistency in the screening process.
[7] See https://dhhs.ne.gov/pages/abuse-and-neglect-central-registry.

perpetrated the abuse is placed on the Central Registry if the finding is that abuse or neglect occurred.

Without a court filing and finding of abuse and neglect, a family cannot be forced to participate in a case with CFS or receive services. Therefore, without a court filing and finding, every child welfare case is voluntary. Even if a child is at a high or very high risk of maltreatment, without an active safety concern and court involvement, CFS can only work with and provide services to a family if the family agrees to receive those services.

Over the years, child welfare systems nationwide have recognized the benefits of having a family voluntarily engage to receive the help they need, provided the home is made safe while the family receives those services. When families voluntarily agree to receive help, it can be less traumatic for the children. It can also prevent the children and the family from deeper and more prolonged involvement in the child welfare system.

One approach to this has been what is referred to in Nebraska as "Alternative Response," also referred to nationally as "Differentiated Response."

Alternative Response in the Child Welfare System

Nebraska law defines Alternative Response (AR) as "a comprehensive assessment of (i) child safety, (ii) the risk of future child abuse or neglect, (iii) family strengths and needs, and (iv) the provision of or referral for necessary services and support."[8]

DHHS describes Alternative Response (AR) as "an approach to working with families to safely care for children in their own homes and communities," and "a different way to respond to allegations of abuse or neglect so children can stay in their homes."[9] DHHS has also recently stated that AR is a "term used to identify reports with families with less severe reports of child abuse and/or neglect that are accepted for assessment. These reports do not focus on an

[8] Neb. Rev. Stat. § 28-710(a)
[9] https://dhhs.ne.gov/Pages/Alternative-Response.aspx.

abuse/neglect investigation, but instead focus on connecting families with supports and services needed to enhance the ability to keep children safe and healthy."[10]

AR is a recognized best practice that is used in over 20 states. It allows for Nebraska's child welfare system to engage with families in a non-investigative and more collaborative way, based on the severity of the allegations received at initial intake.[11] The purpose of implementing the AR program was to improve outcomes for children and families. In addition, AR has been discussed as a means to prevent or lessen the high level of removals of children from their homes for allegations of neglect that are often tied to family poverty, when interventions can be implemented to increase parental protective capacities.[12]

The Nebraska Legislature, DHHS, and stakeholders in the child welfare system have supported the implementation and continuance of AR since 2014. Legislation was introduced in 2014 through Legislative Bill (LB) 853 to approve the use of AR as a pilot project as part of a Title IV-E waiver that would give the state increased federal funding to improve the child welfare system. This type of funding was new, as historically the state could only use IV-E funding for the costs of foster care. This IV-E waiver allowed Nebraska to draw federal funds for services that work to keep children safely in their homes. In 2017, the Legislature extended the AR pilot project until December 31, 2020. In 2020, LB 1061 was introduced to make AR a permanent program in Nebraska. LB 1061 also implemented additional oversight of AR and other non-court involved cases, and created the Alternative Response Advisory Committee under the Nebraska Children's Commission.[13]

In each legislative debate on all three AR bills, the discussion presumed that AR would only be used for lower risk cases.[14] AR was initially described as being an alternative for those families

[10] DHHS Child Abuse and Neglect 2023 Annual Report, dhhs.ne.gov/Pages/CFS-Data-and-Reports.
[11] Nebraska IV-E Waiver Final Report, The University of Nebraska-Lincoln Center for Children, Families, and the Law, December 2019.
[12] Contextual determinants of re-reporting for families receiving alternative response: A survival analysis in a Midwestern State, The University of Nebraska-Lincoln Center for Children, Families, and the Law: Faculty Publications, Published in *Children and Youth Services Review* 155 (2023) 107146.
[13] The OIG is named as a statutory member of the AR Advisory Committee pursuant to Neb. Rev. Stat. §28-712.
[14] See Floor Debate, L.B. 853, Amend. 2266, 103d Leg., 2d Sess. (Mar. 7, 2014) (statements of Senators Coash and Campbell); Floor Debate, L.B. 853, Amend. 2441, 103d Leg., 2d Sess. (Mar. 19, 2014) (statement of Senator Coash);

that are low or moderate risk, to prevent entry into the formal child welfare system, and to keep children in their homes. Specialized AR caseworkers have been used in some service areas and lower caseloads for AR workers were contemplated.

As part of the effort to limit AR to lower risk cases, eighteen exclusionary criteria were created in statute that would prevent a case from being screened as AR.[15] The exclusionary criteria include physical or sexual abuse; convictions of murder, assault and trafficking; exposure to and manufacturing of controlled substances; infants testing positive for drug exposure at birth; abandonment; a current open case or a child living with a parent who no longer has parental rights to the child; and cases where law enforcement is investigating or a forensic interview of the child is needed.[16] The exclusionary criteria are meant to capture situations in which the risk of abuse and neglect is too high to allow an Alternative Response case in which the family can refuse services. If the intake meets any of the exclusionary criteria, the case cannot be assigned to AR.

Neb. Rev. Stat. § 28-712.01 governs the use of AR and states that the "department *may* assign a report for alternative response" provided the allegations do not meet any of the exclusionary criteria. This statute has been adapted into rules and regulations and multiple policies, or Standard Operating Procedures (SOP), used by DHHS. Nebraska Administrative Code (NAC) 395 NAC, Ch. 9 § 003 states:

> "003.04 RESPONSE ASSIGNMENT. Each intake accepted for Assessment that is eligible for Alternative response *will be* assigned to Alternative Response."[17]

AR and TR share the following characteristics[18]:

Hearing on L.B. 417 Before the Health and Hum. Services Comm., 105th Leg., 1st Sess. (2017) (statement of Courtney Phillips, CEO, DHHS); Floor Debate, L.B. 225, 105th Leg., 1st Sess. (Mar. 22, 2017) (statement of Senator Crawford); Floor Debate, L.B. 225, 105th Leg., 1st Sess. (Mar. 23, 2017) (statement of Senator Howard); Hearing on L.B. 1061 Before the Health and Hum. Services Comm., 106th Leg., 2d Sess. (2020) (statements of Senator Crawford and Steven Greene, Deputy Director of CFS, DHHS); Floor Debate, L.B. 1061, Amend. 2417, 106th Leg., 2d Sess. (Feb. 21, 2020) (statements of Senators Crawford, Pansing Brooks, Friesen, and Arch).

[15] See Neb. Rev. Stat. § 28-712.01.

[16] See Appendix A, DHHS AR Exclusionary Criteria Attachment.

[17] 395 NAC, Ch. 9 § 003.04 (emphasis added).

[18] https://dhhs.ne.gov/Pages/Alternative-Response.

- Assesses child safety, risk of future abuse or neglect, and parent's ability to protect their children;
- Connects families to services and/or informal supports to improve parents' ability to protect their children;
- Eligibility is based on information gathered by the Hotline.

The following characteristics are exclusive to AR:

- There is no determination made as to whether abuse or neglect occurred;
- Has exclusionary criteria, or reasons that an intake cannot be screened for Alternative Response;
- Has eight additional criteria that, if present, must be reviewed by the Review, Evaluate, and Decide (RED) Team to determine if the intake is able to be screened as Alternative Response.

Determining Which Intakes are Appropriate for Alternative Response[19]

Once a Hotline intake has been accepted by DHHS, DHHS must then determine if the allegations in the intake meet any of the AR exclusionary criteria. If any of the exclusionary criteria are present, the intake will be screened as a Traditional Response (TR). If none of the listed exclusionary criteria are present within the allegations, the intake is next assessed for RED Team criteria. If no RED Team criteria are present, DHHS regulations require the intake to be assigned as AR.[20]

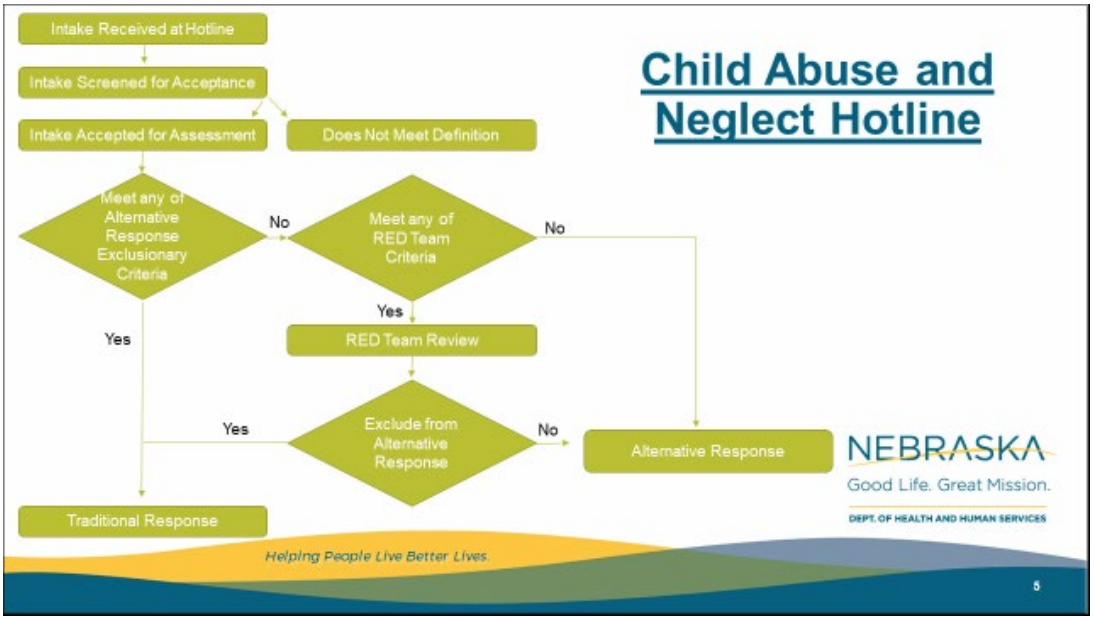
If any of the RED Team criteria are present, the RED Team, which is an internal DHHS team composed of at least two supervisors or administrators and two staff members, then assesses its eight criteria and determines if the intake should be screened as AR or TR. The Red Team criteria include the mental health of the caregiver, whether the family already has an open AR case, any family history of controlled substance use, history of domestic assault, accepted intakes in the past six months, prior court substantiations of child abuse or neglect, any current

[19] DHHS CFS Protection & Safety SOP for Alternative Response Comprehensive Assessment Case Process, 7/1/2024.
[20] See 395 NAC, Ch. 9 § 003.02 and §003.04.

substance abuse affecting parenting ability, or household members currently on the sex offender registry.[21]

Below is a flow chart found in DHHS policy depicting this AR and TR intake screening process.[22]

Chart 1.



Intake Assessment Process

Once an intake is assigned as AR or TR, the assessment process begins. DHHS uses an evidence-based safety model widely used across the country, Structured Decision Making (SDM), which was implemented in Nebraska in 2012. This model includes a set of assessment tools used to guide decisions on child safety, risk of future maltreatment, and a family's need for services. SDM is used in all CFS cases, including all AR and TR intakes and cases.

After an intake is accepted as either AR or TR, the Child and Family Services Specialist (CFSS), also referred to as the caseworker, assigned to the intake will first review the family's history, including its prior DHHS involvement and criminal history. The CFSS may also contact the reporter of the allegation made to the Hotline or other people who may have knowledge of the

[21] See Appendix A, DHHS AR Exclusionary Criteria Attachment.
[22] SDM Intake Screening Policy and Procedures Manual.

family situation, referred to as collaterals, to gather additional information. In TR cases, the CFSS is required to meet with the children first, most often without any advance notice to the family. In AR cases, the CFSS will contact the parent initially to explain the need to meet with their family. The CFSS is able to openly communicate what the concerns are, what they would like to discuss with the children, and can generally be more collaborative in the AR process than in TR cases. If the CFSS is unable to engage the family, the CFSS will make efforts to contact the children at school, daycare, or another setting. At the initial contact between the caseworker and the family in an AR case, the family will be given an AR brochure, which explains how AR works.[23] There is also a Consent to Alternative Response Assessment Form, which the CFSS will ask the caregiver to sign, acknowledging that they received the AR brochure. The family can refuse to sign and the CFSS will document that on the form.

