Office of

Inspector General of Nebraska Child Welfare

Annual Report

2024-2025

September 15, 2025

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

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

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

Email: OIG@leg.ne.gov

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

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

Nebraska Child Abuse and Neglect Hotline
1-800-652-1999 or https://neabusehotline-dhhs.ne.gov/

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

Nebraska Family Helpline
1-888-866-8660

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Message from the Inspector General

The Office of Inspector General of Nebraska Child Welfare (OIG) is honored to present its Annual Report for the fiscal year starting on July 1, 2024, and ending June 30, 2025.

This last fiscal year was a time of adjustment and change for the OIG. As described in this report, throughout the fiscal year, the OIG was working under a Memorandum of Understanding between the Legislature and the Governor's Office. The way the OIG received information changed. The process was more cumbersome and limited in certain ways. But, overall, the OIG received the documents and information from the Department of Health and Human Services necessary to conduct investigations, and we appreciate the Department's responsiveness.

In addition, Speaker John Arch and the Legislature remained dedicated to independent legislative oversight. Through the efforts of the LR 298 Legislative Oversight Review Special Committee, Speaker Arch introduced LB 298 in the 2025 session which restructured, strengthened, and clarified the Legislature's oversight functions. A new Legislative Oversight Committee was formed along with a new Division of Legislative Oversight. The OIG, along with the Office of Inspector General of the Correctional System, and the Legislative Audit Office, were moved into this new Division of Legislative Oversight. We at the OIG are grateful for the support and look forward to working with the Legislative Oversight Committee.

Despite these changes, the OIG staff completed investigations of five deaths and six serious injuries of children in the child welfare system, in addition to other reports and reviews. They are dedicated, hardworking professionals, and I want to acknowledge their good work. We look forward to the year ahead and remain committed to the law and to the principles of accountability, transparency, and good government.

Jennifer A. Carter
Inspector General

Executive Summary

This Annual Report is a summary of the work completed by the Office of Inspector General of Nebraska Child Welfare (OIG) in Fiscal Year (FY) 2024-2025, including an analysis of data reported to the OIG related to deaths and serious injuries of children in the child welfare system, sexual abuse allegations from youth in the child welfare system, data from the Youth Rehabilitation and Treatment Centers (YRTCs), as well as a discussion of key issues monitored by the OIG and a summary of the investigations and reports completed by the OIG this fiscal year.

This fiscal year brought more change to the OIG. This last session the Legislature restructured its oversight responsibilities into a new Division of Legislative Oversight under a new Legislative Oversight Committee which will create additional opportunities to inform the Legislature about the child welfare and juvenile justice systems and the OIG's work.

This last year also brought a change to the way the OIG received information. After a significant disruption in access to information in the prior fiscal year, the OIG began receiving information from the Department of Health and Human Services (DHHS) once again under a new process. While the process can be cumbersome and is still limited in certain ways, it allowed the OIG to complete its work and investigations.

At the core of the OIG's work is the investigation of deaths and serious injuries of children in the child welfare and juvenile justice systems. This year the OIG completed three investigations involving the deaths and serious injuries of 11 children. In one investigation into the deaths and serious injuries of nine children after the acceptance of an Alternative Response (AR) intake within the previous 12 months, the OIG found that AR is not being used solely in cases with a low or moderate risk of abuse and neglect as the Legislature intended, but is used as often for high and very high-risk families, making family engagement critical to mitigating the risk to children. The OIG recommended that DHHS develop a tracking system for evaluating the effectiveness of family engagement within AR and other data points to better analyze outcomes in AR cases. Another investigation reviewed the death of a two-year-old child due to physical

abuse by the significant other of the child's parent. The OIG has addressed this issue before and again found that current DHHS policies and practices do not sufficiently identify or assess all persons in a child's household with regular access to the child who may pose a risk to the child's safety. The OIG recommended that DHHS evaluate and enhance the identification and assessment of all such persons with regular access to a child in the child's home.

Regarding deaths and serious injuries reported to the OIG by DHHS, this year there was a slight increase in the number of deaths reported while the number of serious injuries reported remained the same:

- 27 child deaths were reported to the OIG in FY 2024-2025 compared to 21 in FY 2023-2024.
- 27 serious injuries of children were reported to the OIG in FY 2024-2025, which is the same as was reported in FY 2023-2024.
- Based on a review of these notices, the OIG identified 10 mandatory investigations it must conduct into the deaths or serious injuries of system-involved children.

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

- All of the YRTCs again had an elevated census (population), and YRTC-Kearney in particular saw a significant increase in its census. The other data reported was largely consistent with the data in the previous fiscal year, including a concerning number of youth assaults on staff. The YRTCs also saw numerous improvements in certain areas.
- The number of allegations of sexual abuse of state wards increased from the previous year, from 244 allegations to 293.

The OIG also monitored and reviewed some significant changes to operations and services at DHHS, including changes to Letters of Agreement used to pay for higher-needs children in foster care. DHHS also began providing all new caseworker training in-house. In addition, the OIG reviewed numerous incidents and complaints related to the use of force at the YRTCs and

juvenile detention facilities, including assaults on staff by youth and allegations of excessive use of force and improper treatment of youth by staff.

About the Office of Inspector General of Nebraska Child Welfare

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

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

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

[2] Neb. Rev. Stat. § 50-1802. This language was updated in 2025 by LB 298 to specifically reflect the OIG's oversight of the juvenile justice system as always intended. It should be noted that when the OIG of Nebraska Child Welfare Act was passed, the DHHS Office of Juvenile Services was responsible for the care and supervision of youth in the juvenile justice system. Therefore, when the Act was passed, those youth and that system were included in the stated intent. When the supervision of youth in the juvenile justice system was moved to the Administrative Office of Probation in the judicial branch, the Act was amended to maintain oversight regarding the supervision and care of those youth.

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

The OIG provides accountability for and may conduct investigations involving:

- Nebraska's child welfare system which is administered by DHHS, specifically the Division of Children and Family Services (CFS);
- Child cares and other facilities that are licensed to serve children and youth in the child welfare system by DHHS' Division of Public Health, Children's Services Licensing (Children's Services Licensing);
- Nebraska's juvenile probation system which is administered by the Administrative Office of Probation, Juvenile Services Division (Juvenile Probation);
- Juvenile detention centers and staff secure detention centers; and
- Juvenile Justice Programs administered by the Commission on Law Enforcement and Criminal Justice (Crime Commission).[4]

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

1. Misconduct, misfeasance,[5] malfeasance,[6] or violations of the statutes or rules and regulations of DHHS, Juvenile Probation, the Crime Commission, or juvenile detention facilities by employees or persons under contract with those agencies and facilities;[7]

2. Deaths and serious injuries[8] of youth (a) in homes, facilities, and programs licensed or under contract with DHHS or Juvenile Probation, (b) in cases in which services were being provided to a child or family by DHHS or Juvenile Probation, or (c) in cases that have had an open investigation for child abuse and neglect in the 12 months prior to the

[4] See Neb. Rev. Stat. § 50-1806.
[5] Misfeasance is defined in Neb. Rev. Stat. § 50-1804(12) as "the improper performance of some act that a person may lawfully do."
[6] Malfeasance is defined in § 50-1804(10) as "a wrongful act that the actor has no legal right to do or any wrongful conduct that affects, interrupts, or interferes with performance of an official duty."
[7] See § 50-1806(1)(a).
[8] Serious injury is defined in § 50-1806(11) as an "injury or illness caused by suspected abuse, neglect, maltreatment, self-harm, or assault which requires urgent medical treatment."

death or serious injury.[9] In all these instances, the OIG is required to investigate unless the injury "occurred by chance."

The OIG also receives and assesses complaints from the public and may open an investigation based on those complaints.[10]

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

OIG investigations are focused on whether laws, regulations, and policies were followed by the state agency, as well as identifying issues and gaps in the laws, policies, and procedures in the child welfare and juvenile justice systems. The goal is to make recommendations to the executive agencies for improvement and provide the Legislature with information to assist them in making policy decisions.

In addition to investigations and the production of this Annual Report,[11] the OIG has several other duties. The OIG monitors the YRTCs by reviewing data and information that the YRTCs are required to provide; [12] monitors allegations of sexual abuse of state wards, juvenile probationers, juveniles in a detention facility, and juveniles in a residential child-caring agency; [13] reviews and monitors complaints and incidents related to Alternative Response cases; [14] reviews critical incidents at child cares and Children's Services Licensing's subsequent reviews and compiles that into a Child Care Monitoring Report; and produces an annual report on Juvenile Room Confinement data reported by juvenile facilities.[15] The Inspector General also serves on a variety of committees, commissions, and work groups.

[9] See § 50-1806.
[10] See Neb. Rev. Stat. § 50-1807.
[11] See Neb. Rev. Stat. § 50-1818.
[12] See Neb. Rev. Stat. § 50-1806(3).
[13] See Neb. Rev. Stat. § 50-1806(2)(b).
[14] See § 50-1818; see also Neb. Rev. Stat. § 28-712.01(5).
[15] See Neb. Rev. Stat. § 83-4,134.01(2)(d).

Structurally, the OIG is part of the Division of Legislative Oversight within the Legislature.[16] The Inspector General is appointed to a five-year term by the Director of the Division of Legislative Oversight with the approval of the Chairs of the Legislative Oversight Committee, the Executive Board, and Health and Human Services Committee of the Legislature. The OIG also has two full-time Assistant Inspectors General and one part-time Executive Intake Assistant who are each critical to maintaining the significant duties of the OIG.

[16] The OIG used to be housed in the Office of Public Counsel (or Ombudsman's Office), but was moved into the newly created Division of Legislative Oversight in 2025 through LB 298. The Office of Inspector General of Nebraska's Correctional System and the Legislative Audit Office are also within this new Division of Legislative Oversight.

Year in Review

This section reviews some of the predominant issues and topics the OIG worked on in FY 2024-2025.

LB 298 and Changes to the OIG

This last fiscal year brought both a return to nearly normal operations for the OIG after the challenges in the prior fiscal year, and some significant changes to the office's structure within the Legislature.

As background, in FY 2023-2024, the OIG's work was significantly hampered by DHHS' response to the Nebraska Attorney General's Opinion No. 23-008 (AG's Opinion) from August 2023, which questioned the constitutionality of the laws governing the OIG's duties and responsibilities. Within hours of the AG Opinion's release, DHHS denied the OIG access to information for over seven months. However, on February 14, 2024, the Legislature signed a Memorandum of Understanding (MOU) with the Governor's Office to provide the Ombudsman's Office and the Offices of Inspectors General with access to information. The duties and responsibilities under the MOU reflected much of what was already in the law, and it also outlined protocols for communicating with DHHS and requesting information.

Under the MOU, the OIG began receiving notifications of deaths and serious injuries again, as well as required reports regarding the YRTCs. In addition, the OIG was able to request documents and information from DHHS. Before the AG's Opinion, the OIG had read-only access to NFOCUS—DHHS' case management system—and could view necessary documents through that portal. The OIG's access to NFOCUS was eliminated immediately after the AG's Opinion, and that access has not been restored. As a result, the OIG now makes requests to DHHS for case files and documents and those documents are then shared through a newly created secure site. Initially, this process was very cumbersome and labor-intensive. While it has since been streamlined, it remains more cumbersome for the OIG staff reviewing the documents than accessing that information through NFOCUS. However, DHHS is very responsive to the OIG's requests and the OIG is receiving information in a timely manner.

As is detailed throughout this report, once the OIG began to receive information under the MOU, the OIG was again able to investigate deaths and serious injuries, monitor the child welfare system, and provide recommendations for system improvement.

To be clear, the OIG is also mandated to investigate and review deaths and serious injuries of juvenile probationers and to monitor the juvenile probation system under Juvenile Probation. The OIG, however, has not received a death or serious injury notification from Juvenile Probation since December 2021, and Juvenile Probation stopped sharing all information with the OIG after the AG's Opinion was issued. No MOU was signed between the Legislature and the Judicial Branch, and, as a result, the OIG has not received any information from Juvenile Probation for nearly two years.

The MOU with the Executive Branch expired under its own terms at the end of the 2025 legislative session. Throughout the last two years, the Legislature, and the Speaker in particular, remained supportive and dedicated to legislative oversight. A special legislative committee, the LR 298 Legislative Oversight Review Special Committee, worked through the summer and fall of 2024 to study all the legislative oversight functions of the Legislature and how they might be organized, clarified, and strengthened. The OIG appreciated the opportunity to contribute to these discussions.

