Office of

Inspector General of Nebraska Child Welfare

Annual Report

2023-2024

September 15, 2024

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

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Anyone may file a complaint with the OIG regarding concerns about specific children and cases or broad misconduct in the child welfare and juvenile justice systems. The information provided is confidential, as is the identity of the reporting party. A complaint may be filed online or you may email, write a letter, or call our toll-free number.

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

Email: OIG@leg.ne.gov

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

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

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

National Suicide Prevention Lifeline
Call 1-800-273-8255
or text **988** to access a trained crisis counselor

Nebraska Family Helpline
1-888-866-8660

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Message from the Inspector General

The Office of Inspector General of Nebraska Child Welfare (OIG) is honored to present its Annual Report for the fiscal year starting on July 1, 2023 and ending June 30, 2024. We are grateful for the opportunity to share our work.

Fiscal Year (FY) 2023-2024 was a challenging year for the OIG. On August 16, 2023, the Nebraska Attorney General's Office issued Opinion No. 23-008 questioning the constitutionality of the laws governing the OIGs. In response to this opinion, though the law remains unchanged, the Nebraska Department of Health and Human Services restricted the OIG's access to information, including notifications of deaths and serious injuries of children in the system. As is discussed more fully in this report, this had a significant impact on the OIG's ability to provide the oversight and transparency contemplated by the Legislature.

After a Memorandum of Understanding was signed between the Legislature and the Governor's Office in February 2024, the OIG began to receive information again in late March. We have worked diligently to review seven months' worth of information and notifications of incidents. However, some limitations on our access to information remain, and therefore some of the information and analysis from previous Annual Reports may be missing or changed, and such effects are noted.

Despite these challenges, the OIG remained committed to its mission and statutory obligations. This Annual Report includes a summary of the issues the OIG reviewed in FY 2023-2024, identifies upcoming changes in the child welfare system, details the OIG's monitoring of the Youth Rehabilitation and Treatment Centers, and provides a summary of investigatory reports.

It must also be noted that this last year was difficult for the OIG staff, who are dedicated to this work. I want to acknowledge their hard work and professionalism. We remain committed to the law and to the principles of accountability, transparency, integrity, and good government for the Nebraska agencies serving children, youth, and families.

Jennifer A. Carter
Inspector General

Executive Summary

This Annual Report includes a summary of the challenges to the work of the OIG in FY 2023-2024, an analysis of data related to reported deaths and serious injuries of children in the child welfare system, as well as analysis of data from the Youth Rehabilitation and Treatment Centers (YRTCs), and a discussion of key issues monitored by the OIG.

The work of the OIG was significantly impacted in FY 2023-2024 by the Department of Health and Human Services' (DHHS) response to the Attorney General's Opinion. The OIG did not have access to information from DHHS for much of FY 2023-2024 and similarly received no information from the Administrative Office of Probation, Juvenile Services Division. In February 2024, a Memorandum of Understanding (MOU) was signed between the Legislature and the Governor's Office which reinstated access to certain information from DHHS. Under the MOU, the process for accessing information has changed and is more secure but also cumbersome and time-consuming. The OIG continues to conduct its work while navigating the ongoing effects of the Attorney General's Opinion and DHHS' response to it.

At the core of the OIG's work is the review of deaths and serious injuries to children in the child welfare and juvenile justice systems. This year there was a noticeable increase in the deaths and serious injuries reported to the OIG.

- 21 child deaths were reported to the OIG in FY 2023-2024 compared to 11 in FY 2022-2023.
- 27 serious injuries of children were reported to the OIG in FY 2023-2024 compared to 15 in FY 2022-2023.
- Five of those deaths and 13 of those serious injuries occurred between August 2023 and March 2024 when the OIG was not receiving any notices of deaths or serious injuries.
- Based on a review of these notices, the OIG identified 11 mandatory investigations it must conduct into the deaths or serious injuries of system-involved children.

There have also been significant changes to DHHS' leadership and key decisions made about child welfare policy and practice:

- A new CEO for DHHS was appointed along with a new Director of Children and Family Services after extended vacancies in those positions.
- DHHS announced other significant changes, including the move away from the Structured Decision Making model for assessing families. A new model, called the Safety Assessment Family Evaluation model, is currently being adopted in Nebraska.
- DHHS will also end its contract with the University of Nebraska-Lincoln's Center for Children, Families, and the Law for new worker training, opting to bring this training in-house.

The OIG continued its monitoring of data from the YRTCs and its monitoring of allegations of sexual abuse of state wards:

- Challenges remain regarding the YRTCs, with marked increases in assaults, use of mechanical restraints, and youth self-harm. In addition, the average censuses within these facilities have increased.
- The number of allegations of sexual abuse of state wards decreased slightly, but the number of substantiated cases of sexual abuse increased slightly.

The OIG also noted a concerning increase in reports of infant deaths due to unsafe sleep. While most of these cases will not require an OIG investigation, the increase was notable enough to mention.

The OIG also continued to monitor whether and how any of the recommendations from the LB 1173 effort to transform the child welfare system will be implemented. There has been little discussion or follow-up around LB 1173.

With regard to investigations, the OIG completed an investigation into the death of a child in a licensed child care. A recommendation regarding the monitoring of sleeping infants at licensed child cares was submitted to DHHS and accepted.

Lastly, the OIG continued its work of receiving complaints from the general public about the child welfare and juvenile justice systems. The OIG received 270 complaints and reports of information in FY 2023-2024.

About the Office of Inspector General of Nebraska Child Welfare

The Office of Inspector General of Nebraska Child Welfare was created in 2012 by the Nebraska Legislature following a crisis in the child welfare system caused by a troubled attempt to privatize case management. This crisis resulted in, among other things, an upheaval in the workforce that increased the risk to the children and families being served and the loss of many critical private providers needed to serve children in the system.[1] As part of its inherent power of legislative oversight, the Legislature created the OIG to "[e]stablish a full-time program of investigation and performance review to provide increased accountability and oversight" and to assist the Legislature in improving the child welfare and juvenile justice systems.[2]

The OIG's ultimate purpose is to foster good government and create transparency and accountability in these critical systems.[3] The goal is to ensure that the child welfare and juvenile justice systems are serving children and families well and functioning as the Legislature intended. The OIG does this by monitoring both systems and conducting investigations into the deaths and serious injuries of children. The OIG's work helps the Legislature assess how these systems are functioning and determine if legislative action is necessary to improve these critical systems.

[1] See LR 37 (2011) Report: Review, Investigation, and Assessment of Child Welfare Reform at https://nebraskalegislature.gov/reports/health.php.

[2] Neb. Rev. Stat. § 43-4302. See also Neb. Rev. Stat. § 43-4317. It should be noted that when the OIG of Nebraska Child Welfare Act was passed, the DHHS Office of Juvenile Services was responsible for the care and supervision of youth in the juvenile justice system. Therefore, when the Act was passed, those youth and that system were included in the stated intent. When the supervision of youth in the juvenile justice system was moved to the Administrative Office of Probation in the judicial branch, the Act was amended to maintain oversight regarding the supervision and care of those youth.

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

The OIG provides accountability for and may conduct investigations involving the following agencies: the Nebraska Department of Health and Human Services (DHHS) and its Division of Children and Family Services (CFS), which administers the child welfare system, as well as its Division of Public Health (Public Licensing), which is responsible for the licensing of facilities serving children and youth; the Administrative Office of Probation, Juvenile Services Division (Juvenile Probation) for youth supervised on probation; the Commission on Law Enforcement and Criminal Justice's Juvenile Justice Programs (Crime Commission); private agencies and service providers in the child welfare and juvenile justice systems under state contract; licensed child care facilities; and juvenile detention and staff secure detention centers.[4]

The law requires the OIG to investigate allegations or incidents of:

1. Misconduct, misfeasance,[5] malfeasance,[6] or violations of the statutes or rules and regulations of DHHS, Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities;[7]
2. Deaths and serious injuries[8] of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation, (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation, or (c) in cases that have had an open investigation for child abuse and neglect in the last 12 months, if, after review, the OIG determines the death or serious injury did not occur by chance.[9]

The OIG also receives and assesses complaints from the public and may open an investigation based on those complaints if certain requirements in the law are met.[10] The OIG's process for determining what must be investigated is described in more detail later in this report.

[4] See Neb. Rev. Stat. § 43-4318.

[5] Misfeasance is defined in Neb. Rev. Stat. § 43-4311 as "the improper performance of some act that a person may lawfully do."

[6] Malfeasance is defined in Neb. Rev. Stat. § 43-4309 as "a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty."

[7] See Neb. Rev. Stat. § 43-4318.

[8] Serious injury is defined in Neb. Rev. Stat. § 43-4318(2) as an "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."

[9] See Neb. Rev. Stat. § 43-4318.

[10] See Neb. Rev. Stat. § 43-4320.

As part of the OIG's review and investigative function, it gathers information, analyzes that information, and provides reports to state agencies and the Legislature with recommendations for system improvement. OIG investigations are focused on whether laws, regulations, and policies were followed by the state agency, as well as identifying issues and gaps in the laws, policies, and procedures in the child welfare and juvenile justice systems. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions.

It is important to note that the OIG does not conduct any abuse and neglect investigations, nor does it conduct any criminal investigations into the death or serious injury of a child. The OIG does not have any law enforcement power.

In addition to investigations and the production of this Annual Report,[11] the OIG has several other statutory duties. The OIG monitors YRTCs by reviewing data and information that the YRTCs are required to provide,[12] monitors allegations of sexual abuse of state wards,[13] reviews and monitors complaints and incidents related to Alternative Response (AR) cases,[14] and produces an annual report on Juvenile Room Confinement data reported by juvenile residential facilities.[15] The Inspector General also serves on a variety of committees, commissions, and work groups.

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

[11] See Neb. Rev. Stat. § 43-4331.
[12] See Neb. Rev. Stat. § 43-4318(3).
[13] See Neb. Rev. Stat. § 43-4318(2)(b).
[14] See Neb. Rev. Stat. § 43-4331; see also Neb. Rev. Stat. § 28-712.01(5).
[15] See Neb. Rev. Stat. § 83-4,134.01(2)(d).

Year in Review

This section reviews some of the predominant issues and topics upon which the OIG worked in FY 2023-2024.

Attorney General's Opinion and Effect on the OIG's Work

The work of the OIG this last fiscal year was significantly affected by the Nebraska Attorney General's Opinion No. 23-008 (AG's Opinion) issued on August 16, 2023, which questioned the constitutionality of the laws governing the OIG's duties and responsibilities. Although the law remains unchanged, within hours of the Opinion's release, DHHS denied the OIG's access to previously available information, which affected the OIG's work in three critical ways.

First, DHHS stopped reporting to the OIG the deaths and serious injuries of children involved in the child welfare system. From August 2023 until March 2024, the OIG, and therefore the Legislature, did not know if any children had died or been seriously injured in Nebraska's child welfare system. As discussed in more detail later in this report, within that time, there were five deaths and 13 serious injuries that were not reported until months after they occurred.

Second, DHHS eliminated the OIG's access to NFOCUS, DHHS' electronic case management system. Before the AG's Opinion, the OIG could review much of a case file electronically within NFOCUS. This access was solely for the purpose of reviewing information—the OIG did not have any ability to make changes or alter the information in any way. The OIG used NFOCUS to do an initial review of any reported incidents to determine whether the OIG had jurisdiction and was required to investigate those incidents. The OIG also used NFOCUS to review complaints to determine if those complaints should result in an investigation, as required by law. Without access to NFOCUS, the OIG cannot thoroughly review the complaints that it receives.

Third, the OIG stopped receiving any of the required notifications or data from the YRTCs, such as the number of assaults, escapes, property damage, medical incidents, instances of self-harm, and attempted suicides that may have occurred. The OIG also could not visit the facilities or speak with any youth.

Access to information, including confidential information, is critical to legislative oversight. DHHS' decision to refuse to provide the OIG with information significantly hindered the OIG's ability to do its job. However, the OIG continued to work as best as possible to meet its statutory obligation of providing oversight of Nebraska's child welfare and juvenile justice systems. The OIG was able to complete an investigation of a child death with information acquired before the AG's Opinion. Similarly, the OIG had received all the juvenile room confinement data before the AG's Opinion, so that report was also completed. In addition, the Inspector General continued to participate in various committee and commission meetings, which allowed the OIG to stay informed of general decisions and policy changes at DHHS. A significant amount of time and energy was also spent trying to navigate the OIG's duties and responsibilities in the wake of DHHS' decision to restrict access to all information.

Memorandum of Understanding

On February 14, 2024, the Legislature signed a Memorandum of Understanding (MOU) with the Governor's Office to provide the Ombudsman's Office and the Offices of Inspectors General with access to information. The duties and responsibilities outlined in the MOU reflect much of what is already in the law. It also outlines protocols for communicating with DHHS and requesting information as electronic access to NFOCUS is still not available.

Under the MOU, information must be shared through a secure, shared site created by the Legislature. DHHS, however, required the Ombudsman and IG Offices to use an existing site that DHHS manages to share information. The shared site is referred to as the "partners site." Since it became operational in March, the partners site has worked well as a portal for information sharing. The OIG appreciates the increased security and confidentiality of this new process.

Once the MOU became effective, the OIG's first request for information was for all notifications of deaths and serious injuries that had been missed following the release of the AG's Opinion. It took several weeks, until late March, to receive all those past notifications. Since then, DHHS has resumed the timely notification of critical incidents, including deaths and serious injuries of

children in the child welfare system and in licensed child cares, as well as data from the YRTCs. It took longer to receive the past reports of sexual abuse allegations but those have since been received and timely reporting has been ongoing. The notification process through the partners site is working well.