There are three main SDM assessments completed after an intake is accepted and initial contact with the family is made: (1) a Safety Assessment, completed in both TR and AR cases; (2) a Risk Assessment, completed only in a TR case; and (3) a Prevention Assessment, completed only in an AR case. A safety assessment examines whether there is an immediate safety concern for the child. If the child is determined to be safe or conditionally safe—meaning the unsafe circumstances can be addressed through a safety plan—the case can remain an AR case. If the child is found to be unsafe or if the family situation requires the children to live outside of the parental home, the case will change over to TR.

After the child's safety is assessed, either a risk assessment must be completed in a TR case or a prevention assessment completed in an AR case. Both risk and prevention assessments determine the risk of future maltreatment within a family based on their circumstances at the time of the assessment. But the assessments differ slightly in their focus and purpose. TR cases are meant to focus first on the incident that occurred that was reported to the Hotline. Risk assessments therefore focus more on looking at the specific event reported in the intake, and other family factors. AR cases are meant to look at the family circumstances as a whole, as what was reported to the Hotline involved behaviors or concerns that seem to present less risk of

[23] See Appendix B, AR Brochure Attachment.

harm to the children. Prevention assessments therefore focus more on the family situation, not on any specific event. Both assessments have four levels of risk that can be scored: low, moderate, high, or very high. Unlike a finding that a child is unsafe, the risk score in an AR case does not preclude the case from remaining AR.

The result of the prevention assessment will inform the next steps in an AR case. In all cases where the risk level is determined to be high or very high, the family will be offered ongoing services. However, it is important to note that families at any risk level will be provided services at the family's request. Unlike a TR case, any family assessed through AR has the choice to agree to or refuse to participate in services that are designed to decrease risk and improve outcomes for the family. If the family scores low or moderate risk, or if they refuse services, the CFSS is to refer them to services readily available in the community that they may access on their own.

It should also be noted that there is the potential for a family that is part of an AR intake to receive financial assistance on a one-time basis without agreeing to ongoing services, if the CFSS determines that this assistance will improve the family circumstances. The use of monetary assistance is only to be used if all other funding sources are exhausted and the resource will enhance the parental protective factors or mitigate safety concerns. Some examples of monetary assistance include purchasing food, clothing, or diapers for the family, assisting with fees for identification cards, or housing assistance such as rent or payment of utilities.

When a family agrees to an ongoing AR case, the CFSS is required to meet with them once a month, hold family team meetings once a month, and complete a family plan with the family. The family plan outlines the goals the family sets for themselves, as well as a plan to meet those goals. This plan is adjusted as needed or requested by the family. The family is an integral part in determining when their case will close. At case closure, a closing safety assessment is completed, and the CFSS will ensure that the family has access to all state assistance programs and has the information to contact community supports.

Approach to Family Engagement in Alternative Response Cases

Given that AR cases are voluntary for the family, and ongoing services are offered to those families that are high or very high risk of abuse and neglect, engaging families in those services becomes critical.

Nebraska DHHS uses a Family First Practice Model as a framework for family engagement to support and guide service delivery and decision making at all levels in child welfare.[24] This model includes the use of Safety Organized Practice (SOP). SOP is a collaborative approach that emphasizes the importance of teamwork in child welfare and aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief of SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and wellbeing for children. This method utilizes several different recognized best practices within child welfare.

SOP uses a single definition of safety: the actions of protection taken by the caregiver that mitigate the danger to the child, demonstrated over time. This singular definition ensures consistency in interactions with families, ensures that the family and professionals are working from the same definition, and provides for transparency and collaboration.

There are also three core objectives for SOP: good working relationships, critical thinking, and enhancing safety. SOP uses these objectives to help the family create a network of support to be in their lives long after any child welfare professionals and service providers are gone.

DHHS trains all field staff on the use of SOP, as it is not specific to AR. These family engagement tools are to be utilized with all families interacting with DHHS. While family engagement is essential for success within all families that encounter the child welfare

[24] https://public-dhhs.ne.gov/Children%20and%20Family%20Services%20eLearning/story.html OR https://dhhs.ne.gov/Pages/Safety-Organized-Practice.aspx.

system, in AR cases, family engagement is the only tool that can be used to encourage families with concerning risk factors to address those concerns. There is no external entity, like a court, to require that the family get help.

What follows are the summaries of the nine cases reported to the OIG where there was a death or serious injury of a child following an AR intake. Included in these summaries is a description of how AR and TR worked within those cases.

Case Summaries

AB – Serious Injury

Eastern Service Area

On February 14, 2022, DHHS notified the OIG that seven-month-old AB had sustained a significant skull fracture that appeared to be the result of abuse. Four months before AB's injury, the family had refused to participate in an Alternative Response (AR) case.

The AR case began in August 2021, when DHHS' Child Abuse and Neglect Hotline (Hotline) received an intake alleging that the children in AB's family were usually rarely seen outside, but within the prior two days were seen outside unsupervised twice, running in the street and petting the neighbor's dog. The second time the children were observed unsupervised, police were called and took them home. It was also reported that one child had been seen standing on the window ledge and could possibly fall. The intake was accepted—meaning that CFS would conduct an assessment—and the intake was assigned as an AR case.

Both a safety assessment and a prevention assessment were completed. CFS found the children to be safe in the home, as it was explained that AB's father was sleeping and AB's mother was at work when two of the children snuck out of the house to play with the neighbor kids. The family added additional locks and alarms to the doors to ensure that the children were unable to leave the home on their own. The prevention assessment scored the family at high risk due to the family having been subjects of prior investigations and AB's mother being treated for post-partum depression. The family refused ongoing services and this case was closed.

Less than four months later, in November 2021, DHHS received a TR intake stating that seven-month-old AB had rolled off the couch on two different occasions in the last week and had a small bump on her head. AB was brought to the hospital and the bump on her head had grown to the size of a softball. She was diagnosed with a significant skull fracture. The explanation AB's parents gave for the injury was feasible, but still concerning to hospital staff. The parents reported that the first time AB rolled off the couch, she did so in her sleep. The second time, AB's mother was reportedly changing her diaper on the couch, and when the mother reached for a diaper, AB rolled off. At first, it was reported that AB had no bump on her head, then later

only a small bump. The parents were reported to be appropriate in their demeanor and concern about AB's injury, per reviewed DHHS documents.

Later, however, AB's father admitted to police that he threw the infant against the wall. He was arrested and criminally charged with committing intentional child abuse causing injury. AB's mother was also eventually arrested and charged.

As a result of this new intake and the critical incident, CFS conducted a safety assessment and determined that AB and her siblings were all unsafe in their parents' care, as law enforcement had removed all of the children from the home and DHHS placed them in foster care. The children were observed to be in dirty clothes, with dirty fingernails. One child reported that there were mice and bugs in the home. During this investigation, the children also later disclosed physical abuse and domestic violence regularly occurring in the home.

A risk assessment was conducted and found the family to be high risk due to previous investigations, a prior injury to a child, the caregivers blaming the child, and the caregivers not providing physical care consistent with the children's needs. The children were returned to their mother's care in September 2023, and the case was closed in October 2023. There were no known long-term effects of the abuse on AB.

Nine months before this AR case, in December 2020, the family had one intake alleging the physical abuse of AB's sister, sibling 1, by their father. It was reported that sibling 1 was hit in the head several times by her father and had a large bruise on her forehead. It was also alleged that the father pushed another child down the stairs. CFS accepted the intake for assessment and during the assessment, sibling 1 was able to show the CFSS assigned to the investigation a bruise on her forehead and stated that her father hit her with an open hand several times. Sibling 1 reported that this happened after her younger sister, sibling 2, fell down the stairs, obtaining a small bruise and scratch on her forehead. The CFSS observed these injuries. Sibling 1 stated that her parents were asleep and when sibling 2 started crying, her mother screamed at her and her father hit her, causing the bruise on her head. The parents both reported that the father did not hit sibling 1 in the head, but did spank her when sibling 2 fell, and neither could explain why sibling 1 would lie about him hitting her. The children were found to be safe

due to a determination that the injury did not match the child's description of events, though this finding is not explained in the assessment. The risk assessment found the risk level to be moderate. The assessment noted that the caregivers blamed the child for the incident. The allegation was listed as unfounded and no services were offered to the family.

CD – Serious Injury
Southeast Service Area

On January 5, 2022, the OIG was notified of the serious injury of three-month-old CD. CD was found to be severely malnourished and lacking necessary medical care. Four months earlier, the family had refused to participate in an AR case.

The AR case began after CD's birth in September 2021, when DHHS received a Hotline call regarding CD and his three siblings, ages one to three, that was accepted as AR. The mother had given birth to CD and was discharged from the hospital a couple of days later. After she was discharged, the cord blood test came back positive for cannabis. It was noted in the intake that the mother was formula feeding, so if there was marijuana in her system, she would not be passing it to the child through breast milk. The medical staff discovered a history of substance use for the mother after speaking with medical providers in another state, as the family had only been in Nebraska for a month at the time of CD's birth.

The safety assessment stated that the family was uncooperative and would not let the CFSS into the home. The CFFS was able to observe the children, but the children's parents did not allow them to speak to the CFSS. The children were found to be safe, as they appeared healthy and well cared for with their needs being met, and there were no obvious signs of substance use.

The prevention assessment found the risk level to be high due to substance use and the ages of the children. The family was offered AR services, but declined. They were instead provided with specific referrals to community resources.

The critical incident occurred four months later, on January 2, 2022, when DHHS received a TR intake stating that 911 was called due to four-month-old CD not breathing. First responders

noted that CD was ashy grey in color, had a blank stare, and would occasionally gasp for air. His skin appeared to be loose and saggy and his ribs were showing. Emergency medical services worked on CD for an extended period before taking him to the hospital. The parents advised that they had switched CD's formula several times, as CD had been fussy, colicky, screaming, and crying, as well as vomiting after feeding. CD had also not been to the doctor since he was two weeks old.

After this incident, the initial safety assessment found that CD was safe due to him being in the hospital and there being no determination made as to the cause of his condition. His siblings were also determined to be safe in the home after law enforcement and DHHS completed a walk-through of the home and interviews with the parents.

However, over the course of the next week, it was determined that CD's condition was the result of malnutrition and lack of medical care. It was also discovered that the other children had not been to the doctor since the family moved to Nebraska five months earlier. Law enforcement arrested both parents for child abuse. As a result, another safety assessment was completed and determined that the children were unsafe in the care of their parents.

The risk assessment scored the family at moderate risk, based solely on the history from the short time that the family had been in Nebraska. The case was court substantiated and ongoing services were provided due to the children being placed in foster care. The children were reunified in October 2023, and the case closed successfully in June 2024.

There is no prior system involvement for this family in the state of Nebraska and it is unclear if DHHS ever obtained records from the other state the family had moved from.

EF – Serious Injury
Southeast Service Area

On February 9, 2022, the OIG was notified of the serious injury of five-month-old EF. EF was found to have a serious brain bleed.

The AR case began in November 2021, when DHHS received a Hotline call regarding EF, his mother, and his mother's siblings. The intake alleged that the conditions of the home that the mother and her siblings were living in with their father were unsuitable, that EF was also living there in those conditions, and that the mother was drinking excessively. The intake was accepted as an Alternative Response.

The safety assessment completed regarding EF determined that EF was safe in the care of his father and his father's girlfriend, and that EF does not stay at the home of his mother. EF's mother verified that EF did not stay with her at the home of her father.

The prevention assessment found the family to be at moderate risk. EF's mother was offered services and her father asked DHHS for resources to get a dumpster so they could get the house cleaned up for EF to return to live there. The AR worker stated that they did not know of any resources and did not offer any AR funds. All other services offered to the family were declined.

The critical incident occurred three months later, on February 7, 2022, when DHHS received a TR intake stating that five-month-old EF was brought to the hospital by his parents. EF's father reported that he dropped EF off with a friend for daycare that morning and EF was fine. At 11:45 a.m., the care provider called the father stating that EF was acting weird, not making eye contact, and was lethargic and unresponsive. The father picked up EF, then EF's mother, before going to the emergency room. It was discovered that EF had a brain bleed, though there were no outright injuries observed. Medical staff reported that the injuries were non-accidental and caused by head trauma or shaken baby syndrome. Medical staff could not provide a possible time frame for the injury.