Through the efforts of the LR 298 Special Committee, Speaker Arch introduced LB 298 in the 2025 session which restructured and strengthened the Legislature's oversight functions and clarified the OIG's duties. LB 298 was passed by the Legislature on May 30, 2025, and signed into law by the Governor on June 4, 2025. LB 298 created a new Legislative Oversight Committee, which includes the Speaker of the Legislature, the chairs of the Executive Board, Appropriations Committee, Judiciary Committee, and HHS Committee, and four other members of the Legislature chosen by the Executive Board. This new Legislative Oversight Committee was

created “to exercise the authority and perform the duties provided for” in the Acts governing the Offices of Inspectors General and the Legislative Audit Office.[17]

In addition, a new Division of Legislative Oversight was created, which includes the Office of Inspector General for Nebraska Child Welfare, the Office of Inspector General of the Correctional System, and the Legislative Audit Office. Each of these offices now works directly with this new Legislative Oversight Committee.

LB 298 also made some changes to the laws governing the OIGs to address concerns in the AG’s Opinion and to clarify the OIG processes. It also provides for quarterly reports that will allow the OIGs to provide more regular updates and information to the Legislative Oversight Committee. The juvenile probation system remains within the OIG’s jurisdiction and efforts are ongoing to begin receiving information about juvenile probationers.

DHHS Letters of Agreement Complaint

DHHS occasionally uses Letters of Agreement (LOA) to pay for the care of children in foster care when the rate being paid is higher than the set foster care amounts. This generally occurs in cases in which the child requires a specialized or higher level of care. The LOA acts as a contract between the provider and DHHS as to what services will be provided to the child beyond normal foster care and what DHHS is willing to pay for such services. The majority of the time, the providers that enter into these LOA contracts are licensed as homes for developmentally disabled (DD) individuals, and the youth that are being placed in these settings are not approved and funded as DD individuals. Most of these youth have high behavioral needs that may not be related to delays in their development.

In September 2025, the OIG received a complaint regarding DHHS’ review of and changes to its LOAs. DHHS’ review of LOAs was resulting in some LOAs being restructured to lower payments, some LOAs ending, and some children changing placements and services. There was concern that these decisions were being made without a deliberate process and without considering

[17] Neb. Rev. Stat. § 50-1701(1).

standards of care, which could lead to safety concerns and a lack of proper services for youth. Additionally, there was concern that youth would be unnecessarily moved to new homes that may not be able to meet their higher needs, and these moves would be disruptive to the youth.

The OIG had discussions with DHHS regarding the LOA process and changes that were being made internally. DHHS reported to the OIG that the purpose of the LOA reviews was to ensure that these placement and payment decisions were being made based on what is best for the youth, that the youth are getting what they need from these placements, and that DHHS is getting what it contracted for in exchange for these higher payments. Previously, there was no solid methodology, review process, or payment structure in place for the use of LOAs, which is why DHHS implemented a new process.

DHHS described the process for the use and review of LOAs for placement of high needs youth. For youth who are both Children and Family Services (CFS) wards and approved for DD services through the Division of Developmental Disabilities within DHHS, the existing DD clinical team reviews all information about the youth, visits the youth, speaks with their care providers, and completes a DD tool called the interRAI Children and Youth Mental Health and Developmental Disability tool to determine eligibility, budget, and service planning. Once this assessment is completed, the services needed for the youth are identified, and the rate structure used by CFS matches the DD rate structure.

For children who are CFS wards but are not eligible for DD services, the process is similar. DHHS has hired a clinical team with licensed clinicians, including a Registered Nurse, a behavioral health provider, two licensed social workers, a caseworker, a supervisor, and an administrator. This team then mirrors the process that the DD clinical team completes, but the assessment tool used is different. The Child and Adolescent Functional Assessment Scale is used to determine the needs of these youth. The clinical team reviews all documentation, can visit the youth, and talk with care providers to complete the assessment. The supervision, structure, support, and rate structure match that of DD, for consistency across youth and providers. The clinical team reviews these LOAs every 90 days.

DHHS reviewed 230 LOAs that were in place when this process was started. DHHS found that there were some instances where the foster home was unable to meet the needs of the youth and was not providing services as contracted. Those youth were moved to more suitable homes. The OIG is aware of two homes that gave notice that the youth needed to be moved due to disagreements over pay or level of care. The majority of the LOAs were able to be adjusted through the review process, and the children were able to stay where they were living.

The LOA review process appears to be robust and thoughtful. The OIG has not been made aware of any additional concerns with the LOA process.

Reviews of Assaults on Staff and Uses of Force at Juvenile Facilities

The OIG conducts in-depth reviews of incidents and complaints related to juvenile facilities. These reviews are not full investigations but may include a review of videos and incident reports, conversations with facility administrators, and conversations with the youth involved. These deeper reviews are part of the OIG's obligation to monitor juvenile facilities and the treatment of youth, and also provide some insight into the challenges facing these facilities.

This year, the OIG reviewed five assaults on staff by youth at the YRTC in Lincoln. YRTC-Lincoln often serves youth in the YRTC system who are struggling in other YRTC settings and who have more significant behavioral challenges.

In early 2025, staff at YRTC-Lincoln experienced four assaults on staff within three weeks. Some of these assaults appear to have been premeditated and resulted in injuries to several staff members. The same four youth were involved in these assaults, either separately or together, including a fifth assault in the fall of 2024. As a result of the staff assaults and the coordination between youth during some of those assaults, the YRTC-Lincoln Administrator had to create a plan to have those youth complete their schooling and programming apart from each other. This can be difficult due to existing space and staffing constraints.

The risk of assault is a reality for staff members at the YRTCs and it can have a significant impact on their morale.

The OIG also reviewed three complaints relating to allegations of excessive use of force by staff at YRTC-Lincoln. For these complaints, the OIG reviewed video in cooperation with the Deputy Ombudsman for Institutions, reviewed incident reports, and spoke with the Administrator of the YRTC. The Administration took these incidents seriously. The YRTC has a strong process for internal review of any use of force. YRTC staff are trained in Handle With Care (HWC).[18] The use of force must be reviewed by an employee who is a HWC trainer and who was not a part of the incident itself. That review is then discussed with the facility administrator.

These internal reviews were done in these three incidents, and retraining or other appropriate personnel action was taken in response.

The OIG also received and reviewed complaints regarding the treatment of two youth at the Lancaster County Youth Services Center (LCYSC), which serves as the juvenile detention center for Lancaster County. One complaint involved several allegations regarding the staff's treatment of a youth, including that inappropriate force was being used against them. The OIG reviewed documentation and video related to this complaint. The OIG was able to review video of one incident of physical intervention and did not find any inappropriate use of force. In fact, the OIG was struck by the extensive length of time, nearly 40 minutes, that de-escalation techniques were used by LCYSC staff in that incident.

The other complaint reviewed involved a concern that a youth was injured in a physical intervention with staff. The OIG, in coordination with the Deputy Ombudsman for Institutions, reviewed video of the incident and discussed the incident with LCYSC administrators. The facility administration did not believe the intervention was an excessive use of force, but believed that the physical intervention was handled poorly and the technique was not precise, resulting in the youth hitting their head during the intervention. The youth was examined by medical staff at the facility and at the local emergency room, and it was determined that there

[18] HWC is a physical intervention component of the HWC Behavioral Management System, which is an evidence-based program that trains professionals on how to safely and effectively manage disruptive and aggressive behaviors through verbal de-escalation and physical restraint techniques that are intended to reduce injuries and promote a calmer environment. See generally https://handlewithcare.com/.

was no concussion or injury. The staff member was reportedly given appropriate follow-up and coaching.

Youth Committed to the Lincoln Regional Center

During this last fiscal year, the OIG was made aware of three youth who had been committed by the courts directly to the Lincoln Regional Center (LRC). One youth was placed at LRC for a competency evaluation, one because a placement could not be found that would keep the youth safe given the youth's significant history of self-harm, and one was experiencing such severe psychological issues that no other placement could be found and a competency evaluation could not even be conducted until the youth was stabilized. Two of the youth were being supervised by Juvenile Probation, and the third youth was a ward of the child welfare system.

These placements were significant because LRC is an adult facility that is not structured to serve juveniles. The placements created several challenges, such as with staffing and a lack of a designated space for the youth. In correctional settings, sight and sound separation between juveniles and adults is required. Since LRC is a hospital, DHHS believed that strict sight and sound separation requirements did not apply. However, LRC made every effort to maintain as much sight and sound separation as possible. In addition, these youth needed higher levels of supervision and staffing.

The OIG went with the Deputy Ombudsman for Institutions to visit the youth and observe where they were being housed. The OIG found that LRC was very thoughtful and deliberate in how they handled the care for these youth and coordinated with other DHHS personnel who work regularly with the juvenile population. Staff from the YRTCs were being sent to work with the youth much of the day, both to assist with staffing levels and because the approach, training, and skills used to work with youth are different than those needed to work with adults.

One youth is still being treated at LRC, one returned after a time at another placement and is now being treated there as an adult, and the third youth was moved out of LRC after the competency evaluation was completed.

From a systemic perspective, these placements highlight the significant gaps in the continuum of care for youth in Nebraska, particularly a lack of an adolescent inpatient psychiatric facility for youth. While LRC has appeared to handle the care of these youth as well as they can, the treatment of juveniles is different than the treatment of adults. Courts and youth should have better choices for a youth's care than to require them to be at an adult facility. This is an issue that has come up several times in the past and is one that the OIG recommends the Legislature continue to examine.

DHHS Updates

The OIG has an obligation to stay informed about changes in the policies and practices, as well as any structural changes, in the child welfare system. The majority of this information is learned through DHHS' presentations at many of the public meetings the OIG attends, including the Nebraska Children's Commission, the Supreme Court's Commission on Children in the Courts, and the Governor's Commission for the Protection of Children. Each year, the OIG shares some of the more significant changes in the Annual Report to alert the Legislature to these changes.

SAFE Model

In the fall of 2024, DHHS publicly announced that it intended to transition from the Structured Decision Making (SDM) Model for assessing safety and risk, to a child welfare case management model called the Safety Assessment and Family Evaluation (SAFE) Model.[19] DHHS later stated that the transition was "to ensure a cohesive process to inform child welfare intervention."[20] The SAFE Model has two fundamental intervention concepts that serve as the focus for family

[19] See Holder, Todd, "Safety Assessment and Family Evaluation Model: A Systemic, Change-Based Approach to Public Child Welfare Intervention." *Child Welfare* 99, no. 2 (2021): 103. https://www.jstor.org/stable/48623721 (stating that the SAFE Model has been developed and refined over nearly 40 years in consultation with over 45 public child welfare agencies).
[20] O'Hagan, Kathryn. "Nebraska SAFE Assessment." Nebraska Children's Commission Meeting, October 29, 2024.

engagement and the basis for decision-making and determining child safety: (1) impending danger threats, and (2) caregiver protective capacities.[21] Action for Child Protection and DHHS define impending danger threats as dangerous family conditions within a child's residence that represent situations or circumstances, caregiver behaviors, emotions, attitudes, perceptions, motives, and intentions that place a child in a continuous state of danger.[22] There is the related core concept of "present danger," which DHHS has indicated is a more severe type of danger threat requiring a quicker response time from CFS caseworkers than impending danger threats.[23] The child welfare agency's decision to open or close a case with a family depends on the presence of these impending or present danger threats to a child and whether the caregiver's protective capacities can mitigate or alleviate those safety threats.[24]

However, in February 2025, DHHS reported that it was pausing the implementation and training of the SAFE Model until further notice. It is the OIG's understanding that DHHS still intends to return to implementation of the SAFE Model at some point in the future.

Changes to New Caseworker Training

At the end of 2024, DHHS ended its long-standing contract with the University of Nebraska's Center on Children, Families, and the Law, and began to conduct all new caseworker training in-house by a newly created Learning and Development Team. CFS is using a Learn-by-Doing training model, which allows for more time in the field during the training. DHHS has reported that it is conducting monthly surveys of those being trained and that the feedback has been positive. The OIG will continue to monitor this new training and whether it improves worker retention, which DHHS will also be tracking.

