



Office of  
Inspector General of Nebraska Child Welfare

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ANNUAL REPORT

2019-2020

The OIG thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide support and advice, particularly the Executive Board, Health and Human Services and Judiciary Committees.

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Sharen Saf  
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*Inspector General*

September 15, 2020

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 call, email, or write a letter.

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**Email:** [OIG@leg.ne.gov](mailto:OIG@leg.ne.gov)

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

National Suicide Prevention Lifeline  
1-800-273-8255

Nebraska Family Helpline  
1-888-866-8660



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September 15, 2020

Dear Governor Ricketts, Justices of the Nebraska Supreme Court, and Members of the Nebraska Legislature:

In accordance with Neb. Rev. Stat. §43-4331, it is our honor to present the Office of Inspector General of Nebraska Child Welfare (OIG) Annual Report for Fiscal Year 2019-2020. We submit this report together as Ombuds Rogers served as Inspector General throughout the fiscal year, and Inspector General Carter began her term at the beginning of September.

There are both old and new issues confronting the child welfare and juvenile justice systems in Nebraska. As was noted in the OIG's first annual report and each year thereafter, DHHS has not met the statutory caseload requirement for child welfare caseworkers responsible for keeping maltreated children safe and delivering quality services. There remain too many attempted suicides and suicides of youth who are system-involved. And complaints about children's placement outside their home, child well-being, initial assessment, permanency, case management, and visitation persist.

Recent developments that impact these systems include the significant physical and programmatic changes to the Youth Rehabilitation and Treatment Centers (YRTCs), implementation of the Family First Prevention Services Act, and transfer of private case management from PromiseShip to St. Francis Ministries in Douglas and Sarpy Counties. It cannot be overstated that these changes, no matter how well-intentioned, greatly affect communities, staff, and the children and families served.

As a newcomer to Nebraska and her position, the newly confirmed Director of the Division of Children and Family Services, Stephanie Beasley, has shown an understanding of the importance of oversight in government. We look forward to a productive relationship with her and her team to better learn from harms within child welfare in order to prevent similar tragedies in the future.

Finally, we would be remiss if we didn't acknowledge the COVID pandemic and the enormous challenges it has brought to families and those that serve them. Hard decisions continue to be made throughout the systems about keeping children and youth safe, while staying connected to family.

We remain committed to promoting accountability and integrity in Nebraska's child welfare and juvenile justice systems. Thank you for your time and attention to this report.

Respectfully,

  
Jennifer A. Carter

  
Julie L. Rogers

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*TABLE OF CONTENTS*

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Overview..... 1

Current Issues..... 2

Youth Rehabilitation and Treatment Centers

Caseloads

St. Francis Ministries – Eastern Service Area

Intake Summary FY 19-20..... 8

Critical Incidents

Death and Serious Injury

Complaints

Alternative Response Cases

Investigations ..... 19

FY 19-20 Juvenile Probation Investigations

FY 19-20 DHHS Investigations

Juvenile Room Confinement FY 18-19 Report Synopsis ..... 46

Status of OIG Recommendations..... 49

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## OVERVIEW

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The Office of Inspector General of Nebraska Child Welfare (OIG) provides accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, identification of systemic issues, and recommendations for improvement.

Housed within the Nebraska Legislature, the OIG investigates: complaints and allegations of wrongdoing by agencies and individuals involved in these systems; deaths and serious injuries of system-involved children; system-wide looks at concerning topic areas; and other critical incidents related to children involved with the child welfare and juvenile justice system. The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice system. Instead, investigations and reviews function as part of the Legislature's oversight of these important state functions.

Each year, the OIG is required to publish an Annual Report. The report must provide a summary of the OIG's investigations, including the recommendations it has made and their implementation status.<sup>1</sup> The following summarizes the work of the OIG from July 1, 2019 to June 30, 2020 and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made in prior years.

This year there was a leadership change at the OIG. In January 2020, Julie Rogers who was the inaugural Inspector General and established and grew the office, was appointed as the Ombuds and head of the Office of Public Counsel. Jennifer Carter was appointed as the next Inspector General of Child Welfare in August 2020 and began her tenure in September. Ms. Carter received her undergraduate degree from Columbia University and her juris doctorate from Boston University School of Law. After time as a litigator in New York at Cravath, Swaine & Moore and Sidley Austin LLP, Ms. Carter worked as a staff attorney and the Director of the Child Welfare Program at Nebraska Appleseed and as Appleseed's Director of Public Policy. Most recently, Ms. Carter served as Legal Counsel to the Health and Human Services Committee of the Legislature where she also worked on issues related to child welfare and juvenile justice.

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<sup>1</sup> Neb. Rev. Stat. § 43-4331.

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## *CURRENT ISSUES*

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The Inspector General's office was established to provide increased accountability and oversight of Nebraska's child welfare system.<sup>2</sup> In addition to formal investigations, the OIG monitors continuing and emerging issues, particularly issues that could create challenges and opportunities for the system. The following section provides a description of issues monitored by the OIG that are influencing the current environment within the child welfare and juvenile justice systems.

### **Youth Rehabilitation and Treatment Centers**

Youth Rehabilitation and Treatment Centers (YRTCs) are residential facilities operated by the Department of Health and Human Services (DHHS) serving youth ages 14-18 in the state's juvenile justice system. In August 2019 a crisis arose at the YRTC in Geneva which serves female youth. YRTC-Geneva had become unsafe due to disrepair of the facilities, a lack of programming, and staffing issues. The OIG initiated a full investigation into the circumstances that led to the crisis at YRTC-Geneva. A full report is forthcoming.

Over the course of the last year, however, the YRTCs have been in a constant state of flux and the OIG has been engaged on each new issue as they arise. The following is a brief timeline of events and summary of key issues.

#### *Timeline of Events*

- On Monday, August 12, 2019, DHHS CEO Dannette Smith informed the OIG about the crisis at Geneva. The OIG and a representative from the Ombudsman's office visited YRTC-Geneva two days later on Wednesday, August 14, 2019.
- On Friday, August 16, 2019, the OIG sent a letter to CEO Smith which thanked her for her transparency regarding the crisis and made recommendations to DHHS regarding next steps such as contacting all the legal parties to apprise them of the situation, reviewing staff training, and formulating a plan to improve programming and staffing.
- On August, 19, 2019, all the girls who had been living at YRTC-Geneva were moved to YRTC-Kearney, the previously all-boys facility. Having both the female and male youth reside at YRTC-Kearney was not without significant challenges, however it stabilized the safety situation for the girls.
- In late August, construction began to renovate the LaFlesche building on the YRTC-Geneva campus which can house up to 20 girls. The renovation costs for LaFlesche were nearly \$500,000. At the time, DHHS's stated intent was to address the facility's issues and move the girls back to Geneva by October.
- On October 21, 2019, DHHS released a Draft Youth Rehabilitation and Treatment Center Business Plan. Under this plan, boys and girls committed to the YRTCs would be sent to YRTC-Kearney for evaluation and YRTC-Kearney would continue to house both female and male youth. Youth with high behavioral acuity would be sent to a newly created

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<sup>2</sup> Neb. Rev. Stat. §43-4302.

YRTC-Lincoln for intensive behavioral modification. Once stabilized in Lincoln, the youth would return to YRTC-Kearney. Additionally, for the girls, once they were ready to transition out of the YRTC system, they would be sent to YRTC-Geneva to begin the transition into the community. The plan anticipated three to six girls at Geneva at one time. There was no plan to use YRTC-Geneva for all the girls committed to the YRTC as originally anticipated.

- On October 29, 2019, DHHS signed a five year lease agreement with the Lancaster County Detention Center to use part of that facility as a YRTC in Lincoln. The lease cost \$352,000 the first year with a 2% increase each subsequent year. DHHS had to undertake some renovations to the leased space before they could serve any youth from the YRTC there.
- In early 2020, DHHS purchased mobile units for use as classrooms for the girls at YRTC-Kearney.
- On January 22, 2020, the Health and Human Services Committee of the Legislature released a Report to the Legislature on the Youth Rehabilitation and Treatment Centers which included 14 recommendations. From those recommendations the HHS Committee introduced numerous bills including bills to: define the YRTCs and establish certain standards for the YRTCs (LB 1140); require extensive long-term planning for the operations of the YRTCs (LB 1141); require the immediate creation of emergency plans for the YRTC facilities (LB 1142); require that DHHS hire a superintendent for the educational programming at the YRTCs and other residential juvenile facilities (LB 1188); and create a YRTC Legislative Oversight Committee (LR 298). Hearings were held in February.
- In February 2020, the YRTC program at the Lancaster County Detention Center was opened. The next week YRTC-Geneva was reopened for girls transitioning back into the community.
- On March 5, 2020, the HHS Committee unanimously advanced LB 1140 which had combined several of the YRTC bills, particularly those that created planning requirements. LB 1140 advanced on a first round vote to Select File on March 10, 2020 before the Legislature adjourned due to the COVID-19 pandemic.
- On July 16, 2020, DHHS released a new business plan for the YRTCs which restructures the entire YRTC system as well as other juvenile programs. Under the new plan, the YRTC in Geneva would permanently close and the Geneva facility would be utilized for purposes not related to juvenile programming. Female youth currently served at YRTC-Kearney would be relocated to the Hastings Regional Center which is a state-run facility and is the home for the Juvenile Chemical Dependency Program (JCDP). The JCDP serves male youth receiving substance abuse treatment. DHHS plans to house the female youth in a newly constructed building at the Hastings Regional Center that was specifically designated by the Legislature for the JCDP. The new JCDP building cost approximately \$5 million. To accommodate the female youth at the Hastings Regional Center and have the facility function as a YRTC, DHHS plans to renovate the newly constructed building before moving the girls. The male youth in the JCDP will be relocated to Lincoln alongside the existing Whitehall program (sexual offense program for male youth). DHHS intends to move the JCDP to Lincoln on October 1, 2020. The YRTC-Kearney campus will go back

to serving male youth only. The eventual cost of renovations to the JCDP building at the Hasting Regional Center and Whitehall is unknown.

- In its July business plan, DHHS also stated that it had contracted with the Missouri Youth Services Institute to conduct a pre-assessment of YRTC-Kearney and to provide regular on-site guidance and training for staff at YRTC-Kearney and later at the YRTC DHHS plans to establish at the Hastings Regional Center.
- On July 20, 2020, in light of the proposed plan to establish a YRTC at the Hastings Regional Center, the Legislature passed an amendment, AM 3088, to LB 1140 that prohibits DHHS from establishing or moving a YRTC until March 30, 2021, “after the completion of a planning process” required under LB 1140.
- On July 31, 2020, LB 1140 was passed by the Legislature. It was signed into law by Governor Ricketts on August 11, 2020.

### *Staffing Challenges*

The crisis at YRTC-Geneva, the move to serve both boys and girls at YRTC-Kearney, and the addition of new programming for YRTC youth in Lincoln, led to a variety of staffing challenges and changes. For example, after the girls were moved on August 19, 2019 the teachers and other staff from YRTC-Geneva were transported by DHHS back and forth between Geneva and Kearney each day. In September 2019, a private security company was hired to have four security officers monitoring the perimeter of the YRTC-Kearney campus 24 hours a day, 7 days a week. Staff was also pulled from other facilities, such as the Hastings Regional Center, to help at YRTC-Kearney. The staff from other facilities were not given specific training to work with the unique population of youth at the YRTC.

Hiring recruitment fairs took place in September 2019 at both YRTC-Kearney and YRTC-Geneva. In November 2019, DHHS issued a press release noting the need for additional staffing at Kearney and Lincoln. That same day the majority of staff from YRTC-Geneva received reduction in force letters.

On February 20, 2020, DHHS issued a press release regarding the opening of the Lincoln facility to provide more intensive and individualized programming for certain youth committed to the YRTCs. With regard to staffing, DHHS stated it was partnering with the Nebraska Department of Correctional Services (NDCS) to meet the staffing needs at the Lincoln facility. Three NDCS staff members were to receive DHHS training to work with the youth at the Lincoln facility.

This most recent business plan from July 2020 creates additional staffing changes. Recently, nearly all positions were filled at the YRTC-Geneva campus. However, in light of the recent business plan, those Geneva staff members are being encouraged to find other employment. It is not yet clear what the staffing plan is for the JCDP if it moves to Lincoln or a YRTC if one is created in Hastings.



### *YRTC Escapes and Assaults*

The Office of Juvenile Services (OJS) tracks incidences of assault by youth on staff and assault of youth by other youth at the YRTCs. From July 2019 through June 2020, there were 98 incidences of male youth assaulting staff. The highest numbers of assaults occurred between August and October of 2019.<sup>3</sup> There were 176 incidences of male youth assaulting other male youth. Of the staff assaults, eleven required emergency room care. Seventeen of the assaults on other youth required emergency room visits.

For the female youth, there were 70 assaults by female youth on staff over the course of FY 19-20. Two resulted in emergency room visits. There were 18 assaults between female youth. One required an emergency room visit.<sup>4</sup>

Escapes from the Kearney facility are also tracked. According to OJS data, for the male youth, there were 38 incidences of escapes in FY 19-20. The majority of those came in August 2019, December 2019, and March 2020. For the female youth, there were seven incidences of escape – four in September 2019 and three in March 2020.

### *Leadership Changes*

There were several leadership changes within the OJS just prior to and after the crisis arose at the YRTCs. For example, the long-standing Administrator of YRTC-Geneva was removed months before the crisis at that facility. The OJS Administrator then acted as the Facilities Administrator at YRTC-Geneva hand-in-hand with the CEO starting in the spring of 2019. At that time, the OJS Administrator also oversaw YRTC-Kearney and the Whitehall campus, while the DHHS Facilities Director strictly oversaw the Regional Centers and Beatrice State Developmental Center. Immediately following the YRTC-Geneva crisis, the DHHS Facilities Director was brought back to oversee the YRTCs, ultimately being named the OJS Administrator during the summer of 2020. The office of the CEO also remained directly and integrally involved with the YRTCs throughout this time.

### Conclusion

The events of the last year highlight both the challenges inherent in the YRTC system and the added turmoil created by the crisis at Geneva. In addition to the usual challenges, there has been a great deal of instability in the system with two different business plans within nine months, each plan making major changes to the structure of the system. These plans affect not only the youth at the YRTCs, but the staff at each facility, including their employment, and the communities in which the YRTCs are located.

A major restructuring of the YRTC system should not take place without meaningful input from stakeholders and potential partners. LB 1140 created a statutory obligation to conduct a robust planning process regarding the YRTCs with input from stakeholders. The OIG recommends that DHHS refrain from implementing any additional major changes to the YRTC system, including the impending plan to move the JCDP to Lincoln and create a YRTC in Hastings, until the plans are developed and fully vetted with stakeholders and experts in juvenile justice. In addition, the

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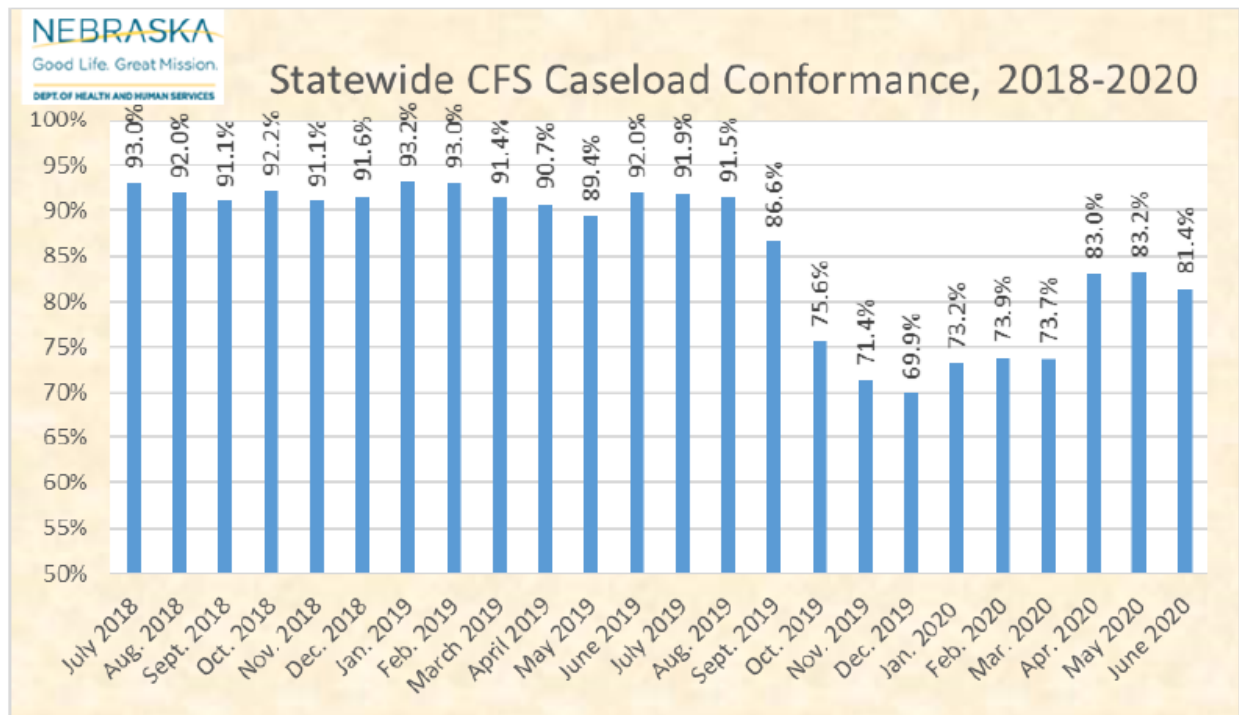
<sup>3</sup> August 2019 (15 staff assaults); September 2019 (12 staff assaults); and October 2019 (17 staff assaults).

<sup>4</sup> There is noted one assault that resulted in a youth being admitted to the hospital. This assault took place in July 2019 when the girls were still at YRTC-Geneva.

OIG encourages DHHS administration to share plans and proposed changes transparently and frequently with community partners, stakeholders and the general public within a reasonable timeframe prior to taking action.

### Caseloads

In 2012, the Legislature passed into law a maximum caseload requirement.<sup>5</sup> High caseloads contribute to worker burnout and turnover and are correlated to poorer outcomes for system involved children and families. Over the past eight years DHHS has improved their efforts to meet the caseload limits set forth in statute. However, caseload issues continued to trouble the Nebraska Child Welfare system during FY 19-20. Historically, DHHS efforts have not resulted in full compliance with the law and improved caseload numbers have been subject to limited sustainability. Based on the overall conformance data provided by DHHS for the FY 18-19 and FY 19-20, the current level of caseload compliance statewide is at 80%, down from 92% in FY 18-19. As noted below, caseloads are particularly high in the Eastern Service Area and that is contributing significantly to the overall statewide decline in caseload compliance. The OIG will continue to advocate for the necessity of DHHS meeting the caseload mandate.



Source: DHHS-Division of Child and Family Services (August 2020)

<sup>5</sup> Neb. Rev. Stat. §68-1207.

### **St. Francis Ministries – Eastern Service Area**

The Eastern Service Area is the only child welfare service area in Nebraska that utilizes a private provider for case management. In June 2019, after the completion of an RFP process, the contract for case management in the Eastern Service Area was awarded to St. Francis Ministries, a Kansas based provider. St. Francis Ministries replaced PromiseShip (formerly Nebraska Families Collaborative) which had served the Eastern Service area since the inception of private case management in 2011.

The transition of case management to St. Francis Ministries began early in October 2019 and was completed by January 2020. Administrators of the organization reported early on that the transition had gone better than expected and that with few exceptions they felt poised to meet the expectations laid out within the contract between themselves and DHHS.

At the end of FY 19-20 the OIG noted that St. Francis Ministries was unable to satisfactorily meet the mandated caseload requirement with only 41% of case managers within guidelines. This is significantly disproportionate compared to ongoing case management compliance in the other service areas for the same period of time (Northern Service Area-100%, Central Service Area- 100%, Western Service Area- 88%, and Southeast Service Area- 92%). It was reported to the OIG that St. Francis Ministries has been unable to stabilize their workforce due to an unbalanced cycling between new hires and exiting workers which in return is facilitating the extremely low conformance level for ongoing caseloads in the Eastern Service Area.

DHHS is currently engaged in supporting St. Francis Ministries through contract monitoring and monthly leadership meetings between the two organizations. DHHS has requested a hiring plan from St. Francis Ministries that includes strategies for worker retention. DHHS has also assigned a seasoned administrator to assist St. Francis Ministries in bridging the gap between their processes and those of DHHS.

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## *INTAKE SUMMARY FY 19-20*

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The following section of the Annual Report provides an overview of the intakes received by the Office of Inspector General of Nebraska Child Welfare (OIG) during FY 19-20. The intake process includes cases reviewed by the OIG as well as death and serious injury investigations that were opened.

The work of the OIG is wholly determined by the intake information that it receives. Information generally comes to the office in the form of a “critical incident” from the Department of Health and Human Services (DHHS) or the office of Juvenile Probation, complaints from the public, reports and/or requests for information and copies of grievance findings from DHHS.

During the fiscal year of 2019-2020 (FY 19-20) starting July 1, 2019 through June 30, 2020, the OIG received 403 total intakes comprised of:

198 Critical Incident Reports;

179 Complaints;

19 Requests for information; and

7 Grievances and their findings from DHHS

After a review of the initial intake, the OIG conducts a preliminary investigation, including a document review, on every complaint, critical incident, and grievance finding. Based on the preliminary investigation, the OIG then determines if the office holds jurisdiction over the incident and whether a full investigation is justified or required by statute and what additional actions may be appropriate.

### *Critical Incidents*

Critical incident reports bring a range of issues to the OIG’s attention. Figure 1 shows the general type of incidents included in the 198 critical incident reported to the OIG in the past year. Those critical incidents involved 185 separate youth and nine youth who were involved in multiple incidents.

Twenty-five of the total critical incidents involved youth with no previous or current system involvement at the time of the report, thus the OIG did not incorporate data from those incidents in the Critical Incidents Based on Youth Involvement within the Child Welfare System section.

Of the 198 critical incidents reported to the OIG in FY 19-20:

- 160 were reported by DHHS;
- 36 were reported by Juvenile Probation; and
- 2 were reported by a Service Provider.

Figure 1 provides the distribution of the 198 incidents by subject matter. The total number of reported critical incidents for FY 19-20 represents a 38% decline from the 317 reported critical incidents for FY 18-19. In general, the number of critical incidents being reported by service providers has remained consistent. Notable is the decline in reported incidents from DHHS and Juvenile Probation. This decline does not necessarily indicate a reduction in critical incidents within the system. Rather, it may reflect a shift in the criteria used to determine which critical incidents are shared with the OIG. Since the inception of the OIG office, DHHS has shared a wide diversity of critical incidents with the office. Voluntarily sharing this expanded information was very helpful and allowed the OIG to assist DHHS in identifying a broader range of systemic issues. The current criteria used by DHHS for sharing critical incidents meets the statutory obligations but are more narrow in scope. As a result, we cannot compare the number of critical incidents in FY 19-20 to years past and draw any reliable conclusion regarding the decline in overall numbers.