The safety assessment found that EF was safe in the care of the hospital. EF was reported to have a bruise on his chin, three hematomas on the left side of his brain, and one hematoma on the right side. EF's father again reported dropping EF off with his friend, who then called him with the concerns. EF's mother reported that EF lived full time with his father and his girlfriend, and that she would visit EF occasionally. There was no clear indication of what happened to EF at that time.

Another safety assessment was completed to determine if EF would be safe in the care of his parents outside of the hospital after further medical treatment and testing. This assessment found that EF was unsafe in his parent's care. EF was determined to have retinal hemorrhages and abusive head trauma most likely from being shaken, and further tests were ordered to determine the extent of the injuries. Law enforcement authored an affidavit for custody of EF and he was placed in a foster home.

The risk assessment found the risk level to be very high due to EF's developmental disability and the father's reported use of alcohol, and other factors. The finding was court substantiated for both parents. EF did continue to suffer from seizures and needed continued seizure medication after his injury and into 2024.

There were no other intakes pertaining to EF prior to the AR case detailed above.

In July 2023, the Hotline accepted an intake which stated that EF's parents had a baby together the previous day. That child was found to be unsafe due to the couple having an open case regarding EF's injury, and EF not having been returned to their care. The newborn child was removed and placed in foster care. The risk assessment found the risk level to be very high, as both parents had failed to address the substance use and mental health concerns in their case with EF, and a termination of parental rights motion had been filed.

The parents relinquished their parental rights to both EF and his younger brother in October 2024. Both children were adopted by their mutual foster parents in April 2025.

GH – Serious Injury
Eastern Service Area

On March 15, 2022, the OIG was notified of the serious injury of nine-month-old GH. GH was found to have 15 bone fractures in various stages of healing. Four months earlier, the family had refused ongoing AR services.

The AR case began in November 2021 when the Hotline received an intake regarding the family. At that time, the children included in the family were sibling 1, age nine; sibling 2, age seven;

sibling 3, age six; and GH and her twin, sibling 4, age four months. The intake was accepted as an Alternative Response. The mother reportedly called sibling 3's school and stated that sibling 3 was hit at recess the previous week and had a bruise on her thigh. The school stated that there was no recess on that day. Sibling 3 was observed to have a large bruise on her thigh that was purple, blue, and red in color. Sibling 3 reported that she fell at home, then shut down and would not disclose any other information. Police interviewed sibling 3 and her siblings and they all had different stories about how she received the bruise. She then reported that she fell off a teeter totter. Another caller reported the next day that sibling 1 stated that their mother works overnights and the children are left home alone.

The safety assessment found the children to be safe in the care of their mother. Sibling 3 stated that she fell off the seesaw in the front yard. Sibling 1 also stated that sibling 3 fell outside. The mother stated that sibling 3 could have fallen off the seesaw, but none of the children told her about it, so when she saw the bruise, she thought it had happened at school. There was no indication of physical abuse.

The prevention assessment found the family to be at very high risk of future harm due to previous investigations, a previous open case, and the mother experiencing abuse as a child. The mother was offered AR services, but she declined and was instead provided with community resources.

Four months later, in March 2022, DHHS received a TR intake stating that nine-month-old GH was brought to the hospital by her mother due to concerns with decreased movement in one of her arms. Initial scans found four to five more fractures in GH's right arm, forearm, ribs, and one leg. Additional scans found a total of 15 fractures in different stages of healing. GH did have a leg that was accidentally broken at birth, but there was no explanation for the additional injuries at the time of the intake.

The safety assessment determined GH and her siblings to be unsafe in their mother's care, as law enforcement made the decision to remove them from the home. There was no explanation given for the injuries, but it was disclosed by another child that the father of GH and GH's twin lived in the home and cared for the children. He was then found to have a violent criminal

history. It also seemed that the oldest child provided care for the younger children consistently while the mother was at work.

The risk assessment found the family to be at very high risk due to previous investigations, a previous open case, prior injury to a child, and the primary caregiver experiencing abuse and neglect as a child.

The children were returned to the care of their mother in March 2023. The case was successfully closed in June 2023. GH does not have any reported long-term effects from her injuries.

The only history before the AR intake was an intake in May 2018. This intake alleged physical abuse of the mother's niece, age four months, whom the mother was caring for. GH's mother brought the child to the hospital and she was found to have bruising around her eye, on her cheek, and petechial damage. There was no explanation for the injuries other than GH's mother reporting that a relative had dropped the baby 10 days prior. This intake was unfounded, but a case was still opened with GH's mother and her niece to provide her in-home services.

IJ – Serious Injury

Eastern Service Area

On May 13, 2022, the OIG was notified of the serious injury of one-year-old IJ. IJ was found unresponsive and was able to be revived through the use of Narcan.

The AR case began in February 2022 when the Hotline received an intake regarding the family. That intake alleged that IJ's mother gave birth to another baby, sibling 1, two days earlier and the medical provider was concerned that the mother required an inpatient psychiatric stay in September 2021 and tested positive for marijuana at that time, when she would have been 15 weeks pregnant. The mother reported not using marijuana since that hospitalization and admitted that she used it for nausea. The parents reported that both sibling 1and IJ were born with heart conditions, which IJ required surgery for at birth. Both children were delivered at 35 weeks gestation due to their heart conditions. The safety assessment found the children to be safe in the care of their parents.

DHHS was unable to locate a completed prevention assessment in this case. As a result, the risk level at the time of the AR intake is unknown. Based on the limited amount of family information, it appears that the risk level would have been high, due to the medical conditions of the children and the mother's mental health and substance use history. At the time of the AR intake, the family was working with community resources for housing, a provider for sibling 1's medical needs, and therapy with medication management for the mother was in place. They were not in need of any other services. Before the AR assessment was completed, an intake was received as additional information in April 2022 stating that sibling 1was unresponsive and was brought to the hospital by ambulance. The baby passed away from cardiac arrest due to his known heart condition and his death was not attributed to abuse or neglect.

Three months later, in May 2022, DHHS received a TR intake stating that one-year-old IJ arrived at the hospital unresponsive. He was given a second dose of Narcan and it was believed that he had overdosed on some type of opioid. In addition, the intake reported that the family had another child that was brought to the hospital three weeks ago unresponsive and had passed away. Law enforcement removed IJ and his older sister, sibling 2, from the home.

The safety assessment found IJ and sibling 2 to be unsafe in the care of their parents, as the children were placed in out of home care by law enforcement due to the concern that there was no explanation for the incident with IJ, and the similarity to the incident where sibling 1 passed away. It was later found that IJ tested positive for Fentanyl and a metabolite of cocaine. Sibling 2 tested positive for cocaine and THC.

The risk assessment found the family to be at high risk due to a prior open case, IJ being medically fragile due to being born with a heart condition, and the mother having a history of mental health needs.

IJ was placed with relatives while sibling 2 was placed with her biological father. She remained with her father and was closed out of the case in July 2022. IJ was adopted in August 2024, after both parents relinquished their parental rights to him.

There was no prior history found for this family before the AR case other than intakes from when the parents were children.

KL – Death

Eastern Service Area

On October 24, 2022, the OIG was notified of the death of three-month-old KL. The cause of death was determined to be "Probable asphyxia in the setting of co-sleeping (bed sharing) and unsafe sleep environment."[25] The family had an open AR case at the time of KL's death.

The AR case began in July 2022, when the Hotline received an intake regarding the family that was accepted as an Alternative Response. The intake stated that KL's mother was developmentally disabled, living in a host home, and had a two-week-old baby. It was reported that the mother was set up to work with some in-home services, but that she was difficult to engage. There was a concern that KL's mother was having trouble comprehending instructions from the pediatrician. She reported feeding KL more than the doctor said to feed him, but indicated that the doctor said to feed him only one ounce at a time. KL was observed to be sleeping in the bed with his mother during a visit in the home. The Extended Family Home (EFH) provider also reported that the mother was sleeping with KL, and KL was observed to be covered with several blankets. The mother reported that she was co-sleeping due to being really tired. She also stated that when KL cried during diaper changes, she would leave the room, leaving him on the bed, until he stopped crying. The bedroom was also cluttered with trash, old food, and dirty bottles and nipples that she was reported to reuse. The mother was unwilling to take direction, got defensive, and would not listen to suggestions for caring for KL. The mother stated that KL liked to be independent so she would let him cry it out or burp himself, that washing the bottles and nipples was a pain so she did not do it, and that she knew KL better than anyone to know how much he should eat. It was stated in the intake that the mother required constant prompting to care for KL from her EFH provider and that the mother was unable to care for her child on her own. The EFH provider expressed concern that the

[25] Autopsy Final Report, 1/12/2023.

mother may not be feeding KL enough and that she did not comfort him when he cried and instead just told him to go back to sleep.

The safety assessment found KL to be safe in his mother's care. KL's mother was able to explain why she should not have KL sleeping in the bed with her, that there were too many blankets, and the risk of Sudden Infant Death Syndrome.

The prevention assessment found the risk level to be high due to KL's mother not providing physical care to meet KL's needs and not providing him with emotional support, as well as her history of mental health issues and the abuse and neglect she suffered as a child. KL's mother agreed to work an AR case with providers coming into the home to assess her ability to parent KL and meet his needs, as well as teach her as needed.

DHHS opened an ongoing case, specifically to give the mother assistance with learning to meet KL's needs, as well as to have someone regularly in the home to evaluate the care being given to KL. Family support services began in August 2022. The first few sessions, the mother was engaged and worked with the Family Support Specialist (FSS), discussing cleanliness of her room and feeding, care, and a schedule for KL. By the third time that the FSS met with her in her home, she was no longer willing to work on parenting skills. Throughout the notes from the provider, it is noted that the mother spent sessions complaining about her EFH provider and other family members. It was noted several times between August and October that the mother was not attentive to KL, did not regularly change his diapers, that he was often not bathed and had an odor, and that when he cried, his mother would just put a pacifier in his mouth instead of soothing him. It was also noted that the mother spent all of her time in her room with KL, either on her phone or computer, often had KL in the bed with her when it was cluttered with blankets and other items, and often had an odor due to not showering. During those months, the mother began to refuse to meet with the FSS and the documentation is clear that there were still concerns present for the care of KL. CFS records also noted that the mother would state to the caseworker that she would start working with family support again, and would schedule appointments, but did not follow through on several occasions. There were no other services provided by DHHS to KL and his mother.

DHHS met with the family on a monthly basis during the time that the case was open and appeared to assess safety based only on the time that caseworkers were in the home, without integrating the concerns of the family support provider into the safety assessment. There is no indication that DHHS spoke with the EFH provider at least every month to ask about the mother's daily care of KL. At the time of KL's death, the EFH provider had not seen KL in over 24 hours due to the mother remaining in her room.

On October 23, 2022, the Hotline received a call regarding KL's death. The EFH provider received a call from KL's grandmother, stating that KL's mother called her stating that KL was dead. When the provider went to the mother's room, she found her hysterical and crying while KL was lying on the bed, not breathing. The provider started CPR as she was calling 911. The provider reported that KL had been to the doctor two weeks ago and was determined to be healthy, received shots, and his formula intake was increased to five ounces per feeding. The provider reported only seeing KL and his mother every other day due to them staying in their room. She stated that she always offered to help, but the mother told her she did not need help. KL's mother was reported to have two family support workers coming to the home to help her learn how to care for KL, but that she often turned them away. The EFH provider had noticed in the last week or two that the crib was full of clothes and clutter. She advised the mother to clean it out. The provider believed that the mother was again sleeping with KL in her bed, after being advised multiple times that this was not safe.

The intake regarding KL's death was screened as law enforcement only, as there were no other children in the care of the mother to be assessed for safety.

The autopsy report in January 2023 determined KL's cause of death to be asphyxia as a result of co-sleeping and an unsafe sleep environment.[26] It was also noted that KL tested positive for SARS-CoV-2, or COVID-19, noting this as a significant condition. There were no criminal charges filed in relation to KL's death.

[26] Autopsy Final Report, 1/12/2023.

There was no previous involvement in regards to KL before the AR case. There are intakes regarding the mother as the victim when she was a child.

MN – Death

Eastern Service Area

On April 19, 2023, the OIG was notified of the death of two-month-old MN. MN suffered a serious brain injury that resulted in his death.

The AR case began in February 2023, when the Hotline received an intake alleging that MN's mother used marijuana during her pregnancy with MN and that MN's umbilical cord tested positive for THC. The intake was accepted as Alternative Response.