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[21] See Holder, 110.
[22] See Holder, 110; "SAFE Model Core Concepts," SAFE: New Assessment Model, Nebraska Department of Health and Human Services, accessed November 5, 2024.
[23] See "SAFE Model Core Concepts" (defining "present dangers" as immediate, significant, and clearly observable threatening family situations that have just occurred, are actively occurring, or are in the process of continuing to occur, which have or will likely result in serious harm to a child and requires immediate action to protect).
[24] See Holder, 110–12; "SAFE Model Core Concepts;" O'Hagan, "Nebraska SAFE Assessment."

Changes to Support of Relative and Kinship Homes

In July 2025, DHHS announced that it would internalize the support of relative and kinship homes, which are presently also supported by private agencies in several service areas. New referrals to private agencies will end as of October 2025. Some homes may be transitioned to DHHS earlier, depending on the agency. DHHS will be using an evidence-based Arizona Kinship Navigation model to support the families. The OIG has heard from some providers with concerns about this change. It is something the OIG will continue to monitor as the transition occurs.

Legislative Updates

Central to the OIG's work is its duty to inform the Legislature of not only how the systems the Legislature created are working, but also how those systems might be improved. Over the years, the OIG's recommendations have led to or informed legislative changes to the child welfare system.

This last legislative session, Senator Fredrickson's LB 217 was the latest example of that. The passage of LB 217 codified in statute the recommendations regarding suicide prevention training found in the OIG's report, *Death by Suicide – 3 Case Review 2023*.[25] The bill requires DHHS to create a baseline curriculum and training materials related to suicide awareness and prevention in consultation with state and national experts. All staff serving the child welfare system will be required to participate in an annual suicide prevention training. In addition, DHHS will implement requirements for suicide prevention training for the staff of child placing agencies and licensed foster parents.

Committees and Commissions

The Inspector General attends several meetings of groups created to oversee and coordinate efforts to improve the systems serving children and youth in the state's care. Participation in these committees and commissions provides the Inspector General with a helpful and up-to-

[25] Office of Inspector General of Nebraska Child Welfare, *Death by Suicide – 3 Case Review 2023.* June 28, 2023. https://nebraskalegislature.gov/FloorDocs/108/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/809_20230725-155459.pdf.

date understanding of the challenges in the child welfare and juvenile justice systems, the efforts to address those challenges, and any other changes or system improvements being made. All this information helps the OIG make better and more relevant recommendations in its reports.

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

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

Deaths and Serious Injuries

The OIG is statutorily mandated to investigate deaths and serious injuries of youth who are: (1) placed in out-of-home care or a licensed facility; (2) receiving child welfare services from DHHS or services from Juvenile Probation; or (3) the subject of a child abuse investigation in the 12 months prior to the death or serious injury.[26]

DHHS, Juvenile Probation, and other agencies are required to notify the OIG of any deaths or serious injuries of system-involved youth. The OIG receives these notices in the form of critical incident reports. The OIG thoroughly reviews each incident to determine if it is within the OIG's jurisdiction and if the law requires the OIG to conduct a full investigation. By statute, the OIG is only required to investigate deaths or serious injuries that did not "occur by chance" and which may have resulted from abuse and neglect.[27] The OIG refers to these as "mandatory investigations."

Deaths and Serious Injuries in the Child Welfare System

There was a slight increase in deaths and the same number of serious injuries reported to the OIG in FY 2024-2025 as compared to the previous fiscal year. The increase in reported deaths was not nearly as significant as that from FY 2022-2023 to FY 2023-2024, as reflected in the table below. It is important to note that not all of the deaths reported to the OIG are the result of abuse and neglect (for example, some may be inevitable medical deaths), and not all of the children who died were known to the system. The abuse that caused the death or serious injury may have been the first incident that brought the family to DHHS' attention. As a result, not every death or serious injury reported to the OIG will result in a mandatory investigation.

[26] See Neb. Rev. Stat. § 50-1806.
[27] *Id*.

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

	FY 22-23	FY 23-24	FY 24-25
DHHS - Deaths	11	21	27
DHHS - Serious Injuries	15	27	27

In FY 2024-2025, DHHS reported 27 deaths of children and youth compared to 21 reported deaths in FY 2023-2024. Of the 27 deaths reported, four require a mandatory investigation by the OIG. Of the remaining 23 deaths that do not require a mandatory investigation, seven of the deaths involved co-sleeping or unsafe sleep, seven were the result of medical issues or accidents, five were caused by abuse or neglect but the child's family was either not known to DHHS before the death or the family's involvement with DHHS was not within the 12 months before the death, and in four of the cases the cause of death could not be determined.

The first half of this last fiscal year, from July to December, had more deaths—16—than the second half of the fiscal year, from January to June—11. In addition, those 27 total deaths occurred in approximate proportion to the populations of each of DHHS' Service Areas (SA): 15 deaths in the Eastern SA, six deaths in the Southeast SA, three deaths in Northern SA, two deaths in the Central SA, and one death in the Western SA. More specifically, the 27 deaths occurred in nine different counties. Douglas County accounted for the overwhelming majority of all the deaths, with 16 of the 27 total. Lancaster County followed, with just three deaths. The other seven counties had one or two deaths each. Despite its high population, Sarpy County had no deaths.

DHHS reported 27 serious injuries in FY 2024-2025, the same number as the previous fiscal year. Of the 27 serious injuries reported, six require a mandatory investigation by the OIG.

Like the deaths reported to the OIG, the first half of this last fiscal year had more serious injuries—17—than the second half of the fiscal year—10. The 27 total serious injuries that occurred in FY 2024-2025 were more evenly distributed across and slightly disproportionate to

the populations of each of DHHS' SAs than the deaths were: 10 serious injuries in the Eastern SA, five serious injuries in the Southeast SA, and four serious injuries in each of the Western, Northern, and Central SAs. The 27 serious injuries occurred in 14 different counties. Douglas County had the most serious injuries with eight, followed by Lancaster County with five, and the remaining 12 counties had one or two serious injuries each.

Unsafe Sleeping Deaths

In the previous fiscal year, FY 2023-2024, DHHS reported seven deaths of infants attributed to unsafe sleeping conditions. In two of those instances, alcohol was involved. This increase in reports from prior years, was attributed in part to DHHS reporting these unsafe sleeping deaths more broadly to the OIG. It is not clear whether it reflected an increase in unsafe sleeping deaths overall.

In FY 2024-2025, there were again seven infant deaths attributed to unsafe sleep, with three involving alcohol and all seven involving co-sleeping. DHHS has actively worked to implement policies and practices that address with families the dangers of unsafe sleeping conditions for infants.

Other than these unsafe sleeping deaths, the OIG observed no other concerning trends and commonalities amongst the causes of the deaths and serious injuries reported to the OIG in FY 2024-2025.

Deaths and Serious Injuries in the Juvenile Probation System

The OIG has not received any notifications of deaths or serious injuries of youth supervised by Juvenile Probation since December 2021. As a result, the OIG has no information on whether any youth on Juvenile Probation have died or been seriously injured in the last three years. With the passage of LB 298, discussed above, the OIG is hopeful that it will begin receiving information again from Juvenile Probation.

Pending Mandatory Death and Serious Injury Investigations

With the addition of the 10 new mandatory investigations added in FY 2024-2025, the OIG now has 32 pending mandatory death or serious injury investigations, each involving children served by DHHS. Twenty-eight of those pending mandatory investigations have been added since 2023. The OIG's ability to conduct that many investigations remains challenging, given the OIG's staff size and resources. The OIG continually strives to meet the highest standards to ensure the office conducts timely yet thorough and accurate investigations, and it will continue to strive to do that even with this steady increase in required investigations. As will be highlighted later in this report in the summaries of the OIG's reports of investigation, since last year's Annual Report, the OIG completed three investigations involving 11 youth, 10 of which were previously included in the OIG's total list of pending mandatory investigations. In addition, another case involving one youth previously included as a pending mandatory investigation was determined to no longer be a mandatory investigation.[28]

Table 2. ***Pending Mandatory OIG Investigations***

	Pending Before FY 24-25	Completed or Removed in FY 24-25	Added in FY 24-25	Current Pending Total
DHHS Reported Deaths	9	4	4	9
DHHS Reported Serious Injuries	24	7	6	23

[28] In that case, the OIG was notified in September 2021 of the serious injury of a four-month-old in a foster home. Although the child's injuries initially appeared to have been caused by abuse or neglect, medical professionals, law enforcement, and CFS later determined that the injuries were accidental and the allegations against the foster parent were unfounded. The OIG notified DHHS in October 2024 that it would no longer be conducting a full investigation into the incident.

Table 3. ***Mandatory OIG Investigations Added in FY 24-25***

Report Type	Cause	Age of Child	System Involvement	Time of System Involvement	Reporting Agency
Death	Neglect	5 yrs.	CFS-State Ward	Current	DHHS-CFS
Death	Abuse	Less than 1 yr.	CFS-State Ward	Current	DHHS-CFS
Death	Suicide	17 yrs.	CFS-State Ward	Current	DHHS-CFS
Death	Neglect	6 yrs.	Open Initial Assessment	Within 12 months	DHHS-CFS
Serious Injury	Neglect	Less than 1 yr.	Open Non-Court	Current	DHHS-CFS
Serious Injury	Neglect	15 yrs.	CFS-State Ward	Current	DHHS-CFS
Serious Injury	Abuse	6 yrs.	Open Initial Assessment	Within 12 Months	DHHS-CFS
Serious Injury	Abuse	Less than 1 yr.	Open Initial Assessment	Within 12 Months	DHHS-CFS
Serious Injury	Attempted Suicide	11 yrs.	Open Non-Court	Current	DHHS-CFS
Serious Injury	Neglect	1 yr.	Open Court Case	Current	DHHS-CFS

Sexual Abuse Data Monitoring

The OIG is tasked with monitoring sexual abuse allegations in the child welfare and juvenile justice systems. Nebraska law requires DHHS, Juvenile Probation, juvenile detention facilities, and staff secure facilities to report to the OIG "all allegations of sexual abuse of a state ward, juvenile on probation, juvenile in a detention facility, and a juvenile in a residential child caring agency."[29] It is critical to note that the required reports to the OIG are **allegations**—meaning an accusation of sexual abuse has been reported, but an appropriate CFS assessment or law enforcement investigation to determine if the allegations can be substantiated has yet to occur.

DHHS Reporting

In FY 2024-2025, DHHS reported 293 allegations of sexual abuse of state wards. This was an increase from 244 in the previous fiscal year. The 293 allegations of sexual abuse involved 196 individual state wards. The sexual abuse allegations were distributed across DHHS service areas in proportion to the populations in those service areas, with the exception of the Central Service Area, which saw its allegations double over the previous fiscal year.

Table 4. ***Total Reports of Alleged Sexual Abuse by Fiscal Year & Reporting Agency***[30]

Fiscal Year	Total	Reported by DHHS	Reported by Juvenile Probation
17-18	45	26	19
18-19	41	31	10
19-20	46	15	31
20-21	69	14	55
21-22	70	21	48
22-23	311	271	40
23-24	247	244	3
24-25	293	293	0

Table 5. ***Sexual Abuse Allegation Reports by CFS Service Area***

Service Area	Total
Central	62
Eastern	119
Northern	31
Southeastern	53
Western	28

[29] Neb. Rev. Stat. § 50-1806(2)(b).

[30] There was a change in how DHHS reported allegations to the OIG in 2022 that accounts for the increase seen that year and in subsequent years.

Previously, when the OIG had access to NFOCUS, it was able to conduct a high-level review of DHHS' handling of the reported sexual abuse allegations. Unfortunately, that level of review would be more time-consuming and labor-intensive for both DHHS and the OIG under the current process, which would require the OIG to request the case file for all 293 allegations. As a result, the OIG did not conduct that level of review for the sexual abuse allegations reported this fiscal year, but was limited to analysis of the numerical data.

The OIG does, however, request information to determine whether the allegation was investigated by either DHHS or law enforcement and to clarify whether any allegations were substantiated. When CFS receives a sexual abuse allegation through the Hotline it can be handled in different ways: (1) it can be screened as requiring no further assessment because the allegations either did not meet the definition of abuse and neglect, or were already assessed as part of an existing case; (2) it can be accepted by CFS to assess the family for safety and risk in conjunction with law enforcement evaluating for criminal wrong doing; and (3) it can be referred to law enforcement without CFS involvement, commonly known as a "law enforcement only" intake.[31]

Of the 293 total sexual abuse allegations reported to the Hotline, 77 of the allegations were accepted for assessment by CFS, 125 allegations were referred to the appropriate law enforcement agency as "law enforcement only," and the remaining allegations did not meet criteria for acceptance, were screened as being information that was additional to another report, or the same allegations were reported by multiple reporters.