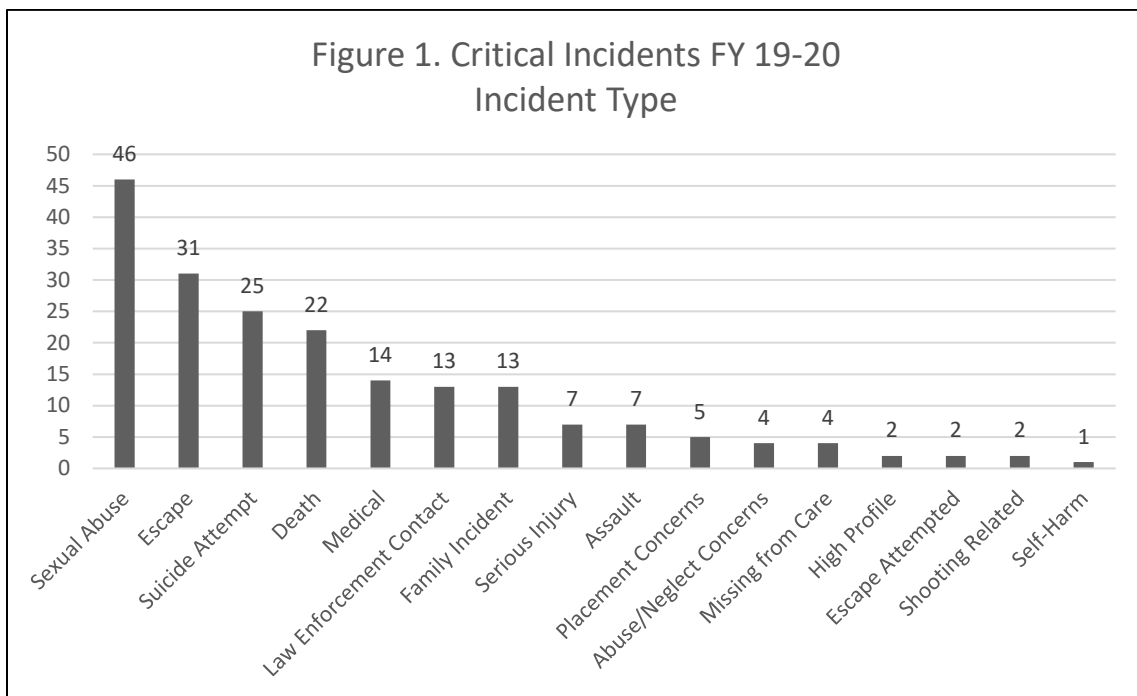
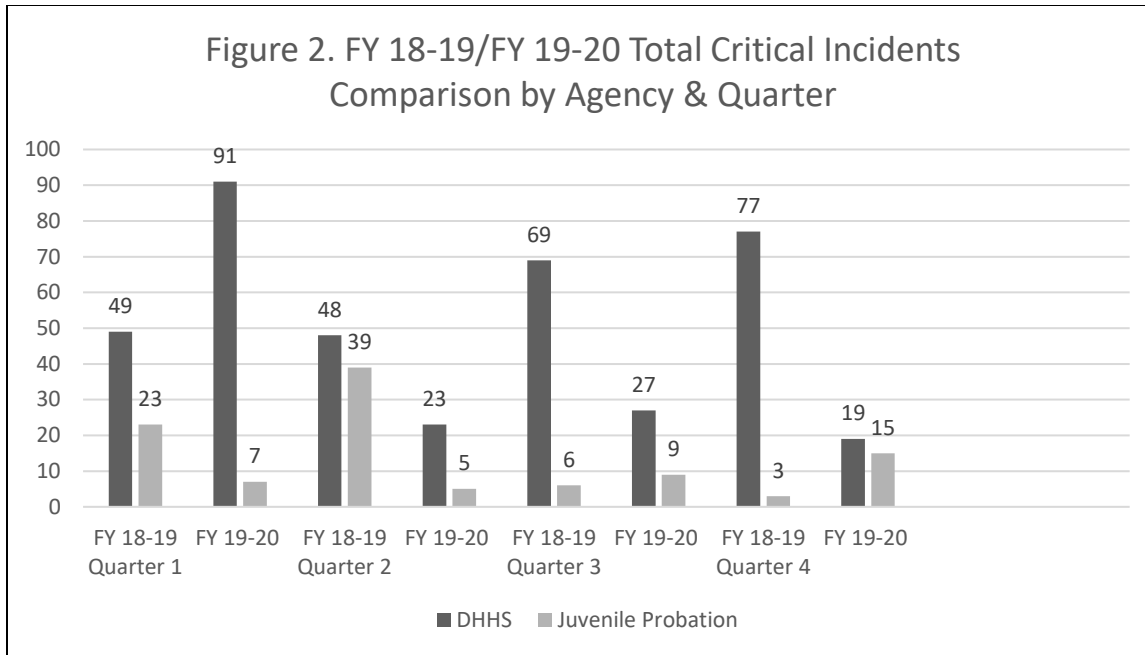


Figure 2 compares the total number of intakes reported by DHHS and Juvenile Probation for FY 18-19 and FY 19-20.



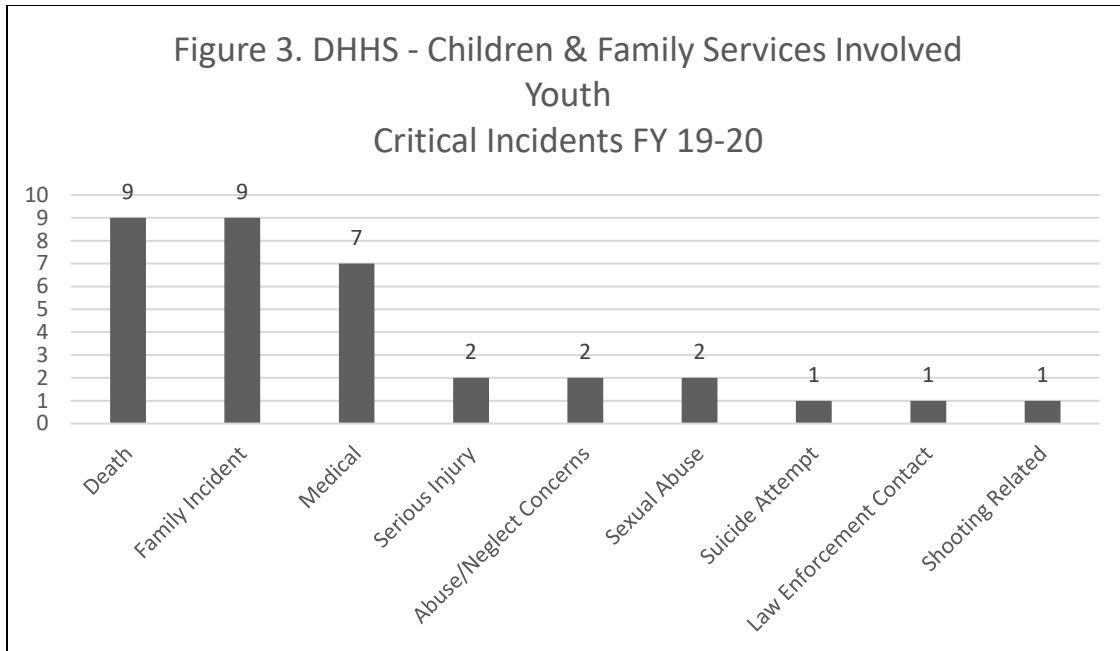
**Critical Incidents based on Youth Involvement within the Child Welfare System**

DHHS- Childen & Family Services Involved: 34 incidents

The OIG defines a family or youth as involved with DHHS under the following circumstances: an intake was received at the Hotline, there is an Initial Assessment investigation, an Alternative Response case, or a non-court (voluntary) case. Involvement is either active at the time of the critical incident or was active within the previous twelve (12) months of the incident. Table 1 indicates the number of critical incidents reported at each level of DHHS-Children and Family Services Division (CPS) intervention. Figure 3 provides data on the types of incidents reported for youth with DHHS involvement. While fifty-nine percent (59%) of critical incidents were due to youth involved in the Initial Assessment process, none of those 20 critical incidents resulted in full OIG investigations.

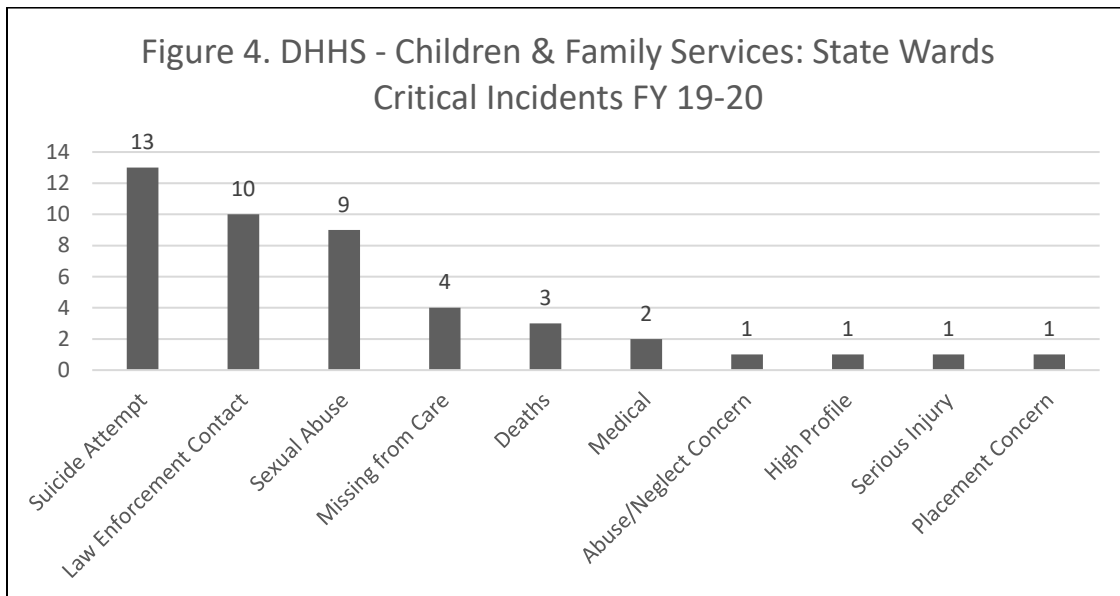
Table 1. DHHS Involved Youth Critical Incidents FY 19-20

DHHS Involvement Point	Total
Intake	9
Initial Assessment	20
Alternative Response	3
Non-Court	2



**DHHS – Children & Family Services: State Wards: 45 incidents**

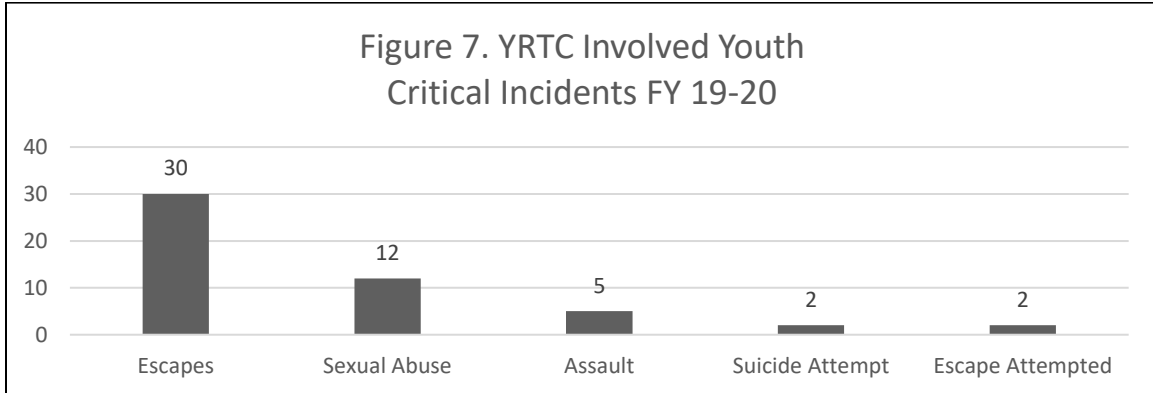
The State Ward category includes youth who, at the time of the incident, were court ordered to be under the care, custody, and control of the Department of Health and Human Services.<sup>6</sup>



<sup>6</sup> The Serious Injury listed in the chart represents a Kansas State Ward.

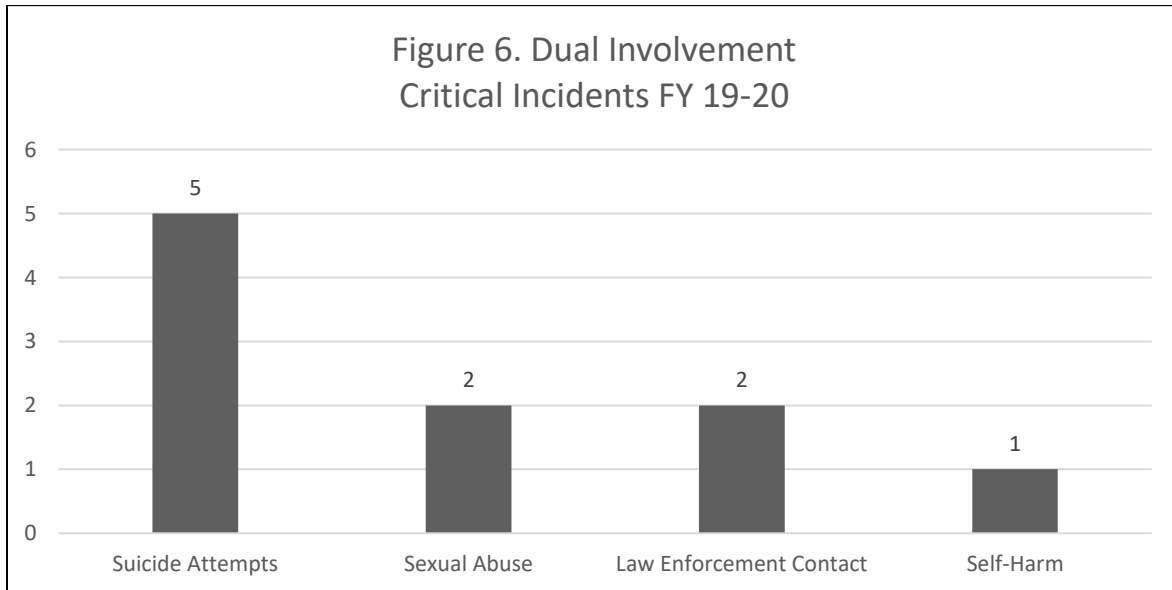
Youth Rehabilitation and Treatment Centers (YRTCs): 51 incidents

The YRTC category includes youth who are committed to the Youth Rehabilitation and Treatment Center (YRTC), which is operated by the Department of Health and Human Services-Office of Juvenile Services (OJS). Youth in this category could be supervised by probation, tribal court, and/or CPS. All youth at the YRTC are considered OJS wards. There are three YRTC campuses: one in Kearney, one in Geneva, and one in Lincoln, Nebraska.



Dual Involvement: 10 incidents

This category involves youth who are involved with both Juvenile Probation and DHHS in some manner at the time of the critical incident.



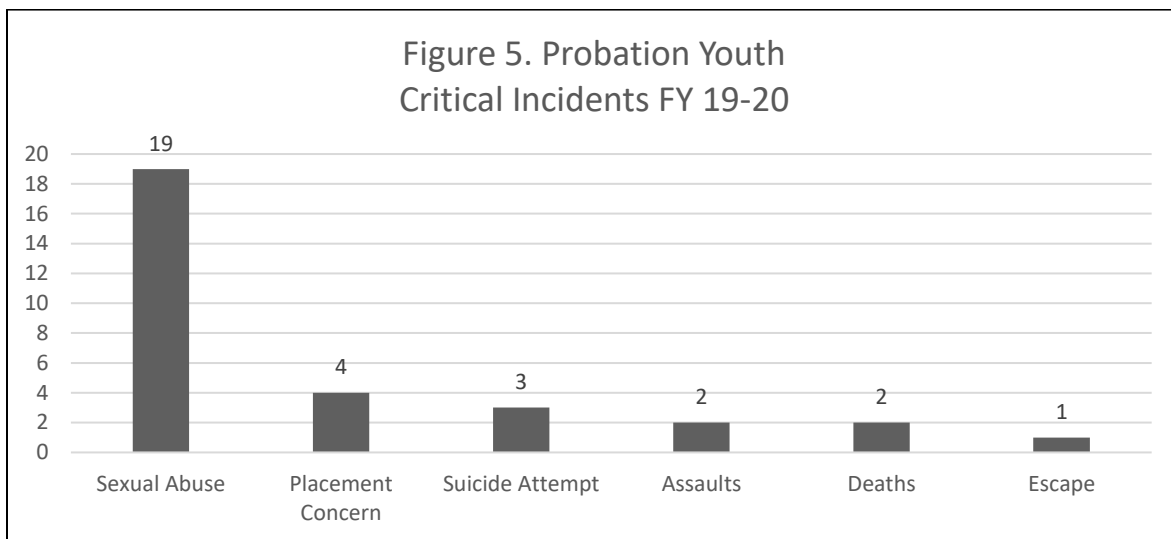


Youth in a Licensed Facility: 2 incidents

This category involves youth who were placed in a Nebraska licensed facility (group home, child care home, etc.) for care during the time of the incident. These youth do not have any type of DHHS or Juvenile Probation involvement other than being cared for within a licensed facility. One youth was alleged to have abuse/neglect concerns and the other a medical issue.

Probation: 31 incidents

Probation youth includes those who at the time of the incident are supervised by Juvenile Probation, but not placed at the YRTCs.



*Death and Serious Injury*

The OIG is required to investigate death and serious injury of system-involved youth who are: (1) placed in an out of home care (2) currently receiving or have received child welfare services from DHHS in the past twelve months (3) currently receiving or have received services from the Juvenile Probation in the past twelve months (4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months (5) in a licensed facility. The OIG is not required to investigate deaths that occurred by chance. Serious injury is defined as, “injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition.”<sup>7</sup>

Of the 22 reported child deaths in FY 2019-2020, two had sufficient contact or involvement in the juvenile justice system to merit opening an investigation. Both youth were on juvenile probation when they completed suicide.

<sup>7</sup> Neb. Rev. Stat. §43-4318 (1)(2).

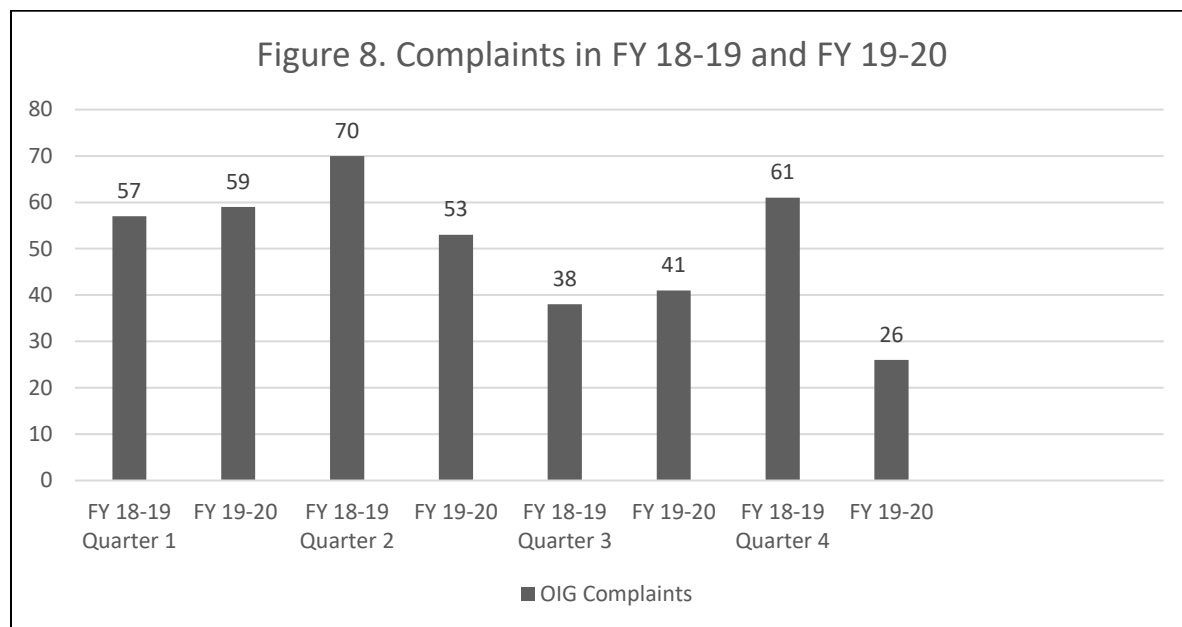
Seven serious injuries were reported in FY 2019-2020. The OIG did not open investigations into these critical incidents as they did not have sufficient contact or involvement in the child welfare system.

### Complaints

The OIG receives complaints and investigates “allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations”<sup>8</sup> by:

- DHHS;
- Juvenile Services Division (Juvenile Probation);
- The Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) juvenile justice programs;
- Private child welfare agencies, foster parents, licensed child care facilities, and contractors of DHHS and Juvenile Probation; and,
- Juvenile detention and staff secure detention facilities.

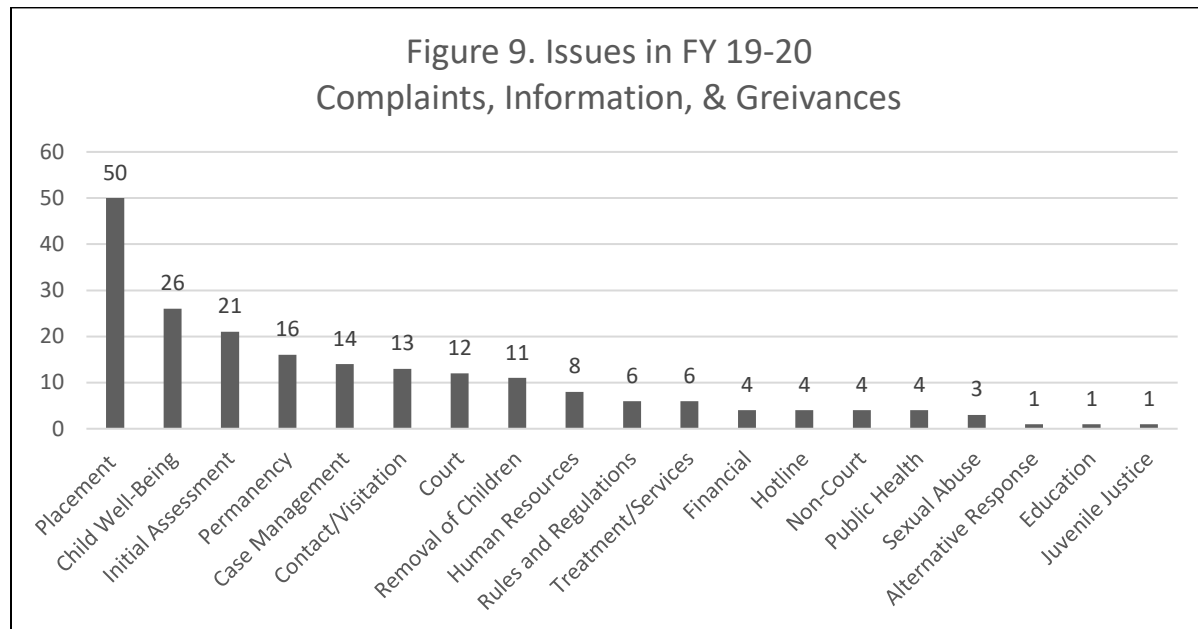
In the past year, the OIG received 179 complaints. This is a 21% decline from the 226 complaints filed in FY 18-19 (see Figure 8). This decline is likely due in large part to the COVID-19 pandemic.



The OIG receives complaints from employees, administrators, foster parents, grandparents, family members, attorneys, parents, and concerned citizens regarding various aspects and issues of the child welfare system and the juvenile justice system. The agencies and issues varied and represented all areas and points in the system. If a complaint is received about an area outside of the OIG’s jurisdiction, then a referral is made when appropriate.

<sup>8</sup> Neb. Rev. Stat. §43-4318 (1)(a).

Figure 9 includes the types of complaints, requested information, and grievances the OIG received in FY 19-20.



The OIG engages DHHS on cases where a systemic issue has been identified or a specific case presents an issue. The following complaints are representative of issues the OIG addressed in FY 19-20 without issuing a formal report:

**St. Francis Ministries:**

A complaint to the OIG was made alleging that due to the accelerated timeline for St. Francis Ministries (SFM) to assume ongoing case management for the Eastern Service Area, the provider was ill prepared and unable to secure enough foster homes to meet the demand for emergency out of home care. The OIG confirmed that while waiting for an appropriate placement, youth were spending multiple days, including overnights, at a location intended for emergency short stays of less than 24 hours. The complaint further alleged that youth were being housed within SFM office space as well. Either situation would have been inappropriate for children experiencing the trauma of an emergency removal or placement disruption.