Unfortunately, the process of accessing case files necessary for the review of incidents, complaints, and investigations has been more challenging. DHHS has been providing the requested information and the OIG appreciates DHHS' efforts. However, the process is cumbersome for both DHHS and the OIG.

Previously, when the OIG had electronic access to NFOCUS, OIG staff could review a case file online and determine fairly quickly if an incident was within the OIG's jurisdiction or if there was validity to a complaint. With NFOCUS, OIG staff could also determine which parts of the file were relevant. Without electronic access and the overview of the case file that access provided, OIG staff cannot determine which parts are relevant and, therefore, must request the majority of the case file for each case. The OIG's understanding is that for several months DHHS had dedicated at least three staff members to printing the documents from NFOCUS and then scanning and uploading those documents to the shared site. It is the OIG's understanding that some of the document retrieval may now be automated and electronic.

The OIG offers to have a conversation with DHHS administrators before requesting case files to create more specific parameters around the request when possible. Generally, however, without even a cursory review of the entire case file, the OIG cannot assess what information may be important.

Notably, this process is time-consuming—both for DHHS staff gathering the information and for OIG staff reviewing it. Even when the case file is received, it is harder to put the information into context than it was when staff could review it within the NFOCUS system. OIG staff, therefore, must review more information than might otherwise have been necessary because it is not possible to know what the case file contains without reviewing its entirety. It is also hard to isolate key pieces of information within the scanned documents. As a result, another

unintended consequence of this process is that OIG investigations will take longer to conduct and complete.

Again, the time and effort DHHS has dedicated to this process is appreciated. However, this is a time-consuming process for both DHHS and the OIG. It is not the best or most efficient use of government resources.

Juvenile Probation

As has been noted in the OIG's annual reports for several years, the OIG has not been able to complete investigations into the deaths and serious injuries of youth supervised by Juvenile Probation due to disagreements on the relevant law and protocols. Despite this challenge, Juvenile Probation continued to provide the OIG with notifications of deaths, serious injuries, and allegations of sexual abuse of juveniles on probation. However, Juvenile Probation stopped providing these notifications after the AG's Opinion was released.

Since Juvenile Probation is not a party to the MOU, the OIG, and therefore the Legislature, has not received any information regarding the deaths, serious injuries, or allegations of sexual abuse for youth on probation since August 2023.

LR 298 – Legislative Oversight Review Special Committee

During the 2024 legislative session, LR 298 was introduced to create a Legislative Oversight Review Special Committee. The Special Committee was introduced as part of an effort to resolve the ongoing issues resulting from the AG's Opinion. LR 298 is also an opportunity to conduct a broader review of legislative oversight and how it is currently organized in the Legislature. The OIG is prepared to provide any information the Special Committee needs or help it in any way.

Significant Changes within DHHS Children and Family Services

Changes in Leadership

Fiscal Year 2023-2024 brought significant changes in leadership to DHHS. Dr. Steve Corsi was appointed CEO of DHHS on August 16, 2023. Dr. Alyssa Bish was appointed Director of the Division of Children and Family Services (CFS) at DHHS on October 24, 2023.

In addition, DHHS decided to decrease the number of Service Area Administrators (SAA). Historically, an SAA oversaw each of the five child welfare service areas in Nebraska.[16] There is now one SAA position leading the Western and Central Service Areas. There is also one SAA position now leading the Northern and Southeast Service Areas, but that position is currently vacant. The Eastern Service Area continues to have one SAA.

New Model for Assessing Abuse and Neglect

DHHS has reported that it is moving away from its current safety model, Structured Decision Making (SDM), which was implemented in 2012. That model is the current framework for how DHHS assesses a family for a child's safety and the risk of abuse or neglect when there is a report to the Nebraska Child Abuse and Neglect Hotline (Hotline). The SDM also helps DHHS determine whether and how it will engage with families, including whether DHHS will recommend the removal of any children in the home based on a safety concern.

DHHS has stated its intention to move to the Safety Assessment Family Evaluation (SAFE) Model as the process for assessing a child's safety and whether abuse or neglect has occurred. The SAFE Model was developed in 1986 by Action 4 Child Protection, a non-profit organization providing technical assistance services to child welfare agencies. Action 4 Child Protection states that "SAFE uses standardized tools and decision-making criteria to assess family behaviors, conditions, and circumstances, including individual child vulnerabilities and caregiver protective capacities, to make well-founded child safety decisions."[17] The focus of the model is

[16] There is a Western, Central, Northern, Eastern, and Southwest child welfare service area, each representing their respective geographical areas of the state.
[17] Action 4 Child Protection. *Practice Model*. https://action4cp.org/our-services/practice-model/. (Retrieved on September 12, 2024).

child safety and caregiver protective capacities. There are six core components to the model. Nebraska can choose to implement some or all of those components. Action 4 Child Protection also offers assistance with program development, implementation, review, quality assurance, and improvements related to the model. DHHS is in the process of adapting the tools used in the SAFE Model to fit existing Nebraska statutes and policies. DHHS has stated its intent to fully implement this new model in 2025.

Changes to Training for New Workers and Staff

The change to a new assessment model is coupled with another significant change regarding new worker training. DHHS has decided to end its training contract with the University of Nebraska-Lincoln's Center for Children, Family, and the Law (CCFL). CCFL has provided new worker training for DHHS since the 1980s. DHHS plans to bring new worker training in-house and develop a new training curriculum focused more on worker competency in the field. This in-house training will reportedly start with a new cohort of workers in mid-December 2024.

Increase in Reports of Unsafe Sleeping Deaths

During FY 2023-2024, the OIG was notified of seven infant deaths determined to be Sudden Unexpected Infant Deaths (SUID). According to the American Academy of Pediatrics (AAP), SUID is a term used to describe any sudden, unexpected death, whether explained or not, that occurs during infancy. The term includes Sudden Infant Death Syndrome (SIDS) as well as accidental deaths due to unsafe sleep practices. SUID remains the leading cause of post-neonatal mortality.[18]

In several of the seven cases, the infants were reportedly co-sleeping in the same bed as one or both parents, with the parent awakening to find the infant unresponsive. In two cases, the infant's parent was determined to be intoxicated at the time the parent laid down to co-sleep with the baby.

[18] Moon, Rachel Y, et al. "Evidence Base for 2022 Updated Recommendations for a Safe Infant Sleeping Environment to Reduce the Risk of Sleep-Related Infant Deaths." *Pediatrics*, vol. 150, no. 1, 21 June 2022, https://doi.org/10.1542/peds.2022-057991.

Other than the education regarding safe sleep that is provided by hospitals when an infant is discharged after birth, there does not appear to be consistent education surrounding the dangers of co-sleeping. Many pediatricians, however, will discuss it at well-baby appointments. In several of the mentioned cases, the parents reported that they did not intend to co-sleep, but had taken the infant into bed to feed them and accidentally fell asleep.

The AAP reports that 3,500 infants die each year from SUID or accidental suffocation and strangulation in bed. The AAP recommends a safe sleep environment to include supine positioning; use of a firm, non-inclined sleep surface; room sharing without bed sharing; and avoidance of soft bedding and overheating.[19]

Given the circumstances of the deaths, most of the mentioned cases will not require an OIG investigation. However, the number of unsafe sleep deaths reported to the OIG this last fiscal year was notable and more than in previous years, and therefore an issue of which the Legislature should be aware. It is important to note that DHHS reports it released a Safe Sleep Standard Operating Procedure for caseworkers on safe sleep practices in 2023.

LB 1173 Reimagine Well-Being Efforts

In 2022, in the wake of the challenges in the Eastern Service Area regarding the termination of the contract for case management with St. Francis Ministries, the Legislature passed LB 1173 to structure and support a plan for systemic transformation of the child welfare system. The law required the creation of a practice and finance model with input from all three branches of government. To that end, LB 1173 created a work group and a leadership group with representation from all three branches of government. The LB 1173 Work Group was required to consult with several groups, including the OIG.

In addition, LB 1173 required that the Work Group and Leadership Group enlist the assistance of a contracted consultant who is an expert in child welfare system transformation. The Stephen Group was hired as the consultant and began its work in early 2023. After an initial

[19] *Id*.

kick-off meeting, the Stephen Group convened community forums throughout the state and conducted interviews and surveys of various key stakeholders and those directly engaged in the child welfare system, such as CFS case managers and supervisors.

The LB 1173 Work Group meetings were held monthly in person and virtually for the remainder of 2023. The Work Group meetings included presentations on a variety of aspects and efforts regarding the child welfare system in Nebraska. The Stephen Group also regularly provided an overview of key themes heard during its information-gathering efforts.

The OIG attended the Work Group meetings throughout this process. The Stephen Group's community engagement efforts resulted in the gathering of important information and have revealed many key trends.

The final draft of the Practice Model and Finance Model report was shared at the November 2023 Work Group meeting. The report was to be submitted to the Legislature's Health and Human Services Committee by December 1, 2023. The goals of the models are to:

- Promote the safety of children and families
- Strengthen community prevention services for at-risk children and families
- Reduce maltreatment and caregiver recidivism
- Reduce family separation
- Improve child and family well-being
- Increase accessibility for all across systems of care and agencies
- Improve family experiences with the child well-being system
- Increase representation of the community in workforce and staffing

The Practice Model emphasizes the use of a Community Response Pathway, which would include the use of local and faith-based organizations, prevention services, and a closed-loop referral system (meaning the agencies providing the referrals ensure that the family has connected with the needed provider or service). Partnerships would be strengthened with schools and community initiatives and include collaboration from all sectors. Another emphasis is alignment across agencies. This alignment includes Juvenile Probation, requires collaboration

across all DHHS divisions, and would utilize Multidisciplinary Team approaches such as collaborative meetings, family treatment courts, and Medicaid Managed Care Providers.

The Practice Model also discusses the need for real-time usable data to be widely available and accessible. It would implement a master data management strategy. It also recommends implementation of a Comprehensive Child Welfare Information System capable of collecting and reporting program information, service authorization, and expenditure data at an aggregate and client-specific level. Improved workforce training is also discussed.

The Finance Model recommends the enhancement of Title IV-E federal financial participation, including increased claiming of funds such as administrative cost claiming and prevention services funds claiming. The Finance Model also recommends a review and change to the use of Developmental Disability level placements for foster care and any placement paid through a Letter of Agreement, as these placements are often more expensive.

The Finance Model also discusses synergy and collaboration across systems, including drawing down IV-E funds for Juvenile Probation, blending Medicaid with prevention funds, and utilizing Temporary Assistance for Needy Families (TANF) surplus funds, among many other suggestions. Finally, the Finance Model addresses provider rates and contracts, recommending changes to the rate-setting process and increasing the frequency at which rates are set, performance-based contracting, and technology advancements to monitor provider outcomes.

The LB 1173 Reimagine Well-Being effort was a large undertaking with a significant cost and mission. The effort required a large amount of data and information to be collected and produced many substantive recommendations. The OIG is continuing to monitor whether and how any recommendations from the Stephen Group report are being implemented. Thus far, no legislation has been introduced in response to the report.

In several public meetings, DHHS has stated that it is working towards several prevention priorities outlined in the Stephen Group report. For example, DHHS has reported that a warm line will be operational in 2024. A warm line is a direct line for families to be connected to

community collaboratives to receive assistance without an intake to the Hotline. Families First Prevention Services Act and TANF funds can be used to support the warm line. Twenty-three collaboratives are working together across the state on this project. DHHS also continues to work on updating data and outcome measures and, as mentioned, has announced its intention to cancel its long-standing contract with the University of Nebraska-Lincoln's CCFL for new worker training and conduct that training in-house.

Juvenile Detention Facilities

Juvenile detention centers are operated by the counties for the "secure detention and treatment of persons younger than eighteen years of age."[20] Detention centers are not intended to be residential facilities but rather secure facilities for the short-term housing of youth awaiting adjudication and proper placement.[21]

The four juvenile detention facilities in Nebraska—Lancaster County Youth Services Center (LCYSC), Douglas County Youth Center, Northeast Nebraska Juvenile Services, Inc. (in Madison County), and the Patrick J. Thomas Juvenile Justice Center (in Sarpy County)—are within the OIG's jurisdiction and the OIG receives complaints regarding these facilities. In addition, as noted previously, the law requires detention facilities to report any deaths or serious injuries to the OIG, and the OIG must review the juvenile room confinement data from these facilities.

In this last fiscal year, the OIG worked with the Ombudsman's office to review complaints about the inappropriate use of force in at least two instances at LCYSC. The review involved interviews, an extensive examination of documentation and video footage, and identified issues beyond the initial complaints regarding the use of force. The OIG did not open a formal investigation into either incident but assisted the Ombudsman's office with its investigation. Since that investigation, LCYSC has addressed several of the identified issues and there have since been leadership changes.

[20] Neb. Rev. Stat. § 83-4,125(2).
[21] Neb. Rev. Stat. § 43-251.01 and § 43-253.