After some unexplained delays in completion, a safety assessment found the children in the home to be safe. MN's mother denied that she used marijuana after she found out that she was pregnant. She did admit to using alcohol on a daily basis before the pregnancy. Her daughter, sibling 1, disclosed that her mother smokes from a device, likely a vape, in the living room sitting next to her. The mother stated this vape contained a strawberry substance that helped her quit smoking. The finding of the safety assessment was that the children were safe, stating that the mother denied drug use and there were no signs of drug use in the home. The prevention assessment found the risk level to be moderate and the case was closed.

Two months later, on April 12, 2023, the Hotline received an intake stating that two-month-old MN was initially taken to a hospital, then transported to another hospital, with serious injuries. This intake was accepted as a TR intake. It was reported that MN's mother and father were at home with their children, sleeping. MN's father was in the living room and woke up to MN crying, before stepping outside to smoke. MN's mother got up and made MN a bottle. She then handed the father the bottle as he was changing MN's diaper and went back to bed. MN's father soon after entered the bedroom with MN not breathing and turning blue, asking MN's mother if this was normal. MN's mother reportedly began CPR and contacted 911. When emergency medical services arrived, they took over CPR.

Doctors stated that MN suffered a serious brain injury consistent with being in a car accident. Given that there was no car accident, it was determined to be shaken baby syndrome. MN also had several rib fractures that were at least a week old, an indication of previous abuse. MN died on April 12, 2023, from his injuries.

MN's father eventually admitted to law enforcement that he threw MN into the air to calm him down, then aggressively put him down on a blanket. When the father realized that MN was unresponsive, he attempted to shake him awake. MN's father was arrested for the death of MN. A safety plan was implemented regarding the siblings of MN. There were no concerns for the behavior of the mother and there were reports that she was protective of her remaining children.

The safety assessment determined that the other children, sibling 1 and sibling 2, were conditionally safe in their mother's care. A safety plan was implemented that stated the mother and the children would reside with their maternal grandmother and have no contact with MN's father, who is not the father to either sibling.

The risk assessment determined that the risk of harm to the children was very high, requiring services to be provided to the family. It was determined through the law enforcement investigation that the mother was not at fault for MN's death. The mother was provided family support services for a short time and assistance with applying for supportive housing. The safety plan ended in June 2023 and the case was closed, with the mother being provided a flyer listing available community services.

MN's mother had history with DHHS dating back to 2016. An intake in 2016 with allegations of substance abuse and domestic violence found the family to be at high risk but the intake was unfounded and the case closed. After a couple of intakes that did not meet the definition to be accepted for assessment by DHHS, there were three separate intakes accepted in 2019 and 2020, all alleging drug and alcohol abuse. An AR case was opened in 2019, and the other intakes were received while that AR case was ongoing. The AR case closed in 2020. At that time, the risk level was very high. There were three more intakes not accepted by DHHS before another

AR intake was accepted in 2021 with concerns of domestic violence. The risk remained very high and the family refused AR services.

There have continued to be Hotline intakes accepted on this family after MN's death. An AR intake was accepted just four months after MN's death, with concerns for the other children's supervision. The family's risk level was high and the family refused the AR services. Two months later, yet another intake was accepted for AR with mental health and substance abuse concerns for the mother. AR services were again refused.

OP – Death

Southeast Service Area

On June 1, 2023, the OIG was notified of the death of five-month-old OP. OP's death was attributed to unsafe sleeping conditions. The family had an open AR case at the time of the child's death.

The AR case began in April 2023, when an intake was accepted regarding the family. It was reported that a three-year-old child, sibling 1, who was non-verbal and suspected to be autistic, was observed wandering around outside and crossing streets without any supervision. The mother told law enforcement officers that she was cleaning up a mess one of her other children had made when she realized sibling 1 had managed to unlock an exterior door and escape. She, her father, and sibling 1's father went outside to look for sibling 1 before encountering officers who had found him shortly before.

The safety assessment found the children safe in their parents' care. The mother explained that in the current instance of sibling 1 escaping the home, and in a prior similar instance, either she or the father fell asleep and sibling 1 managed to open the deadbolt of an exterior door and sneak out. The mother had reportedly asked the landlord with help securing the apartment but he did not assist. The mother told the caseworker that her family "desperately needed help" with housing because they had to be out of the current apartment by the end of next week, as her father's name was on the lease and he was being evicted. The mother stated that she had applied for housing but the waitlist was over a year long. She and the children's father did not

have vehicles or driver's licenses. The mother stated that she utilized SNAP and Medicaid, but not WIC (Women, Infant, and Children's Nutrition Assistance Program) due to not being able to get to regular appointments. The mother had reached out to two apartment complexes but had not heard back. The caseworker went over the AR paperwork with the mother to open an ongoing AR case.

The prevention assessment found the risk level to be very high due to the family's previous intakes, the mother's previous drug use and mental health concerns, and her history of abuse and neglect as a child.

Many services were provided by DHHS in this AR case, such as funding to stay in a motel beginning May 5, 2023, and vouchers for clothing, diapers, food, and doorknob covers and locks to keep sibling 1 from escaping the motel. DHHS also provided the family with regular transportation, groceries, two Pack n' Plays, went over safe sleep practices on more than one occasion, and rented a storage unit for the family's items. DHHS offered other suggestions to the family, such as staying at a shelter and participating in a program where they would reside in the home with another family, but the family declined those alternative housing options. The family also received regular in-home support and visits from family support workers. Between May 5, 2023, and May 24, 2023, the DHHS caseworker either visited the family or contacted the parents or their family support worker about their situation at least seven times. During that time frame, sibling 1 was able to escape from one of the motel rooms before a new lock was placed on the door to prevent further incidents; the family was required to leave the first motel and moved to a different motel; and the DHHS caseworkers, family support workers, and other service providers assisted the family by securing employment for the father, assisting with payment for the second motel stay, finding a permanent housing solution for the family, and checking in on the family's well-being. Notably, on May 9, 10, and 11, the DHHS caseworker noted that although their motel room was cluttered and had lots of items in it, it did not rise to the level of being unsanitary or unsafe. Additionally, before OP's death, the family had secured plans to begin living in a new apartment starting May 31, 2023.

On May 30, 2023, the Hotline received an intake reporting that OP's mother and father were co-sleeping in a bed at a motel with their five-month-old son OP and their two other young children, sibling 1 and sibling 2, when they woke up to find OP deceased. This intake was accepted for TR investigation. The parents called 911 and law enforcement responded to the motel. Law enforcement did not suspect any foul play in OP's death nor observe any indication of injury on the siblings, ages two and three. DHHS did, however, remove the siblings due to the unlivable and filthy conditions of the motel room that DHHS had arranged for the family as a part of the open AR case.

The safety assessment found both sibling 1 and sibling 2 unsafe in their parents' care. The CFS caseworker assigned to the May 30, 2023 intake contacted law enforcement officers who had responded to the motel where OP had died and learned that the mother had told officers that the entire family was sleeping in the same bed because the other bed in the room could not be slept on due to being covered with garbage and various items. Officers took a video of the state of the room and showed it to the caseworker; the video showed the room to be piled with trash, rotting food, and clutter. Law enforcement reports available in court documents further document how the floor of the room was barely visible and it was difficult to walk due to all the clutter, and that a large knife and other dangerous debris were found on the floor. No age-appropriate sleeping arrangements for the children were observed. The caseworker determined that the hazardous living conditions of the room were not appropriate for the young children and immediately threatened their health and safety. Because the parents were unable to find any friends or family willing or able to take the siblings as a relative or kinship placement, the boys were placed into an agency-supported foster home the next day.

The risk assessment determined the family's risk level to be high due to the May 30, 2023 incident, the family's lack of housing, the mother's mental health diagnoses, the mother's history of child abuse and neglect when she was a child, and the previous CFS investigations into the family.

According to criminal court records, the parents were both later charged with negligent child abuse due to the condition of the motel room that the children were living in before OP's

death. They both ultimately pled no contest to that charge and were both sentenced to a term of four months' imprisonment.

The mother relinquished her parental rights to OP's siblings in December 2024. The father's parental rights were terminated that same month. The children are set to be adopted in 2025 by their foster parents.

QR – Serious Injury
Central Service Area

On March 21, 2024, the OIG was notified of the serious injury of three-year-old QR. QR was suffering from a serious infection and was not provided needed medical care in a timely manner.

The AR case began in April 2023, when the Hotline received an intake regarding QR. The intake alleged that QR was diagnosed with short bowel syndrome at birth and that his mother was leaving QR, age two, and her other two sons, sibling 1, age nine, and sibling 2, age 10, home alone for hours in the evenings and not returning home until the children were asleep. The siblings were said to be in charge of QR and his medical needs during those times. QR had a Total Parenteral Nutrition (TPN) feeding tube in his central line, which is placed in his chest, that ran for 18 hours per day plus two feedings. If the central line were to come out, QR would need to be seen in the emergency room. QR also has a gastrostomy feeding tube that could be replaced at home if needed. Sibling 1 reported being scared of QR's tubes coming out and he and sibling 2 having to replace them. In addition, the boys had been getting to school late due to their mother oversleeping. The intake was accepted as Alternative Response.

The safety assessment found the children to be safe in the care of their mother despite both siblings reporting that they were left alone with QR. Both boys also reported that one time, QR's cord came out and they had to call their mom to come home. The boys did report being able to get a hold of their mother through an iPad.

The prevention assessment found the family to be at moderate risk. The case was closed with no services provided to the family.

Eleven months later, on March 17, 2024, a TR intake was accepted regarding QR. The intake reported that QR's mother took QR to the emergency room at 1:00 a.m. due to a high fever that would not go down with medication. QR was determined to have pneumonia and sepsis, and he was given IV fluids and antibiotics. The hospital stated that he needed to be sent to a different hospital for further treatment. QR's mother refused an ambulance, stating that she would take QR herself, and they left the hospital around 3:30 a.m. By noon that day, the second hospital reported that QR had not arrived. Unable to reach the mother, law enforcement was contacted and arrived at her house. At 1:17 p.m., QR's mother reported she was finishing packing and would be on the road. Around this time, QR's blood cultures came back positive for bacteria in his blood, indicating a very serious infection. Around 4:30 p.m., the mother was still packing and was told to take QR back to the local hospital immediately due to his test results. QR's mother arrived at the local emergency room with QR at 6:00 p.m. QR was then life flighted to the second hospital. QR's mother was arrested for medical neglect and QR was placed in the custody of DHHS by law enforcement.

The safety assessment found the children to be unsafe in the care of their mother, due to her failure to seek medical care for QR and her arrest. The siblings went to stay at their paternal grandparents' home with their father. When interviewed, both boys expressed concern about QR receiving care, as they were the ones that usually cared for him. QR remained in the hospital and upon his release was placed with his father.

Another safety assessment was completed and finalized a few days later that found sibling 1 and sibling 2 safe in the care of their mother due to no concerns with their needs being met, and QR was found conditionally safe due to the concerns for his mother meeting his medical needs. QR's father was struggling with meeting QR's medical needs. A safety plan was implemented in the mother's home to allow QR to return to her care. That plan stated that a provider would be in the home from 9:00 a.m. to 5:00 p.m. on weekdays, and 9:00 a.m. to 3:00 p.m. on weekends, to ensure that the mother was providing for QR's needs.

The risk assessment found the family to be at very high risk due to QR's disabilities. QR recovered from this incident.

A court case was filed and QR was a state ward until May 2024, when the case was dismissed. A safety assessment determined QR and his brothers to be safe in the care of their mother, and the case was closed.

This family had no accepted intakes prior to the AR case detailed above.

Case Analysis and Commonalities

There are certain commonalities between all of the cases that the OIG reviewed.

First, in six of the nine reviewed cases, the family scored high or very high risk during the AR assessment.[27]

Second, services were only provided in two of the cases reviewed. Four of those families that were scored as high or very high risk refused services, so the cases were closed. In the two cases where the risk was determined to be moderate, the families were not offered services but referred to community services per policy. In the case without a prevention assessment, services were also not received.

Third, in half of the cases, the families had previous history with DHHS. Four families had at least one previous TR intake accepted, and one family also had multiple AR intakes accepted.

Fourth, in eight of the nine cases, the death or serious injury occurred within four months of the AR assessment. It is not clear if this is a matter of coincidence or if this reflects a systemic issue related to the assessment of risk for these AR families.