The OIG responded to the complaint through informal measures. Based on the facts as they were reported to the office, the OIG ascertained that the majority of youth involved were older teenagers; SFM was addressing the need for foster care homes and emergency care internally through new program development; and, the immediate situation was being addressed by SFM with assistance from existing external partners.

**Unlicensed Daycare/School:**

The OIG received a complaint regarding an unlicensed daycare. Betty, (age 4) attended the unlicensed facility for daycare and preschool. A report was made to the hotline that Betty was sexually abused by two youth during playtime. Law enforcement closed their case based on the ages of the children.

DHHS-CFS conducted assessments on the two households to determine the children were safe. DHHS-CFS also opened an Out of Home assessment, but after finding out the facility is not licensed by DHHS-Public Health, CFS did not complete the investigation.

- The facility's license under DHHS-Public Health was exempt in 2014. Public Health does not have any documentation as to why this facility was granted an exemption.
- The facility is listed as an "Approved" school through the Department of Education (Rule 14) Grades K-8.
- Department of Education does not have authority or jurisdiction on "Private" pre-school programs (Rule 11) and/or children from birth to kindergarten.

Public Health Licensing admitted there should **not** have been an exemption granted in 2014 for the birth to kindergarten program. After discussing these issues with Public Health Licensing multiple times, the facility is now in the process of becoming a licensed daycare.

It has been further discovered there may be multiple "Approved" schools who are also providing daycare unlicensed. The OIG has concerns there are multiple facilities who are responsible for the care of young children operating without any standards and oversight from Public Health Licensing. The Department of Education and Public Health Licensing will need to work together to identify all the Approved schools and determine if they are providing childcare from birth to kindergarten without a license.

#### **Safe and Unable to Locate:**

An intake was called into the Hotline alleging a parent was using meth. The caseworker was in contact with law enforcement who also believed the parent was using meth. The caseworker was unable to locate the parent at the provided address. The caseworker spoke to the grandmother who claimed she did not believe the parent was using meth anymore and refused to give the caseworker the parent's address. The caseworker proceeded to complete the Initial Assessment. The caseworker found the children safe and high risk of future maltreatment. This was done without ever speaking to the parent or children. The finding of the intake was categorized as "unable to locate".

The OIG made a data inquiry to DHHS to determine how many cases were categorized as "unable to locate" and the children were found safe. DHHS provided the OIG the data that showed in year 2017 there were 119 cases; 2018 there were 104 cases; and in 2019 there were 149 cases. DHHS explained these numbers should not be this high and were conducting an internal review. The review led to the discovery of caseworkers not following policy. CFS is now conducting additional training to enhance the importance of face to face contact with families and to ensure intakes are not closed prematurely.

## Alternative Response Cases

Alternative Response (AR) was implemented by DHHS to change the way the system responds to some child welfare and neglect intakes. AR was a pilot project that began in 2014. Legislative bill 1061 was signed into law on July 24, 2020 making AR a permanent intake option at DHHS. The OIG is tasked with reviewing and investigating critical incidents and complaints related to AR.<sup>9</sup> The OIG must report on any AR cases it reviews in its Annual Report<sup>10</sup>.

In FY 2019-2020 the OIG received one complaint and three critical incidents related to AR. The OIG conducted a preliminary review of each case, which did not result in a full investigation. The following critical incidents were reported to the OIG where the family had AR involvement:

### Critical Incident within 12 months of AR involvement:

An intake was accepted for AR alleging the parent was not taking the youth to important medical appointments. The caseworker found the youth safe based on the parent's understanding of the medical issues and the reasons the appointments were missed were reasonable. The mother re-scheduled the appointment and the caseworker confirmed with the physician. The caseworker gave the parent referrals for community resources and closed the case. Approximately seven months later an intake was accepted for an Out of Home Assessment at a child care center where the youth attended. A staff member at the child care center allegedly pulled the youth's arm which caused an injury. The staff member was terminated from the child care center and was arrested for child abuse by law enforcement. The OIG was sent a critical incident regarding this injury.

### Critical Incident with current AR involvement:

An intake was accepted for AR alleging the parent of two youth had medical issues that interfered with the parenting responsibilities. The two youth started staying with their aunt and uncle who needed help establishing a guardianship. The caseworker found the youth safe with their relatives. DHHS paid for an attorney to establish the guardianship for the two youth. The caseworker also helped the parent and youth get signed up for Medicaid. Approximately seven months later an intake was accepted for Initial Assessment alleging one of the youth was being sexual abused by the uncle and his friend. Both youth were removed from the home and made state wards, therefore the AR case was closed. Both adults were arrested and charged with sexual assault. The OIG was sent a critical incident regarding the sexual abuse.

### Critical Incident with current AR involvement:

An intake was accepted for AR alleging a youth is out of control and dangerous to himself and others. The youth ran away and stole a vehicle that eventually crashed. While at the police station he tried to stab police officers. Two days later the youth stole another car. The parent was unable to control the youth's behaviors. The AR intake was re-screened to a traditional response as the county attorney was filing a juvenile petition and requesting the youth be removed from the home. The OIG was sent a critical incident regarding the intake.

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<sup>9</sup> Neb. Rev. Stat. §28-712.01.

<sup>10</sup> Neb. Rev. Stat. §43-4331.

Complaint with family AR involvement:

An intake was accepted for AR alleging the youth is out of control and dangerous to himself and others. The youth would assault his mother and students at school. The youth would run into traffic and set fires. The parent was unable to control the youth's behaviors. The caseworker found the youth safe with the parent. The caseworker attempted to set up services for the family, but there was a lack of communication from the parent. After a month and a half, the county attorney filed a juvenile petition and the youth was removed from the home. The AR intake was re-screened to a traditional response. The complaint centered on the lack of communication between DHHS and the county attorney with the concerns of this family.

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## *INVESTIGATIONS*

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The OIG is statutorily obligated to investigate deaths and serious injuries of Nebraska children and youth who were:

- Being taken care of at a licensed facility, such as a day care or group home;
- The subject of an abuse or neglect assessment (also referred to as an investigation) in the previous twelve months, but the family did not receive services through DHHS;
- Engaged in an alternative response case, voluntary, or non-court case, and received services through their DHHS involvement, but were not involved in a formal court case;
- Involved in a juvenile court case and DHHS had custody of the child, also known as being a state ward;
- Placed at a Youth Rehabilitation and Treatment Center;
- Placed at a juvenile detention center;
- Supervised by juvenile probation.

### *FY 19-20 Juvenile Probation Investigations*

In June 2018, the Administrative Office of Probation (AOP) abruptly stopped interviews and began denying relevant data requests for an on-going OIG investigation into suicidal behavior of probation-involved youth. Consequently, a proper and full investigation could not be completed, and in the fall of 2018 the OIG discontinued the investigation.

Continuing through FY 18-19 and FY 19-20, the OIG has not received the necessary and proper access to information nor people within the AOP in order to carry out investigatory and statutory responsibility under the Office of Inspector General of Nebraska Child Welfare Act. The OIG does continue to get critical incident reports from AOP that are specifically stated in statute.

As was noted in the Intake Summary on page 8 of this report, the OIG received 36 critical incident reports from Probation. Of 22 child deaths reported to the OIG in FY 19-20, only two had sufficient contact or involvement in the juvenile justice system to merit opening an investigation. Both youth were on juvenile probation when they completed suicide. Given the challenges noted above, the required investigations into these deaths have not yet been initiated.

## *FY 19-20 DHHS Investigations*

The following sections provide more detail on the full investigations that were completed<sup>11</sup> during FY 19-20. All recommendations made are based on today's Nebraska child welfare system and identified issues that need addressed presently. In the cases where no recommendations are made, the incident either revealed no issue about the administration of an agency or the agency had already made systemic changes to address the issues found.

Every effort has been taken to keep the actual identity of the child confidential. All names of persons were changed throughout this summary of investigation. The OIG includes details about the case in an effort to be transparent about what was discovered in this investigation and why specific recommendations were made, without compromising the identity of persons involved.

The OIG has taken note of any child welfare themes and issues reflected in each investigation. The OIG will track them as part of its effort to identify systemic issues and consider them as topics for future investigations as necessary and appropriate.

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<sup>11</sup> The serious injuries occurred in 2015.



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## *SUMMARIES OF INVESTIGATIONS COMPLETED IN FY 19-20*

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### *Serious Injury of a 5-month-old within One Year of DHHS Services*

The following report summarizes the OIG investigation into the serious injury of five-month-old “Ethan” due to physical abuse perpetrated by his biological father. The infant’s mother was party to an open Children and Family Services (CFS) case five months prior to the serious injury of the infant. The case included the mother and her two older children.

#### Critical Incident

Ethan (age 5 months) was admitted to a medical center after a visit to the Emergency Room the evening before. The parents brought the infant to the hospital at the recommendation of their primary care physician, as the infant had been vomiting for three days. Tests indicated that Ethan had subdural bleeding, occurring recently and in the past. The physician believed the injury was the result of some sort of trauma, however, there were no outward signs of trauma nor medical indications of abusive head trauma (also known as shaken baby syndrome). A priority one intake was accepted by the Nebraska Child Abuse & Neglect Hotline (Hotline). The intake alleged the physical abuse of Ethan by his parents; Robert and Jennifer.

Jennifer had no explanation for the cause of her son’s injury. Robert, the caretaker of the children while Jennifer worked, indicated he had on occasion flipped the baby from front to back, but maintained that he had handled the child appropriately. Ethan’s older siblings were not able to recall any specific injury to Ethan during a forensic interview conducted. The oldest sibling, Sherry, did disclose that Robert would sometimes wake her up at night to punish her by making her stand against a wall with her arms outstretched. She also disclosed that she was spanked for no reason and that if she did not eat quickly enough, Robert would

feed her meal to the dog. In a police interview, Robert admitted to this behavior, leading law enforcement to charge him with abuse. Law enforcement removed the two older siblings and Ethan from the parental home and placed the three children in DHHS custody.

#### Child Welfare History

Contact between the family and CFS began when an intake was accepted by the Hotline, alleging physical abuse and neglect of Ethan’s older half-sister, Sherry (born to Jennifer and an unidentified father). A babysitter reported that while assisting three-year-old Sherry with a bath, she observed three small, circular scars on the backside of her body, unidentified bumps on her body, and a mark on her arm and right backside which appeared to be cigarette burns. It was also reported that Sherry was observed to be dirty with her hair covered in dirt and clothing that smelled of marijuana and cigarettes.

Collateral information gathered as part of the investigation indicated that it was believed Jennifer gave Sherry alcohol and smoked marijuana in her presence. A hair follicle test conducted as a result of the intake indicated exposure to marijuana. Jennifer denied using marijuana and maintained that she did not know who would have used the drug in the

proximity of Sherry. Jennifer voluntarily submitted to a drug screening, and was found negative for all substances. The bumps on Sherry's body were later determined to be scabies and a staph infection. During the course of the related law enforcement investigation, three pipes – one containing marijuana, were found. Jennifer eventually pled guilty to one count of possession of less than one ounce of marijuana, and one count of possession of paraphernalia. The CFS case was closed after the completion of the Initial Assessment and the allegations were UNFOUNDED. The family was later involved in two more Hotline intakes during the year. Both alleged the physical neglect of Sherry by Jennifer. The first one was accepted for Initial Assessment and determined to be UNFOUNDED, the second intake was screened out as DOES NOT MEET DEFINITION.

Sondra was born to Jennifer and Robert in July 2013. Three months after the birth of Sondra, local law enforcement investigated the family when Sherry (then age 6) reported that she had been elbowed in the eye by her mother. Law enforcement found the injury was accidental. There was no report made to the Hotline regarding this event.

A fourth intake for the family was accepted for initial assessment a year later. The intake alleged physical abuse and neglect of Sherry by her mother, Jennifer. It was reported that Sherry came to school with a red mark under her eye, stating she'd gotten a bloody nose that morning when her mother hit her. Sherry was found SAFE after she provided multiple explanations for the injuries to both law enforcement and the forensic interviewer at the child advocacy center. While first alleging that her mother struck her, she later said that she injured herself.

Several months later, an accepted intake alleged that Sherry came to school with a bruised eye; she reported to school staff that her mother had hit her earlier in the day. Law enforcement completed an affidavit for temporary custody, and Sherry was placed with her great grandmother. Jennifer could not explain the injury, but denied causing it. A safety assessment found Sherry UNSAFE and the Risk Assessment found the risk of future maltreatment as VERY HIGH. Jennifer was cited for neglect by law enforcement and a juvenile petition was filed alleging Sherry lacked proper parental care by Jennifer.

Sondra (ten months of age) was part of the household at the time of the two intakes. She was not marked within the child vulnerabilities section nor was contact with her documented for the safety assessment. Sondra remained in the care and custody of her parents despite it being unsafe for her older sibling and despite her caregivers being considered at VERY HIGH risk for future maltreatment.

The CFS worker documented that she communicated with both law enforcement and the County Attorney's office about whether a juvenile court case should be pursued related to Sondra. According to the CFS worker's documentation, she understood that a case would not be filed because Sondra was an infant and was thought to be easier to care for and thus at less risk for abuse. The caseworker noted that the County Sheriff's Deputy stated that Sherry was more at risk because she was the older child. (Note: This belief is not supported by long standing research.<sup>12,13</sup>)

The juvenile petition was adjudicated and services included supervised parenting time, family support sessions to provide a parenting class, and assistance in accessing community resources.

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<sup>12</sup> Berzin, "Using sibling data to understand the impact of family group decision-making on child welfare outcomes." *Children and Youth Services Review* 28 (2006): 1454.

<sup>13</sup> Hines, Kantor, and Holt (2006). "Similarities in siblings' experiences of neglectful parenting behaviors," *Child Abuse and Neglect* 30. (2006): 632.

Robert, Jennifer's boyfriend, was not part of the juvenile court case and was not consistently considered as a secondary caregiver throughout the CFS case. He intermittently accompanied Jennifer on her supervised visits with Sherry, but it was noted that he did not participate or interact in a quality way. He is not mentioned in the Safety Assessments, but is named as a secondary caregiver in the Risk Assessment, then is listed as "Other" in the following three Family Strengths and Needs Assessments, and again in the Reunification Assessment.

Based on the last completed Reunification Assessment, it was recommended that Sherry be returned to the family home and reunified with her mother. A month later, unsupervised parenting time began and went well. Jennifer completed a Love and Logic parenting class and demonstrated new skills consistently.

Staffing notes from six weeks before it was anticipated that Sherry would be returned to the care and custody of her mother indicated that Jennifer was pregnant with her due date imminent, and the team felt comfortable with Sherry being placed back into the home. Four weeks later at a review hearing, DHHS recommended Sherry be returned to the custody of her mother and DHHS be released of its duties in the case. The judge accepted the recommendations and the case was closed. One day after the hearing, Ethan, was born; five months later Ethan was seriously injured.

The OIG made no recommendations to DHHS as a result of this investigation. The OIG has taken note of child welfare themes and issues reflected in Ethan's case, and they will be tracked in order to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

## Serious Injury of a 7-year-old due to Abuse and Neglect within 12 months of Family Involvement in a Non-Court Case

The following is a report of the OIG investigation into the serious injury of a seven-year-old boy, “Ben”, due to abuse and neglect by his parents, Mitchell and Stephanie. The family was DHHS-involved eight months prior to the critical incident due to the family participating in a non-court case. As part of this investigation the OIG constructed, distributed and analyzed a non-court survey targeted at county attorneys or others within the office responsible for the management of child welfare cases (see page 40). Distribution was done in conjunction with the Nebraska County Attorneys Association. The results of the survey were taken into consideration during the drafting of recommendations to DHHS. Results of the survey can be found in the appendix of this report.

### Critical Incident

In November 2015 a priority two intake was accepted by the Child Abuse and Neglect Hotline (Hotline) alleging physical neglect and abuse of Ben, then seven years old, by his parents, Mitchell and Stephanie. The report alleged Ben had told school personnel that his parents withheld food from him for several days and was asking staff for food. Ben had not returned to school the following two days. The reporter indicated that when the father was contacted about the absence, he stated that Ben had been kept home as a result of having a bowel movement and spreading feces all over himself. The report also alleged that Ben appeared malnourished, underweight and pale, along with concern that he was being teased by other students as he was coming to school smelling of urine due to his parents not allowing him to bathe. The reporter stated that there was a history of Ben reporting food being withheld from him as a form of punishment.

A medical evaluation conducted at the child advocacy center found Ben, who was about one month away from his eighth birthday, to weigh 31 pounds, have a distended abdomen, and nearly disintegrated teeth, along with bruising

and scratches in various stages of healing on multiple areas of his body. During the forensic interview, Ben disclosed that he was often locked in his bedroom, was forced to go to the bathroom in the corner of the bedroom, and was denied food.

The family home consisted of the mom, dad, and four children ages nine, seven (Ben), four, and one. Ben and his three siblings were removed from the custody of Mitchell and Stephanie and placed with kin. At the time, Mitchell was employed by a contracted DHHS provider and had previously worked for the Nebraska Department of Health and Human Services – Division of Children and Family Services.

The family had participated in a Child Protective Services<sup>14</sup> (CPS) non-court case from December 2014 through March 2015.

The father and mother each plead guilty to five counts of felony child abuse with serious bodily injury connected to the abuse and neglect of Ben and both were sentenced to five to ten years of incarceration.

### Child Welfare History

child protective service functions of that division will be referred to as CPS, including the private provider ongoing case management function in the Eastern Service Area.

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<sup>14</sup> The Nebraska Department of Health and Human Services Division of Children and Family Services is responsible for a broad range of services including child protection. For the purpose of this report, the

Ben was born to Justina and Christopher in December 2007. At six weeks of age, Ben was removed from the custody of Justina and Christopher when the infant presented at the emergency room with multiple skull fractures under suspicious circumstances. Three months after being removed from his parents, Ben was placed with Mitchell and Stephanie, who eventually adopted him in 2010.

CPS history for this family started in October 2012. Four-year-old Ben wandered into a local restaurant, naked, and asking for food. Ben walked approximately six blocks from his home at six o'clock in the morning to a local restaurant where he entered and asked for food, saying he was hungry. The manager of the establishment called law enforcement who were on scene at 6:16 a.m. Thirty minutes later Mitchell contacted 911 to report his son missing. The responding officer was informed by Mitchell that Ben was their adopted son, that he'd suffered three skull fractures after birth, had tested positive for both methamphetamine and marijuana, had special needs, had been tested for autism in the past, and that he often took his clothes off after wetting the bed. The Hotline did not accept the report for assessment, and screened it as Does Not Meet Definition (DNM) due to the child reportedly being autistic and law enforcement not citing the parents for abuse/neglect.

Over the course of the next three years the family was the subject of 14 reports to the Hotline; six screened out as DNM, five accepted for investigation as priority two intakes, and three determined to be multiple reports (See intake summary on page 39) .

Following the May 2014 intake which alleged Ben had been forced to stand on his head over the top of a heating vent resulting in a knot on the top of his head, Ben was found SAFE. The

family scored as HIGH risk for future maltreatment. Based on the risk level, the family was offered a non-court case but declined the offer. The Risk Assessment narrative stated that the parents felt that they were aware of, and had access to, community resources and did not need services.

Accepted intakes in November and December 2014 again led to assessments that found Ben SAFE in the care and custody of his parents with HIGH risk of future maltreatment. Mitchell and Stephanie agreed to participate in a non-court case after the December investigation.

The family's non-court case opened in December. The non-court case consisted of four team meetings held approximately every 30 days starting in December 2014 and ending in March 2015. The team meetings were noted as brief or cut short by Stephanie. They were attended by the parents and CPS worker(s) with no others in attendance despite the family being asked to identify people they thought could offer support and be willing to participate in the meetings.

By the end of the first 30 days of the case, Mitchell and Stephanie were promoting the idea that their case was ready to close, however, they were told by the worker that the case would have to remain open for 90 days.<sup>15</sup>In addition to the team meeting there was a meeting between the parents and school staff in February 2015. Documentation indicated the purpose of the meeting was to discuss Mitchell and Stephanie's concerns with the lack of communication and behavior management by school staff. The caseworker coordinated the meeting. Documentation included Stephanie's concerns with the school and her requests that daily emails be sent detailing Ben's behavior during the day. She requested that he only be

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<sup>15</sup> Per the *Voluntary Case Management* brochure provided to families at the time of case transfer by

CPS, voluntary services are provided to the family for three to six months.

given stickers or hand stamps as rewards, and that he not be left alone with other students in the classroom. Stephanie also asked that teachers not leave open containers in the classroom as she had once witnessed Ben spit into a glass of milk belonging to his sister. Finally, the parents directed school staff that Ben be sent to the library during classroom parties or celebrations.

Throughout the non-court case the parents reported that Ben had been evaluated by a mental health provider. They were unable to produce any written reports of diagnosis or professional recommendations, citing that the provider was slow at completing written reports thus they only had verbal information to relay. Both parents freely admitted that since the non-court case had opened they had made no adjustments and were doing nothing different in regards to the treatment of Ben. The parents stated they had no intention of implementing change as a psychiatrist had told them they were doing the best they could to manage Ben's behaviors.

Despite reporting to the worker that Ben's behaviors were getting worse, and expressing frustration with the situation in general, the

## **FINDINGS**

### **RELIABLE BEHAVIORAL INDICATORS OF MALTREATMENT WERE REPEATEDLY DISMISSED AS EVIDENCE**

Ben's parents transferred him to three different schools without the family moving from their home, between Kindergarten and second grade. School staff from all three schools reported to the Hotline that Ben was disclosing being denied food and subjected to physical abuse by his mother. Twelve reports from Kindergarten through the first quarter of second grade were made by school personnel who were concerned that Ben was being physically abused or neglected, and specifically that he consistently

couple requested the case close in March 2015. Both parents maintained that participation in the case was an intrusion on their family and that it was affecting Mitchell's job. The case was closed at the end of the month. While they did agree to work with an after-care specialist following the case closure, neither parent engaged with services or opportunities offered by that program.

A Risk-Reassessment completed the same day as case closure indicated the parents demonstrated new skills consistent with case plan task outcomes and addressing critical needs. A reduction in the risk score to moderate resulted in a recommendation for case closure. The final narrative of the assessment stated that the worker had no concerns for the children and no further recommendations.

There were no reports of abuse made to the Hotline after the non-court case closed in March through the summer of 2015. Two days after the start of the 2015-2016 school year reports to the Hotline by school staff resumed, culminating with the critical incident in November 2015.

described being denied food as a form of punishment. All the reports regularly included concerns related to one or more of the following three areas:

- 1. Ben was obsessed with obtaining food** to the extent he was stealing it, eating it from the trash, and hyper fixated on it in the classroom. Ben maintained that he was being denied food as a means of punishment while the other children in the home were being fed.

**2. Ben was regularly presenting with injuries** such as bruises, scratches, knots, and welts. In conjunction with the injuries, Ben described situations in his home that school staff considered to be excessive discipline. For example, Ben reported being kicked in the groin, being forced to urinate on his school supplies, being locked in his room, being thrown against the wall or to the floor, made to stand on his head while on a heating vent, and his parents allowing the three family dogs to harm him by biting and scratching him.

**3. Parental behavior directed towards Ben was inappropriate.** In response to contact from school personnel, teaching staff found the parents to be severe when speaking of their son and punitive to even minor behavioral infractions, denying him participation in school field trips and classroom celebrations. Staff became reluctant to report classroom concerns or behavior issues to the parents as after the contact Ben would return to school relaying that his parents withheld the evening meal. On multiple occasions Ben missed school for days following contact with the parents.