Committees and Commissions

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

Most notably, the Inspector General participates in the following groups:

- Nebraska Children's Commission (statutory member)
    - Alternative Response Subcommittee (statutory member)
    - Co-chair, AR Subcommittee Oversight Work Group
- Child Death Review Team (statutory member)
- Nebraska Supreme Court Commission on Children and the Courts
- Governor's Commission for the Protection of Children
- Statewide Juvenile Detention Alternatives Initiative

Deaths and Serious Injuries

The OIG is statutorily required to investigate deaths and serious injuries of youth who are: (1) placed in out-of-home care or a licensed facility; (2) receiving child welfare services from DHHS or services from Juvenile Probation; and (3) the subject of a child abuse investigation in the past 12 months.[22]

Each year the OIG receives notices regarding deaths or serious injuries of system-involved youth from various agencies in the form of critical incident reports. The OIG thoroughly reviews each incident to determine if it is within the OIG's jurisdiction and if the law requires the OIG to conduct a full investigation. By statute, the OIG is only required to investigate deaths or serious injuries that did not "occur by chance" and which may have resulted from abuse and neglect.[23] The OIG refers to these as "mandatory investigations."

Deaths and Serious Injuries in the Child Welfare System

There has been a considerable increase in deaths and serious injuries reported to the OIG in the last fiscal year. It is important to note that not all of the deaths are the result of abuse and neglect (for example, some may be inevitable medical deaths) and not all of the children that died were known to the system. The abuse that caused the death or serious injury may have been the incident that brought the family to DHHS' attention. As a result, not every death or serious injury reported to the OIG will result in a mandatory investigation.

Table 1. ***Reported Deaths & Serious Injuries***

	FY 22-23	FY 23-24
DHHS - Deaths	11	21
DHHS - Serious Injuries	15	27

[22] Neb. Rev. Stat. § 43-4318.
[23] *Id*.

In FY 2023-2024, DHHS reported 21 deaths of children and youth compared to 11 reported deaths in FY 2022-2023. Of the 21 deaths reported, three require a mandatory investigation by the OIG.

DHHS reported 27 serious injuries in FY 2023-2024 compared to 15 in the previous fiscal year. Of those serious injuries in FY 2023-2024, eight require a mandatory investigation by the OIG.

Deaths and Serious Injuries in Juvenile Probation

The OIG has not received any notifications of deaths or serious injuries of youth supervised by Juvenile Probation since December 2021. The OIG cannot confirm whether this is the result of a refusal to report any deaths and serious injuries to the OIG, or if in fact there have been no deaths or serious injuries of youth on probation. In addition, as noted repeatedly in previous annual reports, Juvenile Probation requires an investigation protocol that would compromise the integrity of the OIG's investigation. As a result, the OIG has not been able to complete an investigation of any deaths or serious injuries of youth on Juvenile Probation in many years.

Pending Mandatory Death and Serious Injury Investigations

With the addition of the 11 new mandatory investigations added in FY 2023-2024, the OIG now has 32 pending mandatory death or serious injury investigations, each involving children served by DHHS. Over half of those mandatory investigations have been added within the last two years. The OIG's ability to conduct that many investigations is already challenging given the OIG's staff size and resources. Moreover, the OIG's ability to conduct any investigation during this last fiscal year was severely hampered by DHHS' restrictions on information in reaction to the AG's Opinion. The OIG continually strives to meet the highest standards to ensure the office conducts timely yet thorough and accurate investigations and it will continue to strive to do that even with this significant increase in required investigations.

Table 2. ***Mandatory OIG Investigations Added in FY 23-24***

Report Type	Cause	Age of Child	System Involvement	Time of System Involvement	Reporting Agency
Death	Neglect	1 yr.	Licensed Child Care Facility	Current	DHHS-Public Licensing
Death	Homicide	18 yrs.	CFS-State Ward	Current	DHHS-CFS
Death	Abuse	Less than 1 yr.	Open Initial Assessment	Within 12 months	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	Open Initial Assessment	Within 12 months	DHHS-CFS
Serious Injury	Abuse	2 yrs.	Open Non-Court	Within 12 Months	DHHS-CFS
Serious Injury	Abuse	3 yrs.	Alternative Response	Within 12 Months	DHHS-CFS
Serious Injury	Attempted Suicide	13 yrs.	CFS-State Ward	Current	DHHS-CFS
Serious Injury	Abuse	1 yr.	Open Initial Assessment	Within 12 Months	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	Open Initial Assessment	Within 12 Months	DHHS-CFS
Serious Injury	Neglect	1 yr.	CFS-State Ward	Current	DHHS-CFS
Serious Injury	Neglect	4 yrs.	Open Initial Assessment	Within 12 Months	DHHS-CFS

Sexual Abuse Data Monitoring

The OIG is tasked with monitoring sexual abuse allegations in the child welfare and juvenile justice systems.[24] Nebraska law requires DHHS, Juvenile Probation, detention facilities, and staff secure facilities to report to the OIG "all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and a juvenile in a residential child caring agency."[25] It is critical to note that the required reports to the OIG are **allegations** – meaning an accusation of sexual abuse has been reported, but an appropriate CFS assessment or law enforcement investigation to determine if the allegations can be substantiated has yet to occur.

DHHS Reporting

As was noted in the OIG's FY 2021-2022 Annual Report, a misunderstanding regarding the law's requirements led to an underreporting of sexual abuse allegations by DHHS in prior years. This misunderstanding was corrected during FY 2022-2023 when DHHS began sending the OIG all allegations of sexual abuse of state wards on a monthly basis. As a result, the number of allegations reported to the OIG increased dramatically in FY 2022-2023. However, as noted last year, this reflected a correction to the reporting process and should not be read to indicate a stark increase in sexual abuse allegations of state wards.

In FY 2023-2024, DHHS reported 244 allegations of sexual abuse of state wards. This was a slight decrease from the previous fiscal year. The 244 allegations of sexual abuse involved 185 individual state wards. The sexual abuse allegations were distributed across DHHS service areas in proportion to the populations in those service areas. The OIG is unable to show a breakdown of the age of the youth involved in these allegations, as this information is not provided with the data from DHHS. Last year, the age information was found through the OIG's review in NFOCUS. As noted, the OIG no longer has access to NFOCUS and therefore was not able to gather that information this year.

[24] See Neb. Rev. Stat. §43-4318(2).
[25] Neb. Rev. Stat. §43-4318(2)(b). This change in the law came after the 2017 OIG report, Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes & Youth in Residential Placement.

Table 3. *Total Reports of Alleged Sexual Abuse by Fiscal Year & Reporting Agency*			
Fiscal Year	**Total**	**Reported by DHHS**	**Reported by Juvenile Probation**
17-18	45	26	19
18-19	41	31	10
19-20	46	15	31
20-21	69	14	55
21-22	70	21	48
22-23	311	271	40
23-24	247	244	3

Table 4. *Sexual Abuse Allegation Reports by CFS Service Area*	
Service Area	**Total**
Central	29
Eastern	103
Northern	33
Southern	55
Western	24

The OIG also analyzed how the reported sexual abuse allegations were handled and whether any allegations were substantiated. When CFS receives a sexual abuse allegation through the Hotline it can be handled in different ways: (1) it can be screened as requiring no further assessment because the allegations either did not meet the definition of abuse and neglect, or were already assessed as part of an existing case; (2) it can be accepted by CFS to assess the family for safety and risk in conjunction with law enforcement evaluating for criminal wrong doing; and (3) it can be referred to law enforcement without CFS involvement, commonly known as a "law enforcement only" intake.[26]

Of the 244 total sexual abuse intakes reported to the Hotline, 94 of the intakes were accepted for assessment by CFS, 90 allegations were referred to the appropriate law enforcement agency as "law enforcement only," and the remaining allegations were screened as being information that was additional to another report, or the same allegations were reported by multiple reporters.

[26] As the OIG currently understands the Law Enforcement Only intake process, the Hotline refers allegations to law enforcement when the information suggests: the involved family or perpetrator resided in another state, but the incident occurred in Nebraska; the alleged victim is currently 19 years of age or older but was a child at the time of the alleged sexual abuse; or the alleged perpetrator is not a family member of the child's household and no longer has access to the child. All intakes alleging child abuse or neglect that are assigned for law enforcement investigation only do not include direct CFS involvement.

Once again, the OIG receives **allegations**—the data does not reflect the number of substantiated instances of sexual abuse. As a result, the OIG requested data regarding how many of the allegations were substantiated or found to be true. It is important to note, even this data may not be representative of the full problem. Rather, it represents those cases in which there was enough evidence for DHHS to substantiate the allegation or for criminal charges to be brought.

Of the 244 intakes in FY 2023-2024 that alleged the sexual abuse of a state ward, 184[27] were accepted for investigation by law enforcement only or by CFS in conjunction with law enforcement. There were nearly the same number of allegations referred to law enforcement as there were accepted for assessment by CFS. This is a change from last year, where there was a higher percentage of allegations that were referred to law enforcement.

Of the 94 allegations investigated by CFS thus far, six of the cases have been substantiated by a court, eight have been substantiated by DHHS,[28] and seven are awaiting outcomes from court proceedings. Fourteen substantiated cases, with seven other pending, is an increase in substantiated cases from FY 2022 2023 in which there were six substantiated cases of abuse.

Table 5. ***Results of Allegations Accepted for CFS Assessment***

Result	FY 22-23	FY 23-24
Unfounded	57	66
Court Substantiated	4	6
Agency Substantiated	2	8
Court Pending	5	7
Other	5	4
Outcome Not Entered	1	3

[27] Ninety-four (94) accepted for assessment by CFS and 90 referred to law enforcement.
[28] Substantiation by CFS requires a preponderance of the evidence, meaning more likely than not that the abuse occurred. If an allegation is substantiated by CFS, the perpetrator is listed on the Central Registry. Substantiation by law enforcement means the perpetrator has been charged with a crime that requires adjudication through the courts and evidence beyond reasonable doubt. Substantiation by law enforcement can result in sentencing by a judge and inclusion on the National Sex Offender Registry.

In addition, DHHS found that 66 of the allegations were unfounded and only three do not have an outcome entered.

With regard to the allegations investigated by law enforcement only, at the time DHHS reported the data to the OIG, the results of 77 law enforcement investigations were not entered into CFS' system. This could be due to the law enforcement investigation not being completed or the results not yet being entered by CFS. Of the law enforcement investigations that did have findings entered, seven were determined to be unfounded, and one was agency substantiated.

In addition to the monthly data, DHHS also provided critical incident reports in relation to sexual abuse allegations. There were 13 critical incident reports provided to the OIG by DHHS in FY 2023-2024. Of those 13, three were youth that had guardianships or adoptions finalized within the previous 12 months and seven were alleged to have occurred in the foster home. The age range of the youth involved in these intakes was generally evenly distributed.

Of the 13 critical incidents, six of the allegation findings are listed as Court Pending due to arrests being made and criminal cases working their way through the court system, one allegation was agency substantiated, and one investigation found the foster home to be unsuitable.

Juvenile Probation Reporting

Juvenile Probation reported three sexual abuse allegations from July to August 2023. It did not report any sexual abuse allegations after the AG's Opinion. As a result, the OIG is not able to assess how many youth under Juvenile Probation's supervision are alleging sexual abuse, how many of those allegations are substantiated, and how this last fiscal year would have compared to years prior. Of the reports made by Juvenile Probation, two were probation youth with prior CFS involvement, and one was a state ward also on probation. Of the three allegations reported by Juvenile Probation, one was assessed by DHHS as a placement concern, while the other two were not accepted for assessment. The placement concern found the foster home to be suitable, according to information provided by DHHS.

Youth Rehabilitation and Treatment Center Monitoring

Youth Rehabilitation and Treatment Centers (YRTCs) are facilities operated by DHHS' Office of Juvenile Services (OJS)[29] that provide programming and services to rehabilitate and treat youth in Nebraska's juvenile justice system. There are three YRTCs in Nebraska—YRTC-Kearney, which serves male youth; YRTC-Hastings, which serves female youth; and YRTC-Lincoln, which serves both male and female youth.

In 2020, in response to the crisis at YRTC-Geneva, the Legislature enacted legislation to provide increased accountability and oversight regarding the YRTCs. Specifically, Neb. Rev. Stat. § 43-4318(3)(a) requires OJS to report to the OIG as soon as reasonably possible after any of the following incidents occur at a YRTC: an assault; an escape or elopement; an attempted suicide; self-harm by a juvenile; property damage not caused by normal wear and tear; the use of mechanical restraints on a juvenile; a significant medical event suffered by a juvenile; and internally substantiated violations of the Prison Rape Elimination Act (PREA).[30] In addition, the OIG provides legislative oversight by visiting each facility and communicating with the facilities' administration, staff, and committed youth when appropriate.

Subsection (b) of § 43-4318(3) permits the OIG and OJS to work in collaboration to clarify the specific parameters of what is reported, and how it is reported, to comply with the requirements of § 43-4318(3)(a). The OIG and OJS have agreed on the basic parameters of the substance, method, and timing of the information reported to the OIG and further collaborated to clarify those parameters over the past several years. Much of the data and information is provided monthly, while more serious incidents are reported to the OIG as soon as reasonably possible through critical incident reports.

This last fiscal year, each YRTC saw increases in most types of incidents. Particularly concerning was the increase in assaults on staff, the increase in the use of mechanical restraints, and the increase in incidents of self-harm. What follows is the OIG's analysis and key observations from

[29] OJS is within DHHS' Division of Child and Family Services.
[30] 34 U.S.C. § 30301 et seq.

the data compared to previous fiscal years, then a brief recap of the observations and updates that the OIG received at each visit to the YRTC facilities in FY 2023-2024.