Fifth, the OIG noted errors in the completion of the SDM prevention assessments in the AR cases based on the documentation provided in those cases and DHHS policy. In the two cases scored as moderate risk, there were inaccuracies within these assessments including: the incorrect documentation of the history of previous intakes and cases; the child's characteristics not being accurately marked; and the caregiver's history of abuse or neglect as a child being

[27] Note: A completed prevention assessment was not provided for one family.

marked incorrectly. In one case, an override was used incorrectly, actually making the risk score very high when it should have been only high risk.

The OIG also discovered inaccuracies in some of the safety, prevention, and risk assessments with regard to the determination of secondary caregivers. In two cases, the father was living in the home and was listed in the household as the secondary caregiver. However, for all questions pertaining to the secondary caregiver in the prevention assessment, it was indicated that there was no secondary caregiver. In another case, the father was living in the home and providing care, but was not listed as a secondary caregiver. He also was not interviewed as part of the assessment of the family.

Table 1 below shows the progression of these cases through the child welfare system.

Table 1.

Name	Prevention Level	Months from AR to Critical Incident	# of Prior TR Intakes	# of Prior AR Intakes	Outcome of AR Intake
AB	High	4	1	0	Refused Services
CD	High	3	0	0	Refused Services
EF	Moderate	3	0	0	Refused Services
GH	Very High	4	1	0	Refused Services- referred to community resources
IJ	Unknown	3	0	0	Refused Services
KL	High	0	0	0	Case Opened
MN	Moderate	2	3	2	Referred to community resources
OP	Very High	0	2	0	Case Opened
QR	Moderate	11	0	0	Referred to community resources

Data Analysis of Alternative Response

As part of the OIG's investigation of these deaths and serious injuries, the OIG reviewed key data points related to AR. This data was specifically requested from DHHS by the OIG and was provided as requested.

Total Number of Intakes Screened as Alternative Response

Table 2 provides a baseline for what percentage of child welfare cases were assigned as AR cases in the last four years. Generally, a quarter to a third of all accepted intakes were assigned as AR cases, affecting 3,700 families to as many as 5,100 families in these four years.

Table 2. Total Accepted Intakes

	2021	2022	2023	2024
Traditional Response	12,021	9,756	10,271	10,013
Alternative Response	4,089	5,198	4,447	3,716
Total Intakes	16,110	14,954	14,718	13,729
% of Intakes Accepted as AR	25.40%	34.80%	30.20%	27.07%

Proper Screening of Cases to Alternative Response

Intakes that are initially assigned as AR have the potential to be changed over to TR during the assessment process. For example, if the safety assessment determines the children to be unsafe, if an out-of-home safety plan is required to ensure safety, or if criminal charges are filed in relation to the allegations in the intake, the intake will be moved to a TR case. Table 3 shows the prevalence of intakes accepted as AR that are later changed over to TR after the initial acceptance.

Table 3. Intakes Changed from AR to TR after Acceptance

	2021	2022	2023	2024
Intakes Changed from AR to TR	288	285	390	267
Total AR Intakes	4,089	5,198	4,447	3,716
% of AR	**7.0%**	**5.5%**	**8.8%**	**7.2%**

This data serves as an indication of whether intakes are being screened appropriately as AR, including that the exclusionary criteria are working as intended. A relatively small percentage of all intakes that are accepted for AR are changed to TR indicating that the exclusionary criteria are generally appropriate. However, the data also illustrates the importance of the assessment process. The determination that the allegations present low risk to the children is not always correct and can be difficult to determine at the time the intake is screened.

Prevalence of Safety Concerns in Alternative Response Cases

The first thing that a caseworker determines when assessing a family is whether or not the conditions in the home present a threat to the safety of the children. If there is a safety threat, mitigating that threat is necessary either by removing the children from the home or implementing a safety plan within the home. As noted, if there is an immediate safety concern identified during an assessment, the case cannot be served through AR. Cases may remain AR cases, however, if a family is determined to be "conditionally safe"—meaning a safety plan can mitigate the safety concern. Since AR is meant to serve families without safety concerns and with lower risk, it would be expected that a lower percentage of AR intakes would result in a finding of conditionally safe.

The data appears to bear that out. Table 4 shows the prevalence of identified safety concerns within AR intakes. The data indicates that there is a very low percentage of AR accepted intakes that are found to have a safety threat that is then able to be mitigated with a safety plan. This data, coupled with that data above showing a low percentage of intakes changed from AR to TR due to a safety concern, also affirms that there is a low percentage of AR intakes where a safety threat is later found.

Table 4. AR Intakes with a Finding of Conditionally Safe

	2021	2022	2023	2024
Safety Finding of Conditionally Safe in AR Intakes	56	64	49	29
Total AR Intakes	4089	5198	4447	3716
% of AR	**1.4%**	**1.2%**	**1.1%**	**.78%**

In comparison, TR intakes have a higher percentage of cases where the children are found to be conditionally safe, as would be expected based on the intake screening procedure and AR's exclusionary criteria.

Table 5. TR Intakes with a Finding of Conditionally Safe

	2021	2022	2023	2024
Safety Finding of Conditionally Safe in TR Intakes	886	754	716	667
Total TR Intakes	12021	9756	10271	10013
% of TR	**7.4%**	**7.7%**	**7.0%**	**6.7%**

Risk Level in Alternative Response Intakes Compared to Traditional Response Intakes

Table 6 indicates how often a family is assessed to have a high or very high risk of future maltreatment in AR cases. Although the stated purpose of AR was to focus on low and moderate risk families, nearly half of all AR families are assessed as high or very high risk for future maltreatment.

Table 6. AR Intakes with High/Very High Risk Level

	2021	2022	2023	2024
High	1190	1525	1560	1232
Very High	455	711	656	503
Total	1645	2236	2216	1735
% of AR	**40.2%**	**43.0%**	**49.8%**	**46.7%**

In cases where the risk is determined to be high or very high, the CFSS is required to offer the family services that are designed to lower that risk. As stated previously, families may, and often do, refuse all services, which results in the case being closed with the family remaining at high or very high risk of maltreatment occurring. It should be noted that in these AR cases, the children have been found to be safe.

By point of comparison, Table 7 indicates how often families are assessed to have a high or very high level of future maltreatment in TR cases. As stated previously, the assessment of risk in AR and TR cases is different. The AR prevention assessment looks more at the family as a whole,

and their history, while the TR risk assessment has more focus on the incident that brought the family to the attention of DHHS. However, each assessment tool is ultimately judging the risk of future maltreatment of a child.

In the years 2023 and 2024, the percentage of cases with a high or very-high risk score was higher in AR cases, in which services can be refused, compared to TR cases where services can be required.

Table 7. TR Intakes with a High/Very High Risk Level

	2021	2022	2023	2024
High	4446	3256	3904	3413
Very High	1046	944	1050	951
Total	5492	4200	4954	4364
% of TR	**45.7%**	**43.1%**	**48.2%**	**43.6%**

Data on Subsequent Intakes in Alternative Response and Traditional Response Intakes

Table 8 represents recurrence rates in both AR and TR cases. Recurrence rates here refer to the rate at which families that have had an accepted intake and have been assessed by DHHS, then later receive another accepted intake within 12 months, and have to be assessed by DHHS again. Subsequent accepted intakes can include both AR and TR intakes. If a subsequent intake is substantiated, it would have to be accepted as TR. DHHS is able to track when the allegations in the subsequent intake are substantiated. Ultimately, this data only shows how often a family that has been assessed by DHHS returns to the attention of the Department to be assessed again within 12 months and whether the subsequent allegations are substantiated.

As the data indicates, families are assessed a second time in over one-third of the cases for both TR and AR intakes. The rate of substantiation for those subsequent intakes is slightly lower for AR cases than TR cases. In both TR and AR cases, the rate of subsequent intakes and the substantiation of those intakes decreased markedly in 2024.

Table 8. Recurrence Rates

Recurrence Rates **o Substantiated TR intakes received within 12 months for AR and TR intakes.** **o Accepted intakes received within 12 months for AR and TR intakes.**				
	2021	**2022**	**2023**	**2024**
Traditional Response				
Subsequent Accepted Rate	37.4%	34.9%	34.4%	26%
Subsequent Substantiated Rate	2.9%	3.5%	4.0%	1.5%
Alternative Response				
Subsequent Accepted Rate	37.4%	36.7%	35.8%	17%
Subsequent Substantiated TR Intake Rate	2.0%	2.4%	2.8%	.6%

Importantly, this data does not show whether the families with subsequent intakes had refused services in an AR case, had ever received services in a TR or AR case, or whether the subsequent intake indicates that the services provided were not effective. Currently, DHHS does not track data in a way to compare AR to TR cases. Data related to the number of families that choose to participate in AR services, as well as the number of families that are offered but refuse services, is not available from DHHS due to that data not being easily tracked.

FINDINGS OF THE OIG

1. **Alternative Response is not being used solely in cases with a low or moderate risk of abuse and neglect but is used as often for high and very high risk families.**

The goal of AR was to improve outcomes for families and children while reducing the removal of children from their homes by focusing on connecting families with supports and needed services rather than focusing on an abuse and neglect investigation. Throughout the legislative debates on the bills creating, extending, and permanently enshrining AR into law, AR was described as a program for lower risk cases in which children could be safely maintained in the home. However, the data indicates that nearly half of all AR cases involve families at a high or very high risk that abuse and neglect may occur in the home.

To be clear, DHHS has followed the law and its Alternative Response regulations and policies when assigning cases to AR. This is true for each of the cases reviewed in this investigation. As noted, Neb. Rev. Stat. §28-712.01 states that the "department *may* assign a report for alternative response" provided the allegations do not meet any of the exclusionary criteria. DHHS regulations *require* that intakes be assigned to Alternative Response if no exclusionary criteria or RED Team criteria is present.

Cases are assigned to AR before the safety and prevention assessments are completed. In order for a case to remain an AR case, children must be determined to be safe or conditionally safe in the safety assessment. The prevention assessment, which measures risk of future abuse, is completed next. Unlike the safety assessment, the risk level does not prevent a case from remaining an AR case. High or very high risk families can still be served by AR as long as there is no immediate safety risk to the child. The risk level only affects whether services are offered to the family.

In 2023 and 2024, a higher percentage of families in AR cases were found to be high or very high risk of future abuse in the home than in TR cases. In the cases that the OIG reviewed for this report, six of the nine families were determined to be high or very high risk. In all but one

of the nine cases, the death or serious injury occurred within four months of the AR intake being accepted by the Hotline.

While DHHS will provide services to any AR families that request them, DHHS' policy only requires the Department to offer ongoing services to families that are high or very high risk. Families that are determined to be low or moderate risk are referred to the community for services.

It appears then, that AR cases, even if properly assigned, are not focused on low and moderate risk families as originally conceptualized by the Legislature.

This is not to suggest that AR is not a useful tool. It remains a best practice in many states, and does create an opportunity to ensure that poverty is not mistaken for neglect. It can reduce the trauma of removing children from their homes and provide an opportunity for DHHS to work more collaboratively with, and strengthen, the family. It is also important to note that these AR cases do not involve an active safety threat and often may not be cases in which a county attorney would file a petition, meaning there is no court involvement that could require the family to engage with services. AR at least provides an opportunity to engage with the families voluntarily in the hopes of providing services to reduce the risk to the children.

However, if AR in Nebraska is going to serve families with a high or very high risk of abuse and neglect, then attention must be paid to what the outcomes are for these families—such as the rate at which these AR families are returning to the child welfare system with new and substantiated TR intakes of abuse and neglect—and how well DHHS is engaging these families to increase the possibility that the families will receive the services they need to reduce the future risk to the children.

In addition, it may be useful for DHHS and the Legislature to consider whether the risk level should affect whether a case can remain an AR case. Outcome data may inform this discussion. For example, data may indicate whether it would be appropriate to have an additional review of the assignment of a case to AR when a family is assessed at a very high risk of future maltreatment.