When Hotline calls were accepted for initial assessment, SDM narratives would cast doubt on the disclosures due to Ben's lack of detail, inconsistencies and recanting statements. Safety narratives called attention to Ben's changing versions of events when he was asked for details of the incidents, and also cited law enforcement's evaluation of the physical

evidence as support for a finding of SAFE. For example, a Safety Assessment found the children to be SAFE due in part to Ben being unable to recall additional details when the worker asked him to show how the injury happened utilizing a doll. A safety narrative also noted that law enforcement stated that the bruise on Ben's back was inconsistent with Ben's report as Stephanie's foot was larger than the actual bruise.

Upon review it was found that Ben's disclosures were consistent based on the expectations of his age and cognitive development. Ben's inconsistency in relating the facts often occurred when he was questioned in the home while his parents were present, or when he was required to recount his disclosure multiple times to law enforcement or CPS workers.

Disclosing abuse can be difficult for a child. They may experience a wide range of emotions from not knowing if the abuse is wrong to being fearful for their safety. According to research, only 4-8% of all reported cases of abuse by children are fabricated, and most of those are reports made by adults involved in custody disputes or by adolescents.<sup>16</sup> Research on children who recant abuse allegations found that most children between the ages of 6-9 years who recant are telling the truth when they originally disclose. Additionally, recantation is largely a result of familial adult influences rather than a result of false allegations.<sup>17</sup>

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<sup>16</sup> Bruck, M., Ceci, S. J., & Hembrooke, H. (1998). Reliability and credibility of young children's reports: From research to policy and practice. *American Psychologist*, 53(2), 136-151. doi:10.1037//0003-066x.53.2.136

<sup>17</sup> Lawson M., Rodriguez-Steen L., London K. A systematic review of the reliability of children's event reports after discussing experiences with a naïve, knowledgeable, or misled parent. *Developmental Review*, Volume 49, 2018

## BEHAVIORAL DYNAMICS ALMOST ALWAYS PRESENT IN FAMILIES IN WHICH CHILD ABUSE OCCURS<sup>18</sup> WERE NOT IDENTIFIED WHEN EVALUATING THE RISK FOR FUTURE MALTREATMENT.

Dr. Brandt Steele, a psychiatrist and pioneer in the study of child abuse and victim treatment, found that four dynamics are almost always present in families in which child abuse occurs. (1) Parents must have a predisposition to abuse or neglect their children, (2) abused children are often perceived by abusive parents as different or in some way unsatisfactory, (3) high stress and crisis in the family usually contribute to maltreatment, and (4) maltreating parents often lack interpersonal or environmental support.

Mitchell and Stephanie perceived Ben as different or unsatisfactory. Structured Decision Making® (SDM) narratives contained numerous examples of this. For example, Mitchell would say that Ben was sneaky, and that he would plan out his misbehavior. Stephanie was quoted as saying that due to his mother's drug use, Ben would make himself throw up, and urinate or defecate on himself on purpose. The parents often stated that they would or would not do something related to the care of Ben because it was unfair to the other children in the home. A Risk Assessment conducted in December 2014 notes that Stephanie was directly asked twice by the worker if she wanted Ben in her home; she replied "I want him to be safe and successful. I would love for others to see what we deal with every day with Ben. I would like for Ben to stay but I don't know how much more we can take...I want my family to be successful and I feel like this is tarnishing our name."

Once Ben reached school age he was provided a level of contact with persons outside his home that facilitated his almost immediate and

repeated disclosures of abuse. Ben's repeated disclosures and the concern they generated among school staff resulted in attention to the family Mitchell and Stephanie were unaccustomed to. The reports to the Hotline by school personnel brought both law enforcement and CPS into the home creating new stressors.

The parents attributed the intrusions created by the school's calls to the Hotline to Ben's actions. With each new call to the Hotline by school staff, the more they tried to control him and discredit him with teachers. Limiting his participation in school functions such as classroom celebrations or field trips, instructing staff not to provide Ben with snacks or extra food, and returning items such as backpacks, notebooks and winter coats given to him by school staff. When calling the Hotline, staff would note their concern that the parents would change Ben's school at the end of every school year without physically moving into a new district.

Despite self-reports by the parents to the contrary, the couple lacked interpersonal support. The couple admitted they were estranged from Mitchell's family, connection with Stephanie's family was limited to her mother, and with the exception of autism awareness activities, they did not report participation within the community. It was noted that while the family did attend autism support events, Ben was not observed to be with the family during those times. Stephanie was a stay at home mother who identified few personal connections and whose support system was limited to her husband and mother.

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<sup>18</sup>Steele, B. (1987). Psychodynamic factors in child abuse. In R.E. Helfer & R.S. Kempe (Eds.), *The battered child*. (4<sup>th</sup>ed.) Chicago: University of Chicago Press.



Mitchell self-reported that his support system was limited.

The Risk Assessment completed prior to the critical incident, noted concerns regarding the care and well-being of Ben. Pointing out that interviews of the other children in the home were ineffective due to age and developmental delay, and suggesting the possibility that the parents were being untruthful about their actions in relationship to the allegations. However, the assessment went on to state that due to insufficient evidence and information the findings would be entered as unfounded.

Reviewed SDM assessment narratives, including Safety Assessments, Risk Assessments, Family Strengths and Needs Assessments and Risk Reassessments all contained evidence that Mitchell and Stephanie viewed Ben as different and unsatisfactory, that

the parents were under increasing levels of stress and were becoming more controlling of Ben in addition to lacking a support system. Yet, these individual dynamics that are often present in cases of abuse were never put together as a totality indicator of risk to the safety of Ben.

## INEFFECTIVE CHILD PROTECTION PRACTICES ENABLED THE MALTREATMENT TO CONTINUE

**When assessing for safety and risk, Mitchell and Stephanie were permitted to rationalize or deny the repeated injuries to Ben, and reject any culpability.**

According to the U.S. Department of Health and Human Services Administration for Children and Families' Child Welfare Information Gateway, recognizing child abuse includes noting parents who deny the existence of – or who blame the child for problems in school or at home. It also suggests that physical abuse should be considered when the parent or other adult caregiver offers conflicting, unconvincing, or no explanation for the child's injury.<sup>19</sup>

A review of SDM narratives revealed that both parents consistently stated that the injuries to Ben were not injuries at all, but instead benign occurrences. The parents minimized the marks on Ben's body, attributing them to normal rough play with an older sibling, the family dogs, or family time activities such as putting a belt around his feet so he could learn to hop like a bunny. Several assessments document the parents ascribing Ben's injuries to him hurting himself because he asked his three-year-old sister to teach him how to do a back bend or headstand after her tumbling class.

Ben was found to be safe in the care of his parents on four separate occasions due to Stephanie denying that she caused the injuries,

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<sup>19</sup> Recognizing Child Abuse and Neglect: Sign and Symptoms.

[www.childwelfare.gov/pubPDFs/signs.pdf](http://www.childwelfare.gov/pubPDFs/signs.pdf). Retrieved August 19, 2019.

Stephanie stating that she took Ben to the doctor, and a denial by the parents that they used excessive physical discipline. The Safety Assessments noted that others in the household denied the use of physical discipline. Aside from the parents, others in the home who would have been able to deny the excessive use of physical discipline would have been an older sibling who was non-verbal due to Autism, and a younger sibling between two and three years of age at the time of the intakes.

All Risk Assessments completed from December 2013 through November 2015 contained the statement: “[Stephanie] does not blame Ben or the other children for the situation and does not justify maltreatment of Ben as she denies any wrongdoing or maltreatment”. The Risk Assessment requires workers to evaluate the primary caregiver’s assessment of the incident, focusing on whether the caregiver is blaming the child for the incident or justifying the maltreatment of the child. SDM guidance does not include when a primary caregiver provides a conflicting assessment of the incident, provides unconvincing explanations for the child’s injury, or provides no explanation at all.

**Collateral contact with people outside of the home, including classroom teachers and medical professionals, was limited.**

One individual collateral contact who was socially familiar with the family was used in all four of the initial assessments. At the time of the December 2013 intake, a former 2006 co-worker of Stephanie’s who was a current family friend was asked about her observations of the family. She stated that she saw the family weekly and had no concerns for abuse/neglect. This same collateral statement was documented in all subsequent Risk Assessments without an updated statement and without the addition of any new sources of information. The family indicated that their daughter was in

tumbling/dance class, that they participated in autism awareness activities and that Mitchell’s co-workers were a source of support to him. Documentation did not include any information from these additional sources.

Documentation of collateral contact with school staff did not consistently include Ben’s primary classroom teacher. Information obtained from staff peripheral to Ben’s daily routine, such as principals, assistant principals and guidance counselors, while valuable, may not have been based on consistent day to day contact similar to that of a classroom teacher. Reports made by school personnel that were accepted for investigation included the concern that communication between teachers and the parents resulted in excessive disciplining of Ben. This concern was so pervasive teachers would refrain from reporting behavioral incidents to the parents in a daily behavior log out of fear that Ben would suffer harm. Because Ben attended multiple schools in a relatively short period of time, documentation from classroom teachers may have been helpful in identifying patterns of behavior displayed in multiple settings similar in nature.

There is no evidence of verification of medical appointments and diagnoses through collateral contact. The parents’ claim that Ben’s physical condition was the result of prenatal drug exposure, early childhood trauma, and a matter of genetic predisposition offered in the narratives were not validated or verified with medical professionals, thus indirectly endorsed. Unverified medical recommendations also provided an opportunity for the parents to credibly preserve the idea that they were appropriately responding to the behaviors they assigned to Ben per professional recommendations and to assert that he had a condition attributed to a behavioral issue.

Per DHHS policy<sup>20</sup> a collateral contact is defined as a person that provides information. Policy and procedure documents do not specifically prescribe the number and type of collateral contacts that should be engaged other than to say they will be used as part of good social work practice to collect additional information as needed. There are two exceptions to this broad collateral policy. The specific use of collaterals to complete the Family Strengths and Needs Assessment (FSNA) and to complete any assessment involving medical issues or where the alleged child victim is seen by a doctor or hospital. In the case of medical issues, policy states written information from medical providers will be obtained and placed in the case file.

In Ben's case, documentation indicated that as part of the Initial Assessment, medical records were requested from a primary care physician following the December 2014 intake. The Risk Assessment dated three weeks later states the records were not provided by the physician. CPS can request medical information as part of an abuse/neglect investigation, however, medical providers are not mandated to provide the information to DHHS. The OIG did not locate evidence that medical records or collateral information from providers was pursued beyond the initial request for information from one primary care doctor.

**Precautionary steps due to Mitchell having extensive knowledge and involvement in the Nebraska Child Welfare System were not taken.**

Mitchell had previously been employed by DHHS. Following his non-voluntary termination from this position, he gained employment with a DHHS-contracted provider

within the service area he and his family lived. His affiliation with his employer was noted at the time of the December 2013 intake. A later intake alleged that both Mitchell and Stephanie asserted that if anyone "called them in" Mitchell would have connections.

Mitchell would have been able to use his extensive knowledge of the procedures, safety threat definitions and SDM tools used to investigate alleged abuse to his advantage. For example: based on his previous experience, Mitchell would know that when completing the Risk Assessment, workers are instructed to exclude situations in which the caregiver claims the one child injured another child or in which the caregiver claims that the child injured himself when assessing the caregiver's response of the incident. Additionally, via his current position with a DHHS service provider, Mitchell was in frequent and direct contact with professionals within the child welfare system.

The OIG found little evidence that Mitchell's knowledge of the child welfare system and current employment position were addressed in the assessment of the maltreatment or the management of the non-court case. There was only one instance noted where action was taken to address the situation. At the time of the December 2014 intake the CPS supervisor personally met with Mitchell as part of the Initial Assessment process. When the resulting non-court case was offered that same supervisor sent an email to her counterpart handling the non-court case indicating the need for vigilance in regards to the handling of the case. Email communications referenced staffing the situation, but documentation did not contain specific information about how the situation was addressed or confirmation that the staffing occurred.

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<sup>20</sup> Nebraska Department of Health and Human Services Division of Children and Family Services Protection and Safety Procedure #2-2018 and #34-2016.

Throughout the course of the investigation, the OIG encountered no documentation indicating that *prior* to the critical incident, this case was ever referred to or discussed by a multi-disciplinary (1184) team or that Ben was forensically interviewed at the child advocacy

center – both of which would have been prudent actions under the circumstances.

#### MALTREATMENT CONTINUED DUE TO INEFFECTIVE ONGOING CASE MANAGEMENT OF THE NON-COURT CASE

##### **The case plan solely focused on behavior issues ascribed to Ben by his parents.**

As a result of the November and December 2014 intakes, the family agreed to a non-court case. A caseworker made contact with the family, and the SDM Family Strengths and Needs Assessment (FSNA) and case plan were completed.

The case plan identified all 9 FSNA assessment areas as strengths for Mitchell and Stephanie, including coping skills, social support system and parenting skills. The narratives for each of the domains consisted of copied narratives from previously written assessments of safety and risk with little additional information. The assessment did identify emotional/behavioral needs for Ben. The assessment narrative detailed Ben's disruptive behavior in the home and at school, citing that he is lying, stealing and manipulating. The assessment also referenced a diagnosis of Rumination Disorder and Other Disruptive Behavior Disorder. The FSNA provided no collateral documentation of these diagnoses from a provider, or anecdotal evidence based on verbal communication with the medical/mental health provider or school personnel. The assessment relied only on information provided by the parents.

The resulting case plan provided one goal for the parents: Stephanie and Mitchell will use

appropriate behavior management strategies when parenting Ben's difficult behaviors. Strategies for accomplishing this goal included: meeting with the school on at least two occasions to discuss communication strategies and behavior management of Ben in the classroom in addition to following through with all treatment recommendations for Ben. Of the 14 intakes regarding the family, none were based on concerns that Mitchell and Stephanie were not interacting with the school in addressing behavior problems or communication issues in the classroom.

##### **The Risk Reassessment inaccurately captured the family's level of involvement and progress.**

Risk Reassessment combines items from the original Risk Assessment with additional items that evaluate a family's progress towards case plan goals. The Risk Reassessment guides the decision to keep a family's case open or to close it.<sup>21</sup> The Risk Reassessment for the family was completed the same day as case closure and resulted in a score of moderate risk due to two or more prior neglect/abuse investigations of the household, and a child with a diagnosed developmental delay in the home.

When completing the Risk Reassessment workers are to consider whether the household

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<sup>21</sup> DHHS Division of Children and Family Policy and Procedure Memo #34-2016

previously had an open ongoing service case (non-court or court ordered) due to child abuse or neglect. The family had declined an offer for a non-court case in May of 2014. The question does not specify situations in which a family has been offered a non-court case but declined it, thus additional risk was not assessed to the family's situation, not because there had been no non-court case, but because they had declined it.

Per DHHS policy and procedure, it was within Mitchell and Stephanie's rights to close the non-court case regardless of the Risk Reassessment score; the case was voluntary and without court intervention. The significance of a Risk Reassessment score that accurately reflects the family's level of contact with CPS prior to the current assessment is that, had the family continued to be at high risk of future maltreatment when they requested case closure, a mandatory supervisor consultation should have resulted in further evaluation of the case.

The Risk Reassessment also indicated that the caregivers demonstrated new skills consistent with case plan outcomes and/or were actively involved in services and activities to gain new skills consistent with case plan outcomes.

Narratives from multiple sources within SDM narratives did not support the reassessed risk rating. To the contrary, numerous documentation narratives indicated that the parents were refusing to develop their parenting skills, were unable to follow through with treatment recommendations and resisting engaging with any services.

**The parents were allowed to restrict the worker's access to Ben.**

During the three-and-a-half months the case was open, the worker had contact with Ben a

total of four times as part of monthly team meetings. During those four meetings, contact with Ben occurred once fully in the presence of Stephanie, and three times when at least one parent was within hearing distance and/or visible to Ben. This posed a significant obstacle to the assessment of Ben and his family as school staff had reported numerous times that they feared Ben was harshly punished any time the school shared information about him with the parents or when the parents thought Ben was freely sharing information with school staff.

In a non-court case parents do not have to allow CPS workers to meet privately and speak with their children in the home or at other locations such as school. Due to this, Ben was not given the opportunity to speak openly with the worker about what was happening in his home, nor was the worker able to verify information provided by the parents with Ben.

**The parents were not required to sign release of information forms.**

Documentation during the non-court case stated that the parents refused to sign releases of information (ROI) for medical and/or mental health providers. Case plan goals and monitoring for progress hinged on the parents meeting Ben's needs by following through on medical/mental health appointments and recommendations made as a result of evaluations. Without the signed ROIs, professionals would have been unable to discuss pertinent information with the worker, leaving the worker to rely solely on what the parents reported.

**The parents were not required to accept services from providers.**

In a December 2014 email sent to the caseworker and supervisor by the DHHS

supervisor, it was specifically recommended there be in-home services as a means of gaining further insight in the family functioning and parenting dynamics. There is no evidence of the family being offered support through community resources and no completed referrals in an attempt to put formal services in the home. Documentation repeatedly stated that the family has refused to allow any providers in the home or to engage with services outside of the home.

While Mitchell and Stephanie agreed to participate in a non-court case, they refused to allow any outside support into the home, stating that it was unfair to the other children to have someone come to only see Ben, and that it disrupted their daily routines. The family effectively barred outside verification as to the functioning of the family, and the opportunity for Ben to receive additional support.

Documentation by the worker indicated that she was concerned that Ben was always in a state of being punished, that Stephanie and Mitchell were unable to say anything positive about him, and that she observed the subtle ways the parents treated Ben differently from the biological children. Team notes indicated that Stephanie continued to report that things were getting worse with Ben's behaviors, such as he was purposely urinating on the carpet on a nightly basis. All of these issues went unaddressed as the family refused to engage with service providers.

**The non-court case did not include a referral to a multi-disciplinary (1184) team and/or consultation with the county attorney before closing.**

The non-court case was open for three-and-a-half-months. During that time the family refused to sign ROI forms allowing workers to speak with medical/mental health providers and they were unable/unwilling to produce written verification of diagnosis or professional recommendations. They participated in four monthly family team meetings, but would not include any one other than the worker in the meetings. They would not provide the worker access to Ben out of their presence and they did not allow support providers into their home. After the first thirty days, Mitchell and Stephanie began advocating for the case to close and by the time the case had been open 60 days, they indicated that they would not voluntarily participate beyond 90 days – the case closed at their request during the same month as the 90 day benchmark was achieved.

DHHS policy<sup>22</sup> states that non-court cases failing to make sufficient progress or parents refusing to work with DHHS will be evaluated through a mandatory consultation for determination about whether the case should be referred to the multi-disciplinary (1184) team, law enforcement should be asked to consider immediate removal, and/or the county attorney should be contacted to request court intervention. The OIG found no evidence that there was a supervisor consultation about this case due to lack of progress, that a referral was made to the multi-disciplinary (1184) team for staffing, or that there was a discussion about contacting the county attorney in regards to providing an affidavit in support of court intervention.

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<sup>22</sup> DHHS Division of Children and Family Policy and Procedure Memo #34-2016.

## Recommendations

The OIG is tasked with making recommendations in reports of investigation. Recommendations are intended to address any systemic issues that the report identifies. Based on the issues identified in the above cases, the OIG recommended that DHHS take the steps detailed below.

### **I. Create 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.**

In the process of investigating the serious injury of Ben, the OIG discovered a gap in policy related to the Initial Assessment and protection and safety procedures when alleged perpetrators have extensive and/or specific knowledge of the Nebraska child welfare system and Structured Decision Making tools.

Protection and Safety Procedure document # 1-2017 details requirements when a report of abuse/neglect includes a DHHS employee, a family member of an employee or others having access to the information found on the N-FOCUS database. This document does not address those who would have critical knowledge of the child welfare policy, procedure and SDM tools without access to N-FOCUS. For example; former CPS employees, CPS service providers, county attorneys and law enforcement officers.

#### ***DHHS Response: Request Modification***

DHHS is requesting to add training of workers and supervisors as an option in meeting this recommendation. The Division of Children and Family Services (CFS) has a few Program Improvement Plan (PIP) strategies that could contribute to this recommendation. DCFS will ensure the recommendation is considered and addressed in at least one of the following PIP items.

- PIP item: 1.1.1 Implement a standardized case staffing model. DCFS will assess whether this would be an avenue to add a process regarding the assessment of individuals with extensive or specific knowledge of Nebraska Child Welfare systems to ensure rigorous and balanced assessments.
- PIP item: 1.1.5 Modify Structured Decision Making (SDM) Safety Assessment Tool and instruction to ensure accurate decisions about safety and risk are made by staff. With the assistance of the National Council on Crime & Delinquency (NCCD) we will evaluate the instruction regarding safety and risk assessments to clearly define and include mental health, substance abuse, developmental disabilities and domestic violence as “Complicating Factors” within SDM Safety Assessment Tools. DCFS could include in the discussion with NCCD situations when the alleged perpetrator has extensive and/or specific knowledge of Nebraska’s Child Welfare System. This would also include conducting refresher training to ensure understanding of changes to SDM instructions.

- PIP item: 2.2.3 CFS will increase case manager’s proficiency in completing comprehensive and accurate SDM assessments and be able to clearly articulate SDM recommendations to the court and legal parties. DCFS could include training and guidance to staff and supervisors regarding ways to ensure that complete and accurate information is gathered to make informed decisions that are supported by facts as a way to ensure accuracy of information gathered from individuals with extensive or specific knowledge of Nebraska’s Child Welfare system.

**OIG Determination:** The original OIG recommendation did not include training, but was added after accepting DHHS’s request for modification.

## NON-COURT CASE RECOMMENDATIONS

Non-court cases can be effective if families fully participate in them. Successfully engaging parents in the process is a critical task, a review of empirical literature notes there are critical components of engagement in child welfare services including service components and caseworker behaviors.<sup>23</sup> Participation by parents must include both collaboration and compliance. When collaborating with CPS, parents participate in assessing the family’s strengths and needs, contribute to the construction of case plan goals, and take part in team meetings to discuss progress and continuing needs. Along with collaborating, parents must also be compliant in that they display such behaviors as making appointments, keeping appointments, completing tasks, and cooperating with the process in general.<sup>24</sup> Research indicates that influencing collaboration and compliance is most successful when interventions are as follows:

- Requests are specific rather than vague;
- Overt commitments are made by the clients;
- Training in performing tasks is provided;
- Positive reinforcement of the task is supplied; and
- Client participation in the selection and design of tasks is ensured.<sup>25</sup>

Ben’s case exemplified the need for clarity and structure in managing non-court cases. DHHS Division of Children and Family Services Protection and Safety Procedure document #34-2016 (Ongoing Case Management) states the following in regards to non-court cases:

- *The non-court case requires that the family voluntarily agrees to work with the department on identified safety and risk issues.*
- *Non-court involved cases must be provided the same access to services as court involved cases.*

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<sup>23</sup> Dawson, K.; Berry, M. Engaging Families in Child Welfare Services: An Evidence-Based Approach to Best Practice. *Child Welfare*, [s. l.], v. 81, n. 2, p. 293, 2002.

<sup>24</sup> Little, J.H., & Tajima, E.A. (2000). A multilevel model of client participation in intensive family preservation services. *Social Services Review*, 74, 405-435.

<sup>25</sup> Rooney, R.H. (1992). *Strategies for work with involuntary clients*. New York: Columbia University Press.



During the course of a non-court case accurate medical/mental health information and participation in services is vital to assuring child safety and assessing progress towards case plan goals. As was evidenced in this case, without a mandate from the court, parents are under no obligation to provide information or engage in recommended services, thus making an accurate assessment of the family difficult if not impossible.

Because non-court cases are without court mandate, they can be confusing to the family and/or more easily manipulated than court cases. Non-court cases need clear protocols, policies, and expectations for families who are freely and voluntarily agreeing to participate in them. The OIG recommends DHHS:

**II. 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.**

***DHHS Response: Request Modification***

Change to: Create non-court case policy establishing that participating in a non-court case where there is an active safety-threat requires the following.