YRTC Censuses

The monthly census of youth at each YRTC in FY 2023-2024 was slightly higher than the censuses of the previous fiscal year. During the COVID pandemic, the YRTCs' censuses dropped significantly but have been increasing in recent years as more youth are committed there. Like previous years, both the census and number of incidents at each YRTC in FY 2023-2024 generally increased the most in the last quarter of the fiscal year. Given their relative capacities, YRTC-Kearney continues to have a significantly higher census than any other facility, and YRTC-Lincoln continues to have the lowest census. There were several months at YRTC-Hastings where there were 19 or 20 youth in the facility, which is close to the facility's maximum capacity of 24 youth.

Table 6. *YRTC-Kearney Census*

	FY 22-23	FY 23-24
Average Monthly Census	52.75	62
Highest Monthly Census	64	70
Lowest Monthly Census	46	55

Table 7. *YRTC-Hastings Census*

	FY 22-23	FY 23-24
Average Monthly Census	13.33	13.42
Highest Monthly Census	19	20
Lowest Monthly Census	10	7

Table 8. *YRTC-Lincoln Census (Combined Male & Female Youth)*

	FY 22-23	FY 23-24
Average Monthly Census	8.25	11.5
Highest Monthly Census	10	14
Lowest Monthly Census	5	10

Of all of the serious assaults and other incidents reported as critical incidents, most occurred within the first six months that each youth arrived at their respective YRTC facility, as well as later in each day, generally between 3 p.m. and 9 p.m.

Assaults

Of all the reported incidents in FY 2023-2024, youth assaults of staff and youth assaults of other youth were the most prevalent types of incidents that occurred.

At YRTC-Kearney, assaults of staff and youth continue to increase significantly. YRTC-Kearney had the highest amount and most significant increase of assaults in FY 2023-2024 compared to the other facilities.

Table 9. *YRTC-Kearney Assaults*

	FY 22-23	FY 23-24
Youth on Staff Assaults	72	104
Youth on Youth Assaults	71	118

Of the 104 youth-on-staff assaults that occurred in FY 2023-2024 at YRTC-Kearney, 22 required off-campus medical assessment and treatment. Four required on-campus medical treatment beyond basic first aid, and the remaining 78 reportedly either caused no visible injury or pain or required only basic first-aid treatment. Of the 118 youth-on-youth assaults that occurred in FY 2023-2024 at YRTC-Kearney, three required off-campus assessment and treatment, and four required on-campus medical treatment beyond basic first aid. The remaining 111 reportedly either caused no visible injury or pain or required only basic first-aid treatment. Further, of the serious staff assault incidents reported as critical incidents, most were committed by the same five male youth, who often committed the assaults together.

At YRTC-Hastings, compared to the previous fiscal year, the number of staff assaults in FY 2023-2024 was slightly lower, but the number of youth assaults was somewhat higher.

Table 10. *YRTC-Hastings Assaults*		
	FY 22-23	**FY 23-24**
Youth on Staff Assaults	38	36
Youth on Youth Assaults	18	24

Of the 60 combined youth-on-staff assaults and youth-on-youth assaults that occurred in FY 2023-2024 at YRTC-Hastings, six required off-campus medical assessment or treatment. Four required on-campus medical treatment beyond basic first aid, and the remaining 50 assaults reportedly either caused no visible injury or pain or required only basic first aid treatment. Further, of the serious staff assaults reported as critical incidents at YRTC-Hastings, all but one occurred in one of the youth living units. In addition, one female youth was responsible for all of those serious staff assaults.

At YRTC-Lincoln, there was an increase in FY 2023-2024 in both types of assaults for the female youth.

Table 11. *YRTC-Lincoln Assaults (Female Youth)*		
	FY 22-23	**FY 23-24**
Youth on Staff Assaults	13	28
Youth on Youth Assaults	3	10

However, the 38 combined youth-on-staff and youth-on-youth assaults that occurred in FY 2023-2024 for the female youth at YRTC-Lincoln appeared to be relatively minor in severity, as all of them reportedly either caused no visible injury or pain or required only basic first aid treatment.

Of all the YRTC youth, only the male youth at YRTC-Lincoln had lower numbers of assaults in FY 2023-2024 than in the previous fiscal year.

Table 12. *YRTC-Lincoln Assaults (Male Youth)*		
	FY 22-23	**FY 23-24**
Youth on Staff Assaults	17	15
Youth on Youth Assaults	4	3

Of those 18 combined youth-on-staff and youth-on-youth assaults that occurred in FY 2023-2024 for the male youth at YRTC-Lincoln, only one required off-campus medical assessment or treatment. Four required on-campus medical treatment beyond basic first aid, and the remaining 13 reportedly either caused no visible injury or pain or required only basic first aid treatment. Similar to YRTC-Kearney, most of the serious assaults at YRTC-Lincoln were committed by the same three male youth, who often committed the assaults together. Notably, these male youth who committed most of the serious assaults at YRTC-Lincoln were previously at YRTC-Kearney and had also committed some of the serious assaults at YRTC-Kearney. In total, only eight different male youth between YRTC-Kearney and YRTC-Lincoln were responsible for approximately two-thirds of all serious assaults committed at the YRTCs.

Use of Mechanical Restraints

For purposes of the YRTC data reported to the OIG, "mechanical restraints" refers to wrist and ankle restraints. The YRTCs report each incident where staff use mechanical restraints on a youth, other than when the youth is being transported. The use of mechanical restraints in FY 2023-2024 was significantly higher for every YRTC except the male youth at YRTC-Lincoln. YRTC-Kearney's numbers for the use of mechanical restraints increased dramatically from 54 in FY 2021-2022 to 234 in just two years. Similarly, the use of mechanical restraints at YRTC-Hastings also nearly doubled in the last year.

Table 13. *YRTC-Kearney Use of Mechanical Restraints*

	FY 22-23	FY 23-24
Use of Mechanical Restraints	156	234

Table 14. *YRTC-Hastings Use of Mechanical Restraints*

	FY 22-23	FY 23-24
Use of Mechanical Restraints	46	84

Table 15. *YRTC-Lincoln Use of Mechanical Restraints (Female Youth)*

	FY 22-23	FY 23-24
Use of Mechanical Restraints	30	44

Table 16. *YRTC-Lincoln Use of Mechanical Restraints (Male Youth)*		
	FY 22-23	**FY 23-24**
Use of Mechanical Restraints	49	26

Escapes and Elopements

The data reported to the OIG for escape incidents includes youth escapes and attempted escapes from the YRTC facilities, as well as elopements when youth are permitted an off-campus furlough or day pass but do not return to the facility. In FY 2023-2024, each YRTC reported similarly low numbers of escape incidents as in previous fiscal years. In FY 2023-2024, YRTC-Kearney once again had the most escape incidents, with 10 of the 14 total incidents that occurred at the YRTCs, and the female youth at YRTC-Lincoln once again had no escape incidents. All of the youth who escaped or eloped in FY 2023-2024 were eventually found.

Table 17. *YRTC-Kearney Escape Incidents*		
	FY 22-23	**FY 23-24**
Escapes	9	6
Attempted Escapes	5	1
Elopements	1	3

As for on-campus escapes at YRTC-Kearney, three of the youth that escaped did so while being transported from one building at the facility to another, in the same location that numerous youth have attempted to escape in previous years. As was highlighted in last year's Annual Report, the YRTC-Kearney administration has attempted to address this problem by placing razor wire above certain sections of the fence that the youth climb over. The other three youth that escaped did so together in a classroom at YRTC-Kearney's high school by assaulting a teacher and then climbing through a window that leads to an area outside of the fence surrounding the facility. The YRTC has since secured those windows.

Table 18. *YRTC-Hastings Escape Incidents*		
	FY 22-23	**FY 23-24**
Escapes	0	0
Attempted Escapes	1	0
Elopements	0	1

Table 19. *YRTC-Lincoln Escape Incidents (Female Youth)*		
	FY 22-23	**FY 23-24**
Escapes	0	0
Attempted Escapes	0	0
Elopements	0	0

Table 20. *YRTC-Lincoln Escape Incidents (Male Youth)*		
	FY 22-23	**FY 23-24**
Escapes	0	3
Attempted Escapes	0	0
Elopements	1	0

The three male youth who escaped together from YRTC-Lincoln in FY 2023-2024 did so by breaking and climbing through an unfortified window at the facility in a coordinated plan. Youth no longer have access to the area where this escape occurred.

Self-Harm and Attempted Suicide

There was also a significant increase in incidents of self-harm at the YRTCs in FY 2023-2024, especially for the female youth. There were, however, no reported incidents of attempted suicide at any of the YRTCs in FY 2023-2024.

YRTC-Kearney had an increase in self-harm incidents in FY 2023-2024, but the total number of such incidents remains relatively low given the facility's census. Seventeen different male youth committed the 25 incidents of self-harm at YRTC-Kearney, and 13 of the youth had just one incident of self-harm. The vast majority of the self-harm incidents involved youth tying clothing or other items around their necks, causing minor injuries or no injuries at all.

Table 21. *YRTC-Kearney Self-Harm & Attempted Suicide*		
	FY 22-23	**FY 23-24**
Self-Harm Incidents	9	25
Suicide Attempts	1	0

YRTC-Hastings not only had the most significant increase of self-harm incidents in FY 2023-2024 as compared to the other facilities but over double the amount of self-harm incidents at the other YRTC facilities combined.

Table 22. *YRTC-Hastings Self-Harm & Attempted Suicide*		
	FY 22-23	**FY 23-24**
Self-Harm Incidents	59	220
Suicide Attempts	3	0

There were over 26 different female youth who committed the 220 incidents of self-harm at YRTC-Hastings in FY 2023-2024. Of those 26 youth, 17 of the youth each had 10 or fewer incidents, four of the youth each had between 10 and 19 incidents, and five of the youth each had 20 or more incidents. One youth had 35 separate incidents of self-harm. The vast majority of the self-harm incidents involved female youth scratching their skin or picking at wounds on their skin. It should be noted that nearly all of these self-harm incidents were reported to either cause minor injuries or no injuries at all.

The female youth at YRTC-Lincoln, like the female youth at YRTC-Hastings, had a high number and a significant increase in self-harm incidents in FY 2023-2024 as compared to previous fiscal years.

Table 23. *YRTC-Lincoln Self-Harm & Attempted Suicide (Female Youth)*		
	FY 22-23	**FY 23-24**
Self-Harm Incidents	24	78
Suicide Attempts	0	0

Twelve different female youth committed those 78 incidents of self-harm at YRTC-Lincoln. Of those 12, four of the youth had one incident, three of the youth each had between two and eight incidents, and five of the youth each had 10 or more incidents. The vast majority of the self-harm incidents involved female youth tying clothing or other items around their necks. As was noted with YRTC-Hastings and YRTC-Kearney, nearly all of the self-harm incidents involving these female youth caused no reported minor injuries or no injuries at all.

Upon closer examination of the high amount of self-harm reports for the female youth, both YRTC-Hastings and YRTC-Lincoln appeared to have responded in similar ways after each incident, such as by more closely observing the youth, communicating preventative and precautionary measures to all types of staff, giving the youth mental health assessments, addressing the youth's maladaptive coping skills in the context of therapy, and more. Despite these efforts, most of the youth continued to self-harm, usually in the same manner repeatedly.

The male youth at YRTC-Lincoln were the only YRTC population to have a decrease in self-harm incidents in FY 2023-2024.

Table 24. ***YRTC-Lincoln Self-Harm & Attempted Suicide (Male Youth)***

	FY 22-23	FY 23-24
Self-Harm Incidents	13	3
Suicide Attempts	1	0

Significant Medical Events

For purposes of YRTC reporting, the OIG and OJS consider significant medical events to be injuries, medical incidents, and chronic illnesses that result in a trip or admission to a hospital or require other off-campus medical treatment or assessment.[31] Although the YRTCs report significant medical events for both staff and youth, all significant medical events reported for

[31] Significant medical events include incidents of self-harm and suicide attempts that require medical attention.

staff in FY 2023-2024 were the result of an assault and are provided earlier in this report. The numbers below are therefore only significant medical events for youth.

Table 25. *YRTC-Kearney Significant Medical Events*

	FY 22-23	FY 23-24
Significant Medical Events	4	12

At YRTC-Kearney, most of the 12 significant medical events were the result of an assault.

Table 26. *YRTC-Hastings Significant Medical Events*

	FY 22-23	FY 23-24
Significant Medical Events	2	3

At YRTC-Hastings, the three significant medical events were the result of self-harm.

Table 27. *YRTC-Lincoln Significant Medical Events (Female Youth)*

	FY 22-23	FY 23-24
Significant Medical Events	5	0

Table 28. *YRTC-Lincoln Significant Medical Events (Male Youth)*

	FY 22-23	FY 23-24
Significant Medical Events	3	4

For the male youth at YRTC-Lincoln, all four significant medical events involved the same male youth. This male youth had recurring medical episodes that were related to a particularly challenging medical condition.

Property Damage

The OIG and OJS have agreed that damage to property worth $500 or more will be considered damage "not caused by normal wear and tear" and thus reported by the YRTCs every month. Just as in previous fiscal years, there were few of these types of incidents in FY 2023-2024. YRTC-Hastings had the highest number of incidents.