Once again, the OIG receives **allegations**—the data does not reflect the number of substantiated instances of sexual abuse. As a result, the OIG requested data regarding how many of the allegations were substantiated or found to be true. It is important to note that

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

even this data may not be representative of the full problem. Rather, it represents those cases in which there was enough evidence for DHHS to substantiate the allegation or for criminal charges to be brought.

Of the 293 intakes in FY 2024-2025 that alleged the sexual abuse of a state ward, 202[32] were accepted for investigation by law enforcement only or by CFS in conjunction with law enforcement. There was a higher percentage of allegations referred to law enforcement only this year. This is a change from last year, where the number of intakes accepted for CFS investigation and those accepted as law enforcement only were nearly the same.

Of the 77 allegations investigated by CFS thus far, two were substantiated by a court, three were substantiated by DHHS, and eleven are awaiting outcomes from court proceedings. This is a decrease in substantiated cases from FY 2023-2024, in which there were 14 substantiated cases of sexual abuse at the time of this report.

Table 6. *Results of Allegations Accepted for CFS Assessment*

Result	FY 23-24	FY 24-25
Unfounded	66	52
Court Substantiated	6	2
Agency Substantiated	8	3
Court Pending	7	11
Other	4	8
Outcome Not Entered	3	1

In addition, DHHS found that 52 of the allegations were unfounded, and one does not have an outcome entered. The other eight allegations were rescreened and were either not accepted or referred to law enforcement only after more facts were gathered.

Regarding the allegations investigated by law enforcement only, at the time DHHS reported the data to the OIG, none of the results of the law enforcement investigations, except two, were entered into CFS' system. This could be due to the law enforcement investigation not being completed or DHHS not yet entering outcomes of law enforcement investigations into their

[32] 77 accepted for assessment by CFS and 125 referred to law enforcement.

system. As a result, the OIG does not have any data on how many of the 125 allegations investigated by law enforcement have been substantiated. The data did indicate that one allegation was listed with a finding of a multiple reporter, meaning it was a duplicate report. Another allegation was changed to be additional information.

In addition to the monthly data, DHHS also provided critical incident reports in relation to sexual abuse allegations. The OIG did request case file information for these reported allegations. There were eight sexual abuse critical incident reports provided to the OIG by DHHS in FY 2024-2025. Of those eight, three involved teens alleging sexual abuse that occurred while out in the community, and five alleged the sexual abuse occurred in a foster home. The age range of the youth involved in these intakes was as follows: six were between the ages of 13 and 18, one was five years old, and one was 10 years old.

Of the eight critical incidents, two of the allegations are court substantiated, one of the allegation findings is court pending due to an arrest being made and a criminal case working its way through the court system, one investigation found the foster home to be unsuitable, two were law enforcement only with no charges filed, one was not accepted for assessment, and one foster home was found to be suitable.[33]

Juvenile Probation Reporting

Juvenile Probation did not report any sexual abuse allegations after the AG's Opinion in 2023. As a result, the OIG is not able to assess how many youth under Juvenile Probation's supervision are alleging sexual abuse, how many of those allegations are substantiated, and how this last fiscal year would have compared to years prior.

[33] Due to the limitations on the OIG's review, it is not clear if the allegations in these critical incident reports are included in the data in Table 6.

Youth Rehabilitation and Treatment Center Monitoring

Youth Rehabilitation and Treatment Centers (YRTCs) are facilities operated by DHHS' Office of Juvenile Services (OJS)[34] that provide programming and services to rehabilitate and treat youth in Nebraska's juvenile justice system. There are three YRTCs in Nebraska—YRTC-Kearney, which serves male youth; YRTC-Hastings, which serves female youth; and YRTC-Lincoln, which serves both male and female youth.

In 2020, in response to the crisis at YRTC-Geneva (which used to be the YRTC for female youth), the Legislature enacted a law to provide increased accountability and oversight regarding the YRTCs. Neb. Rev. Stat. § 50-1806(3)(a) requires OJS to report to the OIG as soon as reasonably possible after any of the following incidents occur at a YRTC: an assault; an escape or elopement; an attempted suicide; self-harm by a juvenile; property damage not caused by normal wear and tear; the use of mechanical restraints on a juvenile; a significant medical event suffered by a juvenile; and internally substantiated violations of the Prison Rape Elimination Act (PREA).[35] In addition, the OIG provides legislative oversight by visiting each facility and communicating with the facilities' administration, staff, and committed youth when appropriate.

Subsection (b) of § 50-1806(3) permits the OIG and OJS to work in collaboration to clarify the specific parameters of what is reported, and how it is reported, to comply with the requirements of § 50-1806(3)(a). The OIG and OJS have agreed on the basic parameters of the substance, method, and timing of the information reported to the OIG and further collaborated to clarify those parameters over the past several years. Much of the data and information is provided monthly, while more serious incidents are reported to the OIG as soon as reasonably possible through critical incident reports.

This last fiscal year, most of the data reported to the OIG was comparable to the data reported in the previous fiscal year. The data shows that, for most types of incidents, the YRTCs had

[34] OJS is within DHHS' Division of Child and Family Services.
[35] 34 U.S.C. § 30301 et seq.

similar numbers and experienced similar issues as the previous year. One of the bigger issues continues to be, as in FY 2023-2024, a concerning amount of youth assaults on staff. Another overarching concern is that all of the facilities once again had high youth censuses as youth are being committed to the facilities at a higher rate. Although some facilities still had a somewhat high number of uses of mechanical restraints on youth and incidents of youth self-harming, those numbers either decreased or, if they increased, did not increase as dramatically as they did in the previous year. In other areas, such as escape incidents, suicide attempts, significant medical events, and incidents of damage to property worth $500 or more, the YRTCs made improvements and had fewer such incidents than in the previous year. What follows is the OIG's analysis and key observations from the data compared to previous fiscal years, followed by a brief recap of the observations and updates that the OIG received at each visit to the YRTC facilities in FY 2024-2025.

YRTC Censuses

In FY 2024-2025, each YRTC continued the recent years' trend of an elevated census and approached the limit of their facilities' capacity, as high numbers of youth continue to be committed there by court order. Given their relative capacities, YRTC-Kearney continues to have a significantly higher census than any other facility, and YRTC-Lincoln continues to have the lowest census, slightly less than YRTC-Hastings. While the censuses at YRTC-Lincoln and YRTC-Hastings remained almost exactly the same as in the previous fiscal year, YRTC-Kearney saw a significant increase in its census. With the exception of one month, the monthly census was consistently higher in FY 2024-2025 than even the highest monthly census in FY 2023-2024. Although YRTC-Kearney has the capacity for even more youth, and has housed in the past over double the amount of youth currently there, the sudden influx of youth is likely to put a strain on the facility's staff and operations.[36]

[36] Since the conclusion of this last fiscal year's data in June 2025, the OIG has been notified by the YRTC administration that the censuses at the facilities have continued to rise, and that the current youth populations at each facility is even higher than the numbers provided here. YRTC-Kearney, in particular, has seen a dramatic increase of committed youth, with over 100 youth since July and currently with 106 youth, which has presented challenges.

Table 7. *YRTC-Kearney Census*

	FY 22-23	FY 23-24	FY 24-25
Average Monthly Census	52.75	62	76.25
Highest Monthly Census	64	70	95
Lowest Monthly Census	46	55	68

Table 8. *YRTC-Hastings Census*

	FY 22-23	FY 23-24	FY 24-25
Average Monthly Census	13.33	13.42	13.42
Highest Monthly Census	19	20	19
Lowest Monthly Census	10	7	9

Table 9. *YRTC-Lincoln Census (Combined Male & Female Youth)*

	FY 22-23	FY 23-24	FY 24-25
Average Monthly Census	8.25	11.5	11.75
Highest Monthly Census	10	14	16
Lowest Monthly Census	5	10	7

Assaults

In FY 2024-2025, youth assaults of staff and youth assaults of other youth were once again the second most prevalent types of incidents that occurred after the use of mechanical restraints.

At YRTC-Kearney, high amounts of assaults on staff and youth continue to remain, although YRTC-Kearney had fewer total incidents than in the previous year. Despite its high census, YRTC-Kearney was the only facility to have fewer staff assaults than in the previous year, and its increase in youth assaults was not nearly as significant as the increase between FY 2022-2023 and FY 2023-2024.

Table 10. *YRTC-Kearney Assaults*

	FY 22-23	FY 23-24	FY 24-25
Youth on Staff Assaults	72	104	86
Youth on Youth Assaults	71	118	129

Of the 86 youth-on-staff assaults that occurred in FY 2024-2025 at YRTC-Kearney, only five required off-campus medical assessment and treatment, compared to 22 in the previous fiscal year. Seven required on-campus medical treatment beyond basic first aid, and the remaining 74 reportedly either caused no visible injury or pain or required only basic first-aid treatment. Of the 129 youth-on-youth assaults that occurred in FY 2024-2025 at YRTC-Kearney, five required off-campus assessment and treatment, and nine required on-campus medical treatment beyond basic first aid. The remaining 115 reportedly either caused no visible injury or pain or required only basic first-aid treatment. The decrease in the severity and total number of assaults at YRTC-Kearney was reflected in only one serious assault incident reported to the OIG as a critical incident, compared to the two-dozen reported in the previous year.

YRTC-Hastings also had fewer total incidents compared to the previous fiscal year. The number of staff assaults in FY 2024-2025 rose, but the number of youth assaults dropped significantly.

Table 11. ***YRTC-Hastings Assaults***

	FY 22-23	FY 23-24	FY 24-25
Youth on Staff Assaults	38	36	45
Youth on Youth Assaults	18	24	5

Of the 50 combined youth-on-staff assaults and youth-on-youth assaults that occurred in FY 2024-2025 at YRTC-Hastings, only one required off-campus medical assessment or treatment, compared to six in the previous year. Three required on-campus medical treatment beyond basic first aid, and the remaining 46 assaults reportedly either caused no visible injury or pain or required only basic first aid treatment.

Like YRTC-Hastings, for the female youth at YRTC-Lincoln, there was an increase in FY 2024-2025 in youth-on-staff assaults, but a decrease in youth-on-youth assaults.

Table 12. ***YRTC-Lincoln Assaults (Female Youth)***

	FY 22-23	FY 23-24	FY 24-25
Youth on Staff Assaults	13	28	40
Youth on Youth Assaults	3	10	5

However, the 45 combined youth-on-staff and youth-on-youth assaults that occurred in FY 2024-2025 for the female youth at YRTC-Lincoln once again appeared to be minor in severity, as all of them reportedly caused no visible injury or pain.

Of the entire YRTC population, the male youth at YRTC-Lincoln had the greatest percentage increase in both types of assaults in FY 2024-2025 from the previous fiscal year, with 57 combined youth-on-staff and youth-on-youth assaults, compared to 18 in the previous fiscal year.

Table 13. ***YRTC-Lincoln Assaults (Male Youth)***

	FY 22-23	FY 23-24	FY 24-25
Youth on Staff Assaults	17	15	35
Youth on Youth Assaults	4	3	22

Of those 57 combined types of assaults that occurred in FY 2024-2025 for the male youth at YRTC-Lincoln, four were severe enough to require off-campus medical assessment or treatment, compared to only one in the previous year. Two required on-campus medical treatment beyond basic first aid, and the remaining 51 reportedly either caused no visible injury or pain or required only basic first aid treatment. There were half as many serious assaults at YRTC-Lincoln reported to the OIG as critical incidents in FY 2024-2025 as in FY 2023-2024. Similar to FY 2023-2024, almost all of the critical incidents at YRTC-Lincoln in FY 2024-2025 were committed by the same three male youth. In fact, two of the male youth who committed several of these serious assaults were the same youth who committed numerous of the serious assaults at YRTC-Lincoln and YRTC-Kearney in the previous year. In total, only four different male youth between YRTC-Kearney and YRTC-Lincoln were responsible for all of the serious assaults committed at the YRTCs in FY 2024-2025.