**OIG Determination: No modification**

As referred to earlier in this report, based on research, outcomes are significantly better when the expectations are clear and supported prior to the acceptance of a voluntary, or non-court, case.

The adoption of standards, should the family voluntarily abide by them, does not change the non-court process, but rather makes the process clearer. If a family will not accept the expectations set forth, whether there is a safety threat or not, they still have the right to decline the case, and the options available to DHHS and the caseworker do not change—they can offer the family information about community supports; offer to make referrals; consult with, and forward the case to, the county attorney (especially when there's a safety threat and the family chooses not to work a non-court case); and/or close the case as declined. This coupled with the implementation of Safety Organized Practice to help caseworkers engage with families, should help put more structure around non-court cases, leading to better outcomes.

A family can either abide by the standards or choose not to, regardless of safety or risk, DHHS has no official capacity to require the family to work a non-court case. The existence of standards increases the probability that families involved in non-court cases will follow them.

**III. Create a handout/brochure to be provided to the family at the time the non-court case is offered that includes:**

- a. A clearly written explanation of what a non-court case is;**
- b. The legal rights of the parents;**
- c. The responsibilities and expectations of the parent(s) agreeing to a non-court case;**
- d. The role and expectations of the caseworker;**
- e. An outline of when information is shared with the county attorney and/or multi-disciplinary (1184) teams;**
- f. An outline of when a referral to the county attorney can be/is made; and**
- g. Contact information for, and an explanation of, the Office of Inspector General of Nebraska Child Welfare and the Office of Public Counsel (also known as the State Ombudsman's Office).**

***DHHS Response: Accept***

DHHS is creating new materials to satisfy this recommendation.

**IV. 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.**

DHHS Division of Children and Family Services Protection and Safety Procedure document #34-2016 (Ongoing Case Management) states the following in regards to apprising county attorney offices of progress in non-court cases:

- *Non-court cases may move to be court involved if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying the child safety concerns and risk of harm. The worker will have a mandatory consult with his/her supervisor to determine if law enforcement should be asked to consider immediate removal and/or the county attorney should be contacted to request court intervention.*
- *In cases where there are no identified safety threats but there is high or very high risk and the family refuses to work with the department, the worker will have a mandatory consult with his/her supervisor to determine if a referral to the 1184 investigation/treatment team should be made and/or the county attorney should be contacted to request court intervention.*
- *The worker is encouraged to involve the investigative and/or treatment team (LB 1184) in discussion of all cases in which the family's risk level is high or very high and the family is unwilling to engage in interventions.*

The function of non-court cases is to provide services to a family while the child (usually) remains in the home and without court intervention. To have children remain in the family home is an important

option when achieving positive outcomes for families. However, timely and well informed decisions are critical in cases where child safety issues or risk of future maltreatment has been identified.

The evaluation of non-court case progress and the potential need for court intervention is best made with cooperation between DHHS and the county attorney's office. The two professional groups often use different kinds of information when assessing child abuse and neglect. CPS workers often rely on information about the severity and pattern of abuse and on information about the services offered in the past and parental responses to those services. Research indicates prosecutors often rely more heavily on information about the likelihood of a reoccurrence of abuse.<sup>26</sup> Both of these perspectives are necessary for an unbiased evaluation of progress in a non-court case and provides a check-and-balance approach.

***DHHS Response: Request Modification***

Change to: Modify the Department's instruction to staff to include a mandatory consultation with the county attorney to evaluate the progress of a non-court case, where there continues to be an active-safety threat, no less than 60 days after opening.

**OIG Determination: No modification**

Whether there is an active safety threat or not, a non-court case that is not progressing should be communicated to the county attorney's office. Furthermore, under current policy, if there is a safety threat, DHHS must put a safety plan in place. If there's no improvement, and there continues to be safety concerns, the worker should already be communicating with the county attorney about the lack of progress under the current process. This recommendation does not have to do with whether there is a safety threat or whether the family is at high risk for child abuse and/or neglect, but rather the status as a non-court case versus a court case.

**V. 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.**

While DHHS policy indicates a mandatory supervisor consultation shall occur with the caseworker when deciding a course of action for non-court cases that are refused by the caregivers or that are not progressing, DHHS supervisors and administration report that there is no formal supervisor training or evaluation criteria when deciding whether a non-court case requires multi-disciplinary or county attorney review, or court intervention. Such criteria and accompanying training is key in assisting with these important decisions.

***DHHS Response: Accept***

DHHS is currently working toward implementing this recommendation, including developing guidance for staff and training for supervisors. Two DHHS documents pertaining to this

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<sup>26</sup> Britner, P.A., & Mossler, D.G. (2002). Professionals' decision-making about out-of-home placements following instances of child abuse. *Child abuse & neglect*, 26 4, 317-3.

recommendation were noted: the *Working Instruction Document for 1184 Treatment and Investigative Team Meetings* and the Division of Children and Family Services Protection and Safety Procedure #23-2017, *Collaborating with Child Advocacy Center (CAC)*.

The OIG has previously made two recommendations pertinent to this investigation, noting that DHHS has not implemented either of these recommendations. These recommendations are emphasized here as they speak broadly to the bases of social work best practices. Central to the child protective service process are the many decision-making points included in gathering and accurately assessing information, identifying the causes of maltreatment and implementing services to eliminate them while strengthening the family's ability to protect and care for their children.<sup>27</sup>

#### **#16-10 Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.**

The use of SDM® was adopted in Nebraska statewide in 2012 to provide a foundation to CPS workers assisting them in making accurate and consistent decisions about how to keep children safe. The OIG will remain committed to highlighting the importance of ensuring that these tools remain valid as they provide guidance to caseworkers and supervisors in their decision-making.

#### ***DHHS Response:***

The Department acknowledges that during the critical incident involving [Ben], fidelity to the SDM tool was inconsistent by Hotline staff. Since then, the Department contracted with an independent consultant, The Stephen Group (TSG) to evaluate the Hotline's fidelity to the SDM tool. The attached *SDM Design and Technical Assistance Project Final Report* provided in November of 2018 noted that, "two key external assessments found that DCFS was effectively implementing and managing the SDM system with high fidelity and adherence to the decision-making logic of each tool."

In addition, the Department contracted with Scott Burdick of Orange County, CA for advanced training for supervisors regarding "*Improved Assessments for Improved Outcomes for Supervisors*." This one-day training for all CFS supervisors was held August 19-23, 2019. Mr. Burdick also provided the curriculum to integrate into an ongoing training for new CFS supervisors. The objectives of this training focused on

- 1) *Understanding the role of bias and strategies for managing bias in making assessments;*
- 2) *Understanding the roles of engagement in making thorough assessments;*
- 3) *Assessing for risk and safety threats for families in reunification and family preservation;*
- 4) *Assessing for family strengths and needs;*
- 5) *Conducting balanced assessments for reunification to include key elements, including case plan progress, visitation evaluation and safety assessment;*
- 6) *Understanding the benefit and use of decision support tools;*
- 7) *Understanding the supervisor's responsibility in helping staff make effective assessments.*

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<sup>27</sup> Rycus, J.S. & Hughes, R.C. (1998). Child Welfare Values. *Field Guide to Child Welfare, Volume 1, Foundations of Child Protective Services*, 123-128. Washington, DC: Child Welfare League of America.

The training provided information to supervisors about helping staff develop critical thinking skills and using decision making tools to make informed decisions. DHHS believes this strategy is an effective initial step to build and maintain a competent, well-trained workforce, able to make informed decisions regarding safety of children.

**#19-06 Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.**

The OIG will continue to recommend that caseworkers and supervisors be required to complete additional SDM logic training, including refreshers on how to utilize the SDM tools using critical thinking skills. As demonstrated by this case, this type of training is especially critical when an SDM tool does not give specific guidance for a unique situation. For example, SDM Risk Assessment guidance does not include when a caregiver provides a conflicting assessment of an incident, provides unconvincing explanations for the child’s injury, or provides no explanation at all. As referenced in the November 2016 Case Reading Report by NCCD’s Children’s Research Center, Nebraska DHHS was advised that staff would benefit from a logic refresher. According to NCCD, it was “the biggest shortcoming in terms of SDM system fidelity in Nebraska . . . It would help workers avoid getting stuck in technically supportable interpretations that nonetheless clearly miss the intent of the item . . . Providing training on using the SDM system to organize clear and concise case notes may strengthen documentation and help reduce workload” (A2-A3).<sup>28</sup>

***DHHS Response:***

The Department contracted with Scott Rudnick of San Diego County, CA for Advanced SDM training for supervisors. CFS supervisors in each service area attended required SDM refresher training in August. The Department supports SDM refresher training, especially if it includes case review, inter-rater reliability reviews, and updates to the model in various dynamics. Safety Organized Practice (SOP) is also being delivered to CFS caseworkers and supervisors across the state. SOP training enhances engagement, provides interviewing tools and improves information gathering skills designed to better assess for safety and risk.

**OIG Comment:**

It is exemplary that DHHS initiated this technical assistance project around SDM, culminating in The Stephen Group (TSG) *SDM Design and Technical Assistance Project Final Report*. As DHHS noted, they said this, “Two key external assessments found that DCFS was effectively implementing and managing the SDM with high fidelity and adherence to the decision-making logic of each tool.” (page 15).

One assessment was from the National Council on Crime and Delinquency Children Research Center (NCCD/CRC), which audited the intake tool designed to assess implementation. Nebraska workers did indeed score well, a compliment to CPS workers given the expertise of NCCD/CRC on the SDM algorithm and its applications. However, the same report also noted that risk validation and recalibration analysis is recommended every five years (page 14). TSG specifically recommended

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<sup>28</sup> National Council on Crime and Delinquency, *Case Reading Report, Structured Decision Making System November 2016*.

obtaining a newer version of the Risk Assessment tool, or have the one they have recalibrated, and they pointed out that other, specialized tools may be of interest as well.

Nebraska has used SDM since 2012, with no formal Nebraska validation process undertaken. Workers have identified issues with both the process and the available tools.

TSG specifically discussed the issue of Safety “Safe” versus Risk “High/Very High” when they conflict, and notes the high rates of recidivism among these families. The recommendation on page 31 states, “DCFS should establish reports for regular executive and management review of all of the instances in which case action is taken contrary to the tools and on the types of over-rides used, which would allow trends to be identified at a system level and interventions to be designed as appropriate (i.e., staff coaching or re-training).”

Application and fidelity to the tool do not mean the tool is valid. Given that CPS relies so heavily on the SDM tools for crucial decision-making within the child welfare system, the OIG remains of the view that they be validated.

DHHS should be commended for the significant improvements in further training the CPS supervisors, and for supporting SDM logic refresher training with case review, inter-rater reliability reviews, and updates to the model.

## Intake Summary for Ben 2012-2015

DATE	REPORTER	ALLEGATIONS	HOTLINE SCREENING
10-2012	Law Enforcement	Entered restaurant naked-asking for food	<b>Not Accepted:</b> Child is autistic. Police did not cite parents.
12-2013	Educational Staff	Physical abuse Denied food	<b>Accepted</b> for assessment: Concerns of abuse to the child. He was out of school for three days last week, possibly to delay him being seen
01-2014	Educational Staff	Physical abuse Denied food	<b>Not Accepted:</b> Information does not meet the statutory guidelines for abuse/neglect. LE made contact with the child and did not have any concerns of abuse/neglect. The previous CPS worker noted that Ben has been known to be a very active 6 year old and plays roughly with his brother and pets.
02-2014	Educational Staff	Physical abuse Denied food	<b>Not Accepted:</b> Police did a well check and found no marks or bruises. Police called back another worker. (CPS) Supervisor said close intake as does not meet definition (DNM). (Old concerns with the family were re-evaluated).
04-2014	Educational Staff	Physical abuse Denied food	<b>Accepted</b> for assessment: Physical Abuse. Child suffered injury due to parent's use of physical discipline also use of cruel punishment.
05-2014	Educational Staff	Physical abuse Denied food	<b>Accepted</b> for assessment: Mother made child stand on his head on a rough surface (vent) for a long enough time that child has a red knot on the top of his head.
10-2014	Educational Staff	Physical abuse	<b>Not Accepted:</b> Does not meet Definition - Ben has not had any known injuries from abuse.
11-2014	Anonymous Relative	Physical abuse Emotional abuse Denied food	<b>Accepted</b> for assessment: Emotional/Physical Abuse and Physical Neglect- Stephanie tells her 6 year old adoptive son Ben that she doesn't want him around and is going to send him to a group home when he turns 8 and also calls him stupid. She hits him and jerks him around by the arm in a rough manner that could cause harm (bruises have been noted in the past). Mitchell is failing to protect Ben and condones Stephanie's treatment of Ben saying that the child is "deceptive and horrible".
11-2014	Educational Staff	Emotional abuse Physical neglect	<b>Not Accepted:</b> No abuse or neglect indicated
12-2014	Educational Staff	Physical abuse	<b>Multiple Reporter:</b> The concern identified was already called in to the CPS Hotline in November and was accepted for Safety Assessment. This new report is being concluded as a "Multiple Reporter" to that prior intake.
08-2015	Educational Staff	Physical abuse Physical neglect Denied food	<b>Not Accepted:</b> There is no chronic lack of hygiene at this time as school just started and the child has been in school for two days. Parents are having a meeting with the school next week. Child has no bruises.
11-2015 [CRITICAL INCIDENT]	Anonymous Educational Staff	Physical abuse Physical neglect Denied food	<b>Accepted</b> Assessment: Parents allegedly withholding food as punishment. Child lost 8 lbs. from end of last school year to the beginning of this year. Children at school are teasing Ben about have a urine smell. On Tuesday, Ben asked R to bring him some food on Wed. He said his s parents withhold food as punishment. Then he did not show up for school on Wed or today. His dad called and said he has not been at school for past 2 days as he had a bowel movement and spread it all over himself.
11-2015	Educational Staff	Physical abuse Denied food	<b>Multiple Reporter:</b> The child is saying that the parents will not give him food at home. The child appears to be malnourished and very skinny. This is being accepted as a multiple reporter
11-2015	Educational Staff	Physical abuse Denied food	<b>Multiple Reporter:</b> Caregivers reported to be withholding food from child as a form of discipline.

## Non-Court Survey



# Non-Court CPS Survey

Office of Inspector General  
of Nebraska Child Welfare

The following survey pertains to the general topic of non-court CPS cases. Per DHHS policy, a family participating in a non-court case works with DHHS without the involvement of the court on a voluntary basis. The case will remain open until the safety threats have been mitigated and/or until the risk level has been reduced to the point that the likelihood of future maltreatment is low to moderate. Non-court cases must be provided the same access to services as court-involved cases. Non-court involved cases may move to be court-involved cases if the family's situation changes to such a degree that child safety cannot be maintained in the home or the family is not making sufficient progress in remedying child safety concerns and risk of harm. Please answer the questions based on your experience as a deputy county attorney or county attorney working with juvenile cases.

For the purpose of internal data interpretation, please identify your county. This information will not be made public or referenced in the final report. It is our goal to examine issues and patterns related to non-court cases statewide, not to specifically address issues by county.

What county are you in?

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1. Adequate information is provided to my office about non-court cases by the local DHHS office.

- Strongly Disagree     Disagree     Neither Agree or Disagree     Agree     Strongly Agree

2. Based on the current level of non-court case information provided by the local DHHS office, should the amount of information your office receives about non-court cases be altered?

- More shared information is needed     Less shared information is needed     Shared information should be kept about the same

3. How frequently does your office communicate with the local DHHS office about non-court cases?

- On an as needed basis or when there is a request to file affidavit of information     Every Few Months     Monthly (outside of 1184 meetings)     Weekly     Several times a week



4. What form does communication about non-court cases with the local DHHS office most frequently take?

- Informal Conversations     Email     Phone Calls     Scheduled Meetings     Formalized Documents

5. How do you most prefer to communicate about non-court cases with your local DHHS office?

- Informal Conversations     Email     Phone Calls     Scheduled Meetings     Formalized Documents     No Preference

6. On a scale of 1-5 with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the current working relationship between your office and the local DHHS office?

1                      2                      3                      4                      5

*Dissatisfied*     —————  —————  —————  —————     *Satisfied*

7. From what source do you get the majority of your information about non-court cases?

- DHHS case worker or administration     Other Service Providers     1184 Team     Other \_\_\_\_\_

8. On a scale of 1-5 with 1 being very dissatisfied and 5 being very satisfied, how satisfied are you with the current DHHS non-court case policy?

1                      2                      3                      4                      5

*Dissatisfied*     —————  —————  —————  —————     *Satisfied*

9. Based on your experience, non-court cases are an effective method of helping families alleviate maltreatment.

- Strongly Disagree     Disagree     Neither Agree or Disagree     Agree     Strongly Agree

10. What suggestions would you make to improve the non-court process?

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## Initial Assessment and non-court cases

The following questions pertain to the Initial Assessment (IA) phase of intakes and non-court CPS cases. Initial Assessment refers to the CPS process after a report to the Abuse/Neglect Hotline has been accepted as an intake. The process requires investigating allegations, assuring the safety of the child and making decisions regarding case status including referring a case to the county attorney's office for juvenile court filing.

11. Does your office monitor intakes to the Child Abuse/Neglect Hotline that originate from your county?

- Yes  
 No

12. Is your office notified when a family declines an offer from DHHS for a non-court case?

- Yes  
 No

12a. If yes, what is the time frame for notification?

- Immediately    Within the week    1-2 weeks    3-4 weeks    Other \_\_\_\_\_

13. Are you aware of the criteria a family must meet to be offered the opportunity to work a non-court case?

- Yes  
 No

14. On a scale of 1-5 how confident are you that children are safe in cases where a non-court case is offered by DHHS?

- 1                      2                      3                      4                      5  
*Not Confident*                                                                                                                 *Very Confident*

## Ongoing Case Management of non-court cases

The following questions pertain to the Ongoing phase of case management and non-court CPS cases. Ongoing case management services are based on the results of safety and risk assessment and include working collaboratively with the family to assist them in accessing informal and formal supports, implementing a written case plan, and ensuring the safety of the child.

15. Is your office notified by DHHS when a family is not making progress in a non-court case?

Yes

No

16. How frequently do you and/or your office staff discuss progress by families on non-court cases with the local DHHS office?

On an as-needed basis

Every few months

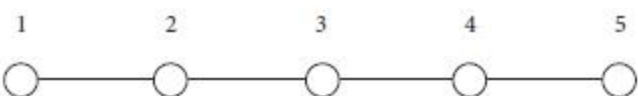
Every month  
(outside of  
1184 meetings)

Weekly

Several times  
a week

17. On a scale of 1-5, how confident are you that those families who are not demonstrating quality participation in non-court cases are referred for court intervention?

Not Confident      1      2      3      4      5      Very Confident



18. Is there a need for a standardized level of participation in a non-court case (explicit expectations) to be established and explained to parents at the time of case opening?

Definitely don't need

Probably don't need

Neutral

Probably need

Definitely need

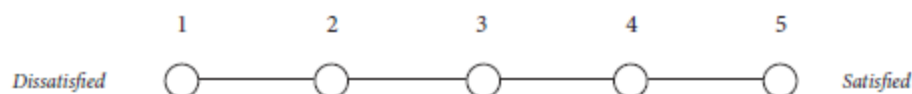
## 1184 Team Process and non-court cases

The following questions pertain to the 1184 team and non-court CPS cases. Responses should be based on your overall experience with the 1184 team process as it relates to non-court CPS cases.

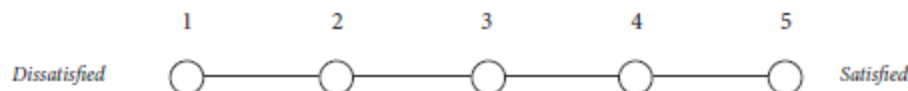
19. How frequently do you or someone from your office meet with 1184 team members to staff non-court cases?

- Less than quarterly     Quarterly     Monthly     Bi-weekly     Weekly     Several times a week

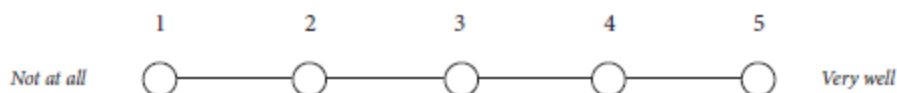
20. On a scale of 1-5, with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the current level of functioning/effectiveness of the 1184 process as it relates to non-court cases?



21. On a scale of 1-5, with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the information DHHS provides on a non-court case when staffed at an 1184 meeting?



22. On a scale of 1-5, how well does the 1184 process produce adequate information to make a determination about filing a 3a?



23. What changes would you suggest be made to improve the 1184 process?

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# Thanks for taking the survey!

Would you like our office to contact you? If so, please provide your name, phone number and email.

Name:

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Phone:

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Email:

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## Office of Inspector General of Nebraska Child Welfare

*The Office of the Inspector General (OIG) provides an independent form of inquiry and review of the actions of individuals and agencies responsible for the care and protection of children in the Nebraska child welfare and juvenile justice systems.*

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## *JUVENILE ROOM CONFINEMENT FY 18-19 REPORT*

### *SYNOPSIS*

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The OIG released its third annual report on the use of juvenile room confinement in November 2019.<sup>29</sup> The report examined juvenile room confinement in Nebraska between July 1, 2018 and June 30, 2019.

Based on definition in Nebraska law, juvenile room confinement is an umbrella term.<sup>30</sup> Different facilities keep youth involuntarily alone by using practices which may be known as segregation, restrictive housing, special management, isolation, seclusion, disciplinary confinement, time-out, and room restriction, among others.<sup>31</sup>

For FY 2018-19 the OIG received room confinement reports from 32 individual facilities comprised of five different types of juvenile facilities in Nebraska—correctional institutions, youth rehabilitation and treatment centers, detention centers, mental health and substance abuse treatment centers, and residential child-caring agencies. In FY 18-19, the total number of youth subject to room confinement was 631, with 2,683 incidents. Youth ranged in age from 13-18 years and were put into room confinement most frequently due to physical assault, verbal assault, administrative reasons and behavioral infractions/rule violations.

As a result of the inquiry and data analysis undertaken for the 2018-2019 Juvenile Room Confinement in Nebraska Annual Report, the OIG found the following:

***Over the past three years, limited changes have been made to decrease reliance on juvenile room confinement as a management tool among the facilities that report.***

Formal changes to policies and practices on the use of room confinement have not contributed to a comprehensive facility change in reliance on the practice.

***Subjective interpretations of the current statute has resulted in inconsistent reporting.***

The OIG found that the subjectivity applied to juvenile room confinement practices and reporting has resulted in data that cannot be used to definitively quantify the use of juvenile room confinement by facilities in Nebraska. Each individual facility or agency is interpreting the statute, and therefore has determined its own definitions and practices which could be out of alignment with the legislative intent. Examples of this would include facilities that do not view the statute as applying to them, leading to sporadic reporting or no reporting at all; the narrow interpretation of room confinement to disciplinary or behavioral reasons only, thus ignoring the “involuntary”

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<sup>29</sup>

[https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Inspector\\_General\\_of\\_Nebraska\\_Child\\_Welfare/650\\_20191121-131305.pdf](https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/650_20191121-131305.pdf)

<sup>30</sup> Neb. Rev. Stat. § 83-4,125 states, “Room confinement means the involuntary restriction of a juvenile to a cell, room, or other area, alone, including a juvenile's own room, except during normal sleeping hours.”

<sup>31</sup> Individual facilities have specific definitions and practices for each type of room confinement. These practices are discussed in detail in sections on types of facilities in the full report.

portion of the definition; and, the subtraction of “normal sleeping hours” from the duration of a room confinement event.