Table 29. *YRTC-Kearney Property Damage $500+*		
	FY 22-23	**FY 23-24**
Property Damage $500+	2	3

Table 30. *YRTC-Hastings Property Damage $500+*		
	FY 22-23	**FY 23-24**
Property Damage $500+	1	5

Table 31. *YRTC-Lincoln Property Damage $500+ (Female Youth)*		
	FY 22-23	**FY 23-24**
Property Damage $500+	0	0

Table 32. *YRTC-Lincoln Property Damage $500+ (Male Youth)*		
	FY 22-23	**FY 23-24**
Property Damage $500+	0	1

PREA Allegations

As noted previously, the YRTCs are also statutorily required to report alleged violations of PREA. PREA was enacted to eliminate and prevent the sexual assault and abuse of individuals such as the juveniles committed to a YRTC.[32] To accomplish this purpose, PREA establishes, among other things, strict prohibitions on the sexual touching and sexual harassment of youth and procedures that the facilities must undertake to investigate an alleged PREA violation. PREA is broad and includes both incidents of non-sexual touching or harassment between youth to more serious allegations of sexual assault committed by youth or staff. Each YRTC reported higher numbers of substantiated PREA allegations in FY 2023-2024 than in the previous two fiscal years. Most of the substantiated PREA allegations across the YRTCs were youth-to-youth touching or harassment that the YRTCs classified as "behavioral," meaning not done with sexual

[32] See 34 U.S.C. § 30302.

intent, and there was one incident of staff-to-youth sexual harassment that resulted in that staff member being terminated.

Table 33. *YRTC PREA Allegations*

	FY 22-23 Substantiated Allegations	FY 22-23 Total Allegations	FY 23-24 Substantiated Allegations	FY 23-24 Total Allegations
YRTC-Hastings	17	28	28	55
YRTC-Kearney	15	43	20	54
YRTC-Lincoln (Combined Male & Female)	13	23	13	31

YRTC-Kearney Facility Visit

The OIG visited YRTC-Kearney in March 2024. During the visit, the OIG spoke with the OJS and YRTC-Kearney administration about issues that the YRTC-Kearney facility and other YRTCs face. The OIG was once again made aware of how many of the youth at YRTC-Kearney have gang affiliations, which has required the facility to keep rival gang-affiliated youth separate from each other in the living units and at the school. YRTC-Kearney also faces the issue of serving youth with aggressive behaviors who regularly assault staff and other youth.

In terms of staffing, YRTC-Kearney currently has two staff members for every living unit of 16 youth. At the time of the visit, the facility had recently trained approximately 30 staff members. YRTC-Kearney also recently hired two additional therapists. Each youth is assigned a therapist and provided weekly check-ins and therapy as needed.

The OIG also received an update on the progress of the new housing units approved and funded by the Legislature which are intended to provide individual rooms rather than the current barrack-style dorms. The new building will have a shared recreational space for the youth, four units that each have a yard, common areas for the youth, therapist offices, and more. The construction of the new building is expected to begin soon. YRTC-Kearney has also

continued to provide and seek additional community engagement and volunteer opportunities for youth.

YRTC-Hastings Facility Visit

The OIG visited YRTC-Hastings in March 2024 as well. The OIG toured the campus, briefly spoke with some of the youth in the living units, and spoke at length with the YRTC-Hastings administration. As mentioned in the OIG's last two Annual Reports, there continue to be challenges in operating a YRTC on the Hastings campus. The facility itself was designed for substance use treatment programs for male youth and is not necessarily conducive to handling the many challenges presented by the female youth at the YRTC. The facility lacks sufficient space in the living units for the youth to reside together comfortably. This is particularly challenging when, as was the case in FY 2023-2024, YRTC-Hastings was at near capacity. While the living units have enough beds to accommodate 20 youth, the common areas in the units are not large enough to comfortably fit 10 youth from each unit while maintaining the necessary physical distance that many of them need or which is necessary to help manage behaviors. This issue persists as the facility's census continues to rise each year.

There also continues to be a need for more designated recreation space on the YRTC-Hastings campus, as the campus' chapel is still being used as a gym. As was noted in the OIG's Annual Report last year, the lack of recreational facilities at YRTC-Hastings is one of the main areas of significant inequity between the male and female YRTC facilities.

Another area of concern in FY 2023-2024 was the lack of dedicated mental health staff on the YRTC-Hastings campus. The facility did have access to a therapist who provided telehealth but was only on campus four days a month. Mental health staff from YRTC-Kearney would also come to Hastings to conduct the initial assessment of youth newly committed to the facility. However, given the needs of the youth served at YRTC-Hastings, as evidenced by the high number of self-harm incidents, YRTC-Hastings should have a robust mental health staff. Recently, a full-time Licensed Mental Health Professional and a full-time Licensed Psychologist have been hired.

In terms of programming, there are some opportunities for community engagement offered to the youth, including the ability to attend church, bingo, and alcoholics anonymous and narcotics anonymous meetings. This last fiscal year, YRTC-Hastings was able to utilize more of its outside space and construct a greenhouse and garden on the campus. The administration hopes to turn the greenhouse and garden into another community engagement opportunity for the youth by having the youth donate the produce for sale at the local farmer's market.

YRTC-Lincoln Facility Visit

The YRTC-Lincoln facility at the Lancaster County Youth Services Center houses both male and female youth, with the two populations kept separately. The youth at YRTC-Lincoln are typically youth with more significant behavioral issues. The OIG visited YRTC-Lincoln in April 2024.

As with the other YRTCs, one of the primary issues regarding the youth at the facility is that many of them have prior histories with each other or gang involvement, which requires OJS to be strategic about where these youth are placed within the YRTC system. This last fiscal year, YRTC-Lincoln served a male youth with particularly challenging and aggressive behaviors. As a result, the youth were separated into different groups to reduce the likelihood of altercations. This youth's behavior appears to have stabilized in the past couple of months.

The OIG reviewed several incidents related to staff assaults and other uses of force involving both males and females at YRTC-Lincoln. After review, none of these incidents required a full investigation. The OIG noted how professional and calm staff remained particularly during the incidents of staff being assaulted. We appreciated the YRTC-Lincoln administration's cooperation with these reviews.

Education

Due to the OIG's inability to visit the YRTCs more than once in FY 2023-2024, it could not observe the educational programming at the YRTCs in the same way as it did in previous years. However, it is the OIG's understanding that the YRTC schools are now fully staffed.

YRTC Five-Year Strategic Planning Advisory Group

DHHS created a five-year strategic plan for the YRTCs as required by statute.[33] The OIG was included in the initial advisory group for that plan which previously met quarterly for updates. Unfortunately, just as with the previous fiscal year, those meetings did not occur in FY 2023-2024. It is unclear to the OIG whether the five-year plan is still being implemented.

Conclusion

Overall, the yearly data and the OIG's conversations with the OJS and YRTC administrations have made clear that the YRTCs have been given the difficult task of rehabilitating and treating youth with significant behavioral, mental health, medical, and other types of needs as well as extensive prior involvement in the state's juvenile justice system. The increase in many of the critical indicators, like staff assaults, underscores the challenges that the YRTCs face. Moreover, the YRTCs often lack the resources and specialized care necessary to meet such a wide variety of needs. The OIG continues to believe that a greater continuum of care is necessary in Nebraska to meet the evolving and wide-ranging needs of every youth in the juvenile justice system. The OIG again recommends that DHHS and the Legislature have a more comprehensive vision for what Nebraska needs the YRTCs to be and what additional services and placements need to be enhanced or developed in Nebraska to serve its youth.

[33] See Neb. Rev. Stat. § 43-427.

Complaints, Incidents, and Grievances

Intake Process

The OIG's work is driven by the information it receives. Accountability and good government is only possible when information about government systems and agencies is available. Some of that information must come from the government agencies themselves through basic and necessary transparency. As noted, this has been a significant challenge for the OIG during this last fiscal year.

However, other critical information comes from the people served by those same government agencies. For this reason, the OIG is required to make itself available for complaints and it relies on complaints and information from the public to understand how the child welfare and juvenile justice systems are working for the people they are meant to serve. The OIG refers to the information it receives as "intakes."

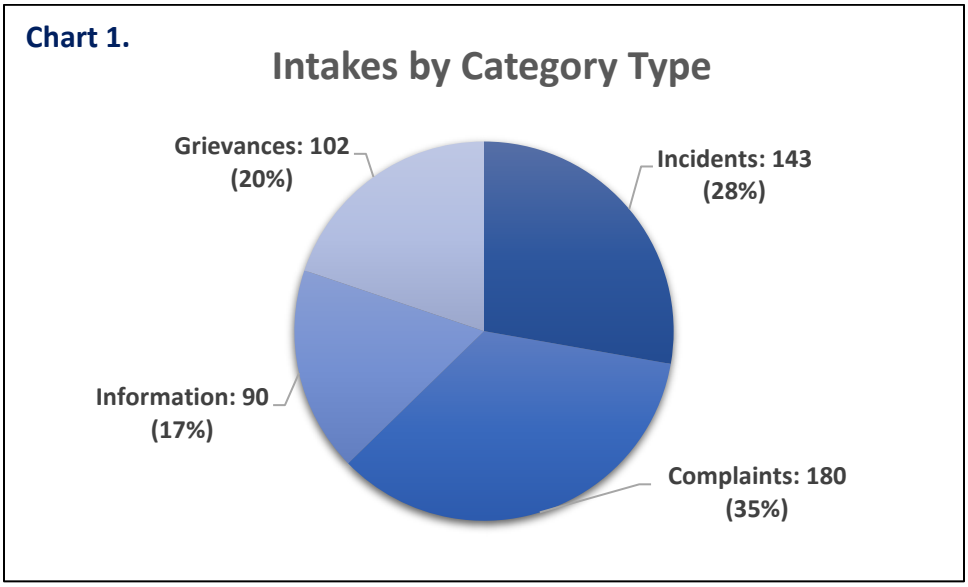
Intakes come in the form of notifications of incidents or reports from agencies, grievances filed with DHHS including DHHS' response to the individual filing the grievance, and from complaints or reports of information made by members of the public. After receiving information as described above, the OIG assesses every incident report, complaint, information report, and grievance referred to it. Each intake is subject to a preliminary review which includes a thorough document review, and collateral contacts if necessary, for complete vetting. Based on the findings of the preliminary review, the OIG then determines if the office holds jurisdiction over the incident, whether or not a full investigation is justified or required by statute, and what additional actions may be appropriate. Although a complaint or incident may not result in an investigation, it can assist the OIG in identifying concerning trends or systemic issues that not only may need to be investigated by the OIG but also brought to the attention of the agencies responsible or to the Legislature for legislative change.

This last fiscal year, the OIG received a total of 515 intakes, similar to the 522 intakes received by the OIG in the previous year. The breakout of information received is presented in the figures below.

Table 34. *Incidents Reported to the OIG FY 23-24*	
Reporting Agency	**Number Reported**
CFS	120
Public Licensing	17
Juvenile Probation	3
OIG Discovered	3
Total	**143**

Table 35. *Other Types of Reports Made to the OIG FY 23-24*	
Type of Intake	**Number Reported**
Complaints	180
Reports of Information	90
DHHS Reported CFS Grievances	102
Total	**372**

Chart 1.



Complaints

The OIG receives complaints from a wide variety of individuals, including foster parents, grandparents and other family members, attorneys, parents, employees, administrators, and concerned persons regarding various aspects and issues of the child welfare and juvenile justice systems. This diverse set of individuals provides the OIG with insights into a wide range of potential issues within the system.

For FY 2023-2024, the OIG received a comparable number of complaints and grievances as it did in FY 2022-2023. The OIG received 180 complaints this year compared to 203 last year.

Individuals who contact the OIG raise many kinds of concerns. Most often, complainants allege issues with how a case is being managed by DHHS, citing delays in receiving services and maintaining contact with caseworkers and involved parties. The OIG receives many unsupported complaints, and upon further review by the OIG, the complaint demonstrates that DHHS appropriately responded to a given situation. Conversely, a complaint often reveals a problem with the child welfare system, either at a local or systemic level.

The OIG vets each complaint to determine not only whether the complaint is supported but also whether it is an example of a broader systemic issue. Unfortunately, as noted, the OIG's ability to review complaints has been severely limited by the lack of access to the NFOCUS system. This issue persists even with the protocols under the MOU between the Legislature and the Governor's Office. The confidentiality of complainants is paramount to the OIG. Often, complainants are concerned about a perceived risk of retaliation in a child welfare case should their complaint be known by DHHS. Under the MOU, the OIG would have to reveal the names of the children involved in the case that was the subject of the complaint to request information. This new protocol has created some concern among complainants, making it more difficult for the OIG to request information relevant to the complaints.

Working with the Ombudsman

In other cases, the OIG receives complaints about an individual case that are concerning but do not reveal broader problems with the child welfare system. In these cases the OIG tries to provide assistance by referring the complainant to a more appropriate entity to handle that concern. Often, the OIG will refer individual concerns to the Ombudsman's Office. The Ombudsman's Office addresses complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office can investigate and resolve complaints informally by working with parties involved while promoting accountability in public administration. If, after a preliminary review, the OIG determines that a complaint does not rise to the level of an investigation but that the complainant may benefit from the help of the Ombudsman's Office, the OIG can refer

the complaint to that office. This prevents the complainant from having to repeat the often-traumatic circumstances of their complaint. In total, the OIG formally referred 60 complaints to the Ombudsman's Office in FY 2023-2024.

Complaints Referred to Hotline

In FY 2023-2024, the OIG received 270 complaints and reports of information from the public via email, submission of a web form, or phone call. Each of these complaints was reviewed. At times, the information received was in regard to current concerns for child abuse or neglect occurring in the community. These complainants were encouraged to contact the Nebraska Child Abuse and Neglect Hotline and the Hotline's phone number was provided to them. Seventy-eight, or 28.9% of complaints and reports of information received by the OIG, were referred to the Hotline. In addition, if a complaint includes adequate identifying information and raises concerns of current abuse or neglect, OIG staff, as mandatory reporters, will pass the information on to the Hotline.