Use of Mechanical Restraints

For purposes of the YRTC data reported to the OIG, “mechanical restraints” refers to wrist and ankle restraints. The YRTCs report each incident where staff use mechanical restraints on a youth, other than when the youth is being transported. The use of mechanical restraints in FY

2024-2025 was slightly higher for some YRTCs, and slightly lower for others. Of the facilities that had an increase in use, that increase was not nearly as dramatic as in past years.

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

	FY 22-23	FY 23-24	FY 24-25
Use of Mechanical Restraints	156	234	261

Table 15. *YRTC-Hastings*
Use of Mechanical Restraints

	FY 22-23	FY 23-24	FY 24-25
Use of Mechanical Restraints	46	84	58

Table 16. *YRTC-Lincoln Use of Mechanical Restraints (Female Youth)*

	FY 22-23	FY 23-24	FY 24-25
Use of Mechanical Restraints	30	44	32

Table 17. *YRTC-Lincoln Use of Mechanical Restraints (Male Youth)*

	FY 22-23	FY 23-24	FY 24-25
Use of Mechanical Restraints	49	26	41

Escapes and Elopements

The data reported to the OIG for escape incidents includes youth escapes and attempted escapes from the YRTC facilities, as well as elopements when youth are permitted an off-campus furlough or day pass but do not return to the facility. In FY 2024-2025, each YRTC reported either no incidents at all or low numbers of escape incidents, just as in previous fiscal years. YRTC-Kearney was the only facility to report an escape incident in FY 2024-2025, but that one incident is a significant improvement from the 10 escape incidents at the facility in the previous fiscal year. In that one incident in FY 2024-2025, the youth was permitted an off-campus furlough to visit his family shortly before he was scheduled to be discharged from the facility, but he ran away during the furlough. This youth was eventually found.

Table 18. *YRTC-Kearney Escape Incidents*

	FY 22-23	FY 23-24	FY 24-25
Escapes	9	6	0
Attempted Escapes	5	1	0
Elopements	1	3	1

Table 19. *YRTC-Hastings Escape Incidents*

	FY 22-23	FY 23-24	FY 24-25
Escapes	0	0	0
Attempted Escapes	1	0	0
Elopements	0	1	0

Table 20. *YRTC-Lincoln Escape Incidents (Female Youth)*

	FY 22-23	FY 23-24	FY 24-25
Escapes	0	0	0
Attempted Escapes	0	0	0
Elopements	0	0	0

Table 21. *YRTC-Lincoln Escape Incidents (Male Youth)*

	FY 22-23	FY 23-24	FY 24-25
Escapes	0	3	0
Attempted Escapes	0	0	0
Elopements	1	0	0

Self-Harm and Attempted Suicide

Although the reported incidents of self-harm at the YRTCs in FY 2024-2025 were still higher than had been typically reported in the past, only one facility had more incidents than in the previous fiscal year. Another positive is that there were no reported incidents of attempted suicide at any of the YRTCs for a second consecutive year. The female YRTC youth were again involved in many more self-harm incidents than their male counterparts. Most of the self-harm incidents in FY 2024-2025 occurred in the first two quarters of the fiscal year, between July and December, whereas most of the FY 2023-2024 incidents occurred in the last two quarters of that fiscal year, between January and June.

YRTC-Kearney was the lone facility with an increase in self-harm incidents in FY 2024-2025, but the total number of such incidents again remains relatively low given the facility's census, and rise in census this last fiscal year. Like the previous year, the vast majority of the self-harm incidents involved youth tying clothing or other items around their necks, causing minor injuries or no injuries at all.

Table 22. ***YRTC-Kearney Self-Harm & Attempted Suicide***

	FY 22-23	FY 23-24	FY 24-25
Self-Harm Incidents	9	25	33
Suicide Attempts	1	0	0

YRTC-Hastings once again had by far the most self-harm incidents amongst all YRTC facilities, with nearly double the amount of self-harm incidents at the other YRTCs combined. However, the facility improved from the previous fiscal year and reported a great deal less than the 220 incidents reported the previous year, despite the facility's census remaining approximately the same.

Table 23. ***YRTC-Hastings Self-Harm & Attempted Suicide***

	FY 22-23	FY 23-24	FY 24-25
Self-Harm Incidents	59	220	158
Suicide Attempts	3	0	0

Just as in the previous year, the vast majority of the facility's self-harm incidents in FY 2024-2025 involved female youth scratching their skin or picking at their fingernails or wounds on their skin. Once again, nearly all of these self-harm incidents were reported to have either caused minor injuries or no injuries at all.

The female youth at YRTC-Lincoln, like the female youth at YRTC-Hastings, had a higher number of self-harm incidents in FY 2024-2025 as compared to previous fiscal years, but reported fewer incidents than the high amount reported in FY 2023-2024.

Table 24. *YRTC-Lincoln Self-Harm & Attempted Suicide (Female Youth)*			
	FY 22-23	**FY 23-24**	**FY 24-25**
Self-Harm Incidents	24	78	54
Suicide Attempts	0	0	0

As was noted with YRTC-Hastings and YRTC-Kearney, nearly all of the self-harm incidents involving these female youth reportedly caused minor injuries or no injuries at all.

YRTC-Lincoln reported just one self-harm incident for its male youth in FY 2024-2025.

Table 25. *YRTC-Lincoln Self-Harm & Attempted Suicide (Male Youth)*			
	FY 22-23	**FY 23-24**	**FY 24-25**
Self-Harm Incidents	13	3	1
Suicide Attempts	1	0	0

In this last fiscal year, the YRTCs reported various treatment responses and intervention strategies to address these self-harming behaviors, many of which appeared to be more individualized to each youth's needs and circumstances than in past years. This is an improvement from FY 2023-2024, when the YRTCs appeared to respond in similar ways after each self-harm incident, but most of the youth continued to self-harm, usually in the same manner repeatedly. In FY 2023-2024, there were more distinct youth who self-harmed, and more youth who each had higher numbers of different self-harm incidents than in FY 2024-2025. In FY 2024-2025, there were 51 distinct youth who self-harmed at the YRTC facilities. Of those 51, 40 of the youth each had five or fewer incidents. The remaining 11 youth each had between seven and 20 incidents. Again, most of the incidents involved youth tying items around their necks or scratching at their skin, each reportedly causing only minor injuries or no injuries at all. In most of the other self-harm incidents, youth would reportedly hit their heads or fists against the walls, floor, or other items in their rooms. For nearly every self-harming incident, each YRTC reported that staff were able to quickly intervene and stabilize the youth, assess them, and address their behaviors through therapy.

Significant Medical Events

For purposes of YRTC reporting, the OIG and OJS consider significant medical events to be injuries, medical incidents, and chronic illnesses that result in a trip or admission to a hospital or require other off-campus medical treatment or assessment.[37] Although the YRTCs report significant medical events for both staff and youth, all significant medical events reported for staff in FY 2024-2025 appeared to have again been the result of a youth assault and are provided earlier in this report.[38] The data below is therefore only significant medical events for youth. Like previous years, all of the YRTCs reported few significant medical events, or no such events at all. Every facility but the female youth at YRTC-Lincoln had fewer medical events in FY 2024-2025 than the previous fiscal year.

Table 26. *YRTC-Kearney Significant Medical Events*

	FY 22-23	FY 23-24	FY 24-25
Significant Medical Events	2	3	0

Table 27. *YRTC-Hastings Significant Medical Events*

	FY 22-23	FY 23-24	FY 24-25
Significant Medical Events	2	3	0

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

	FY 22-23	FY 23-24	FY 24-25
Significant Medical Events	5	0	2

Table 29. *YRTC-Lincoln Significant Medical Events (Male Youth)*

	FY 22-23	FY 23-24	FY 24-25
Significant Medical Events	3	4	1

All three of the significant medical events at the YRTCs involved youth having a seizure.

[37] Significant medical events include incidents of self-harm and suicide attempts that require medical attention.
[38] Many of the staff assaults and injuries in FY 2024-2025 reportedly occurred when staff were intervening with a youth. Other injuries appear to have been the result of youth assaulting staff in targeted attacks.

Property Damage

The OIG and OJS have agreed that damage to property worth $500 or more will be considered damage "not caused by normal wear and tear" and thus reported by the YRTCs every month. Just as in previous fiscal years, there were few of these types of incidents reported in FY 2024-2025. YRTC-Hastings was the only facility to report one such incident.

Table 30. *YRTC-Kearney Property Damage $500+*

	FY 22-23	FY 23-24	FY 24-25
Property Damage $500+	2	3	0

Table 31. *YRTC-Hastings Property Damage $500+*

	FY 22-23	FY 23-24	FY 24-25
Property Damage $500+	1	5	1

Table 32. *YRTC-Lincoln Property Damage $500+ (Female Youth)*

	FY 22-23	FY 23-24	FY 24-25
Property Damage $500+	0	0	0

Table 33. *YRTC-Lincoln Property Damage $500+ (Male Youth)*

	FY 22-23	FY 23-24	FY 24-25
Property Damage $500+	0	1	0

PREA Allegations

As noted previously, the YRTCs are also statutorily required to report alleged violations of PREA. PREA was enacted to eliminate and prevent the sexual assault and abuse of individuals, such as the juveniles committed to a YRTC.[39] To accomplish this purpose, PREA establishes, among other things, strict prohibitions on the sexual touching and sexual harassment of youth and procedures that the facilities must undertake to investigate an alleged PREA violation. PREA is broad and includes both incidents of non-sexual touching or harassment between youth and more serious allegations of sexual assault committed by youth or staff.

[39] See 34 U.S.C. § 30302.

Both YRTC-Hastings and YRTC-Lincoln reported lower numbers of total PREA allegations and PREA allegations that were substantiated after an investigation in FY 2024-2025 than in the previous two fiscal years. YRTC-Kearney, however, reported almost three times as many substantiated PREA allegations in FY 2024-2025 as in the previous year, and nearly four times as many as two years ago. As has been the case in previous years, however, most of the substantiated PREA allegations across all the YRTCs in FY 2024-2025 were youth-to-youth touching or harassment that the YRTCs classified as "behavioral," meaning not done with sexual intent. Approximately 90% of all substantiated PREA allegations this last fiscal year were deemed behavioral. Of the 143 total PREA allegations across the three facilities, 66 distinct youth were listed as the alleged perpetrators. Seven of the PREA allegations alleged staff-on-youth sexual touching, abuse, or harassment, but after investigation, each allegation was determined to be unfounded or unsubstantiated. In instances where a PREA allegation against a youth was substantiated—often by YRTC staff conducting interviews or reviewing security camera footage—the YRTCs provided education to the youth on PREA and refreshed them on the facility policies, authored incident reports and issued rule violations, and separated youth and implemented safety plans, when necessary.

Table 34. ***YRTC PREA Allegations***

	FY 22-23 Total Allegations	FY 22-23 Substantiated Allegations	FY 23-24 Total Allegations	FY 23-24 Substantiated Allegations	FY 24-25 Total Allegations	FY 24-25 Substantiated Allegations
YRTC-Kearney	43	15	54	20	101	55
YRTC-Hastings	28	17	55	28	25	15
YRTC-Lincoln (Both Male & Female)	23	13	31	13	17	3

YRTC Facility Visits and General Observations

The OIG visits each facility at least once in each fiscal year or more often when appropriate in response to serious incidents and complaints. The OIG also has regular communication with YRTC administrators and the Ombudsman's Office, which visits the facilities more frequently than the OIG and can share pertinent information. Visiting the facilities in person allows the OIG to better understand the needs and challenges that the YRTCs and youth experience. At the visits, the OIG tours the facilities and speaks with the facilities' administration, staff, and committed youth when appropriate. The OIG also receives an update on each facility's census, staffing, programming, education, activities, and any other notable changes to the facilities' operations or campus. The OIG also receives an update on each YRTC's current youth population and how well the youth are behaving and adapting to their environment, interacting with staff and other youth, and being rehabilitated through programming, therapy, and more.

The OIG learned that many of the challenges that the YRTCs collectively faced in FY 2024-2025 were the same as or slightly more prevalent than those in the past few years. At each YRTC, the staff have had to manage a select group of youth with more aggressive and violent behaviors who assault staff and other youth. Complicating this is the fact that there are a large number of youth with gang affiliations that have conflicts with each other and significantly disrupt facility operations. In addition, the YRTCs are managing the mental health and other behavioral struggles that most of the youth deal with. The increases in the census only exacerbate these challenges. The OIG was also made aware of other issues at some or all of the YRTC facilities, such as with youth continually causing minor property damage or having inappropriate physical contact with each other, and miscellaneous physical plant limitations and needs for repair or expansion.