2. **Since Alternative Response is voluntary and families assessed at high or very high risk of future maltreatment may refuse services, family engagement is critical to mitigating the risk to the children in those families.**

The nature of AR—working with families collaboratively to address challenges and reduce the likelihood of maltreatment—relies on the ability to engage the family in needed services. In five of the nine cases reviewed by the OIG, attempts at engaging the family in addressing the risks were unsuccessful. It is impossible to say that AR services being provided would have stopped the incidents from occurring in those cases. But in AR cases, unlike court-involved cases, engaging the family during the AR assessment is the only way to provide the family with the supports they need to address concerns in the home. The courts are not available in AR cases to order needed services. Family engagement and DHHS' approach to family engagement then, is critical.

DHHS uses the SOP model as a tool to increase family engagement. This approach includes engagement strategies, involves family voice, is strength-based, and creates a support network around the family to support the family when the family is no longer involved in the child welfare system. This approach replaces the compliance-based approach, where family success is based only on compliance with services, not actual, sustainable change within the family that lends to child safety. SOP is considered a best practice in the child welfare field.

The challenge, however, is how DHHS measures the effectiveness of its efforts at engaging families, including how well SOP works as the tool for engaging families. Currently, the attempts at engaging a family may only be documented in NFOCUS—DHHS' electronic case management system—within a case narrative, and a family's refusal to accept services may also be documented within narratives or the prevention assessment. In addition, the AR assessment consent form verifies that the family was provided with the AR brochure and explained the AR process. This form was not found in any of the nine cases reviewed.

Thus, the effectiveness of SOP requires case-by-case reviews. There are no specific data points that can be easily gathered. As a result, measuring the effectiveness of family engagement is difficult. Yet, given that engaging families is the core work of AR, it is essential that there be a

measure of effectiveness of the family engagement strategies currently in use. Without any active evaluation of the effectiveness of engagement with these families, it is unknown if more families could be helped and future maltreatment mitigated. Additionally, there is no way to measure how effective services have been when families do, in fact, accept services in AR cases.

3. **The limited review of a family's history and previous risk determinations when assigning cases to Alternative Response can create a gap and a challenge in serving some families.**

When an intake is screened, the previous history of the family within the system is considered. However, the main factor considered when determining if an intake is accepted for assessment is the current behavior or incidents occurring within the children's environment. Once an intake is accepted, the decision to assign an intake to AR is largely based on the specific AR exclusionary criteria previously noted.

The review of the family's previous intakes and history when deciding to assign a case to AR is limited. DHHS regulations state that the following should be considered: The household's past history or current involvement with the Department, including completed assessments and services provided by household.[28] DHHS policy, however, is more time-limited.

While a previous court-substantiated allegation is a RED Team exclusionary criterion, the RED Team's review of the family's history of intakes and previous cases is limited to the previous six months. A family could have extensive previous intakes over many years that indicate a pattern of concerning behavior that are not considered if outside that six-month window. Similarly, previous risk levels are not considered when screening intakes for AR. A family could have had an intake more than six months before the current intake or could have been assessed to have been at very high risk but never received services due to either a lack of a safety threat, the family refusing services, or the denial of a filing in juvenile court by the county attorney. A new intake in that case could be screened as AR, regardless of the fact that the family was previously determined to be at very high risk for future maltreatment. In one of the cases reviewed, the

[28] 395 NAC, Ch. 9 § 003.03(A) Review, Evaluate, Decide (RED) Team Review Process.

family had multiple intakes screened as AR, despite the fact that the allegations were the same as in previous intakes, the family was assessed to be at high or very high risk of future maltreatment multiple times, and, in fact, AR was still offered to the family after the child's death.

As some researchers have found, "differential response programs will create significant problems for child protection if the use of data about the prior involvement of the family with CPS is limited because prior reports are among the best predictors of the seriousness of the threat to children."[29]

The current limitation on how much a family's previous history and risk assessments can inform the decision to assign a case to AR is a gap through which families can fall. This can create situations where there is no immediate safety concern requiring intervention by DHHS or the courts, but the family still has a significant history and the risk of maltreatment to the child is still present, potentially making voluntary intervention too risky.

4. **Additional data points are necessary to evaluate the effectiveness of Alternative Response.**

Recurrence rates—meaning whether a family has a subsequent intake and whether those subsequent allegations are substantiated and result in a new case—are an important way to measure how effective DHHS' intervention with a family has been. DHHS tracks a lot of information related to recurrence rates in TR cases, but similar information is not tracked in AR cases. This information would be helpful in assessing both AR itself and AR as it compares to TR.

As noted, there is data to compare the rate of subsequent intakes between AR and TR. On that limited data point, there was not much difference between AR cases and TR cases—meaning AR did not appear to be any more successful than TR in reducing the likelihood that a family would come back into the child welfare system. However, there is not enough information for a true comparison. DHHS does not currently track whether, in an AR case, those subsequent

[29] Board on Children, Youth, and Families; Institute of Medicine; National Research Council. Washington (DC): National Academies Press (US); 2012 Apr 5.

intakes were with families that received services, whether services had been refused in an AR case, or if the services that were provided were effective.

Until recently, a case-by-case review was necessary to determine how many families are offered services after an AR intake and how many refuse to participate in any services. Recently, DHHS updated its NFOCUS case management system to allow cases to be marked when a family refuses services. This data can now be more easily tracked. In the future, it will be helpful to have data to compare the effectiveness of services between AR and TR cases, and to compare the effectiveness of services within AR cases to those where services are refused. It would also be important to know if there is any correlation between families that are determined to be high or very high risk, but refuse services, and recurrence rates.

In addition, it would be helpful to have additional data on the use of direct financial assistance available through AR. One of the hopes for AR was that it would serve as a means to assist those in poverty or struggling financially with meeting a one-time financial need in order to prevent families from entering the child welfare system for those reasons. It is currently unclear in how many cases a family was provided financial assistance and how effective that intervention was. For example, did the financial assistance prevent a case from being opened with the family? It would be helpful to have this information to illustrate prevalent needs within AR cases and to evaluate whether this type of intervention is effective and being utilized as it should.

The more data points that are tracked, the more that the efficacy of AR can be evaluated. Not only would it be helpful to compare data between AR and TR, but there are many AR data points and outcomes that are not being evaluated within the program itself to ensure that AR is doing what it was meant to do within the child welfare system. It is essential that all facets of the child welfare system be analyzed to determine how effective they are in meeting the needs of vulnerable children in our state.

5. **The OIG found errors in the completion of SDM prevention assessments when determining future risk scores.**

Through this investigation, the OIG found errors in the completion of the SDM prevention assessments in the AR cases. In these cases, the information that was incorrectly marked in the assessments was readily available within the records held by DHHS, such as the child's characteristics and the caregiver's history of abuse or neglect as a child. One case had no prevention assessment completed at all.

Additionally, the determination and evaluation of secondary caregivers within these assessments has an impact on the risk scores and is often incorrect. If an adult parent of a child is living in the home and is not included as a secondary caregiver, there should at least be an explanation as to why that is, and that person should be interviewed as to the concerns reported in the intake as part of the assessment. Collateral information was often not gathered from these secondary caregivers or included in the assessments. In three cases, the father of at least some of the children was residing in the home, but was not interviewed or included in the prevention assessment. In two of these cases, the father is listed as a secondary caregiver on the SDM assessments, but the questions pertaining to the secondary caregiver indicate that there is no secondary caregiver in the home. In one of these cases, the father, who was not interviewed or listed as a secondary caregiver, was the perpetrator whose actions resulted in the death of the child two months later. In order to gain a full picture of the family situation, it is necessary to accurately determine secondary caregivers, and collateral sources of information are vital.

It is imperative that DHHS follow its policy when completing SDM assessments to have a clear picture of what is going on within families, to be able to determine the level of risk of future maltreatment, as well as determine what services would best assist a family.

RECOMMENDATIONS

1. **Enhance the tracking system for Alternative Response to better analyze outcomes in Alternative Response cases.**

Better data and tools for evaluation are needed to assess the effectiveness of AR. In February of 2025, DHHS added an enhancement within their system that enables a case to be closed with a designation "family declined services." This is a great step in tracking within AR cases. Additionally, it would be helpful to cross reference that information with subsequent intakes for those families and it would be particularly helpful to know if families that refuse services have a higher rate of subsequent intakes. That could provide helpful insight into the importance of family engagement. Similarly, if families that did receive services come back into the child welfare system, there is an opportunity to evaluate whether the services were ineffective.

It would also be useful to also track the utilization of AR's more flexible financial assistance for families, to better understand the impact of AR in keeping those in poverty from entering the child welfare system due to perceived neglect.

Alignment between information tracked in AR cases and TR cases would be useful whenever possible to evaluate the effectiveness of an AR approach to cases compared to a TR approach. There appears to be a lack of comparable data points to illustrate the differences in AR and TR cases. For example, TR intakes and open cases are able to be looked at separately. But AR intakes that are closed without services are not differentiated from AR intakes that resulted in an open case. If AR intakes could be tracked separately depending on the family's engagement in an ongoing case, more direct comparisons with TR might be able to be made. Creative ways to track and analyze the efficacy of AR efforts are necessary to determine how the program is working in the community.

2. **Develop a system for evaluating the effectiveness of family engagement within Alternative Response.**

It does not appear that DHHS has a system in place to evaluate how effective family engagement is – the core component of AR. While all caseworkers receive evidence-based

training on family engagement skills, DHHS should examine whether additional or different engagement skills training is necessary in AR cases. This would include an evaluation of how Safety Organized Practice (SOP) is influencing that engagement. There is a difference between implementing the tools included in SOP, and actually incorporating the concepts of SOP to increase family engagement.

DHHS should also consider implementing family engagement surveys, as were utilized in the pilot of AR, in order to continue to ensure that family engagement practices are being used, and used effectively, to bring the families into AR who could benefit from it the most. There is a large body of research addressing how family engagement can be measured within child welfare cases in ways other than through service compliance. It would be prudent for DHHS to look into a system that continuously evaluates the level of engagement of families and how that affects important outcomes.

In addition, DHHS should continue to grow and develop the knowledge and skills of family engagement among staff and examine whether having dedicated AR caseworkers and lower caseloads effect family engagement. The family engagement skills of staff working with families should be evaluated on an ongoing basis for both TR and AR intakes.

Family engagement is the most important piece of Alternative Response, the very thing that will allow for more families to be assisted and lower the risk of future harm to the children. Ensuring that caseworkers have these high-level skills and are putting them into practice is essential.

APPENDICES

APPENDIX A – Exclusionary and RED Team Criteria

APPENDIX B – AR Brochure

APPENDIX C – AR Consent Form

APPENDIX D – Family Plan Template

APPENDIX E – DHHS' July 14, 2025 Memorandum: Formal Response and Clarification to the OIG report

APPENDIX F – OIG's July 30, 2025 Letter to DHHS in response to DHHS' July 14th Memorandum

Alternative Response Exclusionary Criteria:

1. **Physical Abuse** of a child:
   (i) to the head or torso of a child; or
   (ii) that results in a bodily injury.
   - Physical abuse can be identified as severe injury (Bodily Injury) to a child (i.e. shaken baby, rough handling of an infant) and physical abuse can also be identified when the child required emergency medical care, was admitted to the hospital, and/or requires ongoing medical/mental health/physical or occupational therapy care for a long-term disability or condition resulting from the incident.
   - Substantial risk of death, or which involves substantial risk of serious permanent disfigurement, or protracted loss or impairment of the function of any part or organ of the body, any incident which is likely to cause death or severe injury to a child.

2. **Domestic violence** involving a caretaker in situations in which the alleged perpetrator has access to the child or caretaker:
   - Domestic violence involves physical assaults and/or periods of intimidation/threats/harassment between caregivers or between a caregiver and another adult.
   - Access means the ability, right, or permission to approach, enter, speak with, or use.

3. **Sexual abuse, sexual assault, or sexual exploitation**, including acts prohibited by Neb. Rev. Stat. §§ 28-318, 28-319.01, 28-320, 28-320.01, 28-320.02, 28-322.01, 28-322.02, 28-322.04, 28-322.05, 28-703, 28-707(d), and 28-367.01:
   - Any sexually oriented act, practice, contact or interaction where the child is or has been used for the sexual stimulation of a parent, child, vulnerable adult or another person. This includes sexual contact or intentional touching of a child's genital area, groin, inner thigh, buttocks, breasts or the clothing covering any of these areas.
   - Sexual penetration, cunnilingus, fellatio and anal sex. Any penetration, however slight, of any part of the body or any object placed into the genital or anal opening for non-medical purposes.
   - Incest – any sexual penetration involving parents and children, grandparents and grandchildren (including stepparents or unmarried partners identified as such by the child victim), brothers, sisters (including half-siblings), uncles, nieces/nephews, aunts or nephews/nieces. No person may consent to incest.
   - The legal minimum age for a person to consent to sexual activity is 16 and persons under that age are deemed incompetent to consent. Consideration should be given for individuals 16-19 with developmental delays who may not be competent to consent to sexual activity.
   - Sexual exploitation can be any person causing, allowing, permitting, inflicting or encouraging a child to engage in voyeurism, exhibitionism or prostitution; or in the production, distribution or acquisition of pornographic photographs, films or depiction of the child in the same when the child is unable to give consent due to the child's age or incapacity.
   - Include parents/caregivers who deliberately engage in sexual activity in the presence of a child as causing or inflicting engagement in voyeurism.