It is difficult to determine if there is an underlying cause of so many child abuse and neglect reports being directed to the OIG rather than the Hotline. In 2024, DHHS launched an online form that the public can use to submit concerns regarding child or adult abuse and neglect. The OIG will monitor to see if the online form has any effect on the number of complaints that the OIG refers to the Hotline in the next fiscal year.

Incidents

The other critical way the OIG receives information is through reports from DHHS (including CFS, Public Licensing, and the YRTCs) and Juvenile Probation. As noted above, these come in the form of incident reports typically involving the deaths and serious injuries of children or in reports of sexual abuse allegations.

In addition, Public Licensing provides incident reports related to suspected abuse and neglect of children in licensed child care facilities. In FY 2023-2024, the OIG received only 16 incident reports from Public Licensing, compared to 65 reports in FY 2022-2023 and 101 reports in FY 2021-2022. The decrease in child care incident reports is likely the result of a narrowing of what

Public Licensing is reporting. Previously, Public Licensing reported a broad scope of incidents that may have reflected licensing violations but not abuse and neglect. Therefore, this year's data will serve as a baseline and cannot be analyzed to draw any conclusions regarding safety in child cares in general.

Grievances

In FY 2023-2024, the OIG received 102 grievances from DHHS. The grievance process is open to families who are currently involved with CFS, either in an Initial Assessment or Ongoing Services Case, at times when they may be unable to resolve case issues with their caseworker or supervisor. The grievance is submitted through an online form and a review is completed by DHHS staff through speaking with the reporting party, the case team, and reviewing case files. DHHS provides the OIG with both the initial grievance form and its response letter detailing what was found through its review.[34] The OIG reviews these grievances to determine if there are broader systemic issues that become apparent across the grievances that would require a more extensive investigation.

[34] Neb. Rev. Stat. § 81-603.

Investigations, Reports, and Recommendations

Nebraska law requires the OIG to summarize any investigations from the last year in its Annual Report and to provide an update on the status of implementation of any OIG recommendations. As noted throughout this report, the work of the OIG was significantly hampered by DHHS and Juvenile Probation's response to the AG's Opinion. However, despite that significant challenge, the OIG did complete one death investigation as well as the required annual Juvenile Room Confinement report. The summaries of those reports follow.

Summaries of OIG Reports of Investigation

A full investigation by the OIG includes:

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

After a full investigation, the OIG issues an investigative report and shares the report with the state agency for review.[35] The law requires the state agency to respond by accepting, rejecting, or requesting a modification of the recommendations and the agency may also make any factual corrections if necessary.[36] A private agency that is also the subject of the report similarly has an opportunity to review the report and respond to the recommendations.[37]

In FY 2023-2024, the OIG completed one mandatory investigation into the death of a child in a licensed child care facility. That investigation is summarized below.

[35] Neb. Rev. Stat. § 43-4328(1).
[36] *Id*.
[37] Neb. Rev. Stat. § 43-4328(2).

Death of an Infant in a Family Child Care Home

In June 2021, the OIG received notice from DHHS that an infant had died from accidental asphyxiation while sleeping in a Pack 'n Play at a Family Child Care Home II (child care). Both law enforcement and DHHS' Division of Children and Family Services (CFS) investigators determined that the child care provider had put the infant down for a nap and did not check on the infant for several hours. During that time, the infant had become wedged underneath the mattress pad and bottom of the Pack 'n Play and died by accidental asphyxiation. Neither law enforcement nor CFS determined that any wrongdoing occurred related to the infant's death. However, DHHS' Division of Public Health, Office of Children's Services Licensing (Public Licensing) substantiated several violations of regulations against the child care provider and revoked its license.

Both CFS and Public Licensing conduct investigations into alleged abuse and neglect in child cares; however, each agency conducts investigations for different purposes. CFS investigates to determine if abuse or neglect occurred and if the alleged perpetrator of the abuse or neglect should be formally placed onto the Child Abuse and Neglect Central Registry. Public Licensing investigates to determine if the child care or licensee violated any rules and regulations, as defined in the Nebraska Administrative Code. Typically, these investigations are conducted at the same time to share both information and resources.

The OIG's investigation identified a significant difference in the concerns and outcomes between Public Licensing and CFS' investigations. CFS did not substantiate the allegations of abuse or neglect against the child care provider and provided little, if any, analysis as to how the infant's death could have occurred and if it was a result of abuse and neglect by the child care provider. CFS records only stated that the allegations were unfounded. Public Licensing's investigation records noted strong concerns for abuse and neglect due to the circumstances surrounding the infant's death, as well as a violation of several regulations including not providing adequate and appropriate supervision, not properly following sleep surface regulations, and not following proper infant and toddler care regulations. The substantiation of these regulations resulted in Public Licensing revoking the child care provider's license.

The OIG reviewed relevant infant safe-sleep best practices, Nebraska regulations, and other states' regulations regarding infant safe-sleep in child cares. The OIG's review of best practices found that it is recommended for child care providers to either be in constant supervision of sleeping infants or to frequently check on infants at regular intervals to assess their condition and breathing. The OIG's review of Nebraska regulations found that child care providers are required to be within sight or sound of children at all times and are not required to regularly check on sleeping infants. Therefore, Public Licensing did not, and could not, cite the child care for failing to check on the infant for two hours because there is no existing provision in Nebraska state regulations requiring a child care provider to frequently check on a sleeping infant. The OIG's review of other states' regulations found that 31 other states have adopted regulations that require child care providers to either be in constant supervision of sleeping infants, check on them at regular intervals, or both. Nebraska is only one of 19 states that do not require constant supervision or regular checks.

Through its investigation of this infant's death, the OIG found:

1. Nebraska's Public Licensing regulations do not require either constant supervision or regular checks of sleeping infants and are not as robust as the majority of other states.
2. There was a significant difference in the analysis, concerns, and outcomes between Public Licensing and CFS' investigations into the infant's death.

Based on its findings, the OIG recommended that DHHS should:

1. Update the child care regulations to reflect best practices related to the supervision of sleeping infants by child care providers.

DHHS accepted this recommendation and informed the OIG that it "is currently in the process of promulgating regulations related to the supervision of sleeping infants by child care providers in the near future, including regular visualization and assessment of sleeping infants to meet their physical needs and safety."

Juvenile Room Confinement Report

Neb. Rev. Stat. § 83-4,134.01 was enacted in 2016 "to establish a system of investigation and performance review in order to provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility." Section 83-4,134.01 requires certain juvenile facilities to document each incident where a juvenile is involuntarily placed alone in a room or area for one hour or longer within a 24-hour period.[38] It also requires facilities to submit quarterly reports to the Legislature detailing the data about those juvenile room confinement incidents. The OIG is similarly mandated to review that data to assess the use of room confinement for juveniles at each facility and to submit an annual report of its findings to the Legislature.[39] As has been done in previous Annual Reports, below is a brief summary of the OIG's most recent Juvenile Room Confinement in Nebraska report, which was released in December 2023.[40]

Fiscal Year 2022-2023 Juvenile Room Confinement Report Summary

The goal of the OIG's Juvenile Room Confinement report is to establish a foundational understanding of juvenile room confinement, compare Nebraska data to established best practices, and highlight significant findings regarding the application and trends of juvenile room confinement within the state.

While Nebraska juvenile room confinement statutes incorporate best practices, those best practices are not always reflected in their application. The juvenile room confinement statutes, though robust in intent, are inconsistently applied across facilities, leading to varied interpretations and applications of juvenile room confinement. This inconsistency hampers efforts to gauge the full scope of juvenile room confinement's use and its impact on the welfare of juveniles affected.

[38] See Neb. Rev. Stat. § 83-4,125(4).
[39] See § 83-4,134.01.
[40] The full 2022-2023 report can be accessed on the Nebraska Legislature's website: https://nebraskalegislature.gov/reports/public_counsel.php.

The OIG's analysis of the available data raises significant areas of concern, notably an increase in the usage and duration of confinement practices across juvenile facilities in Nebraska. As compared to FY 2021-2022, the FY 2022-2023 data indicated a 44% increase in the total number of confinement incidents, a 32% increase in total confinement hours, and a 24% increase in the total number of confined youth. For example, the number of confinement hours reported by the Youth Rehabilitation and Treatment Center in Kearney increased from 2,359 in FY 2021-2022 to 9,010 in FY 2022-2023. In addition, facilities sometimes used confinement for several consecutive days, although most facilities limited the number of consecutive days of confinement to between two and eight days. However, the reported data shows that at the Lancaster County Youth Services Center, one youth was confined for at least 13 hours for 129 out of 133 days for safety and security reasons including protective custody.

Overall, the data indicated a move away from best practices. The increase in the use and duration of confinement across facilities indicates that confinement is not being used as a last resort or in a time-limited manner.

Fiscal Year 2022-2023 data highlights the need for stricter adherence to state law and more robust monitoring and enforcement mechanisms to ensure that juvenile room confinement in Nebraska is utilized in a manner consistent with established best practices. Continued monitoring and efforts to align practices with best standards are essential to ensure the well-being of youth in confinement and to meet the intended objectives of these best practices and statutory requirements.

To achieve a true reduction in juvenile room confinement use, the OIG suggested, once again, that facilities implement dedicated staff for oversight within the facilities. In addition, the Legislature must understand the needs of these facilities better to provide the resources necessary to ensure the safety and security of youth and staff without relying as heavily on the problematic practice of juvenile room confinement.

OIG Recommendations Status Update

Reports of OIG investigations contain recommendations for systemic reform or case-specific action. The OIG's annual report is required to describe those recommendations and the status of their implementation.[41] Before the AG's Opinion, the OIG and DHHS met every quarter to discuss the recommendations and to allow DHHS to highlight any actions taken related to the recommendations. The OIG found these meetings helpful and informative. DHHS administrators demonstrated a willingness to engage in an open dialog about the status of recommendations. These meetings did not occur as frequently this last fiscal year.

One of the most significant updates that DHHS provided in FY 2023-2024 regarding the OIG's recommendations is the previously mentioned move to the SAFE Model for assessing safety and risk, as well as the move to bring new worker training in-house moving forward. Neither of these changes were implemented in the 2023-2024 fiscal year, but both changes are relevant to past recommendations.

As discussed previously, the OIG completed one investigation in the 2023-2024 fiscal year, which contained one recommendation that was accepted by DHHS.

The OIG has made 116 total recommendations in the past 13 years. Updates regarding the status of these recommendations are attached in the appendix.

[41] See Neb. Reb. Stat. § 43-4331.

Alternative Response Oversight & Case Summaries

Alternative Response (AR) is a different approach to handling reports that are assessed by the Nebraska Child Abuse and Neglect Hotline. The goal of AR is to meet families where they are by connecting families with local community resources, providing economic resources, and finding solutions for families in times of crisis. Unlike traditional response assessments, AR is not a formal investigation as to whether child abuse or neglect occurred. [42] Safety is still assessed in an AR case, and, if a family is found safe, DHHS attempts to provide resources to address the concerns that prompted the Hotline report. [43] After safety is assessed, AR cases are completely voluntary, allowing families to either accept or refuse the services that DHHS offers.

The use of AR in child welfare cases throughout the state has continually increased each year. The number of AR cases has risen significantly since 2020 after AR transitioned from a pilot project to full implementation. In 2020, AR cases comprised 10.2% of all child abuse and neglect reports assessed by the Hotline. In 2021, the number of AR cases jumped to 22.6% and in 2022 that number grew to its all-time height of 31%. In 2023, DHHS reported a slight decrease in AR cases at 29.7% of all reports assessed by the Hotline.[44]

By statute, the OIG's Annual Report must include a summary of any case reviewed by the office that includes an AR.[45] AR cases reviewed by the OIG typically take the form of either (1) a complaint made directly to the OIG regarding an AR case, (2) an incident report related to the death or serious injury of a system-involved child in an AR case, or (3) a DHHS grievance provided to the OIG. In the case of a death or serious injury, the review is twofold: first, a

[42] Neb. Rev. Stat. §28-710(a).

[43] Neb. Rev. Stat. §28-712.01(1)(b)(i), (ii), (x), (xiii). There are certain types of cases that do not qualify for AR. These exceptions reflect instances where the risk to the safety of the children are higher, such as allegations involving the murder of a child, sexual abuse of a child, a history of termination of parental rights, or allegations that a household member is illegally manufacturing methamphetamine.

[44] Nebraska Department of Health and Human Services. *Child Abuse and Neglect Annual Report 2023*. https://dhhs.ne.gov/Pages/Children-and-Family-Services-Reports.aspx. (Retrieved on August 28, 2024). In 2023, there were 36,366 total reports received by the Hotline. Of those, 14,419 (42% of total reports) reports were assessed by CFS. The 4,279 AR cases comprised 29.7% of the 14,419 total assessed reports—meaning that the remaining 70.3% of assessed reports were given a traditional response.

[45] See Neb. Rev. Stat. § 43-4331.

review of the AR case as required by statute, and second, a review to determine if the report meets the criteria for a mandatory investigation by the OIG.

In FY 2023-2024, the OIG reviewed five AR-related cases, one from a complaint and four from reported incidents. This is a decrease from FY 2022-2023, when the OIG reviewed 20 cases involving AR—the highest number to date.

The decrease in the number of AR cases reviewed this year may be another consequence of DHHS' response to the AG's Opinion. Before the AG's Opinion, the OIG would discover that complaints, grievances, and reports of incidents involved AR through its review of those cases in NFOCUS. It is possible that some of the cases that the OIG received in FY 2023-2024 involved AR without the OIG's knowledge. Without access to NFOCUS nor the time and resources to request and review the entire case file for every complaint or grievance, the OIG cannot know whether those involved AR.