In terms of the administration of the facilities, this past fiscal year, YRTC-Kearney made significant progress on the construction of the new building intended to serve as an additional housing unit, and YRTC-Hastings began planning the construction of a similar building as well.

The OIG was made aware that each YRTC has had fewer problems filling vacancies for front-line staff who most often interact with the youth and that each YRTC's school remains fully or mostly staffed with teachers. In speaking with committed youth and YRTC administrators and staff, it appears that although the dedicated mental health staff that the YRTCs do have are invaluable, each facility would greatly benefit from even more mental health staff to address the severe needs of the youth. The OIG also learned about how each YRTC made various efforts to offer more and improved programming, recreational activities, and community engagement opportunities for the youth. Notably, in speaking with individual youth during the visits in FY 2024-2025, the OIG was consistently told by the youth that they had a positive relationship with and trusted the YRTC staff, felt like the staff genuinely cared about them and wanted them to succeed, and that they understood the purpose of the YRTC program and believed they were being equipped with skills to change and overcome their struggles.

The OIG hopes to visit the YRTCs more frequently in the future and will continue to collaborate with the Ombudsman's Office about its visits and the information it receives.

Complaints, Incidents, and Grievances

Intake Process

The OIG's work is driven by the information it receives. Accountability and good government are only possible when information about government systems and agencies is available. Much of that information must come from the government agencies themselves through basic and necessary transparency.

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

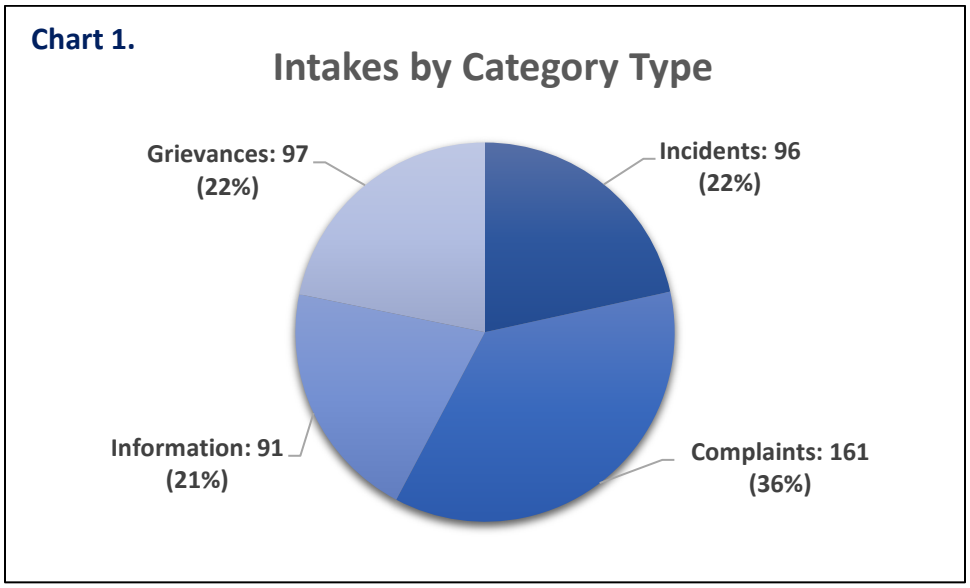
Intakes come in the form of notifications of incidents or reports from agencies, grievances filed with DHHS, including DHHS' response to the individual filing the grievance, and from complaints or reports of information made by members of the public. After receiving information as described above, the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

This last fiscal year, the OIG received a total of 445 intakes, a much lower number than the 515 intakes received by the OIG in the previous year. The breakout of information received is presented in the figures below.

Table 35. *Incidents Reported to the OIG FY 24-25*	
Reporting Agency	**Number Reported**
CFS	70
Children's Services Licensing	25
Juvenile Probation	0
OIG Discovered	1
Total	**96**

Table 36. *Other Types of Reports Made to the OIG FY 24-25*	
Type of Intake	**Number Reported**
Complaints	161
Reports of Information	91
DHHS Reported CFS Grievances	97
Total	**349**

Chart 1.



There was a marked decrease in incidents reported to the OIG by DHHS, as there were 120 reported in FY 2023-2024, 50 more than the 70 reported in FY 2024-2025. In addition, there were 19 fewer complaints in FY 2024-2025 than in the previous year.

Approximately two-thirds of the total number of incidents and CFS grievances reported to the OIG occurred in the first half of the fiscal year, from July to December, whereas the complaints and reports of information received by the OIG were generally evenly distributed across each month of the fiscal year.

Complaints

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

For FY 2024-2025, the OIG received a slightly lower number of complaints than it did in FY 2023-2024. The OIG received 161 complaints this fiscal year, compared to 180 the previous year.

Individuals who contact the OIG raise many kinds of concerns. Most often, complainants allege issues with how a case is being managed by DHHS, citing delays in receiving services and maintaining contact with caseworkers and involved parties. Specifically, in FY 2024-2025, the OIG received many complaints regarding the actions of DHHS caseworkers, the suitability of a placement that DHHS moved a child to, DHHS' decisions in removing children from their homes, or DHHS not accepting an allegation of abuse or neglect made to the Hotline and, therefore, not investigating.

The OIG thoroughly reviews each complaint through interviews with complainants and a review of documentation. The majority of the time, the OIG's review concludes that the complaint demonstrates that DHHS appropriately responded to a given situation. However, if a complaint, or a series of complaints, demonstrates a systemic issue, the OIG can decide to conduct a deeper review or open an investigation.

In addition, the OIG received an increase in complaints in FY 2024-2025 regarding issues that the OIG lacks jurisdiction over, especially complaints against various aspects of the judicial system and ongoing court cases. These complaints often involved court orders and proceedings or law enforcement actions, which, again, are outside of the jurisdiction of the OIG. The OIG encouraged these complainants to continue working with their attorneys and proceeding with

the judicial process, and, when appropriate, referred the complainants to offices with the authority to review such issues.

Unfortunately, as noted, the OIG's ability to review complaints has been severely limited by the lack of access to the NFOCUS system. This issue persists even with the passage of LB 298. The confidentiality of complainants is paramount to the OIG. Often, complainants are concerned about a perceived risk of retaliation in a child welfare case should their complaint be known by DHHS. Under the current process, the OIG would have to reveal the names of the children involved in the case that was the subject of the complaint to request information. This protocol has created some concern among complainants, making it more difficult for the OIG to request information relevant to the complaints.

Working with the Ombudsman

In other cases, the OIG receives complaints about an individual case that are concerning but do not reveal broader problems with the child welfare system. In these cases, the OIG tries to provide assistance by referring the complainant to a more appropriate entity to handle that concern. Most often, the OIG will refer individual concerns to the Ombudsman's Office. The Ombudsman's Office addresses complaints concerning the actions of administrative agencies within state government, which includes those state agencies serving children and state wards. The Ombudsman's Office can investigate and resolve complaints informally by working with the parties involved while promoting accountability in public administration. If, after a preliminary review, the OIG determines that a complaint does not rise to the level of an investigation but that the complainant may benefit from the help of the Ombudsman's Office, or if the complaint is directed against a state government entity outside of the child welfare and juvenile justice systems, the OIG can refer the complaint to the Ombudsman's Office directly, or direct the complainant to contact that office themselves. This process is efficient and often prevents the complainant from having to repeat the often-traumatic circumstances of their complaint. In total, the OIG referred 63 complaints to the Ombudsman's Office in FY 2024-2025. This is comparable to the 60 complaints referred to the Ombudsman's Office in the previous year.

While LB 298 moved the OIG out of the Ombudsman's division and into the new Division of Legislative Oversight, the law still allows for the OIG to refer complaints to the Ombudsman's Office.

Complaints Referred to the Hotline

In FY 2024-2025, the OIG continued to receive complaints and information regarding current concerns for child abuse or neglect occurring in the community. This is information that needs to be provided to the Nebraska Child Abuse and Neglect Hotline. In response, the OIG immediately asks the person to contact the Hotline and directs them to the Hotline's phone number and reporting website.

In FY 2024-2025, 67, or 26.6% of all complaints and reports of information received by the OIG, were referred to the Hotline. This is a slight decrease from FY 2023-2024, where 78, or 28.9% of all complaints and reports of information received by the OIG, were referred to the Hotline. In addition, if a complaint includes adequate identifying information and raises concerns of current abuse or neglect, OIG staff, as mandatory reporters, will report the information to the Hotline as well. The OIG appreciates the communication with DHHS this last year about the most efficient way to pass along such information to the Hotline.

The OIG will continue to monitor this trend and work to ensure that the information that should go to the Hotline gets to the Hotline.

Incidents

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

In addition, Children's Services Licensing provides incident reports related to suspected abuse and neglect of children in licensed child care facilities. In FY 2024-2025, the OIG received 25 incident reports from Children's Services Licensing, compared to 16 reports in FY 2023-2024.

These are monitored and reported out in a Child Care Monitoring Report annually, beginning last fiscal year. That report found that CFS and Children's Services Licensing do well at collaborating on investigations of incidents that occur in child care settings, and write thorough reports.

Grievances

Neb. Rev. Stat. § 81-603 requires DHHS to provide the OIG with grievances the Department receives and "the determination of any action to be taken by the department." In FY 2024-2025, the OIG received 97 grievances from DHHS, similar to the 102 grievances in the previous year. The grievance process is open to families who are currently involved with CFS, either in an Initial Assessment or Ongoing Services Case. It is most often used when they may be unable to resolve case issues with their caseworker or supervisor. The grievance is submitted through an online form, and a review is completed by DHHS staff through speaking with the reporting party, the case team, and reviewing case files. DHHS provides the OIG with both the initial grievance form and its response letter detailing what was found through its review. The OIG reviews these grievances to determine if there are broader systemic issues that become apparent across the grievances that would require a more extensive investigation.

In the overwhelming majority of the grievances reviewed by the OIG in FY 2024-2025, the primary concerns raised by families were with the actions of DHHS caseworkers or the decisions of DHHS and a juvenile court in removing a child from their home, the child's new placement, and various other court matters.

Alternative Response Oversight and Case Summaries

Alternative Response (AR) is an approach used by DHHS and in many other states that allows those working in the child welfare system to engage with families in a less adversarial, more collaborative way and to respond to less severe allegations of child abuse or neglect without a traditional investigation. Instead, AR allows children to stay in their homes and offers families voluntary services and community support to enhance their ability to keep the children safe. AR was intended to improve outcomes for Nebraska families and lower the number of children being removed from their homes and formally entering the child welfare system. To proceed as an AR case, the children must be found to be safe. AR was intended to serve families at a lower risk of future maltreatment.

The use of AR in child welfare cases throughout the state has fluctuated through the years. The number of AR cases has risen significantly since 2020 after AR transitioned from a pilot project to full implementation. In 2020, AR cases comprised 10.2% of all child abuse and neglect reports assessed by the Hotline. In 2021, the number of AR cases jumped to 25.4% and in 2022, that number grew to its all-time high of 34.8%. In 2023, DHHS reported a slight decrease in AR cases at 30.2%, with another decrease to 27.1% in 2024.[40]

By statute, the OIG's Annual Report must include a summary of any case reviewed by the office that includes AR.[41] AR cases reviewed by the OIG typically take the form of either (1) a complaint made directly to the OIG regarding an AR case, (2) an incident report related to the death or serious injury of a system-involved child in an AR case, or (3) a DHHS grievance provided to the OIG. In the case of a death or serious injury, the review is twofold: first, a review of the AR case as required by statute, and second, a review to determine if the report meets the criteria for a mandatory investigation by the OIG. The OIG will conduct a full investigation into those deaths and serious injuries determined to be mandatory investigations.

[40] This data comes from the OIG's recent Alternative Response investigation discussed later in this report, which can be found on the Legislature's website: https://www.nebraskalegislature.gov/pdf/reports/oversight/OIG_AR_investigation_w_appendices.pdf.
[41] See Neb. Rev. Stat. § 50-1818; see also Neb. Rev. Stat. § 28-712.01(5).