4. **Neglect of a minor child that results in serious bodily injury** as defined in Neb. Rev. Stat. § 28-109, requires hospitalization of the child or an injury to the child that requires

ongoing medical care, behavioral health care, or physical or occupational therapy, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect:

- Serious bodily injury is defined as a bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ or mental faculty (1365 (h) (3) of title 18, U.S. Code).
- The current report involves a child who has sustained a physical injury due to the inaction of the alleged perpetrator. Serious injury is defined as brain damage, skull or bone fracture, subdural hemorrhage or hematoma, dislocations, sprains, internal injury, poisoning, burns, scalds, severe cuts, or any other physical injury that seriously impairs the health or well-being of the child (e.g. suffocating, shooting, bruises/welts, bite marks, choke marks) and requires medical treatment.

5. An allegation that requires a **forensic interview at a child advocacy center, coordination with Law Enforcement, or coordination with the child abuse and neglect investigation team** pursuant to Neb. Rev. Stat. § 28-728:
   - There is a request for a forensic interview, hair test for drug exposure or medical assessment by CAC staff to assist in identifying if abuse or neglect has occurred.
   - Any report containing allegations of sexual abuse.
   - Local law enforcement has requested a forensic interview for any other reason or circumstance.
   - Any intake referred through an 1184 team meeting.
   - Note: children who have witnessed a violent crime, are found in a drug endangered environment or have been recovered from a kidnapping may be referred to the CAC for forensic interview (Neb. Rev. Stat. § 28-728) which would require coordination.

6. A household member has been **convicted of a crime that resulted in the death of a child** or has **criminal charges pending** for a crime that resulted in the death of a child:
   - The report contains information that a child under the care of the perpetrator has died from maltreatment and there are other children being cared for in the home.
   - A search of records indicates there are other children currently residing in the home OR there are children who regularly reside but are not currently present (i.e. visiting other family members).

7. Household member **illegally manufactures methamphetamine or opioids or other controlled substances** as defined in Neb. Rev. Stat. §§ 28-401 and 28-405:
   - The current report contains information that a Household Member, including youth, is manufacturing or allowing illegal substances to be manufactured on the premises. Signs of manufacturing methamphetamine may be but are not limited to: A strong smell of ammonia, ether, vinegar or other solvents. Excessive amounts of packaging or purchase of over-the-counter cold medicines, Epsom salts or rock salt. It may also include the presence of Coleman fuel containers, compressed gas cylinders, LP gas containers or gas cans.
   - This Exclusionary applies and should be marked when the Intake involves a temporary or alternate caregiver who is alleged to be manufacturing methamphetamine/controlled substances.
   - If a household member or alternate caregiver noted on the Intake Accepted for Assessment has a history of manufacturing methamphetamine or other controlled

substances as defined in Neb. Rev. Stat. §§ 28-401, 28-405 refer to RED TEAM (RED Team Criteria 3) for review.

8. A **child has had contact with methamphetamine or other non-prescribed opioids** including a positive drug screening or test:
   - Drug screening at birth (urine or meconium).
   - A hair follicle test completed at the request of an investigating agency indicates that the child has been exposed to controlled substances.
   - The report indicates that methamphetamine or other controlled substances are accessible to the child(ren) (i.e. illegal substances left within reach of small children, prescription medications not properly stored) and there is concern that the child(ren) may accidentally ingest the substance.
   - The report indicates the use of methamphetamine in the presence of the child(ren).

9. A child resides with a household member whose **parental rights have been terminated**:
   - CFS records indicate that the adult or caretaker has had their parental rights terminated because of involvement with child protection. Court action was taken to terminate parental rights based on a history of child abuse/neglect or other maltreatment. This may include narrative documentation that termination has happened in a different state if the CFS Specialist has been in contact with child protection workers in that state.

10. Abuse or neglect of a child who resides with (i) the subject of an active **Traditional Response**; or (ii) an individual or family that is **receiving services through the CFS Protection and Safety section**; or (iii) an individual or family who is **involved in a juvenile court petition** pursuant to Neb. Rev. Stat. § 43-247(3)(a):
    - One or more Household Members identified in the intake is currently involved with CFS and is currently receiving in-home services. This includes families receiving services through Eastern Service Area Case Management Contracted Provider and has a caseworker assigned. *This does not apply to families receiving an Alternative Response or services through B2i.*
    - When the Department is able to verify that the family has an open CFS case in another state.
    - This Exclusionary applies if the Intake Accepted for Assessment is received via Court Order and should be marked.
    - This Exclusionary applies to a dependency allegation if one of the three criteria listed above is met.
    - This Exclusionary would not apply for Dad's household if Mom & Dad have separate households and Mom has an open CFS case (either investigation or receiving services).
    - This Exclusionary would not apply when families are involved in juvenile court pursuant to Neb. Rev. Stat. § 43-247(3)(b), these families are ELIGIBLE for Alternative Response.

11. **Out-of-home** child abuse or neglect:

    The child is currently residing in:
    - Foster Care – private single family living unit, under one roof, housing no more than nine children/ youth under the age of 19.

- Kinship Care – the family has voluntarily placed the child out of home with another family member or other individual (i.e. neighbor, co-worker, etc.) known to the child and approved by CFS because safety threats were identified and no in-home interventions were possible.
- Congregate Care – Includes licensed and unlicensed daycare homes, facilities or centers. This also includes Residential facilities such as group homes, shelters, foster homes with no current placements and the Youth Rehabilitation and Treatment Centers in Kearney and Geneva.

12. Absence of a caretaker without having given an alternate caregiver authority to make decisions and grant consents for necessary care, treatment, and education of a child or without having made provision to be contracted to make such decisions or grant such consents:
    - The parent left a child unattended, the child is unable to identify themselves and there is no evidence with which to identify the child's family.
    - The caregiver left the child unattended or in the temporary care of an adult caregiver, and it is not known where the caregiver is or if the caregiver will return.

13. Law enforcement has **cited** a Caretaker for the child abuse or neglect alleged in the Intake Accepted for Assessment:
    - Law Enforcement Officers issued a citation for child abuse/neglect based on the current circumstances being reported. For Example, the parent is arrested or ticketed for DUI and the child was in the car at the time of the incident.

14. An allegation **being investigated** by a law enforcement agency at the time of assignment:
    - Law Enforcement has indicated that they are investigating the current circumstances being reported.
    - If Law Enforcement asks that CFS accept a report to provide supports to the family the intake can remain eligible for Alternative Response.

15. **Murder** in the first or second degree as defined in Neb. Rev. Stat. § 28-303 or 28-304 or **manslaughter** as defined in Neb. Rev. Stat. § 28-305:
    - A household member causes the death of a person:
        - Purposely and with deliberate and premeditated malice.
        - In the perpetration of or attempt to perpetrate any sexual assault, arson, robbery, kidnapping, hijacking or any public or private means of transportation, or burglary.
        - By administering poison.
    - A household member causes the death of a person intentionally.
    - A household member cases the death of a person without malice upon a sudden quarrel or unintentionally while in the commission of an unlawful act.

16. **Assault** in the first, second, or third degree or assault by **strangulation or suffocation** as defined in Neb. Rev. Stat. §§ 28-308, 28-309, 28-310, or 28-310.01:
    - A household member intentionally or knowingly causes serious bodily injury to another person.
    - A household member intentionally or knowingly causes serious bodily injury to another person with a dangerous instrument.
    - A household member menacingly threatens another.

- A household member impedes the normal breathing of another person by covering the mouth and nose of the person.

17. **Labor trafficking** of a minor as defined by Neb. Rev. Stat. § 28-830:
    - This also includes Human Trafficking as defined in Neb. Rev. Stat. § 28-830

18. For a report involving an infant, a household member **tests positive for methamphetamine or non-prescribed opioids at the birth of such infant.**

Alternative Response RED Team Criteria:

1. A caretaker **exhibits symptoms related to significant mental illness** including but not limited to psychotic behaviors, delusional behaviors and danger to self or others:
   - Psychosis is a serious mental disorder characterized by thinking and emotions that are so impaired that they indicate the person experiencing them has lost contact with reality;
   - Psychosis may also cause loss of motivation and social withdrawal;
   - Parent is delusional or having false thoughts. Individuals in a delusional state will often see and/or hear things that are not there;
   - Parent is making threatening statements toward or about the child (i.e. The child will die soon, the child is evil and needs to be destroyed);
   - Parent exhibits extreme paranoia and threatens others who try to intervene or offer assistance; and/or,
   - Parent has attempted to harm themselves.

2. The family currently receives an **Alternative Response**:
   - Families currently receiving services through an open Alternative Response Case.

3. Household Member or alternate Caregiver noted on the Intake Accepted for Assessment has a **history of using or manufacturing methamphetamine or other controlled substances** as defined in Neb. Rev. Stat. 28-401 and 28-405:

4. **Domestic assault** as defined in Neb. Rev. Stat. § 28-323 or domestic violence in the family home:
   - There is an active protection order in place.

5. A family member residing in the home or a caregiver that has been the **subject of a report accepted for traditional response or assigned to alternative response in the past six months**:
   - Subject means the family member or caregiver was listed as a perpetrator in the report accepted for assessment.

6. Use of alcohol or controlled substances as defined in section 28-401 or 28-405 by a caregiver that **impairs the caregiver's ability to care and provide safety for the child.**

7. A Household Member has a **prior court substantiated report of child abuse or neglect**; or,

8. A Household Member is a **sex offender** who is on the sex offender registry.

APPENDIX B

AR Brochure

In Alternative Response, you have the right to:

- Be notified that a report of suspected child abuse or neglect has been made against you.
- Refuse entry into your home by the CFS Specialist.
- Obtain an attorney to represent you at any point during the assessment. If there is not an open court case, you are responsible for the cost of an attorney.
- Contact the CFS Supervisor if the CFS Specialist is not available.
- Make a report of concerns to CFS if you are not in agreement with your CFS Specialist regarding service decisions. If the CFS Specialist is not available, contact a Supervisor.
- Make a report of concerns to the Inspector General or State Ombudsman's Office at:

Office of the Inspector General of Nebraska Child Welfare

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

In Lincoln:
402-471-4211

Toll Free:
855-460-6784

oig@leg.ne.gov

Office of the State Ombudsman

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

In Lincoln:
402-471-2035

Toll Free:
800-742-7690

ombud@leg.ne.gov

You know what your family needs. The CFS Specialist will work with you to determine if your family could benefit from services or supports to lower the risk of child abuse and/or neglect. Your CFS Specialist will help your family work through challenges. Together we will work to build your skills and strengthen relationships to reduce stressors and risk factors.

Please call the following CFS representative to discuss the report and answer questions you have about Alternative Response:

Children and Family Services Specialist

Name: _____

Telephone: _____

Supervisor: _____

Supervisor's Phone: _____

_____

_____

Department of Health and Human Services
Division of Children and Family Services

AR Alternative Response

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DEPT. OF HEALTH AND HUMAN SERVICES

CFS-PAM-24 9/2017

Alternative Response

Partnering with families to safely care for children in their own home and community

A DHHS Children and Family Services (CFS) Specialist has contacted you because a concern about your child(ren) was reported to the Nebraska Child Abuse and Neglect Hotline. CFS is required by law to assess child safety, as safety is our first priority.

Your family is eligible for Alternative Response, a program where CFS and families partner to keep children safe in their own home and community.

What does Alternative Response (AR) mean?

AR means a CFS Specialist will partner with your family to provide services and supports to keep your children safely in your home, your community and their school.

How can AR help your family?