The following are summaries of the five AR cases of which the OIG was aware.

Complaints

Complaint Made Directly to OIG About CFS Caseworker

The complainant alleged that a CFS caseworker intimidated her and threatened to bring law enforcement to her house if she did not allow the caseworker entry into the house to check on her two children and their living conditions. The complainant stated that her children's school contacted DHHS concerned about one of her children's unexplained absences from school and the generally unsanitary state of both children. The complainant stated that although the caseworker previously checked on the children and told her that they appeared clean and safe, the caseworker contacted her again weeks later to enter into her home to check on them. The complainant stated that the caseworker had no legal right to enter her home and denied him entry. The OIG referred this complainant to the Ombudsman's Office, which discovered that the complainant had worked with CFS in an alternative response case. The Ombudsman's Office reviewed the complainant's case and did not find that the caseworker was unprofessional or intimidating towards the complainant.

Incidents

Infant Death

The OIG received notice of a two-month-old infant who had died due to medical conditions. The family did not have a history with CFS until the infant was born. The family worked with CFS in an alternative response case due to the substance use and mental health concerns of the infant's mother and the lack of prenatal care that the infant received. The family received alternative response services until the infant's death. The OIG determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Child Death

The OIG received notice of a 15-year-old child who had died due to medical conditions. The family had a history of CFS involvement, which included the children being made state wards. At the time of the child's death, the family worked with CFS in an alternative response case for truancy concerns related to the child's siblings. The OIG determined this incident did not meet the criteria for a mandatory investigation under the statute.

Child Serious Injury

The OIG received notice of a three-year-old child who had suffered a serious injury due to the mother's medical neglect of the child. The child's family had a history with CFS, which included declining services in an alternative response case as well as intakes accepted for a traditional response. The family's most recent CFS involvement was an intake assigned as an alternative response case at the time of the infant's birth, but the family declined services at that time as well. The OIG found that this incident was subject to a mandatory investigation and report. The final report will be released after the investigation and report process is completed.

Child Sexual Abuse

The OIG received notice of the alleged sexual abuse of a six-year-old child. The child's family had a history with CFS, which included the child's sibling being a state ward. The family had an active alternative response case within one year of the alleged sexual abuse. During that alternative response case, the family was provided ongoing services such as intensive family

preservation services. The OIG determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Appendix

Fiscal Year 2023-2024 Recommendation Report

OIG Recommendation Report

ADMINISTRATIVE OFFICE OF PROBATION

Juvenile Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-22	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-23	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt policy on child welfare referrals and joint case management.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-24	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Adopt policy on documentation and record keeping.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-25	2015-2016	Death of Youth Served by Probation and DHHS	Administrative Office of Probation	Juvenile Services	Rejected

Recommendation: Increase internal quality assurance efforts at the state level.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-01	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-02	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-03	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Implement guidelines on when it is appropriate to use specific types of alternatives to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response
17-04	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

17-05	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

17-06	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did Not Accept or Reject

Recommendation: Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

17-07	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

17-08	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

17-09	2016-2017	Suicide of Youth Placed on Alternatives to Detention	Administrative Office of Probation	Juvenile Services	Did not Accept or Reject

Recommendation: Assess whether Probation has the authority to monitor alternatives to detention.
Agency Update FY 22-23: No response to OIG request for fiscal year 2022-2023 updates.

Number	Annual Report	Report Name	Agency	Division	Agency Response

DHHS

Children and Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-01	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible.
Agency Update FY 23-24: CFS is currently updating assessments to the SAFE model and will be phasing out the use of SDM. No additional changes.

15-02	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Expand mental health training for DHHS staff and other stakeholder, including medical professionals.
Agency Update FY 23-24: No changes during fiscal year.

15-03	2014-2015	Child Death I	DHHS	Children and Family Services	Accepted

Recommendation: Enhance continuous quality improvement and quality assurance processes for mental and behavioral health care, including psychotropic medications.
Agency Update FY 23-24: Quality assurance case reviews continue to be conducted on a quarterly basis to monitor the assessment of needs and services to address the child's physical, mental and behavioral health. The reviews include a review of oversight of the child's prescription medications including psychotropic medications. Review results are utilized to identify program strengths and areas needing improvement.

15-04	2014-2015	Child Death II	DHHS	Children and Family Services	Accepted

Recommendation: Make improvements to the Home Study Process.
Agency Update FY 23-24: We are starting a work group in the near future that will be a collaboration between DHHS and a couple of providers to look at the home study itself as well as the process. We are also looking at moving the home study contract to the master contract as a service attachment which will improve our access to providers across the state.

15-05	2014-2015	Child Death II	DHHS	Children and Family Services	Accepted

Recommendation: Provide stronger supports for kinship and relative foster families.
Agency Update FY 23-24: The relative/kinship incentive program has ended and new federal rules allow for separate relative/kinship licensing standards. CFS has made updates to the approval/licensing process to streamline the approach and make it easier for relative/kinship homes to be approved, which allows increased IV-E funding. Relative/kinship homes are required to complete RPPS, Human Trafficking, Sexual Abuse Prevention and Car Seat Training. Agencies supporting relative/kinship homes are also able to provide individualized training based on the needs of each home.

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-06	2014-2015	Child Death II	DHHS	Children and Family Services	Accepted
Recommendation: Ensure “Absence of Maltreatment in Foster Care” calculation is as accurate as possible. **Agency Update FY 23-24:** CFS is looking at moving the home study contract to the Master contract as a service attachment in 2025 which will improve our access to providers able to complete home studies across the state.					
15-07	2014-2015	Child Death III	DHHS	Children and Family Services	Accepted
Recommendation: Develop and provide training to frequent reporters and law enforcement on reporting to the Child Abuse and Neglect Hotline **Agency Update FY 23-24:** Prior draft RFP was not executed. The training team is now going to develop this internally.					
15-08	2014-2015	Child Death III	DHHS	Children and Family Services	Accepted
Recommendation: Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline. **Agency Update FY 23-24:** The OIG did not receive an update on this recommendation for this fiscal year.					
15-09	2014-2015	Child Death III	DHHS	Children and Family Services	Accepted
Recommendation: Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities. **Agency Update FY 23-24:** No changes during fiscal year.					
15-14	2014-2015	General Investigation I	DHHS	Children and Family Services	Accepted
Recommendation: Clarify Hotline policy and procedure when receiving a report of sexual assault. **Agency Update FY 23-24:** No changes since last update. The process and functionality remain in place.					
16-01	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted
Recommendation: Implement training on the medical aspects of child abuse. **Agency Update FY 23-24:** No changes during fiscal year.					
16-02	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted
Recommendation: Adopt policy on photographing injuries during Initial Assessment. **Agency Update FY 23-24:** No changes during fiscal year.					

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-03	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted

Recommendation: Develop additional training for Initial Assessment staff.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-04	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted

Recommendation: Further define process for utilizing child advocacy centers by Initial Assessment.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-05	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted

Recommendation: Update and provide additional detail on response priority definitions.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-06	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted

Recommendation: Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.
Agency Update FY 23-24: A lead worker was added to the Hotline through the reclassification process. There are currently two lead workers who will be providing trainging and support to the Hotline.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-07	2015-2016	Serious Injury of Child After 11 Reports of Alleged Physical Abuse	DHHS	Children and Family Services	Accepted

Recommendation: Expand quality assurance and continuous quality improvement (CQI) at the Hotline.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-08	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.
Agency Update FY 23-24: Weekly monitoring of caseload compliance continues across each Region and we have nearly reached 100% compliance. In June of 2024, IA only caseloads were 97.8% in compliance statewide.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-09	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Take steps toward greater Initial Assessment workforce specialization and experience.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-10	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.
Agency Update FY 23-24: DHHS has decided to move away from SDM Model and is working to implement the SAFE Model.

16-12	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Increase the capacity for the CFS workforce to participate in pediatric abusive head trauma prevention efforts.
Agency Update FY 23-24: No changes during fiscal year.

16-13	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.
Agency Update FY 23-24: A lead worker was added to the Hotline through the reclassification process. There are currently two lead workers who will be providing trainging and support to the Hotline. Hotline staffing is evaluated ongoing on a quarterly basis and adjustments are made according to the results.

16-14	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.
Agency Update FY 23-24: Caseload reports continue to be generated monthly and posted on the DHHS website.

16-15	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Collect data on high and very-high risk cases that do not accept services and implement better, more promising approaches to family engagement.
Agency Update FY 23-24: DHHS is working with Action for the Protection of Children to Implement the Safe Model. This model focuses on the child safety and enhancement of protective capacities. As safety factors are identified risk is increased, as protective capacities are enhanced risk is reduced.

16-16	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Children and Family Services	Accepted

Recommendation: Restructure the Children's Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-20	2015-2016	Suicides of State Wards	DHHS	Children and Family Services	Accepted

Recommendation: Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible.
Agency Update FY 23-24: CFS is currently updating assessments to the SAFE model and will be phasing out the use of SDM. No additional changes.

16-21	2015-2016	Suicides of State Wards	DHHS	Children and Family Services	Accepted

Recommendation: Enhance efforts to reduce caseworker turnover.
Agency Update FY 23-24: Turnover data has stabilized over the last year and continues to be well within national averages.

16-26	2015-2016	Death of Youth Served by Probation and DHHS	DHHS	Children and Family Services	Accepted

Recommendation: Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.
Agency Update FY 23-24: No changes during fiscal year.

16-27	2015-2016	Death of Youth Served by Probation and DHHS	DHHS	Children and Family Services	Accepted

Recommendation: Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.
Agency Update FY 23-24: CFS created another one document for field staff regarding youth involved with DD and CFS (last updated Feb 2024). The CFS' Well-Being team hosted a Learning Lab for CFS staff in February 2024 about the Division of Developmental Disabilities. Probation has taken the lead while CFS, MLTC, MCOs, DBH and other community stakeholders have all been participating in an Access to Services workgroup. CFS continues to participate in, schedule, and moderate ongoing child-specific staffings with MLTC, MCOs, and DD to all collaborate. The DD clinical team has been assisting CFS with aligning DD eligible youth with the correct level of care and services to meet their individual needs.

16-28	2015-2016	Death of Youth Served by Probation and DHHS	DHHS	Children and Family Services	Accepted

Recommendation: The Division of Developmental Disabilities should coordinate with Juvenile Probation to improve care to youth with developmental disabilities in the juvenile justice system.
Agency Update FY 23-24: Probation has taken the lead while CFS, MLTC, MCOs, DBH and other community stakeholders have all been participating in an Access to Services workgroup. DHHS/CFS continues to participate in, schedule, and moderate ongoing child-specific staffings with MLTC, MCOs, DD, and Probation (when applicable) to all collaborate. The DD clinical team has been assisting CFS with aligning DD eligible youths with the correct level level of care and services to meet their individual needs, which include youth involved in the juvenile justice system.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-01	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Rejected

Recommendation: Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-02	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: End the practice of screening "Law Enforcement" reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-03	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-04	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-05	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-06	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Rejected

Recommendation: Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.
Agency Update FY 23-24: FAST Program no longer exists.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-07	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-08	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Adhere to policy on out of home assessments and enhance quality assurance.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-09	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.
Agency Update FY 23-24: Law Enforcement Only intakes no longer require DHHS to make a finding. Duty falls to Law Enforcement or County Attorney to provide adequate information to make a finding. Finding is entered as LE ONLY until supporting documentation is provided to make a different designation.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-10	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Meet the statutorily required caseload standard for initial assessment and ongoing case management.
Agency Update FY 23-24: Weekly monitoring of caseload compliance continues across each Region and while we have not reached 100% compliance, we have seen drastic improvements and statewide we are averaging over 80% compliance. In June of 2024, IA only caseloads were 97.8% in compliance.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-11	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-12	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Review and revise training on child sexual abuse for DHHS staff.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-13	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.
Agency Update FY 23-24: Critical Incidence/Quality assurance review are completed for youth placed in out of home care with intakes received and ials received involving sexual abuse. Review results are utilized to identify program strengths and areas needing improvement.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-14	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Accepted

Recommendation: Strengthen foster care licensing to remove inappropriate and unsuitable homes.
Agency Update FY 23-24: 395 NAC 3 finalized.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-15	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Children and Family Services	Rejected

Recommendation: Include a component on child sexual abuse prevention in foster and adoptive parent training.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
19-01	2018-2019	Death of a 14-month-old State Ward	DHHS	Children and Family Services	Accepted

Recommendation: Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.
Agency Update FY 23-24: No changes during fiscal year.

19-02	2018-2019	Death of a 14-month-old State Ward	DHHS	Children and Family Services	Accepted

Recommendation: Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.
Agency Update FY 23-24: No changes during fiscal year.

19-03	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS	Children and Family Services	Rejected

Recommendation: Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.
Agency Update FY 23-24: No changes during fiscal year.

19-04	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS	Children and Family Services	Rejected

Recommendation: Clarify the definition of “change in circumstance” as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.
Agency Update FY 23-24: No changes during fiscal year.

19-05	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS	Children and Family Services	Rejected

Recommendation: Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.
Agency Update FY 23-24: No changes during fiscal year.

19-06	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS	Children and Family Services	Rejected

Recommendation: Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.
Agency Update FY 23-24: DHHS is working with Action for the Protection of Children to Implement the Safe Model. Statewide training will be conducted with the roll out of this new Model.