***The Jail Standards Board at the Nebraska Crime Commission and the Department of Health and Human Services-Division of Public Health have not revised their regulations to incorporate statutes related to juvenile room confinement.***

Neither agency has implemented rules and regulations that mandate each facility to collect data and submit a report to the legislature.<sup>32</sup>

In conjunction with the 2018-2019 findings, the OIG recommended the following actions to reduce reliance on juvenile room confinement:

Implement legislation that requires the following:

- ***All facilities adhere to best practices to reduce reliance on juvenile room confinement.***
- ***Clarification of current legislative provisions related to juvenile room confinement.***
- ***Extension of the Crime Commission and Department of Health and Human Services-Division of Public Health responsibilities related to juvenile room confinement to include, at a minimum, on-site verification and standardized data collection and content.***

**FY 19-20 Juvenile Room Confinement Facility Summaries**

Nebraska Department of Correctional Services (NDCS)

The Nebraska Department of Correctional Services (NDCS) operates facilities that house people convicted of crimes in Nebraska’s criminal courts and sentenced to prison terms. While most of its inmates are over 19 years of age (the age of majority in Nebraska), some NDCS inmates are minors housed at the Nebraska Correctional Youth Facility (NCYF).

<b>FY 18-19</b>	<b>Incidents/ Individual</b>	<b>% ending in 4 hours</b>	<b>% ending in 8 hours</b>	<b>Median duration (hours)</b>	<b>Longest incident (hours)</b>	<b>Shortest incident (hours)</b>
NCYF	482/57	79	83	2.5	2731	1.0

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<sup>32</sup> §83-4,134.01

### DHHS Youth Rehabilitation and Treatment Centers (YRTCs)

At the time of the report, DHHS Office of Juvenile Services (OJS) operated two Youth Rehabilitation and Treatment Centers (YRTCs) in Kearney (boys) and Geneva (girls) that served youth in the juvenile justice system, ages 14 through 18.

<b>FY 18-19</b>	<b>Incidents/ Individual</b>	<b>% ending in 4 hours</b>	<b>% ending in 8 hours</b>	<b>Median duration (hours)</b>	<b>Longest incident (hours)</b>	<b>Shortest incident (hours)</b>
YRTC-K	956/134	18	31	15.5	135.75	1.25
YRTC-G	460/52	31	37	18.5	111.5	1.0

### Juvenile Detention Facilities

The Nebraska Jail Standards Board, housed at the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission), has the authority over the four juvenile secure and staff secure detention facilities in Nebraska. Douglas County Youth Center (DCYC), Lancaster County Youth Services Center (LCYSC), Northeast Nebraska Juvenile Services Center (NNJSC), and the Patrick J. Thomas Juvenile Justice Center (PJTJC). These facilities have primarily housed youth under 18 after initial arrests, youth who are sent to detention after probation violations, and youth awaiting placement while on probation.

<b>FY 18-19</b>	<b>Incidents/ individual</b>	<b>% ending in 4 hours</b>	<b>% ending in 8 hours</b>	<b>Median duration (hours)</b>	<b>Longest incident (hours)</b>	<b>Shortest incident (hours)</b>
PJTJC	114/45	71	97	3.0	9.5	1.0
NNJSC	78/63	94	96	1.5	15.0	1.0
LCYSC	130/67	90	99	2.0	13.0	1.0
DCYC	463/201	6	14	45.75	346.5	.25



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## *STATUS OF OIG RECOMMENDATIONS*

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Reports of investigation issued by the OIG contain recommendations for systemic reform and/or case-specific action. The OIG's annual report is required by Neb. Rev. Stat. § 43-4331 to detail recommendations and the status of implementation of recommendations.

The table below contains a summary of all recommendations made by the OIG in its investigative reports. The recommendations are numbered based on the year and order the recommendation appeared in an annual report. For example, the first recommendation appearing in the 2015 Annual Report is numbered 15-01.

Each recommendation is categorized as either accepted or rejected by the agency<sup>33</sup>, based on an official response to the investigation, and then is assigned an implementation status of incomplete, no further action, progress, or complete by the OIG based on information provided by the subject agency. The definitions of each status are:

**Accepted:** The agency accepted the recommendations as part of the original investigation.

**Rejected:** The agency rejected the recommendation as part of the original investigation.

**Incomplete:** The agency has not taken relevant action to address the recommendation.

**No Further Action:** The agency has taken some relevant action to address the recommendation, but has no plans to take additional necessary action to address the recommendation.

**Progress:** The agency has taken relevant action to address the recommendation and has plans to take additional necessary action to address the recommendation.

**Complete:** The agency has taken all relevant and necessary action to address the recommendation.<sup>34</sup>

The OIG monitors shifts to established policy/procedure as well as changes in implementation status of previously completed recommendations. Recommendations with revised status will be noted, including the fiscal year in which the revised status occurred.

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<sup>33</sup> In cases where the subject agency requested modification to the recommendation and the OIG agreed, the recommendation is categorized as accepted. When the requested modification was denied by the OIG, the recommendation is categorized as rejected.

<sup>34</sup> In cases where the implementation status of complete is no longer appropriate, a revised status has been noted.

*OIG Recommendations to DHHS Divisions*

2020

OIG Recommendation	Agency	Implementation Status
<p>20-01. 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.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Progress</b>                      DHHS will conduct quality assessments and utilize supervisory consultation specifically in cases in which an alleged perpetrator is well versed in the child welfare, law enforcement, or legal settings. DHHS will be conducting a series of trainings regarding this recommendation.</p>
<p>20-02. Create non-court case policy establishing that participating in a non-court case requires the following:</p> <ul style="list-style-type: none"> <li>• 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,</li> <li>• Parents allow contact between the worker and their children, without caregivers present, and</li> <li>• Parents must formally agree to participate in recommended services.</li> </ul>	<p>DHHS-CFS</p>	<p><b>Rejected - Completed</b>                      DHHS rescinded Protection and Safety Procedure #34-2016.                      DHHS created Standard Work Instruction, “Ongoing Case Management” that includes the case management of “non-court” cases when there is an active safety threat and/or the risk level is determined to be “high” or “very high”.                      Parents/caregivers will be required to sign a Release of Information form for all related medical/mental health providers for the purpose of gathering collateral information and assessing progress on the case plan/foster care prevention plan goals; allow contact between the worker and the child(ren), without the caregivers present, and; must formally agree to participate in the recommended services. Record of this formal agreement will be documented within the Foster Care Prevention Plan.</p>
<p>20-03. Create a handout/brochure to be provided to the family at the time the non-court case is offered.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Progress</b>                      A brochure has been created for families who are participating in a non-court case and is waiting on final draft approval and printing. The brochure will be stored within CFS offices for CFS staff to disseminate to the families who are involved in a non-court case.</p>

<p>20-04. 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.</p>	<p>DHHS-CFS</p>	<p><b>Rejected -Progress</b>  DHHS created a Standard Work Instruction, “Mandatory Consultation Points” which clarifies that a consultation point is required <u>when there continues to be an active safety threat in a non-court case</u>, no less than 60 days after opening. Workers are required to document their consultation regarding any staffing with the County Attorney regarding a non-court case <u>with an active safety threat</u> which has been open less than 60 days.  A new Quality Assurance Review was implemented in July 2020 to determine adherence to this policy change. The review looks at active non-court cases with a duration of &gt;60 days and an identified safety threat. This new review will be conducted bi-annually. At least 100 cases will be selected for review each review period. A report with review results and recommendations will be posted on the internally and shared with Administrators, supervisors and staff, within the month following the completion of the reviews.</p>
<p>20-05. 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.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS created a Standard Work Instruction “Ongoing Case Management” which includes direction regarding the case management of non-court cases. It states the worker and their supervisor will collaborate to determine if a referral for the LB 1184 for review and/or a referral to the County Attorney’s office is necessary.    DHHS created a Standard Work Instruction, “1184 Team Meetings” to provide guidance to staff regarding when, how and what types of cases are to be referred for 1184 team review. It also includes a flowchart to follow regarding referrals and a template to be used when making a referral and attending 1184 team meetings.</p>

2019

OIG Recommendation	Agency	Implementation Status
19-01. Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.	DHHS-CFS	<b>Accepted - Complete</b> DHHS created Standard Work Instruction, “Foster Home Placement Disruption and Foster Home Hold and Review Process”, that outlines the process for workers in the field. The new procedure was finalized in August 2020.
19-02. Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.	DHHS-CFS	<b>Accepted - Complete</b> DHHS created Standard Work Instruction, “Participating in a Case Staffing with Managed Care Organizations” that addresses the assessment and well-being needs of youth in care in conjunction with placement, services and support needs.  DHHS created Standard Work Instruction, “Foster Home Placement Disruption and Foster Home Hold and Review Process” to specify where to document and locate placement disruption plans within NFOCUS.
19-03. Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.	DHHS-CFS	<b>Rejected - Incomplete</b>
19-04. 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.	DHHS-CFS	<b>Rejected- Complete</b> DHHS created Standard Work Instruction, “Initial Assessment” that includes language specific to the birth of baby in July 2020. The language states that additional safety assessments are required when there is a change in family conditions including when a new baby is born. The response time is set as a priority 2, unless a more immediate response is required.

<p>19-05. 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.</p>	<p>DHHS-CFS</p>	<p><b>Rejected – Complete</b>  DHHS created Standard Work Instruction, “Mandatory Consultation Points”, in July 2020 which clarifies the required consultation when a parent has voluntarily relinquished their parental rights as well as direction to staff to conduct a mandatory consultation with their supervisor when a CFS case closes due to reunification with the non-custodial parent.</p> <p>DHHS also created Standard Work Instruction “Non-Custodial Parents Identification and Engagement” in July 2020 specifically outlines the required steps to be taken prior to case closure with a non-custodial parent, which includes staffing the closure with the CFS Supervisor.</p>
<p>19-06. Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.</p>	<p>DHHS-CFS</p>	<p><b>Rejected – Progress</b>  DHHS notes that any worker or supervisor can request a refresher of the Initial Assessment or Ongoing training which includes the SDM modules. They state that they are planning to take the following actions in response to this recommendation: obtain data on SDM as well as other topics to identify areas needing improvement; create a survey for front line staff to obtain information on training topics related to SDM; and, create a survey for supervisors on training needs identified for staff as well at the supervisor role. The surveys were sent out and analyzed in July 2020. A finalized plan for training needs for SDM is expected to be complete September 2020.</p>
<p>19-07. 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.</p>	<p>DHHS-CFS</p>	<p><b>Rejected- Progress</b>  DHHS is engaging in a partnership with the Quality Improvement Center for Workforce Development (QIC-WD). QIC-WD interventions will focus on addressing Secondary Traumatic Stress (STS) among CFSS and supervisors. DHHS has implemented the CFS Strong program which includes curricula to address on-going and acute traumatic events.</p>

2018

OIG Recommendation	Agency	Implementation Status
18-01. 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.	DHHS-CFS	<b>Rejected - Complete</b> LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS has created a new Critical Incident Reporting form accordingly. The form will be utilized statewide by September 2019.
18-02. 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.	DHHS-CFS	<b>Accepted - Complete</b> At the time of completion DHHS reported that CFS Central Office Administrators and other staff review every "Does Not Meet Definition" screen. DHHS analyzed reasons why intakes were being re-screened and adopted definitions. The CQI team was performing qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, were following proper practice and policy.
18-03. 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.	DHHS-CFS	<b>Accepted - Complete</b> DHHS reports that the Hotline Administrator reviewed the intake process, and QA staff put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed to ensure appropriate use of policy and discretionary overrides. At the time of completion over 1700 intakes that had been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.
18-04. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.	DHHS-CFS	<b>Accepted - Complete</b> DHHS contracted with Project Harmony to create three modules related to preventing and educating about the sexual abuse of children.

<p>18-05. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - No Further Action</b>  DHHS has created a new finding: Law Enforcement Refusal, which indicates that law enforcement is choosing to not investigate the allegation. In these cases, DHHS is not investigating the allegations either. This change in Hotline protocol has been implemented statewide. Staff at the Hotline continue to reach out to law enforcement. The Hotline Administrator has met with law enforcement across the state about the importance of communicating these investigatory conclusions with the Hotline.</p>
<p>18-06. 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.</p>	<p>DHHS-CFS</p>	<p><b>Rejected – No Further Action</b>  DHHS reports that this is already occurring, based on assessments and referrals that take place at the Hotline. Hotline staff will connect families to other hotlines and the CACs when appropriate. DHHS has implemented a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. All referrals through the FAST program are documented on NFOCUS.</p>
<p>18-07. Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS reports that a curriculum has been developed on the preponderance of the evidence standard. Trainings for all supervisors occurred across the state beginning in April 2018.</p>
<p>18-08. Adhere to policy on out of home assessments and enhance quality assurance</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS has created Standard Work Instruction “DHHS Facility Investigations” that details how investigations will be completed for facilities managed by DHHS effective October 2019. DHHS has an Out of Home Assessment policy for facilities that are not managed by DHHS effective November 2017. DHHS also created a Standard Work Instruction, “Facility Assessments-Out of Home Assessment Team” effective August 2020. DHHS plans to implement a QA process for out of home assessments.</p>

<p>18-09. Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS has transferred the responsibility for entering findings to the Hotline for investigations conducted by law enforcement only. (Program Memo #33-2017). In May 2018, Hotline staff began addressing the backlog of law enforcement cases where no findings had been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked.</p> <p><b>FY 19-20:</b> DHHS has rescinded Program Memo #33-2017 and created a Standard Work Instruction, “Monitoring of Law Enforcement Only Intakes by Hotline” effective December 2019.</p>
<p>18-10. Meet the statutorily required caseload standard for initial assessment and ongoing case management.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Incomplete</b>  DHHS reports indicate that during FY 19-20, the average of caseload conformity was about 80%. DHHS continues to be out of compliance with statutorily required caseload standards.</p> <p>DHHS believes that due to a low turnover rate, open positions will decrease, time needed to fill vacancies will decrease, and as a result of this, more case managers will be eligible to carry full caseloads, thus compliance with the caseload mandate will improve.</p> <p>A monthly caseload report can be found on their website.</p>
<p>18-11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS contracted with Project Harmony to develop the curriculum for developmentally-appropriate education to prevent sexual abuse and exploitation within the child welfare system. A 3-module training was developed:</p> <ol style="list-style-type: none"> <li>1. Darkness to Light</li> <li>2. Sexual Health, Behaviors, and Abuse of Children</li> <li>3. Bringing it Home: Managing Sexual Abuse and Behaviors.</li> </ol>



<p>18-12. Review and revise training on child sexual abuse for DHHS staff.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS has contracted with Project Harmony to implement the training. See 18-11.</p>
<p>18-13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS has revised contracts with child-placing agencies to better align caregiver and child needs. Specific training for foster parents will be provided based on the specific child’s needs. A request for proposals has been developed for resource families. The family’s voice and choice is being incorporated into these revisions. Caseworkers are utilizing Safety Organized Practice across the state. Many of these strategies are incorporated into Nebraska’s performance improvement plan (PIP).</p>
<p>18-14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS enhanced the application process for foster parenting to better screen foster homes, and DHHS issued an RFP for home studies in order to improve the process. DHHS made modifications to regulations, which are presently in the promulgation process, to comply with more stringent foster care, adoptive, and guardianship model licensing standards.</p> <p>When currently licensed foster parents apply to renew their license, they will have to be in compliance with the new requirements—complete the updated application, home study, compliance checklist, and the like. Those not in compliance with the new regulations no longer remain as a licensed foster parent.</p>
<p>18-15. Include a component on child sexual abuse prevention in foster and adoptive parent training</p>	<p>DHHS-CFS</p>	<p><b>Rejected - Complete</b>  The training that Project Harmony is implementing will also be utilized in foster and adoptive parent training. See 18-11.</p>
<p>18-16. Ensure adequate staffing for residential-child caring agency licensing operations.</p>	<p>DHHS- Public Health</p>	<p><b>Rejected – No Further Action</b></p>

<p>18-17. 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.</p>	<p>DHHS- Public Health</p>	<p><b>Accepted - Complete</b> LB 59 was passed into law during the 2019 Legislative Session, which requires that investigatory reports made under the Children’s Residential Facilities and Placing Licensure Act be issued 60 days after the determination is made to conduct the investigation, except that the report may be filed within 90 days if an interim report is filed within 60 days.</p>
<p>18-18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.</p>	<p>DHHS- Public Health</p>	<p><b>Accepted - No Further Action</b> Public Health reports reviewing PREA regulations and incorporating some standards into regulations being promulgated.</p>

OIG Recommendation	Agency	Implementation Status
17-10. Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.	Private Agency: Owens Educational Services, Inc.	<b>Accepted - Complete</b> Owens now requires staff to contact & stay in communication with mental health professionals when a release is signed.
17-11. Implement training on suicide warning signs and prevention in youth.	Private Agency: Owens Educational Services, Inc.	<b>Accepted - Complete</b> In April 2017, an LIMHP, PLADC Mental Health Practitioner trained staff company-wide on QPR (Question. Persuade. Refer.) Training for suicide prevention. This curriculum was also added to New Hire Training.
17-12. Promulgate rules and regulations related to the Children’s Residential Facilities and Placing Licensure Act as soon as possible.	DHHS- Public Health	<b>Accepted - Progress</b> DHHS has had a draft set of regulations with stakeholder input ready for promulgation. These regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.
17-13. Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.	DHHS- Public Health	<b>Accepted - Progress</b> The regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.
17-14. Adopt clear requirements on medical record-keeping and documentation in regulations.	DHHS- Public Health	<b>Accepted - Progress</b> DHHS draft regulations include record keeping requirements for medications and specify that facilities must adopt policies on medical record-keeping. The regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.

OIG Recommendation	Agency	Implementation Status
<p>17-15. Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.</p>	<p>DHHS- Public Health</p>	<p><b>Accepted - Progress</b> DHHS draft regulations specify that facilities must adopt policies obtaining consent for medical treatment. The regulations have now entered the formal promulgation process and a public hearing was held in August 2019.</p> <p>DHHS is also planning to develop additional guidance for facilities on how to comply with regulations, while not adding requirements to regulations themselves.</p>
<p>17-16. Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.</p>	<p>DHHS- Public Health</p>	<p><b>Accepted - Complete</b> Public Health has reported sharing information with both CFS and Probation in a more timely way, and, when possible, conducting joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing. DHHS reports that it shares information on licensing actions and has been coordinating effectively on investigations.</p>

2016

OIG Recommendation	Agency	Implementation Status
16-01. Implement training on the medical aspects of child abuse.	DHHS-CFS	<p><b>Accepted - Complete</b>            CCFL consulted with Dr. Bleicher as a medical expert for curricula review in August and September 2017. The following recommendations were made:</p> <ul style="list-style-type: none"> <li>• Spiral fractures in toddlers and young children are often activity related but the same fracture in the arms (especially infants) are highly suspicious of abuse. References made to spiral fractures need to be clarified (revision meeting scheduled for 12.05.17)</li> <li>• Incorporate the article Bruising Characteristics Discriminating Physical – help to distinguish accidental from abusive injuries (revision meeting scheduled for 12.05.17).</li> </ul> <p><b>02/02/18</b> This training was created and trained for the first time with the 1117 training group.</p>
16-02. Adopt policy on photographing injuries during Initial Assessment.	DHHS-CFS	<p><b>Accepted - Complete</b>            In February 2016, DHHS adopted <a href="#">Protection and Safety Procedure #5-2016</a>, "The use of Photographs from Intake through Case Closure."</p>
16-03. Develop additional training for Initial Assessment staff.	DHHS-CFS	<p><b>Accepted - Complete</b>            CCFL updated its New Worker Training in 2016 to include a more intensive focus on family engagement. Caseworker in-service training on Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, Human Trafficking, Advanced Testifying, and Engaging Families in Safety and Risk Assessments have been developed and are being offered around the state.</p>

<p>16-04. Further define process for utilizing child advocacy centers by Initial Assessment.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - No Further Action</b>  After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers, DHHS decided not to update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. DHHS indicated they did not believe the burden for referral should be on DHHS staff alone. DHHS issued a revised memo on use of CACs, <a href="#">Protection and Safety Procedure #23-2017</a>, however, none of the OIG’s suggestions were incorporated.</p>
<p>16-05. Update and provide additional detail on response priority definitions.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS updated its intake manual in August 2017 in <a href="#">Protection and Safety Update #26-2017</a>. The updated manual provides clarification on priority response time definitions involving injuries to children under age six.</p> <p><b>FY 19-20:</b> DHHS updated the intake manual in October 2019.</p>
<p>16-06. Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  In September 2016, new guidelines for supervisory review of intakes (calls to the Hotline) went into effect, reducing the percentage Supervisors had to review and extending the timeframe for them to complete reviews. However, these changes were implemented without an analysis of supervisory staffing and a review of all of their responsibilities. In 2017, DHHS added a supervisor position at the Hotline and refocused supervisors on reviewing accepted reports. CFOMs were also transferred to the Hotline and now review screened out reports.</p>
<p>16-07. Expand quality assurance and continuous quality improvement (CQI) at the Hotline.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  At the time of completion quality assurance efforts included DHHS reviewing additional Hotline calls related to physical abuse allegations of children under 7 on a quarterly basis.</p>

<p>16-08. Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Incomplete</b>  The Initial Assessment workforce has averaged at a rate of about 93% compliance with caseload standards.</p> <p>The DHHS caseload initiative (whereby caseloads are counted by the number of children as opposed to number of families, and worker skill level is incorporated) has not resulted in a proposed change to statutory caseload requirement language during the 2020 Legislative Session, as was projected by DHHS in 2019.</p>
<p>16-09. Take steps toward greater Initial Assessment workforce specialization and experience.</p>	<p>DHHS -CFS</p>	<p><b>Accepted - No Further Action</b>  DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts of the state.</p> <p>DHHS has enhanced training for workers assigned to Initial Assessment, held internal discussions about additional CFS paygrades, and made adjustments to team composition such as end-to-end teams and allowing IA partnering caseloads between two workers.</p>
<p>16-10. Contract with an independent entity to perform a validation study of Nebraska’s SDM Risk Assessment instrument.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - No Further Action</b>  DHHS contracted with the National Council on Crime and Delinquency to conduct independent case reads on SDM safety and risk assessments. The results of the case reads were fairly positive.</p> <p>However, this was <i>not</i> a validation study. There is still no research demonstrating whether Nebraska’s SDM tool is accurately predicting risk or not and whether adjustments to the tool may need to be made.</p>
<p>16-11. Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials.</p>	<p>DHHS – Public Health</p>	<p><b>Accepted - Complete</b>  The Child Safety Collaborative Innovation &amp; Improvement Network (CoIIN), housed at Public Health, has developed a Crying Plan and has gathered data from Hospitals on the materials they distribute and education they provide on abusive head trauma.</p>

<p>16-12. Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>          In April 2016, CFS Central Office distributed an “Under 2” packet, in English and Spanish, designed with input from the Division of Public Health, to field staff. Information about pediatric abusive head trauma is included in the packet. CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.</p>
<p>16-13. Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>          DHHS added a supervisor position to the Hotline and placed 3 CFOM positions at the Hotline to review screened out reports to ensure appropriate screening decisions occurred. Supervisors review all screened out reports and listen in on calls. A new process has been set up so that quality assurance staff review accepted intakes that the field wants re-screened. Hotline processes have been reviewed through the Lean Six Sigma process to improve performance. An additional staff member was also added to the Hotline to take calls. If an intake is not accepted for initial assessment, all referrals are now tracked. All CFSS trainees will begin to shadow at the Hotline.</p>
<p>16-14. Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>          DHHS has developed a monthly report on CWLA caseload compliance, including initial assessment and mixed caseloads. An overall report is posted publicly on their website and updated monthly.</p>
<p>16-15. Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>          DHHS has collected data on high/very-high risk families declining services and has seen a slight increase in the acceptance of services.</p> <p>DHHS has implemented Safety Organizing Practice (SOP), a family engagement model, over the past 6-12 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement.</p>