Summary of AR Complaints

Complaint Made Directly to OIG About CFS Caseworker Offering AR Services

The complainant alleged that a CFS caseworker came to her home to offer her family AR services even though she was not aware of an allegation of abuse or neglect that had been made to DHHS. The complainant alleged that the caseworker was not forthcoming about why DHHS was offering services to the family, that the caseworker was not knowledgeable or clear about the different types of services available in an AR case, and that the caseworker pressured the complainant to decide on the spot to accept or decline the services. The OIG referred this complainant to the Ombudsman's Office.

Complaint Made Directly to OIG About CFS Caseworker in AR Case

The complainant alleged that she was having issues with the caseworker assigned to her AR case within only a couple of days after the case was opened. The complainant alleged that the caseworker was known for making false allegations against parents in other cases and treated the AR case no differently than a traditional response case. She stated that the caseworker contradicted themselves when explaining the allegations made to the Hotline about the complainant's family and was not knowledgeable about the laws and policies governing how AR was supposed to work. The complainant contacted the caseworker's supervisor at the same time as it contacted the OIG. Soon after, the complainant notified the OIG that she was assigned a new caseworker. The OIG told the complainant she could contact our office again if any other issues arose, but the complainant never did so.

Summary of AR Incidents

Child Death I

The OIG received notice of an 11-month-old child who had died due to medical conditions. The child had been the subject of one previous intake accepted as AR four months before the death. In that intake, it was alleged that the child had diabetes and that the child's blood sugar readings were dangerously high because the child's mother was not correctly administering their insulin. CFS closed the AR case after the mother improved in her ability to correctly administer the insulin, and the child received a device that allowed the insulin to be

administered automatically and more accurately. Medical professionals and law enforcement determined that the child's death was attributable to the diabetes and an illness that the child had recently received medical attention for, but was not attributable to abuse or neglect. The OIG thus determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Child Death II

The OIG received notice of a one-year-old child who had died due to medical conditions. Two months before the death, an intake was accepted as AR after it was reported that the child was being physically neglected and was taken to a hospital for weight loss and failure to thrive. The child's weight loss was due to various medical conditions that made feeding difficult. The child's mother reportedly sought appropriate medical attention and addressed the concern. The child's death was later determined to be the result of cardiac arrest caused by the child's many severe lifelong ailments, and there was no indication of abuse or neglect. The OIG determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Child Death III

The OIG received notice of a 13-year-old child who had died due to medical conditions. Seven months before the death, an AR intake was accepted on the family that involved concerns with one of the child's siblings having severe mental health needs. The sibling was eventually admitted to a psychiatric residential treatment facility, and the AR case was closed. The 13-year-old's death was determined by medical professionals to be from natural causes and law enforcement did not investigate or suspect abuse or neglect, as the child had numerous severe lifelong ailments and was medically fragile. The OIG determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Child Attempted Suicide

The OIG received notice of an 11-year-old child who had attempted suicide by ingesting and overdosing on medications not properly secured in their home. Eight months before the suicide attempt, the child's family agreed to receive ongoing AR services after it was reported that the

child had poor school attendance. One month before the suicide attempt, the AR case was switched to a voluntary non-court case after it was reported that the child's mother had overdosed and that the child had begun self-harming behaviors and the child's mental health was not being appropriately addressed. That non-court case remained open at the time of the child's suicide attempt. The child received psychiatric treatment and was eventually discharged from the hospital. The OIG found that this incident was subject to a mandatory investigation and report. The final report will be released after the investigation and report process is completed.

Child Serious Injury

The OIG received notice of a two-year-old child who had suffered a serious injury initially suspected to be caused by physical abuse. The child's family had an extensive history with CFS, including an AR case that had closed two months before the child's injury. In that AR case, it was reported to the Hotline that the child's mother was an alcoholic and had a relapse with alcohol, and that she wanted CFS' help. The intake was screened as AR, and the family agreed to receive AR services. CFS did not directly provide any services to the family, however, as it connected the family to community resources that were able to help the mother maintain her sobriety instead. The child's serious injury was later determined by medical professionals and law enforcement to be accidental and not the result of abuse or neglect. As such, the OIG determined that this incident did not meet the criteria for a mandatory investigation under the statute.

Investigations, Reports, and Recommendations

Nebraska law requires the OIG to summarize any investigations from the last year in its Annual Report and to provide an update on the status of implementation of any OIG recommendations.

Process of OIG Investigations

A full investigation by the OIG includes:

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

After a full investigation, the OIG issues an investigative report and shares the report with the state agency for review.[42] The state agency may respond by accepting, rejecting, or requesting a modification of the recommendations and the agency may also make any factual corrections if necessary.[43] A private agency that is also the subject of the report similarly has an opportunity to review the report and respond to the recommendations.[44]

Summaries of OIG Reports of Death and Serious Injury Investigations

Deaths and Serious Injuries of Children After an Alternative Response Assessment[45]

Between 2021 and 2024, the OIG received notices from DHHS' Division of Children and Family Services regarding nine children in Nebraska, six of whom were seriously injured and three of whom had died, after the acceptance of an AR intake within the previous 12 months. AR was

[42] Neb. Rev. Stat. § 50-1815(1).
[43] *Id*.
[44] § 50-1815(2).
[45] Office of Inspector General of Nebraska Child Welfare, *Deaths and Serious Injuries of Children After an Alternative Response Assessment.* July 30, 2025. https://www.nebraskalegislature.gov/pdf/reports/oversight/OIG_AR_investigation_w_appendices.pdf.

initially introduced by the Nebraska Legislature as a pilot project in 2014, and implemented by the Legislature as a permanent program in 2020. There were no deaths or serious injuries of children related to an AR case reported to the OIG until 2021. The nine cases that were the subject of this investigative report include all the deaths and serious injuries related to an AR case of which the OIG had been notified of at the time of that report.

The following are the nine cases included in the report:

1. On November 22, 2021, seven-month-old AB suffered a significant skull fracture in her home less than four months after an Alternative Response Assessment was completed for her family.
2. On January 3, 2022, three-month-old CD suffered severe neglect resulting in malnutrition and severe illness three months after an Alternative Response Assessment was completed for his family.
3. On February 7, 2022, five-month-old EF suffered a brain bleed three months after an Alternative Response Assessment was completed for his family.
4. On March 11, 2022, nine-month-old GH suffered multiple fractures four months after an Alternative Response Assessment was completed for her family.
5. On May 11, 2022, one-year-old IJ ingested some type of opioid, requiring multiple doses of Narcan to be administered, three months after an Alternative Response Assessment was completed for his family.
6. On October 23, 2022, three-month-old KL died at home due to unsafe sleeping conditions while receiving services through an Alternative Response case.
7. On April 12, 2023, two-month-old MN died after suffering physical abuse in his home two months after an Alternative Response Assessment was completed for his family.
8. On May 30, 2023, five-month-old OP died at home as a result of unsafe sleeping conditions while receiving services through an Alternative Response case.

9. On March 17, 2024, three-year-old QR suffered medical neglect due to his family's failure to seek medical care 11 months after an Alternative Response Assessment was completed for his family.

The investigative report includes an explanation of AR in Nebraska's child welfare system, a history of AR's implementation and changes over time, a summary of the critical incidents and analysis of any commonalities between the cases, and a review and analysis of data related to the use of AR. In addition to reviewing the specific critical incidents, the report is focused on how AR is implemented in Nebraska and how well and whether AR is meeting the Legislature's stated goals for this approach to child welfare cases.

As a result of this investigation, the OIG found:

1. Alternative Response is not being used solely in cases with a low or moderate risk of abuse and neglect but is used as often for high and very high-risk families.
2. Since AR is voluntary and families assessed at high or very high-risk of future maltreatment may refuse services, family engagement is critical to mitigating the risk to the children in those families.
3. DHHS' limited review of a family's history and previous risk determinations when assigning cases to Alternative Response can create a gap and a challenge in serving some families.
4. Additional data points are necessary to evaluate the effectiveness of Alternative Response.
5. Errors in the completion of Structured Decision Making assessments that impacted the accuracy of future risk scores and possibly child safety.

The OIG recommended that DHHS:

1. Develop a tracking system for Alternative Response that includes a family's refusal of services and financial assistance provided to the family to better analyze outcomes in Alternative Response cases.

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

Death of Two-Year-Old Child Due to Physical Abuse by Parent's Significant Other[46]

On February 27, 2021, two-year-old Z.Y. died as a result of serious injuries suffered in his home the day prior. The OIG was notified of Z.Y.'s death on March 2, 2021, and opened this investigation as mandated by law.

Law enforcement and DHHS' Division of Children and Family Services determined that Mr. X, the boyfriend of Z.Y.'s mother, physically abused Z.Y. while his mother was briefly away from the home. DHHS conducted two separate child abuse and neglect investigations within the three months before Z.Y.'s death. Mr. X was in a relationship with Z.Y.'s mother during that time, and he was at least occasionally living in or visiting the family's home when Z.Y. was present. Mr. X also contributed to Z.Y.'s care in the month before Z.Y.'s death. However, under DHHS' implementation of its Structured Decision Making (SDM) Model policy and practice, Mr. X was not included as a member of Z.Y.'s household in those investigations or DHHS' safety assessments. Based on the OIG's review of this case, previous OIG investigations similar to this case, DHHS policy, and the SDM Model, the OIG found that:

1. Current SDM policies and practices do not sufficiently identify or assess all persons in a child's household with regular access to the child who may pose a risk to the child's safety.

As the OIG has noted in two previous reports in 2016[47] and 2020,[48] the OIG again found that DHHS policy and practice can focus too narrowly on assessing a child's primary or secondary

[46] Office of Inspector General of Nebraska Child Welfare, *Death of Two-Year-Old Child Due to Physical Abuse By Parent's Significant Other (August 2025).* August 28, 2025. https://nebraskalegislature.gov/pdf/reports/oversight/OIG_Death_of_2_Year_Old_w_appendix.pdf.
[47] Office of Inspector General of Nebraska Child Welfare, *Death and Serious Injury Following Child Abuse Investigations October 2013–June 2015*. March 17, 2016.
[48] Office of Inspector General of Nebraska Child Welfare, *Death or Serious Injury Following a Child Abuse Investigation June 2016–June 2019*. August 7, 2020. https://nebraskalegislature.gov/pdf/reports/public_counsel/Final_IA_Report_9-20.pdf.

caregivers, while failing to fully assess those in the child's household with regular access to the child who may pose a safety threat to that child. With those previous reports, in addition to the death in this report, the OIG has now investigated 15 cases where children have died or were seriously injured by persons who may not qualify as a caregiver under the SDM Model, but would likely qualify at some point as a member of the child's household under the SDM Model because of how often they were in the child's home and cared for the child.

The plain language of DHHS' current policy and guidance regarding the makeup of a child's household does, in principle, capture persons who may not always qualify as a caregiver but still have regular access to the child in the household. Since the policy states that all SDM Assessments are completed on the members of a child's household, members of that household, beyond the caregivers, should be included in the subsequent safety and risk assessments. The tools used for safety and risk assessments, however, were found to only focus on primary caregivers and secondary caregivers.

In its response to this OIG report, DHHS stated that DHHS policy and SDM tools required a person to provide 50% of a child's care and reside in the child's home to be considered part of the household. DHHS explained that while a household may be determined as required under the policy, the focus of any assessment would be on the caregivers that reside in the home. However, there is nothing in the plain language of the SDM policy that requires someone to reside in the home to be considered a member of the household. There is also nothing in written policy that limits SDM households to caregivers for an assessment. DHHS' practical application of the SDM policies were therefore found to be more limiting in terms of the persons assessed than the written policies. Given DHHS' very narrow interpretation of its policy, the danger that Mr. X may have posed to Z.Y. as a member of the household and an alleged perpetrator was therefore not assessed or considered.

While the roles of primary and secondary caregivers are key, the OIG found that more robust attention should be paid to the threats that may come from other adults in the household who do not meet DHHS' definition of a caregiver but still have regular access to the child or regularly

contribute to the child's care. The OIG also found that the implementation and practice of DHHS' written policy should ensure that significant others are part of the household and safety and risk assessments.

The OIG recommended that DHHS:

1. Evaluate and enhance the identification and assessment of all persons with regular access to a child in the child's home.