Number	Annual Report	Report Name	Agency	Division	Agency Response
19-07	2018-2019	Infants Born with Current Family CPS Involvement Death or Serious Injury (Sibling Report)	DHHS	Children and Family Services	Rejected

Recommendation: Implement trauma informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.
Agency Update FY 23-24: No changes during fiscal year.

20-01	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	Children and Family Services	Accepted

Recommendation: Create a policy or training to address when the alleged perpetrator or involved caregiver(s) of the named child victim has extensive and/or specific knowledge of the Nebraska child welfare system.
Agency Update FY 23-24: No changes during fiscal year.

20-02	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	Children and Family Services	Rejected

Recommendation: Create non-court case policy establishing that participating in a non-court Case requires the following: Parents sign a release of information for all related medical/mental health providers specific to obtaining collateral information and assessing progress on case plan goals, Parents allow contact between the worker and their children, without caregivers present, and Parents must formally agree to participate in recommended services.
Agency Update FY 23-24: No changes during fiscal year.

20-03	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	Children and Family Services	Accepted

Recommendation: Create a handout/brochure to be provided to the family at the time the non-court case is offered.
Agency Update FY 23-24: No changes during fiscal year.

20-04	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	Children and Family Services	Rejected

Recommendation: Change DHHS policy to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case no less than 60 days after opening.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
20-05	2019-2020	Serious Injury of a 7-year-old due to Abuse and Neglect within 12 Months of Family Involvement in a Non-Court Case	DHHS	Children and Family Services	Accepted

Recommendation: Develop specific non-court evaluation criteria to help caseworkers and supervisors determine when a non-court case should be referred to the multi-disciplinary (1184) team and/or county attorney for review, and require formal training for supervisors to ensure they can assist caseworkers in making referral decisions.
Agency Update FY 23-24: No changes during fiscal year.

21-01	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS	Children and Family Services	Accepted

Recommendation: Enhance policy and tools specific to the examination of secondary caregivers in an investigation.
Agency Update FY 23-24: The new SAFE Model currently in development allows for the assessment of all caregivers in the home weighted equally. Field Guidance was also provided to staff effective 12/1/2023, advising that documentation expectations in the risk assessment have been modified to reflect: Information must be documented as it pertains to the parent/caregivers: Cultural identity and Physical Health.

21-02	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS	Children and Family Services	Accepted

Recommendation: Provide training and tools for workers and supervisors to better evaluate drug/alcohol use to ascertain whether caregive substance use is affecting the safety of the child.
Agency Update FY 23-24: No changes during fiscal year.

21-03	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS	Children and Family Services	Accepted

Recommendation: Provide educational and community resource referral material to the family during every Initial Assessment and require documentation of what materials or referrals were provided.
Agency Update FY 23-24: No changes during fiscal year.

21-04	2020-2021	Death or Serious Injury Following Child Abuse Investigation June 2016-June 2019 (IA-2020)	DHHS	Children and Family Services	Accepted

Recommendation: Conduct a work study of Child Protective Services (CPS) Supervisors.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
22-01	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS	Children and Family Services	Rejected

Recommendation: DHHS should terminate the current Eastern Service Area contract with Saint Francis.
Agency Update FY 23-24: ESA pilot project ended through the termination of the Saint Francis contract in 2022.

22-02	2021-2022	Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services	DHHS	Children and Family Services	Rejected

Recommendation: DHHS should end the Eastern Service Area Pilot Project.
Agency Update FY 23-24: ESA pilot project ended through the termination of the Saint Francis contract in 2022.

23-01	2022-2023	Serious Injury of a 2-year-old State Ward while in Foster Care	DHHS	Children and Family Services	Accepted

Recommendation: Review and revise its policies and procedures to create a method to verify that the overfill process has been followed by the Division of Children and Family Services and licensed Child Placing Agencies and to ensure ongoing quality assurance and accountability in that process
Agency Update FY 23-24: No changes during fiscal year.

23-02	2022-2023	Serious Injury of a 2-year-old State Ward while in Foster Care	DHHS	Children and Family Services	Accepted

Recommendation: Review current policy, procedure and contract language with providers to assure the expectations for communicating concerns about foster homes is done in a timely manner
Agency Update FY 23-24: No changes during fiscal year.

23-03	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: Develop a comprehensive suicide prevention plan
Agency Update FY 23-24: A suicide prevention plan was developed in collaboration with DBH, the Kim Foundation and the Suicide Prevention Coalition. The plan can be found online at: https://sprc.org/wp-content/uploads/2022/11/Nebraska-Statewide-Suicide-Prevention-Plan-2022-2025.pdf.

23-04	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: Develop dedicated suicide prevention policy and procedure
Agency Update FY 23-24: CFS is in the process of developing a clinical team and youth with behavioral and mental health needs including self-harm or suicide attempts will be referred to the clinical team for additional support and assessment. The clinical team will also be reviewing youth identified as having high behavioral and mental health needs regardless of history of suicide or self-harm and this will provide additional review and support for youth at higher risk.

Number	Annual Report	Report Name	Agency	Division	Agency Response
23-05	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: The Department of Health and Human Services Division of Children and Family Services should mandate gatekeeper training for all staff
Agency Update FY 23-24: Suicide Prevention training is currently part of the ongoing training plan for case managers. A new training plan and model will be launched in 2025 and will include mandatory suicide prevention training.

23-06	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: The Department of Health and Human Services Division of Children and Family Services should standardize training requirements for Child Placing Agencies
Agency Update FY 23-24: The 2023 and 2024 agency-supported foster care contracts require agencies to ensure foster parents are trained in suicide prevention. DHHS supported homes are also required to complete suicide prevention training.

23-07	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: The Department of Health and Human Services Division of Children and Family Services should provide suicide prevention content and required gatekeeper training to foster care providers
Agency Update FY 23-24: The 2023 and 2024 agency-supported foster care contracts require agencies to ensure foster parents are trained in suicide prevention. DHHS supported homes are also required to complete suicide prevention training.

23-08	2022-2023	Death by Suicide - 3 case Review	DHHS	Children and Family Services	Accepted

Recommendation: The Department of Health and Human Services Division of Children and Family Services should actively participate in the State Suicide Prevention Coalition
Agency Update FY 23-24: Camas Holder is the CFS representative currently attending quarterly meetings with the Suicide Prevention Coalition.

23-09	2022-2024	Serious Injury of a 4-month-old State Ward while in Foster Care	DHHS	Children and Family Services	Accepted

Recommendation: DHHS should develop a comprehensive health care management plan for state wards.
Agency Update FY 23-24: No update was received for fiscal year 2023-2024.

Number	Annual Report	Report Name	Agency	Division	Agency Response

Youth Rehabilitation and Treatment Centers

Number	Annual Report	Report Name	Agency	Division	Agency Response
15-10	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.
Agency Update FY 23-24: The YRTCs have SOPs that address transportation, furloughs, and transfers of juveniles. All SOPs include the applicable accreditation standards for each procedure to include transportation of pregnant youth.

15-11	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.
Agency Update FY 23-24: OJS has a Compliance team comprised of specialists across all YRTCs that rigorously oversees all PREA related implementation. The Compliance team does not report to anyone within the YRTC chain of command to ensure there are checks and balances in place. Please note YRTC-Geneva is no longer in operation.

15-12	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Provide increased guidance and oversight from DHHS Central Office for cultural change at YRTC-Geneva.
Agency Update FY 23-24: There is a Facilities Investigations Team out of DHHS Central Office that provides guidance and oversight for the YRTCs. Please note YRTC-Geneva is no longer operational.

15-13	2014-2015	General Investigation I	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva.
Agency Update FY 23-24: All policies are reviewed annually and all staff receive annual training on PREA guidelines and procedures.

16-29	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Rejected

Recommendation: Make the OJS Administrator a Full-time Position.
Agency Update FY 23-24: Not applicable as recommendation was rejected.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-30	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson Unit.
Agency Update FY 23-24: The program within the Dickson Unit has been appropriately restructured.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-31	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Develop Continuous Quality Improvement Process at YRTCs Led by Central Office.
Agency Update FY 23-24: There is a Facilities Investigations Team as well as an Ethics and Compliance Team out of DHHS Central Office that provides continuous quality improvement for the YRTCs

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-32	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney.
Agency Update FY 23-24: All YRTC's complete an annual Staffing Plan that is reviewed periodically.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-33	2015-2016	Deteriorating Conditions at the Youth Rehabilitation and Treatment Center-Kearney (YRTC-K)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Digitize Records at YRTC-Kearney.
Agency Update FY 23-24: All YRTCs utilize an electronic data system (MyAvatar) for the digitization of youth records.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-06	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.
Agency Update FY 23-24: OJS falls under the Director of CFS. This is reflected on the state's public website. Please note YRTC-Geneva has not been in operation since 2018.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-07	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Rejected

Recommendation: Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.
Agency Update FY 23-24: Not applicable as recommendation was rejected by DHHS.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-08	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Implement a fully digital case management system.
Agency Update FY 23-24: All YRTCs utilize MyAvatar as the youth's digital case management system.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-09	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Conduct a detailed analysis of the YRTC workforce and implement a plant to ensure appropriate staffing of YRTC positions at all levels
Agency Update FY 23-24: All YRTC's complete an annual Staffing Plan that is reviewed periodically.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-10	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Implement evidenced-based programming consistently throughout the YRTC system.
Agency Update FY 23-24: All YRTCs implement evidence based programming, the details of this can be found in the §43-407 legislative report

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-11	2020-2021	The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center (YRTC-G)	DHHS	Youth Rehabilitation and Treatment Centers	Accepted

Recommendation: Implement a Trauma-Responsive environment across the YRTC system.
Agency Update FY 23-24: Mental Health staff provide trauma-informed care training upon hire at all of the YRTC facilities and mandatory annual refreshers. Please note YRTC-Geneva is no longer in operation.

Public Health-Licensure

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-11	2015-2016	Death and Serious Injury Following a Child Maltreatment Investigation	DHHS	Public Health-Licensure and	Accepted

Recommendation: Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials distributed by the Division of Public Health
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-19	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS	Public Health-Licensure	Accepted

Recommendation: Revise regulations to require infant safe sleep training before granting a child care license.
Agency Update FY 23-24: LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted [Statute 43-2606(3)]. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted. Proposed child care regulations will include this requirement.

17-12	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensure	Accepted

Recommendation: Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible.
Agency Update FY 23-24: No changes during fiscal year.

17-13	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensure	Accepted

Recommendation: Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.
Agency Update FY 23-24: No changes during fiscal year.

17-14	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensure	Accepted

Recommendation: Adopt clear requirements on medical record-keeping and documentation in regulations.
Agency Update FY 23-24: No changes during fiscal year.

17-15	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensure	Accepted

Recommendation: Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.
Agency Update FY 23-24: No changes during fiscal year.

17-16	2016-2017	Death of a State Ward in a DHHS Licensed Group Home	DHHS	Public Health-Licensure	Accepted

Recommendation: Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.
Agency Update FY 23-24: No changes during fiscal year.

18-16	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Public Health-Licensure	Rejected

Recommendation: Ensure adequate staffing for residential-child caring agency licensing operations.
Agency Update FY 23-24: There are no changes from last year's update.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-17	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Public Health-Licensure	Accepted

Recommendation: Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
18-18	2017-2018	Sexual Abuse of State Wards, Youth in Adoptive or Guardian Homes and Youth in Residential Placement (Sexual Abuse-2017)	DHHS	Public Health-Licensure and	Accepted

Recommendation: Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.
Agency Update FY 23-24: No changes during fiscal year.

Number	Annual Report	Report Name	Agency	Division	Agency Response
21-05	2020-2021	Infant Death in Licensed Family Child Care Homes March 2016-Septemeber 2018 (Daycare 2020)	DHHS	Public Health-Licensure	Accepted

Recommendation: Create specific guidelines for how frequently and in what manner sleeping infants should be checked.
Agency Update FY 23-24: LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted [Statute 43-2606(3)]. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted. Proposed child care regulations will include child care provider requirements related to frequency of checks and documentation of checks of sleeping infants.

Number	Annual Report	Report Name	Agency	Division	Agency Response
24-01	2023-2024	Death of an Infant in a Family Child Care Home II	DHHS	Public Health-Licensure	Accepted

Recommendation: Update the child care regulations to reflect best practice related to the supervision of sleeping infants by child care providers.
Agency Update FY 23-24: LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted [Statute 43-2606(3)]. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted. Proposed child care regulations will include child care provider requirements related to frequency of checks and documentation of checks of sleeping infants.

DHHS AND PRIVATE AGENCY

Public Health-Licensure

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-17	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS and Private Agency	Public Health-Licensure	Accepted

Recommendation: Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.
Agency Update FY 23-24: CFS released a Safe Sleep SOP in 2023 with guidance for case managers on safe sleep practices.

Number	Annual Report	Report Name	Agency	Division	Agency Response

Children and Family Services

Number	Annual Report	Report Name	Agency	Division	Agency Response
16-18	2015-2016	Sudden Unexpected Infant Deaths (SUIDS-2016)	DHHS and Private Agency	Children and Family Services	Accepted

Recommendation: Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.
Agency Update FY 23-24: CFS released a Safe Sleep SOP in 2023 with guidance for case managers on safe sleep practices. Public Health is engaged in an initiative around Safe Sleep in their maternal/child health area. Information about safe sleep practices can be found at: https://dhhs.ne.gov/Pages/Nebraska-Safe-Babies-Hospitals.aspx

PRIVATE AGENCY