<p>16-16. 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.</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017.</p> <p>The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.</p>
<p>16-17. Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.</p>	<p>DHHS-CFS  Private Agency:  Nebraska Families Collaborative (NFC)</p>	<p><b>Accepted - Complete</b>  In August 2017, DHHS adopted Protection and Safety Procedure #28-2017, “Mandatory Monthly Visits With Children, Parents &amp; Out of Home Care Providers,” which includes the Nebraska Safe Sleep Environment Checklist developed by Public Health and policy for workers regarding safe sleep.</p> <p><b>FY 19-20:</b> DHHS has rescinded Protection and Safety Procedure #28-2017 and created a Standard Work Instruction on “Mandatory Monthly Visits with Children, Parents, &amp; Out of Home Care Providers” effective April 23, 2020.</p> <p>NFC updated the monthly Walkthrough Checklist, adding prompts to address children ages 0-5 sleeping location, the condition of the room/bed etc.</p> <p><b>FY 19-20:</b> Nebraska Families Collaborative (NFC) or PromiseShip is no longer providing case management services in the Eastern Service Area.</p>

<p>16-18. Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.</p>	<p>DHHS-CFS Private Agency: Nebraska Families Collaborative</p>	<p><b>Accepted - Complete</b> In 2016, DHHS incorporated infant safe sleep into New Worker Training. An “Under Two Packet” with information about safe sleep was created with assistance from the Division of Public Health. This is distributed to all families and caregivers of children under two.</p> <p>In 2016, NFC incorporated Safe Sleeping into New Worker Training and a webinar has been created that is mandatory for all permanency staff. The training includes information on items that should/shouldn’t be in the crib, co-sleeping, blankets, infant sleepwear, etc. This training will be completed annually by all permanency staff. NFC has attached Safe Sleep Guidelines to ages 0-5 Walkthrough Packet that is to be reviewed and/or given to the caregiver at each walkthrough when assessing non-agency/kinship homes.</p> <p><b>FY 19-20:</b> Nebraska Families Collaborative (NFC) or PromiseShip is no longer providing case management services in the Eastern Service Area.</p>
<p>16-19. Revise regulations to require infant safe sleep training before granting a child care license.</p>	<p>DHHS- Public Health</p>	<p><b>Accepted - Complete</b> LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted. 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.</p>
<p>16-20. Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible</p>	<p>DHHS-CFS</p>	<p><b>Accepted -No Further Action</b> See Recommendation 15-01</p>

16-21. Enhance efforts to reduce caseworker turnover.	DHHS-CFS	<p><b>Accepted - Complete</b> At the time of completion DHHS made changes to job recruitment strategies, revisions to New Worker Training to make it more accessible and less travel-intensive to complete. In July 2017, DHHS initiated a supervisor training program to better ensure caseworkers are supported.</p>
16-26. Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.	DHHS-CFS	<p><b>Accepted - Complete</b> DHHS has issued Administrative Memo 1-2018, Crossover Youth Practice Model, and, with Probation, presented the Statewide Crossover Youth Initiative Training to all case managers and juvenile probation officers.</p> <p><b>FY 19-20:</b> DHHS has rescinded Protection and Safety Procedure #1-2018 and created a Standard Work Instruction on “Crossover Youth Practice Model” effective November 12, 2019.</p>
16-27. Increase training and coordination between the Division of Children and Family Services and the Division of Developmental Disabilities.	DHHS-CFS DHHS- Developmental Disabilities	<p><b>Accepted - Complete</b> At the time of completion both CFS and DD participated in the Cross Divisions Solution Team. In 2017, DD helped provide information and feedback on CFS New Worker Training and developed a PowerPoint on available services for CFS staff.</p>
16-28. Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system	DHHS - Developmental Disabilities	<p><b>Accepted - Complete</b> DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTCs for service eligibility.</p>

<p>16-29. Make the OJS Administrator a Full-time Position</p>	<p>DHHS-CFS</p>	<p><b>FY 19-20</b>  <b>REVISED STATUS: Incomplete</b>  During the summer of 2020, Mark LaBouchardiere was named as the OJS Administrator, though that information is not reflected on DHHS’s current organizational charts. In addition to the YRTC system, two facilities were added to the OJS Administrator role, according to the DHHS Division of Behavioral Health organizational chart—Hastings PRTF (Hastings Regional Center) and Whitehall.</p> <p><b>FY 18-19</b>  <b>Rejected-Progress</b>  Trevor Speigel was the named OJS Administrator, but it was unclear whether he was acting in that capacity with regard to the Youth Rehabilitation and Treatment Centers in September of 2019. In addition, two facilities were added to the OJS Administrator role, according to the DHHS Division of Behavioral Health organizational chart—Hastings PRTF (Hastings Regional Center) and Whitehall.</p>
<p>16-30. Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  In 2016, DHHS ended the full-time care program in Dickson. Currently, youth can live in Dickson for a short period of time if they have had struggles in their living unit. Each youth in Dickson has a Reintegration Plan that must be developed where the youth begins participating in normal activities as soon as they are able (example - school, group meetings). YRTC-Kearney reported that youth have not stayed in Dickson for longer than three to four weeks. These changes have not been codified in policy.</p>
<p>16-31. Develop Continuous Quality Improvement Process at YRTCs Led by Central Office</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  In 2017, DHHS Central Office began putting together monthly data reports on Performance-based Standards at the YRTCs. They include information on assaults, confinements, escapes, injury, restraints, misconduct, property incidents, suicidal behavior, youth seen for medical treatment, and staff-to-resident ratio.</p>

<p>16-32. 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</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  DHHS examined staffing at YRTC-Kearney, and calculated how many staff it needed to comply with PREA. Additional staff for YRTC-Kearney were included in the 2016 DHHS budget request and funded by the Legislature in 2017. DHHS reports that recruitment of staff at YRTC-Kearney has significantly improved.</p>
<p>16-33. Digitalize Records at YRTC-Kearney</p>	<p>DHHS-CFS</p>	<p><b>Accepted - Complete</b>  In January 2017, the YRTCs began loading information on incident reports into an online portal, Salesforce. The system is now fully operational and allows facilities to review records of individual incidents as well as track specific incidents, including escapes, use of force, restraints, and seclusion.</p>

2015

OIG Recommendation	Agency	Implementation Status
15-01. Adopt federally mandated mental & behavioral health policies.	DHHS - CFS	<p><b>Accepted - No Further Action</b></p> <p>In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in <a href="#">Protection and Safety Procedure #13-2017</a>.</p> <p>DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.</p>
15-02. Expand training on mental and behavioral health.	DHHS - CFS	<p><b>Accepted - Complete</b></p> <p>DHHS added in-service training on these topics, and added suicide prevention training to topics covered in New Worker Training. In July 2017, an updated mental health desk aid was made available to all staff.</p>
15-03. Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications	DHHS- CFS	<p><b>Accepted - Complete</b></p> <p>DHHS updated its N-FOCUS system in March 2015 to allow for easy record keeping on medications, health care appointments, and medical conditions. At the time of completion, information entered was reviewed by administration and at Continuous Quality Improvement (CQI) meetings.</p>
15-04. Improve Home Study Process	DHHS-CFS	<p><b>Accepted - Complete</b></p> <p>To help ensure quality home studies across the state, DHHS entered into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts began November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.</p>

OIG Recommendation	Agency	Implementation Status
15-05. Provide stronger supports for kinship and relative foster families	DHHS-CFS	<p><b>Accepted - Complete</b> Pre-service foster parent online training is offered to relative and kinship placements in order to get more of such placements licensed. As a foster child’s needs are identified, the relative and kinship foster placement will receive specialized training accordingly.</p> <p>The Nebraska Foster and Adoptive Parent Association provides specialized training, Kinship Connection, across the state.</p> <p>Nebraska received Kinship Navigator funds available through the Family First Prevention Services Act—U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACYF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska’s Kinship Navigator program began October 1, 2019.</p>
15-06. Ensure “Absence of Maltreatment in Foster Care” is as accurate as possible	DHHS-CFS	<p><b>Accepted - Complete</b> Since May 2016, DHHS has listed the number of maltreatment cases that have been “court pending” between 8 and 12 months in its CQI reports.</p> <p>This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.</p>
15-07. Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.	DHHS-CFS	<p><b>Accepted - No Further Action</b> In the fall of 2015, the League of Municipalities distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. No training for other frequent reporters – schools, medical professionals, etc. has been produced or made easily available.</p>
15-08. Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.	DHHS-CFS	<p><b>Accepted - Complete</b> In February 2016, DHHS adopted <a href="#">Protection and Safety Procedure #5-2016</a>, "The use of Photographs from Intake through Case Closure."</p>

OIG Recommendation	Agency	Implementation Status
15-09. Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.	DHHS-CFS	<p><b>Accepted - Complete</b>            DHHS developed a quarterly report to review information captured by N-FOCUS to develop outreach strategies in immigrant communities. Substantive collaboration between DHHS and Bring Up Nebraska has been developed as means of furthering strategies to collect consistent, statewide data, provide funding, and prioritize culturally appropriate and competent prevention service delivery. In May 2018, DHHS partnered with the Nebraska Coalition to End Sexual and Domestic Violence and funded a Community Engagement Coordinator position to collaborate with local and tribal domestic violence programs and community based organizations to address family violence issues in racial and ethnic minority populations and underserved populations.</p>
15-10. Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.	DHHS-CFS	<p><b>Accepted - Complete</b>            On July 1, 2017, DHHS’s “Secure Transportation” service definition for transport to and from YRTCs became effective.</p>
15-11. Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.	DHHS-CFS	<p><b>FY 19-20</b>  <b>REVISED STATUS: No Further Action</b>            DHHS Plans to close the YRTC Geneva Campus permanently in October 2020.</p> <p><b>Accepted – Complete</b>            In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs.</p> <p>In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place. OJS is currently planning for the next round of PREA audits.</p> <p>Both YRTCs underwent a PREA Audit in the fall of 2018. The final PREA Audit reports were released on November 18, 2018 which found compliance with PREA standards at each facility.</p>



OIG Recommendation	Agency	Implementation Status
15-12. Provide increased guidance for culture change at YRTC-Geneva	DHHS-CFS	<p><b>FY 19-20</b>  <b>REVISED STATUS: No Further Action</b>  DHHS Plans to close the YRTC Geneva Campus permanently in October 2020.</p> <p><b>Accepted - Complete</b>  In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs.</p> <p>Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists.</p>
15-13. Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva	DHHS-CFS	<p><b>FY 19-20</b>  <b>REVISED STATUS: No Further Action</b>  DHHS Plans to close the YRTC Geneva Campus permanently in October 2020.</p> <p><b>Accepted - Complete</b>  In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics.</p> <p>YRTC-Geneva made changes to OM 115.17.5 in August 2015 to clarify facility specific policy and procedure. Work to standardize policies and procedures at both YRTCs is ongoing.</p>
15-14. Clarify Hotline policy and procedure when receiving a report of sexual assault	DHHS-CFS	<p><b>Accepted - Complete</b>  The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency. The OIG reviewed intakes about YRTC-Geneva for the 2016-17 fiscal year and identified only one error.</p>

## *OIG Recommendations to Juvenile Probation*

### Documents:

- A. Request for update from OIG to Administrative Office of Probation
- B. Response to OIG from Administrative Office of Probation
- C. OIG Recommendation Attachment

JULIE L. ROGERS  
Inspector General



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

August 13, 2020

Deb Minardi  
Probation Administrator  
1445 K Street, State Capitol, Room #1209  
Lincoln, NE 68508

Dear Ms. Minardi:

The Office of Inspector General of Nebraska Child Welfare (OIG) is in the process of compiling its Annual Report which is due from our office on September 15. Neb. Rev. Stat. §43-4331 requires the OIG, in the annual report, to detail recommendations made in investigative reports and their implementation status.

Although Probation has not formally accepted any of the OIG recommendations, the OIG is committed to providing updates on all of the improvement you have made specific to these areas. To that end, we are requesting the OIG is provided information on what action, if any, Probation has taken on the recommendations. The present day *draft* of the status of probation recommendations is attached. Please provide any information related to these recommendations by **Monday, August 31, 2020**.

Please do not hesitate to let me know if you or members of your team have any questions or concerns about the updates. I look forward to highlighting the specific progress Probation is making regarding these particular recommendations in our annual report.

Respectfully,

A handwritten signature in blue ink that reads "Julie L. Rogers".

Julie L. Rogers

Attachment

Corey R. Steel  
State Court Administrator



Deborah A. Minardi  
State Probation Administrator

August 26, 2020

Julie Rogers  
Office of the Public Counsel / Ombudsman  
State Capitol, P.O. Box 94604  
Lincoln NE 68509

**RECEIVED**

**AUG 27 2020**

CLERK  
NEBRASKA SUPREME COURT  
COURT OF APPEALS

Re: Office of Inspector General (OIG) Annual Report for 2019-2020

Dear Ms. Rogers:

This correspondence is in response to your August 13, 2020, letter outlining the duty of the OIG to provide an annual report pursuant to Neb. Rev. Stat. § 43-4331.

Your letter indicated that "Probation has not formally accepted any of the OIG recommendations" from previous reports. For the record, the incidents you are referencing are from 2016 and 2017. Work has been completed in many of the areas your recommendations covered. We would invite you to review the numerous published reports available on our website. I think you would find that probation has continued to achieve numerous accomplishments, including increasing positive outcomes and advancing evidence-based juvenile justice best practices. I would also note, there has not been an investigative report involving Probation completed since the publication of your last annual report.

Probation maintains committed to continuous quality improvement and an ongoing evaluation of our performance. Any recommendations provided will assist in identifying staff development topic areas for Probation employees. It is the mission of Nebraska Probation to create constructive change and improve the lives of juveniles' placed under our supervision through rehabilitation, collaboration, and partnerships in order to enhance community safety.

I look forward to reviewing your annual report.

Sincerely,

Handwritten signature of Deb Minardi in cursive script.

Deb Minardi  
Probation Administrator

C: Wendy Wussow, Supreme Court Clerk

Administrative Office of the Courts & Probation  
P. O. Box 98910, Lincoln, Nebraska 68509-8910  
[www.supremecourt.nebraska.gov](http://www.supremecourt.nebraska.gov)  
Phone (402) 471-3730  
Fax (402) 471-2197

Attachment: OIG Recommendations to Probation

OIG Recommendations to Probation	Implementation Status
16-22. Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).	<p><b>Rejected - Progress</b></p> <p>Probation provides the Nebraska Developmental Disabilities Access Guide to Probation Officers; to date Probation has been unable to locate a suitable training vendor and plans to coordinate with DHHS to accomplish training; there are no policies yet created, and the OIG is unaware of any action to create a policy.</p>
16-23. Adopt policy on child welfare referrals and joint case management.	<p><b>Rejected - Complete</b></p> <p>Probation released a policy regarding this subject. Probation has been training probation officers and DHHS caseworkers across the state with DHHS on the new joint case management policy.</p>
16-24. Adopt policy on documentation and record keeping.	<p><b>Rejected</b></p>
16-25. Increase internal quality assurance efforts at the state level.	<p><b>Rejected</b></p>
17-01. Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.	<p><b>Complete</b></p> <p>Probation approved a Predisposition Supervision Policy in September 2017. The policy sets forth the circumstances under which predisposition, court-ordered probation supervision may occur.</p>
17-02. Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.	<p><b>Incomplete</b></p>
17-03. Implement guidelines on when it is appropriate to use specific types of alternatives to detention.	<p><b>Incomplete</b></p>
17-04. Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.	<p><b>Incomplete</b></p>

OIG Recommendations to Probation	Implementation Status
17-05. Adopt policy requiring probation officers to make and document mental health referrals if an intake interview suggests that the youth has mental health needs.	<b>Incomplete</b>
17-06. Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.	<b>Progress</b>  Probation has created this form. It is unknown whether the form has been approved and implemented.
17-07. Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.	<b>Incomplete</b>
17-08. Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.	<b>Incomplete</b>
17-09. Assess whether Probation has the authority to monitor alternatives to detention.	<b>Complete</b>  Probation implemented a Predisposition Supervision Policy in September 2017 clarifying the circumstances under which predisposition, court-ordered supervision may occur.

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*APPENDIX*

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Appendix A: Non-Court Survey of County Attorneys – Results

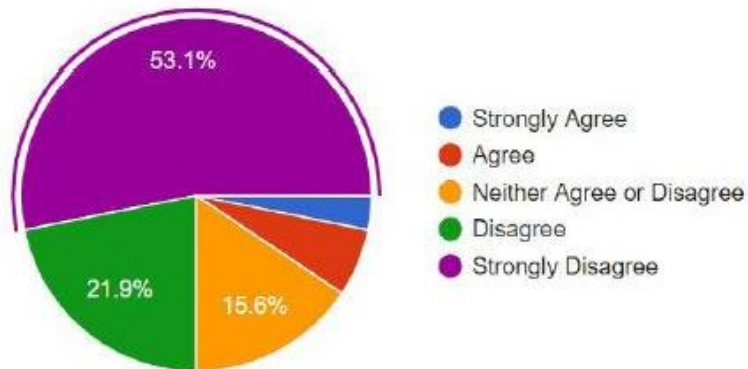


## Non-Court Survey of County Attorneys

Office of Inspector General  
of Nebraska Child Welfare

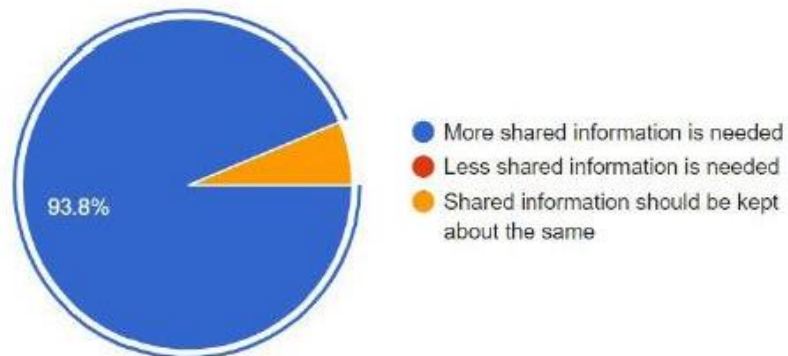
1. Adequate information is provided to my office about non-court cases by the local DHHS office.

32 responses



2. Based on the current level of non-court case information provided by the local DHHS office, should the amount of information your office receives about non-court cases be altered?

32 responses

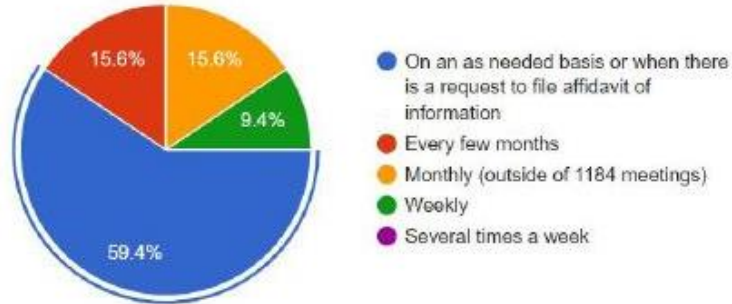


Survey administered 9/4/2019 to 10/22/2019



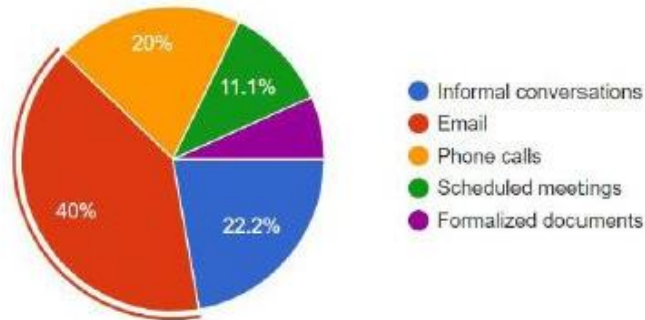
### 3. How frequently does your office communicate with the local DHHS office about non-court cases?

32 responses



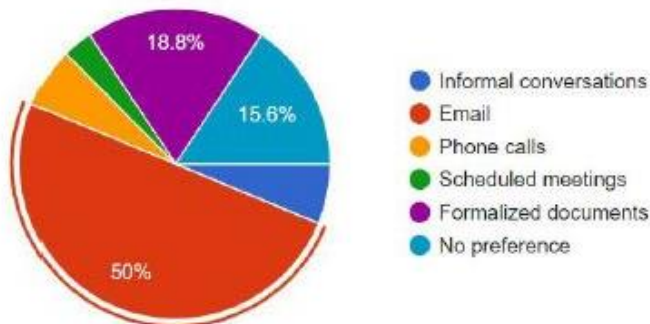
### 4. What form does communication about non-court cases with the local DHHS office most frequently take?

32 responses



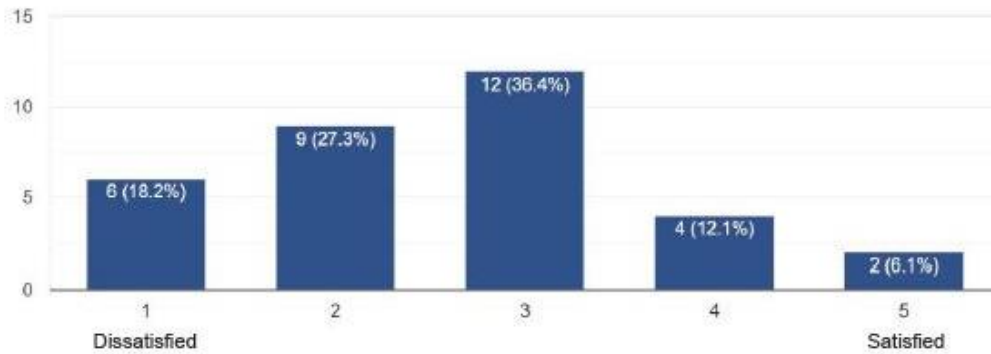
### 5. How do you most prefer to communicate about non-court cases with your local DHHS office?

32 responses



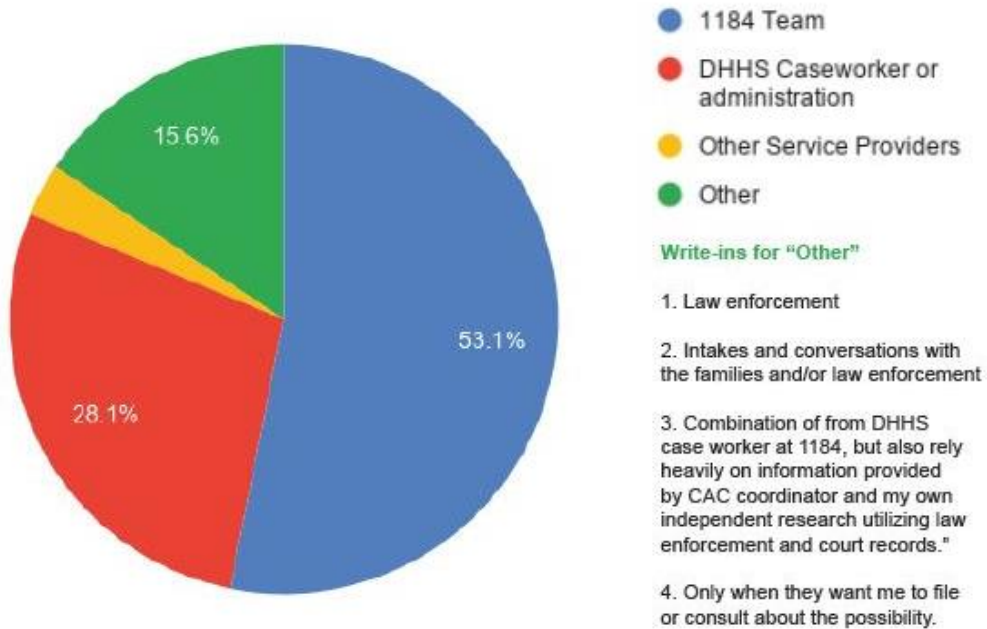
6. On a scale of 1-5 with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the current working relationship between your office and the local DHHS office?