Through AR, services and supports are put in place that can help your family with:

- Connecting you to local community resources.
- Struggles with the day-to-day demands of parenting.
- Improving family relationships.
- Increasing parenting knowledge about children of all ages.
- Increasing your ability to work through stress and develop long-term supports.
- Finding solutions in times of need or crisis.
- Identifying resources for children experiencing educational, medical or behavioral challenges.

How does Alternative Response compare to Traditional Response?

- With both, a CFS Specialist will talk with you and your family about the safety of your children and help find solutions to the identified concerns so your children remain safe.

Alternative Response

- A program to assist you with connecting to community supports and services that meet your basic needs, for example: housing, medical and mental health services, food programs and transportation challenges.
- Through Alternative Response, no one is classified as a perpetrator (offender) or victim.
- If your child(ren)'s safety is compromised during the Alternative Response, the CFS Specialist will review the concerns with you and inform you if there is a need to change (*from Alternative Response to Traditional Response*) the assessment to a Traditional Response.

Traditional Response

- An initial assessment is completed to determine if a child has been abused or neglected.
- The initial assessment may result in Court involvement.
- If the report is substantiated, names of the perpetrator/s are placed on the Child Abuse and Neglect Central Registry, which may be accessed by current and potential employers and for volunteer opportunities with children and vulnerable adults.

What are your choices?

- Families eligible for **Alternative Response** can request **Traditional Response**.
- You may request a meeting with your CFS Specialist or supervisor at any time to review family needs and services.
- After the assessment phase, you may choose to accept supports and/or services for your family. Keeping your child(ren) safe is a priority.

APPENDIX C

AR Consent Form

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Division of Children and Family Services (Alternative Response)
CONSENT TO ALTERNATIVE RESPONSE ASSESSMENT

I, _____, have been advised by the Nebraska Department of Health and Human Services that my family is eligible to receive an Alternative Response assessment.

I understand that the assessment of my children's safety is not optional, and that if I do not wish to receive an Alternative Response assessment, that a traditional investigation will be conducted regarding the safety of my children.

The following information has been explained to me:

- In order for DHHS to complete an Alternative Response assessment, a DHHS caseworker will have contact with my family, including my children. There may be times when this contact occurs in my family home.
- After my caseworker has determined my children are safe and has completed a comprehensive assessment of my family, we are not required to participate in Alternative Response and may choose to end our participation at any time with no action taken against my family.
- My DHHS caseworker is a mandatory reporter under state law, and if at any time during contact with my family, my caseworker has reason to believe my children are unsafe, the law requires that the caseworker report this information.
- If my children are determined to be unsafe by my DHHS caseworker, my family may no longer be eligible to receive an Alternative Response, and a traditional investigation may begin. My caseworker will notify me if this transition is necessary.
- DHHS may determine that Alternative Response is no longer appropriate for my family and end our Alternative Response. My caseworker will notify me if this occurs.
- I have the right to speak with an attorney, at my own expense, at any point during my cooperation with the DHHS.

I acknowledge that I have been provided with the Alternative Response informational pamphlet and have had an opportunity to review that pamphlet and ask questions regarding the information contained in the pamphlet.

Information regarding Alternative Response has been shared with me and I, _____, desire for my family to participate in Alternative Response and consent to my family having continued contact with our caseworker.

Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

☐ Mark the box if the Parent/Guardian declined to sign consent form.

Dates presented to the family and explanation:

APPENDIX D

Family Plan Template

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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

FAMILY PLAN

Alternative Response

☐ Initial ☐ Review ☐ Closing

Name Family Plan

Date

1. Family Need(s):

2. How do we get there?

3. Who or what can help us?

4. Plan created by:

Signature	Date
Signature	Date
Signature	Date

APPENDIX E

DHHS' July 14, 2025 Memorandum: Formal Response and Clarification to the OIG Report

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DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

To: Jennifer Carter, Inspector General
From: Dr. Bish, Director of Children and Family Service, Department of Health and Human Services
Date: July 14, 2025
Re: "Deaths and Serious Injuries of Children After an Alternative Response Assessment" report shared June 30, 2025.

DHHS Formal Response and Clarification:

Page 3, Recommendation #1:
"Alternative Response is not being used solely in cases with a low or moderate risk of abuse and neglect, but is used as often for high and very high risk families."

DHHS Response:
It is important to clarify that cases are only assigned to Alternative Response (AR) after a thorough review. Currently, regulations *require* that an intake be assigned to AR when no exclusionary criteria or Review, Evaluate, and Decide (RED) Team criteria are present. Current AR policy and regulations explicitly exclude cases where the child is determined to be "unsafe." However, it does not preclude the assignment of AR based solely on "high" or "very high" risk ratings. It is important to clarify that the level of risk can only be evaluated after an intake is determined to be eligible for AR and the assigned Children and Family Services Specialist has made contact with the family. It is also critical to distinguish between *risk* and *safety,* as these are separate constructs evaluated through different assessment tools. Safety determinations reflect immediate threats of serious harm and are made in real time, while risk assessments project the likelihood of future maltreatment and incorporate static and historical factors, and a family can score as "high" or "very high" risk due to historical factors outside of the family's control, such as the parents' involvement in the child welfare system as youth. Therefore, assignment to AR is consistent with policy and regulation, even if the risk level is elevated.

Additionally, regulations provide for a process to reassign AR cases to Traditional Response (TR). The case will be reassigned to TR if a safety threat is present, safety cannot be assessed, law enforcement has cited a caretaker for a crime related to the allegations of child abuse and neglect in the intake, the caretaker requests TR, or when a household member caused the death of a child.

Response to Recommendations on Page 3:

Recommendation #1:
In response to this recommendation and feedback from the AR Advisory Committee, DHHS has implemented a system enhancement through a Workfront request (part of the February 2025 NFOCUS release). This enhancement enables staff to close a case with the designation "family declined services," thereby improving the consistency and clarity of data entry. While such data has historically been documented in NFOCUS narratives, this update will enhance the ability to analyze and report on engagement trends systematically.

Recommendation #2:
DHHS has developed a Quality Assurance (QA) Case Review Tool specific to AR cases. This tool includes review elements related to the frequency and quality of contact with families; however, it does not currently evaluate the *effectiveness* of family engagement. DHHS acknowledges the importance of this recommendation and is open to further exploration and development of metrics or tools that could more explicitly assess engagement outcomes.

Page 8, Last Paragraph:
The narrative in the final paragraph may create a misleading impression that AR cases do not involve a safety assessment. As stated on page 10 of the same report and required by Nebraska law, safety is assessed in all AR cases. DHHS reiterates that safety assessments are an integral part of the AR process and are consistent with both agency policy and national best practice.

Page 37, Table 1 – Risk Level of AR Case:
Pursuant to the Child Protection and Safety Act, DHHS is the sole entity responsible for assessing safety and risk of children, and any safety or risk assessment must be completed using an evidence-informed and validated tool. Proper administration of the Structured Decision Making (SDM) risk assessment tool requires more than a review of written policy. An appropriate score involves real-time engagement with families, full review of the case file, and the application of a trauma-informed approach during the assessment process. Even if the OIG reviewer had previous training on SDM, the lack of direct interaction with the family and contemporaneous case knowledge compromises the validity of the score and fidelity to the model. Furthermore, scoring risk retrospectively is inherently different than assessing risk in real time, as it is influenced by knowledge of subsequent events. DHHS notes that, notwithstanding the attempted rescoring, none of the cases reviewed by OIG met criteria for a traditional response investigation. Therefore, the Department acted appropriately in accordance with current statute and policy regarding AR case assignment.

Page 43, Table 8 – Recurrence Rates:
The label "AR subsequent substantiated rate" is inaccurate and potentially misleading. Pursuant to Nebraska law, AR cases are not subject to substantiation. A substantiated finding following an AR case would occur only in the context of a *new*, screened-in traditional response case. Therefore, what is being represented is not a "substantiated AR case," but rather a subsequent contact with the agency that resulted in a substantiation within the TR pathway.

Page 44 – OIG Findings:
The current language suggests that the risk level is determined prior to completion of the family assessment, which is inaccurate. Risk level is not assessed until the full Prevention Assessment, which includes the assessment of risk, is completed. Additionally, risk scores are composed of multiple factors, many of which are historical and outside the family's present control (e.g., a family member's prior involvement with the child welfare system). It is essential for readers to understand that the SDM risk assessment tool does not solely reflect immediate risk conditions; it integrates both current and historical data to generate a composite risk score, which may elevate a family's risk level despite an absence of immediate concerns.

APPENDIX F

OIG's July 30, 2025 Letter to DHHS in response to DHHS' July 14th Memorandum

JENNIFER A. CARTER
Inspector General

STATE OF NEBRASKA
OFFICE OF INSPECTOR GENERAL OF CHILD WELFARE
State Capitol, P.O. Box 94604
Lincoln, Nebraska 68509-4604
402-471-4211
Toll Free 855-460-6784
Fax 402-471-4277
oig@leg.ne.gov

Dr. Alyssa Bish
Director, Children and Family Services
Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Dear Dr. Bish,

Thank you for your July 14, 2025 memorandum detailing DHHS' Formal Response and Clarifications regarding the OIG's Investigative Report, "Deaths and Serious Injuries of Children After an Alternative Response Assessment." I am writing to follow up on your response and make clear what if any changes the OIG has made in the final report.

As we have discussed previously, while our offices have very different roles, we share the ultimate goal of making sure the child welfare system is working as best as it can for children and families. When the OIG identifies a gap in law or policy or potential for improvement, we appreciate hearing from the Department on the best way to fill the gap or solve the problem.

With respect to DHHS' responses and clarifications, many of the responses shared a similar, overarching concern that the OIG's report was not clear that (1) DHHS' assignment of cases to AR was appropriate and required by regulation and (2) risk is not assessed until after a case is assigned to AR and a case is not precluded from continuing as AR based on the risk score. In response to the first point, the report was edited in several places to add an express statement that the assignment of cases to AR appears to have followed the law and regulations. (*See* pgs. 3, 40, 44.) The report also makes clear that while the law does not require the assignment of a case to AR, DHHS regulations do. (*See* p. 10.)

To the second point regarding the risk score, we believe the report is clear that children must be safe for the case to remain an AR case and that the risk assessment happens after a case has already been assigned to AR. However, we appreciate the importance of that clarification and have edited the report in several places to reinforce the process and timing of the prevention assessment in AR and to clarify that the risk score does not prevent a case from remaining AR. (*See* pgs. 2, 8, 11-13, 44.)

With regard to the OIG's main finding that many AR cases involve high or very high risk families, DHHS' response also notes that risk scores consider multiple factors including "historical factors outside of the family's control" which can increase a family's risk score even when there is no immediate safety threat. The OIG report is clear that there can be no immediate safety concern present in an AR case. But the fact remains that nearly half of the families being served through AR are scored as high and very high risk based on the prevention assessment criteria DHHS uses. We presume that DHHS would not be assessing risk based on irrelevant factors.

As a result, the OIG's findings and conclusions remain the same. However, the first finding was edited to note that DHHS or the Legislature might use AR data to determine if it would be appropriate to require an additional review of the assignment of a case to AR when the case scores as very high risk. (*See* p. 45.)

Another concern raised by DHHS related to the OIG's determination that two of the prevention assessments were incorrectly scored as moderate rather than high risk. The OIG's determination was based on departures from DHHS policy found in the documentation. However, taking DHHS' concerns into consideration, the report has been edited to note only where policy was not followed and no longer suggests that the scoring should have been different in those particular cases. (*See* pgs. 37-38, 50.)

Regarding the language in Table 8 with the "AR subsequent substantiated rate" label, that was the language in the table as sent to the OIG by DHHS. But we agree it could be clearer and have edited the label in Table 8, as well as the language in the report, to clarify that any substantiated subsequent intakes are necessarily receiving a Traditional Response. (*See* pgs. 42-43.)

Finally, the report was edited to reflect the update in NFOCUS that allows an AR case to be closed with the designation "family declined services." (*See* pgs. 49 and 51.)

Once again, we appreciate DHHS' feedback and believe that feedback and the changes made in response have strengthened the report.

With these changes, the report is considered to be final. We plan to release the report publicly in the next week. It will, of course, also be included in the annual report this fall as required by law.

As always, we welcome any questions and would be happy to speak.

Sincerely,

Jennifer A. Carter