The OIG made this recommendation regardless of the child welfare case management model used by DHHS moving forward, whether that be the SDM Model or a new model that DHHS is considering a move to called the SAFE Model.

The OIG also recommended that DHHS enhance the training and guidance around SDM Households to ensure that caseworkers are identifying all members of a household, including persons who regularly visit the home when the children are present. Similarly, the OIG recommended that DHHS should also evaluate and enhance its safety and risk assessment tools to ensure that they do not focus too narrowly on primary and secondary caregivers to the exclusion of other persons identified to be in the household with access to the children.

Death of Seventeen-Year-Old Involved with DHHS and Juvenile Probation After Running Away from Home

In March 2021, the OIG received notice from CFS and Juvenile Probation that seventeen-year-old L.M. had run away with another youth a few days prior, stolen vehicles and firearms, and then died in a shootout with law enforcement in another state. L.M. was involved with Juvenile Probation several years before her death. She was not supervised by Juvenile Probation at the time of her death, but it is believed that she was going to be placed back on Juvenile Probation as a result of criminal cases pending at that time. Despite that involvement, the OIG's investigation was limited to the role of DHHS in L.M.'s case due to Juvenile Probation not sharing information with the OIG, as has been the case for several years.

In the eight years before her death, L.M.'s family was involved in many Hotline calls and several CFS assessments. Most of the Hotline intakes were not accepted by DHHS because they did not meet the definition to be accepted for assessment, and, as a result, no DHHS services were provided to L.M.'s family. Throughout that history, the OIG's investigation identified that the primary concern with L.M. was her significant mental health issues and struggles with self-harming, suicidal ideations, and drug use that began when she was 13 years old. L.M.'s parents reportedly attempted to help her over these years by having her regularly attend therapy, take various prescribed medications, and undergo numerous treatment programs at many different psychiatric residential treatment facilities and hospitals in and outside of Nebraska. DHHS also offered the family AR services on one occasion, but the family declined those services.

L.M. began to show improvement with her mental health for a short period. But approximately one week before L.M. ran away from home, she was found unresponsive in her mother's care after ingesting a large quantity of prescription medication. L.M. was then removed from her mother's home and placed in her father's care, where DHHS and Juvenile Probation believed that L.M. would be better supervised while they figured out a more permanent solution for her. Two days later, L.M. ran away from her father's home in the middle of the night with her boyfriend and was subsequently killed.

Based on the OIG's review of CFS records, court documents, law enforcement reports, an interview with a DHHS employee, and relevant statutes, rules and regulations, and DHHS policy documents in effect at the time of this case, the OIG found:

1. That DHHS followed statute, rules, and regulations in this case, that DHHS' limited involvement with L.M. that began shortly before her death was appropriate, and that no significant systemic issues were identified in this investigation.

The OIG's investigation also acknowledged that it is challenging to reach youth who have extensive trauma and are struggling with severe mental health issues. The documentation in this case indicated that L.M.'s parents and the numerous professionals over the years were engaged and tried to help her, but that they had great difficulty in preventing her self-harm,

suicidal ideations, substance abuse, negative peer influences, and various destructive and rebellious behaviors. The OIG noted that this case highlights the importance of continuing to examine whether Nebraska has the continuum of mental health services needed to serve its youth. It also confirmed the importance of training for DHHS staff and a regular review of the effectiveness of the policies and procedures meant to address the mental and behavioral health issues and suicidal ideations of system-involved youth like L.M.

Based on the OIG's findings, the OIG made no recommendations to DHHS as a result of this investigation. The OIG took note of the child welfare themes reflected in L.M.'s case, which will be tracked to identify systemic issues and considered as topics for future investigations as necessary and appropriate.

Summaries of Other OIG Reports

Child Care Monitoring Report

Beginning with the 2023-2024 fiscal year, the OIG completed a Report of Monitoring regarding critical incidents in licensed child cares that were reported to the OIG by the DHHS Division of Public Licensing, Children's Services Licensing (CSL). Statute mandates that the OIG investigate any death or serious injury of a child in a child care facility when the office determines that the death or injury did not occur by chance. This report summarizes the OIG's in-depth review and monitoring of child injuries and accidental deaths in licensed child cares reported to the OIG during the fiscal year. The report does not include any incidents that warrant further investigation under statute. The report will be completed annually.

There was a total of 20 incidents that occurred in child care settings reported to the OIG in FY 2023-2024. One of these 20 is not included in the monitoring report, as the death requires a full investigation by the OIG because the nature of that death is indicative of child abuse. Of the remaining 19, CFS accepted 16 for assessment, with the other three not meeting the definition for an investigation. Of those 16 investigated, 15 were determined to be unfounded for child abuse or neglect. One investigation was agency substantiated, as the child care provider was

found to be at fault for the injury to the child. This incident did not warrant a full investigation by the OIG under the law.

CSL investigated all 19 incidents. Five cases were substantiated as being out of compliance with licensing regulations or statutes and required some form of action from the child care. These actions can be as simple as providing training or updating records, or more detailed plans set forth by CSL through formal corrective action or probation terms.

The nature of the incidents reported to the OIG ranged from serious injuries such as a skull fracture, broken bones, and hematomas, to less severe injuries such as bruises, scratches, bite marks, and rug burns. There were also sexual abuse allegations reported. In one instance, a child was able to access improperly stored chemicals. There was also one death due to Sudden Infant Death Syndrome. The incidents reported to the OIG occurred in licensed child care homes and licensed child care centers.

The OIG's monitoring of these incidents included a review of the critical incident report, licensing history available on DHHS' public website, Intakes and Out-of-Home Assessments (OHA) completed by CFS, and complaint investigations completed by CSL. Relevant statutes, policies, and regulations were reviewed as well.

Findings

After its review, the OIG found that the majority of the investigations by CFS were thorough and detailed, particularly when documenting what was said in interviews and the events of the day of the critical incidents. A few OHAs were less thorough due to a lack of details, information being copied and pasted into different sections of the OHA or not matching the section it was documented in, and the need for further explanation for the basis of the finding. As for CSL, the investigations were thorough and detailed. In many cases, the scope of the investigation not only pertained to the complaint being investigated, but while visiting the child care, the investigator also reviewed for any present violations of regulations or statutes, noting these in their documentation. The specific regulations and statutes reviewed for compliance and all violations were clearly identified in the CSL complaint review form. It was also noted that

licensed child cares are being regularly monitored through unannounced semi-annual visits from licensing staff.

The OIG commends CFS and CSL for working together on the reviewed investigations, as it allowed parties to only need to be interviewed once and for information to be shared freely. This collaboration is a great way to preserve government resources and decrease stress and trauma to children.

The OIG had no formal recommendations regarding the investigative processes within CFS and CSL. Although not all investigations were exemplary, the OIG's overall review determined that the work was done well and collaboratively within DHHS.

Juvenile Room Confinement Report

Neb. Rev. Stat. § 83-4,134.01 was enacted in 2016 "to establish a system of investigation and performance review in order to provide increased accountability and oversight regarding the use of room confinement for juveniles in a juvenile facility." Juvenile room confinement statutes require certain juvenile facilities to document each incident where a juvenile is involuntarily placed alone in a room or area for one hour or longer within a 24-hour period.[49] It also requires facilities to submit quarterly reports to the Legislature detailing the data about those juvenile room confinement incidents. The OIG is similarly mandated to review that data to assess the use of room confinement for juveniles at each facility and to submit an annual report of its findings to the Legislature.[50] As has been done in previous Annual Reports, below is a brief summary of the OIG's most recent Juvenile Room Confinement in Nebraska report, which was released in December 2024.[51]

[49] See Neb. Rev. Stat. § 83-4,125(4); Neb. Rev. Stat. § 83-4,134.01.
[50] See § 83-4,134.01.
[51] The full 2023-2024 report can be accessed on the Legislature's website: https://nebraskalegislature.gov/FloorDocs/108/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/650_20241230-130157.pdf.

Fiscal Year 2023-2024 Juvenile Room Confinement Report Summary

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

In the OIG's FY 2023-2024 juvenile room confinement report, the OIG highlighted, as it has for the past several years, that Nebraska juvenile room confinement statutes are robust in intent and incorporate best practices, but are not reliably followed and are inconsistently applied across Nebraska juvenile facilities, leading to significant variations in the use and reporting of juvenile room confinement. Based on the OIG's review of the FY 2023-2024 juvenile room confinement data, this inconsistency and the disconnect between the law and the practical application of juvenile room confinement in Nebraska appeared to remain. This again hampered the OIG's ability to gauge the full scope of how juvenile room confinement is used and its impact on the welfare of youth.

This past fiscal year, the OIG observed various concerning trends regarding juvenile room confinement in Nebraska. Namely, compared to the previous fiscal year, there was a significant increase in the total number of hours that youth were confined across all the facilities combined. Together, facilities reported approximately 119,300 total hours of juvenile room confinement in FY 2023-2024. This was a 110% increase from the approximately 56,900 total hours of confinement reported in FY 2022-2023.

There was also a significant increase in the number of incidents of confinement. The number of confinement incidents increased by 48%, from approximately 4,000 incidents in FY 2022-2023 to approximately 5,900 in this past fiscal year.

Based on the data alone, it appeared that these increases were contrary to Nebraska law and best practice, which state juvenile room confinement should be time-limited and used as a last resort. However, the OIG acknowledges that the data alone did not fully explain the complexity of juvenile room confinement nor the extensive challenges that many individual juvenile

facilities face in reducing the reliance on the practice. For most of the reporting facilities, the number of youth being served has increased after several years of decreases in their populations due to the COVID pandemic. In addition, these facilities are serving more youth who have gang affiliations, adult criminal charges, mental health issues, and highly aggressive and assaultive behaviors, all of which create challenges that may increase the risk of disruption and threats to facility safety and security. Juvenile room confinement may occasionally be necessary for such reasons, so long as it is used reasonably, sparingly, and in compliance with Nebraska law and best practices.

That said, this past year also had several positive trends and improvements regarding the practice of juvenile room confinement in Nebraska. For example, despite the increase in total room confinement hours and incidents, most of the incidents were resolved more quickly than those in the previous year. In other words, confinement may have been used more frequently, but each occurrence may have been for a shorter period of time, making its overall use more time-limited. Other notable positive trends from this past year include an across-the-board decrease in the use of consecutive days of room confinement, as well as a drastic decrease in room confinement for medical reasons (94% decrease) as compared to the previous fiscal year.

The OIG suggested that addressing the significant gap between Nebraska statutes and best practices on juvenile room confinement, with the practical application of these principles, requires a multi-faceted approach involving policy reform, culture change within facilities, rigorous oversight, and a commitment to continuous improvement. If the goal of the state is to truly reduce the use of juvenile room confinement within juvenile facilities, the OIG once again suggested that the Legislature may need to further engage with these facilities to fully understand their challenges and determine what additional supports or resources are required to successfully facilitate the reduction in juvenile room confinement usage.

OIG Recommendations Status Update

Reports of OIG investigations contain recommendations for systemic reform. The OIG's Annual Report is required to describe those recommendations and the status of their implementation.[52]

The updates to the recommendations provided by DHHS-CFS in 2025 mainly state that past recommendations have been operationalized. In regards to a 2023 recommendation that DHHS should develop a comprehensive health care management plan for state wards, DHHS stated that in the fall of 2025, they are internalizing support of all relative and kinship foster homes and working with Medicaid MCOs to ensure state ward medical needs are met. DHHS-YRTC recommendation updates all stated that the FY 2023-2024 updates provided are all fully operational. DHHS-Public Health recommendation updates state that there were no changes in the past fiscal year, with one exception. In response to the 2016 recommendation that they adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible, Public Health stated that LB 217 was signed into law on June 4, 2025, requiring suicide awareness and prevention training for child welfare workers, for certain licensure, and for employees of child-placing agencies. Public Health and CFS are working together to coordinate training requirements and establish approved training.

Three new recommendations were made to DHHS as part of the three completed investigations regarding 11 children in the 2024-2025 fiscal year. Those recommendations are included in this Annual Report.

The OIG has made 117 total recommendations in the past 14 years. A full list of the OIG recommendations and status updates from DHHS over the years can now be found on the Legislature's website at http://nebraskalegislature.gov/divisions/oig-recommendations.php.

[52] See Neb. Reb. Stat. § 50-1818.

Office of

Inspector General of Nebraska Child Welfare

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

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