33 responses



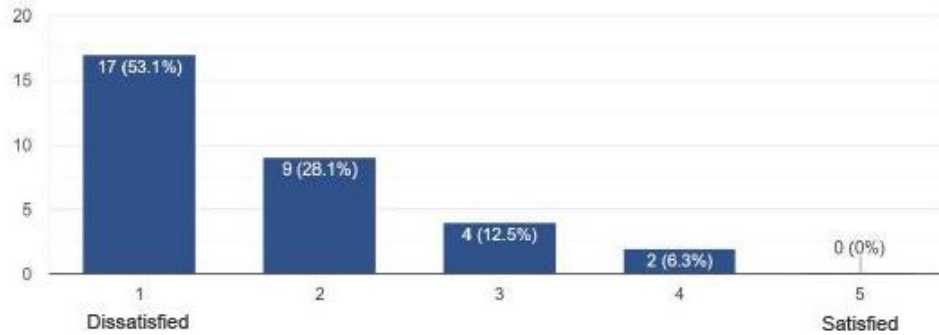
7. From what source do you get the majority of your information about non-court cases?

32 responses



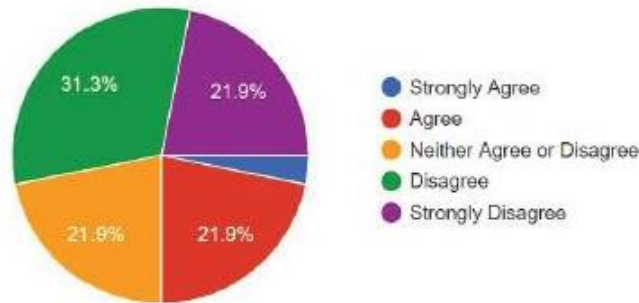
8. On a scale of 1-5 with 1 being very dissatisfied and 5 being very satisfied, how satisfied are you with the current DHHS non-court case policy?

32 responses



9. Based on your experience, non-court cases are an effective method of helping families alleviate maltreatment.

32 responses



10. What suggestions would you make to improve the non-court process?

20 responses

Needs to be more collaborative with HHS, County Attorney and Law Enforcement. HHS doesn't know our community as there is a new caseworker each time. They don't care how many times the family has been through the system. Every case is first attempted to be non-court. HHS does not submit any information about the cases unless specifically asked. They refuse to allow us to send community supports to the family. They will not talk about the cases at the 1184 meetings unless asked. Generally, the county attorney nor law enforcement has any idea there are non-court cases going in the county without stumbling upon them.

More communication. There is absolutely NO communication about how families are doing unless it's initiated by the county attorney's office and even then, it's very cursory info such as "they're doing great." Months later, I find that many of the families that started out "doing great" quit about three months in and the cases are simply closed with no communication to keep an eye on the family, no request to file, nothing.

Actually following through on addressing the issues raised in the intake.

## What suggestions would you make to improve the non-court process? (continued)

DHHS to amend their policy to allow workers to utilize drug testing and hair follicle testing.

Require updates on all non-court cases be presented monthly at the 1184 meeting. Right now DHHS has no accountability on these cases.

Be more proactive with communication. When HHS knows about a case - they need to inform the juvenile prosecutor.

Non-court processes require participation of families and initiative from DHHS workers. Neither of those things happen. DHHS and Probation seem to spend more time trying to get out of cases than they do working cases.

It needs to be stopped. HHS does not understand how things like Powers of Attorney work and moms who abandon their kids are continuing to receive child support and SNAP benefits while the kids go without. The entire screening process of intakes needs to be a joint decision between HHS, law enforcement and the county attorney. Also, there needs to be a system in place, like CHARTS, where all the information on these families is centralized so we can all know what is going on and the history if they move to another county.

HHS hides information and does not share it with MDT nor with CA

Many non-court involved cases eventually end up with court case filed so services are either not being provided or are ineffective.

I am very concerned about the requirement that the County Attorney oversee non-court cases. When I meet with Department workers to speak about non-court cases I only receive the information they want me to receive. I am not afforded written documentation, safety plans, etc. I am told what they want me to know, so the case will not be filed with the Court. I believe it is imperative that the Department provide me with a case plan a week before our monthly meetings, so I can have time to read them and check facts if necessary. Without a formal process and formal documents I feel the Department will continue to "hide the ball".

The Department continues to change policies to make it more difficult to file Petitions. Transparency is not their milieu. They continue to hide the ball, make it more difficult to obtain hair follicle testing, make it more difficult to get drug patch testing for parents, etc. I am completely frustrated with the Department and "their Administration".



## What suggestions would you make to improve the non-court process? (continued)

DHHS needs to be more transparent with attorneys, schools, parents, attorney for parents and foster parents. As a GAL I am constantly needing to keep schools and foster parents in the loop because DHHS "can't" disclose any information to other parties. I am also having to constantly get court orders to get information, to have services such as counseling, drug/alcohol testing and evaluations done by DHHS. The includes getting them done and paid. I have also had significant issues getting information from probation when a parent is on probation. A parent has had to have his attorney get a order in the district court criminal case for probation to disclose information court ordered by the juvenile judge and even though a release of information has been signed by the parent who was on probation. Communication is a big issue. The best cases are when parents, foster parents, school, daycare, attorneys, etc are all working together. Communication has definitely gone down hill in the last five years. While I believe there are many great things happening in the juvenile court world I also feel it has become more adversarial in the last five years. While I understand and agree that rights must be protected and adversarial proceedings are necessary at time, it shouldn't be the norm.

Most of the non-court cases I hear about are closed because the parent refuses to cooperate and then nothing further happens. The safety risk is still present and there are no services in place because the non-court case is voluntary.

Better communication, more dialog with DHHS

Quit trying to save money by making everything non court

I would like to see consistent communication about the progress families are or are not making so that I can make an informed decision about filing.

Have someone communicate that NDHHS is providing non court case services

As to Questions #8 and #9: It is my belief that the case workers and their supervisors are working hard to make non-court cases successful. However, when they are not successful and/or cannot adequately meet the safety needs of the children the workers are not able to request court intervention due to DHHS administration. There has been, at times, a lack of reliance on the case worker's education, training, experience, and firsthand knowledge of the family and an overemphasis on policy to determine when to offer a non-court case or continue with a non-court case. Additionally, I believe improvements could be made with additional access being given to the CAC Coordinator of DHHS' historical information on children and families.

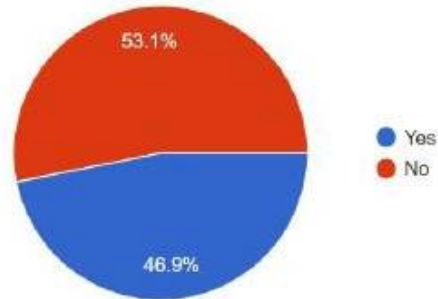
A list of cases and case plan. Follow through provided by hhs and status reports. CASA and myself are concerned about communication and appropriate safety planning. This is a high risk population. Like the idea of non court prevention but need a gatekeeper to ensure safety and follow through. Make sure all resources are available, other partner get involved. Would like that gatekeeper to be the County Attorney office or a similar individual not involved with HHS.

"1) Do drug testing if they have drug + alcohol cases \*\*\* Drug testing also needs to be done during investigation. 2) Send over a list of non-court cases to the DCA in the county served and the reasons why they came into the system. 3) Review the non-court cases at the 1184 treatment team if they are not going well."

## Initial Assessment and non-court cases

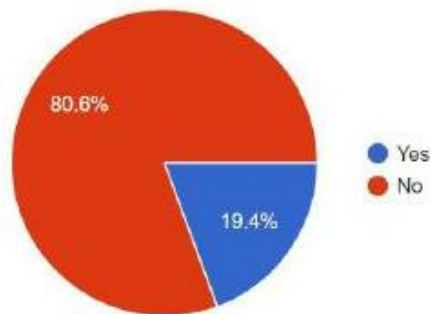
11. Does your office monitor intakes to the Child Abuse/Neglect Hotline that originate from your county?

32 responses



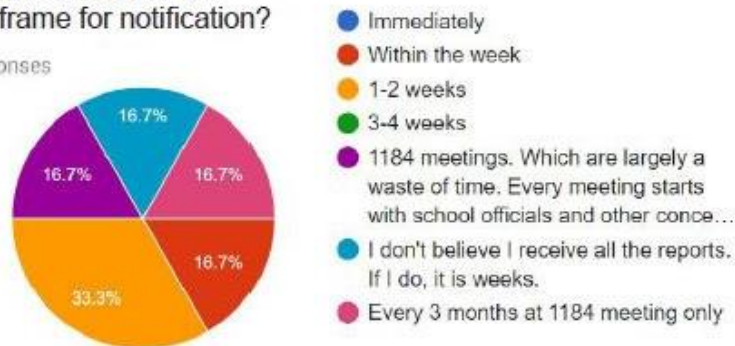
12. Is your office notified when a family declines an offer from DHHS for a non-court case?

31 responses



12a. If yes, what is the time frame for notification?

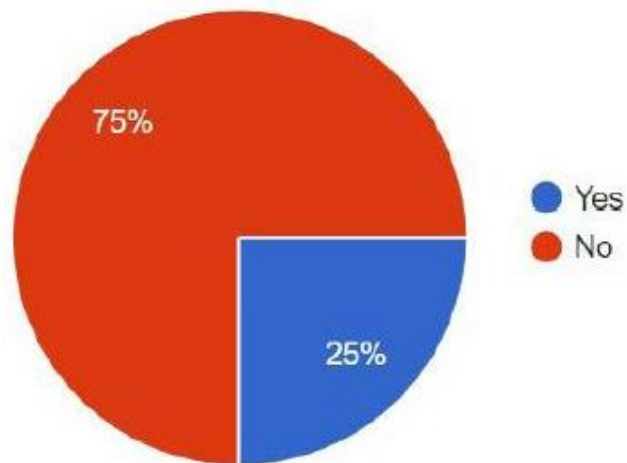
6 responses



## Initial Assessment and non-court cases (continued)

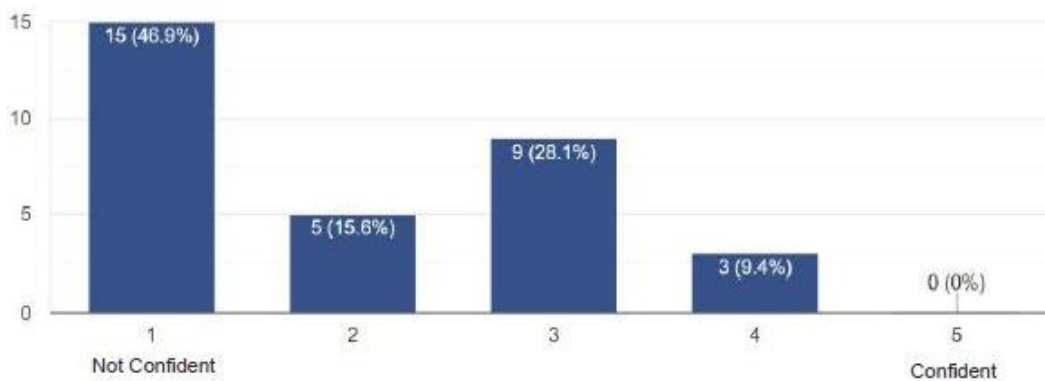
13. Are you aware of the criteria a family must meet in order to be offered the opportunity to work a non-court case?

32 responses



14. On a scale of 1-5 with 1 being not confident and 5 being very confident, how confident are you that children are safe in cases where a non-court case is offered by DHHS.

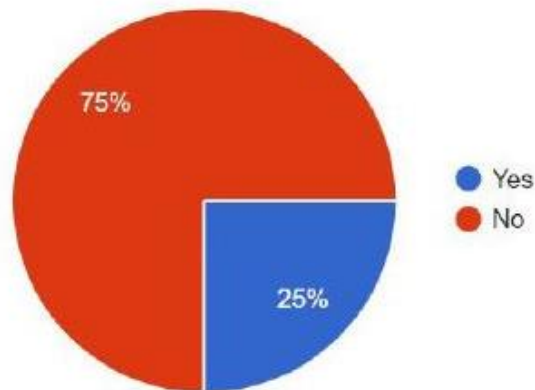
32 responses



## Ongoing Case Management of non-court cases

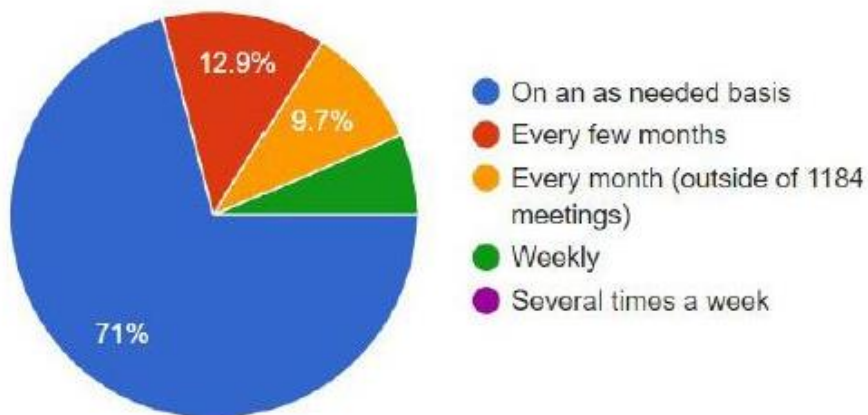
15. Is your office notified by DHHS when a family is not making progress in a non-court case?

32 responses



16. How frequently do you/your office staff discuss progress by families on non-court cases with the local DHHS office?

31 responses

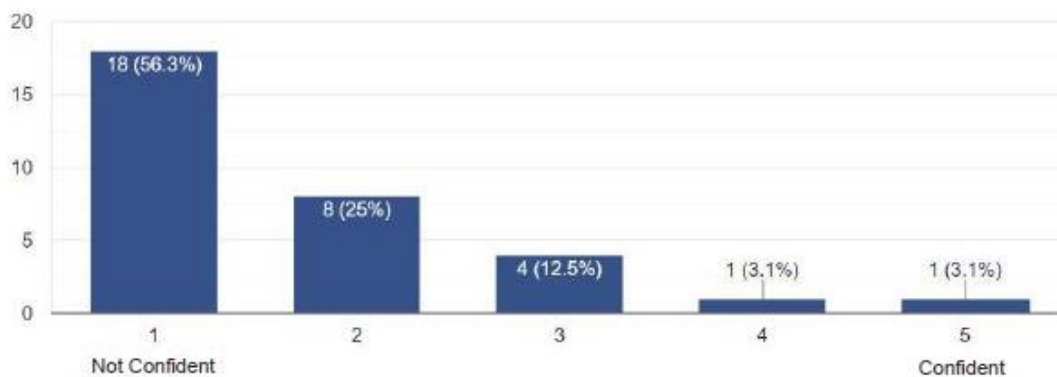




## Ongoing Case Management of non-court cases (continued)

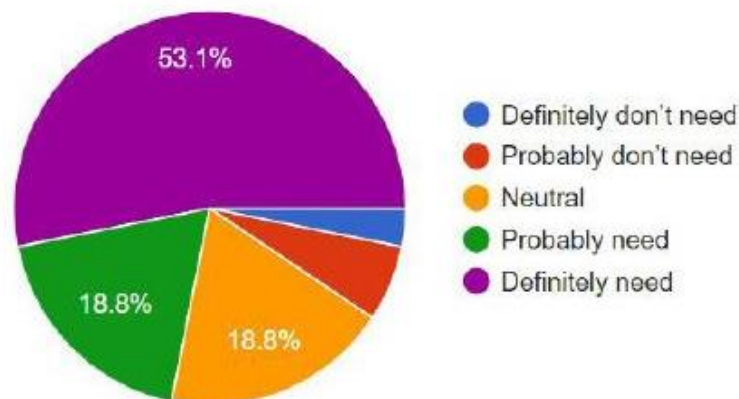
14. On a scale of 1-5 with 1 being not confident and 5 being very confident, how confident are you that those families who are not demonstrating quality participation in non-court cases are referred for court intervention?

32 responses



18. Is there a need for a standardized level of participation in a non-court case (explicit expectations) to be established and explained to parents at the time of case opening?

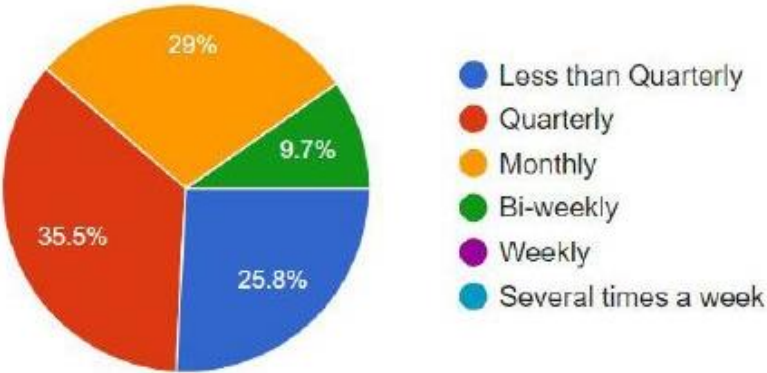
32 responses



## 1184 Team Process and non-court cases

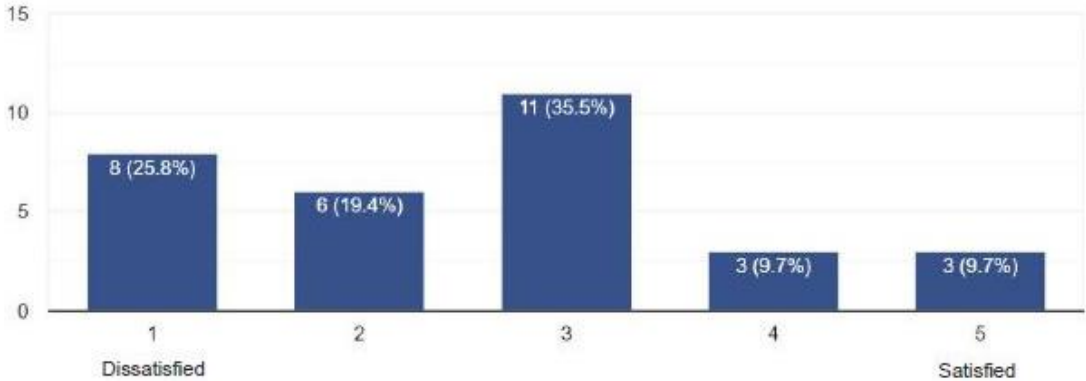
19. How frequently do you or someone from your office meet with 1184 team members to staff non-court cases?

31 responses



20. On a scale of 1-5, with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the current level of functioning/effectiveness of the 1184 process as it relates to non-court cases?

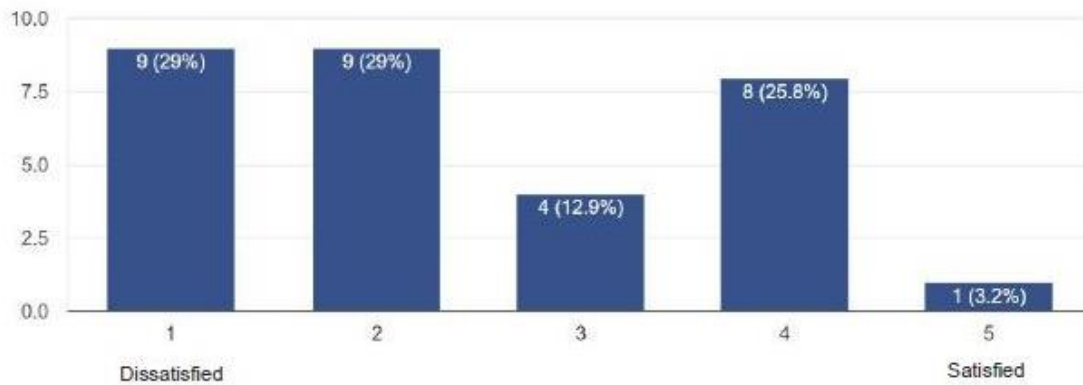
31 responses



**1184 Team Process and non-court cases (continued)**

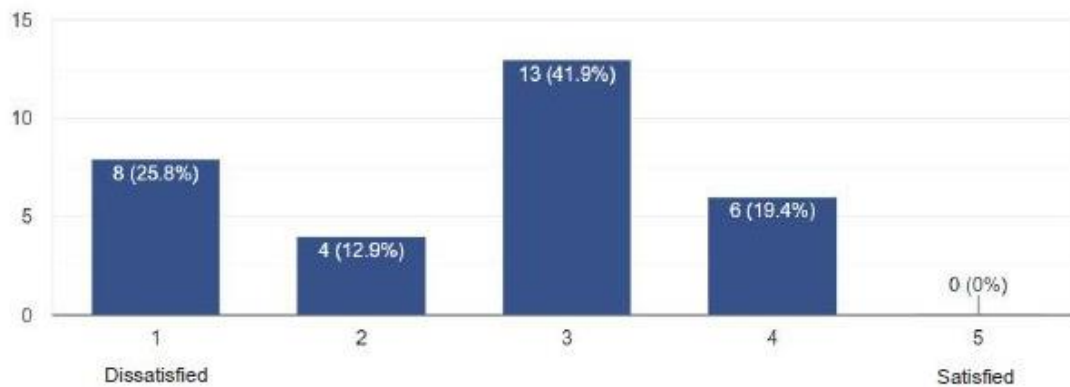
21. On a scale of 1-5, with 1 being dissatisfied and 5 being satisfied, how satisfied are you with the information DHHS provides on a non-court case when staffed at an 1184 meeting?

31 responses



22. On a scale of 1-5, how well does the 1184 process produce adequate information to make a determination about filing a 3a?

31 responses



## 1184 Team Process and non-court cases (continued)

### 23. What changes would you suggest be made to improve the 1184 process?

10 responses

We need to look at how to help the families discussed instead of being told by HHS that it doesn't meet definition. The whole point should be to provide resources to families to keep them from needing HHS involvement at all.

Well, DHHS doesn't tell us what families are working a voluntary case, so if there are concerns about a specific child, another shareholder will mention them and the DHHS representative will then share if the family is involved or not. DHHS does not share information about their voluntary cases - they do not add children to the list. They have also implemented a new policy rule that we can not discuss children who are state wards at 1184 team meetings.

Definitely need more communication from HHS intake - it just doesn't happen

You can't have two separate agencies with as much overlap as DHHS and Probation. The current logic that leaving children in bad homes is better than having children in foster care is deeply flawed. Both DHHS and Probation refuse to do anything or offer any services without a Court order. It is time consuming and energy consuming to have to seek Court orders to make agencies do a job they are allowed and required to do. As an example, hair testing of children for meth exposure. Both agencies refuse to do it, even though it is clearly needed in many cases.

HHS needs to be more forthcoming in the meetings or we need to stop having them. HHS never wants to assist any family unless they are forced to do so and is not willing to provide us with resources to help families that need assistance.

that hhs be more forthcoming with information

I believe that the only way to ensure I am getting all the information I need is to receive a case plan (a week before the meeting), so I can read the information and fact check the report. I have found that the negatives of the non-court case are not adequately conveyed to me. It is only later when I am made aware by reading a police report, speaking with a school official, etc. that I find out the truth.

1184 is when we as county attorneys are blindsided by a whole bunch of cases one or two days before a meeting we know nothing about and see that lot has not met definition and then school comes and moans about what are you doing about it mr county attorney and im like nothing I literally found out about it a day or two ago and I am not dhhs hotline screening. It is a frustrating and embarrassing experience.

I would recommend providing the CAC Coordinators working in 1184 greater access to DHHS' historical information involving the children and families being discussed. I would also recommend empowering the case worker and their supervisor to make recommendations about submitting Requests to File 3a cases without fear of administration questioning their decision to seek court oversight and intervention in the rehabilitative process.