OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

REPORT OF INVESTIGATION
EXECUTIVE SUMMARY

Subject: Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney

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EXECUTIVE SUMMARY

The Office of Inspector General of Nebraska Child Welfare (OIG-CW) was notified of 44 different sexual-abuse-related allegations made by 37 separate youth against 19 different staff members at the Youth Rehabilitation and Treatment Center at Kearney (YRTC-Kearney) occurring between March 2025 and March 2026. The allegations ranged from more severe allegations of staff abuse of youth, including sexual abuse, assault, touching, or harassment, to less severe allegations of staff violations of appropriate and professional boundaries with youth. Within those 44 allegations were over 200 specific claims of a variety of improper conduct by staff. These allegations implicated violations of the Prison Rape Elimination Act (PREA), Nebraska state law, and Nebraska Department of Health and Human Services (DHHS) policies regarding appropriate and professional boundaries between staff and youth.

As of the date of this report, the status of the 44 allegations is:

- Four staff members have been criminally charged with sexual abuse of protected individuals, one of whom was also charged with additional felonies.
- Three other allegations have been substantiated by the Office of Juvenile Services' (OJS) Compliance Department (Compliance) at YRTC-Kearney.
- Nine allegations were unfounded or unsubstantiated by Compliance and the Nebraska State Patrol's (NSP) investigations into those allegations were also closed.
- The remainder of the allegations, which include the majority, have been unsubstantiated or unfounded by Compliance.

This investigation includes allegations of staff sexual abuse of youth from March 2025 through March 2026. However, the OIG-CW did not receive notice of any allegations until August 2025. The Office of Public Counsel, or Ombudsman's Office, which investigates complaints of any juvenile committed to the YRTCs, received some information about an incident in March 2025, but was not made aware that concerns included sexual abuse by a staff member. The Ombudsman's Office also received a complaint related to the August 2025 incident. It was not until late September and early October 2025 that the OIG-CW and Ombudsman's Office became aware of several other allegations. On October 17, 2025, the OIG-CW notified DHHS that it was opening an investigation into the sexual abuse allegations at YRTC-Kearney. Under the law, the OIG-CW and the Ombudsman's Office may coordinate on investigations in circumstances of overlapping jurisdiction and, as a result, the Deputy Ombudsman for Institutions participated in this investigation.

Summary of Critical Incidents

Four of the most serious allegations involving three separate youth (one youth alleged abuse by two different staff members) are summarized in detail in this report.[1]

The first incident and allegation occurred in March 2025 when three youth, including Youth A, were found with a cell phone at the facility. When YRTC-Kearney staff accessed the phone, they observed social media posts and photos of all three youth, as well as text messages that included plans to escape. It was quickly discovered, however, that the phone also contained sexually explicit content from two adult females—one who did not work at YRTC-Kearney, and one who was a current YRTC-Kearney Youth Program Specialist (YPS) staff member. In addition to photos, the phone contained four sexually explicit videos of that staff member—Staff 1—including ones of her masturbating dressed only in underwear or entirely naked. The phone also contained text messages between Youth A and Staff 1 that included terms of affection, discussion of the two living together in the future, and Staff 1 referring to Youth A as her "future hubby." Several months later, in September 2025, Youth A also disclosed that he and Staff 1 had engaged in sexual activities while at the facility. Compliance notified NSP of both the March incident and the September disclosure. During the internal compliance investigation, Staff 1 resigned. The incident and allegations related to the cell phone were substantiated by Compliance as a staff-to-youth boundary violation, rather than a PREA violation.

The second incident occurred in April 2025. Initially, this allegation came to the attention of YRTC leadership when another YPS staff member, Staff 2, reported that Youth B had touched her thigh. Youth B received a major rule violation and was placed in confinement. The next day, Youth B shared with YRTC staff a note between Staff 2 and himself, which included sexually graphic statements exchanged between the two. Video was then reviewed, which showed Staff 2 allowing Youth B to touch her buttocks and holding Youth B's hands on her hips while his pelvis touched her buttocks as they descended a stairwell in the living unit. Youth B later alleged that the two were in a relationship and that additional sexual contact had occurred between them. Compliance notified NSP. During the Compliance investigation, Staff 2 resigned. Compliance substantiated the incident as a staff-to-youth boundary violation, rather than a PREA violation.

A third allegation of staff sexual abuse was disclosed in October 2025 and also involved Youth B. The day after he was moved from YRTC-Kearney to another placement, Youth B alleged that

[1] To ensure confidentiality, all names and identifying information of the youth and staff members involved in this investigation have been changed.

he also had a sexual relationship with another YPS staff member, Staff 3, for the entire time he was at YRTC-Kearney. More specifically, he alleged that on his last night at YRTC-Kearney, Staff 3 had opened the door to his room to provide him with medications, and put her hand under his pants and provided manual stimulation of his penis. After the Nebraska Child Abuse and Neglect Hotline (Hotline) report related to this allegation was received by the YRTC, Staff 3 was placed on paid leave pending an investigation by Compliance and NSP. Compliance reviewed the evidence, but found that the allegation was unsubstantiated. Staff 3 later resigned.

The fourth incident was discovered in August 2025. In this case, a YRTC-Kearney staff member was told that a youth, Youth C, and a YPS staff member, Staff 4, were passing notes to each other. Video was immediately reviewed, and the note passing was confirmed. Staff 4 turned over the note and claimed Youth C was touching her thigh while they were passing the notes. She was suspended pending an investigation. Youth C was sent to confinement based on the allegation that he was touching the staff member's thigh. Later that day, Youth C was overheard by staff talking about kissing Staff 4. Additional video was reviewed and confirmed that Staff 4 and Youth C were kissing or groping each other on the landing of the stairwell of the living unit on three separate occasions over the course of two days. Staff 4 was terminated.

Each of the four staff members described above has been criminally charged in connection with conduct related to this investigation.

The remaining 40 allegations are discussed and analyzed through a composite summary later in this report. As noted, there were over 200 specific claims of a variety of behaviors by YRTC-Kearney staff. The result was a complicated web of allegations and facts. Allegations from one youth might involve multiple staff members. Youth also made allegations regarding abuse of other youth—not always just themselves—that they claimed to have witnessed or about which other youth told them. Often, the investigation into one allegation led to new revelations about different alleged incidents involving different youth or staff. These factors resulted in a remarkably high number of allegations within a short period, which were quite difficult to keep separate, and made it even more challenging to determine what had actually occurred.

The most common type of allegation, which arose approximately 50 times, involved allegations that staff made inappropriate statements to youth, including flirtatious comments and sexually suggestive or explicit conversation, shared intimate details of their personal lives, and expressed a desire to have sexual contact or relationships with the youth. The next most common allegation was that staff inappropriately touched youth, most commonly by touching a youth's legs and thighs, but it was also alleged that staff would press their buttocks or breasts

against youth in a way that might appear to be inadvertent, but the youth believed to have been deliberate. Many allegations also involved staff giving the youth their personal phone numbers. In at least 15 instances, youth were in possession of the personal phone numbers of staff. No conclusion was ever reached on how the youth obtained the phone numbers. Other specifics of the myriad of allegations are detailed within this report.

To provide background and context for these allegations and the OIG-CW's findings and recommendations, this report also includes: a summary of the legal framework for sexual abuse allegations of youth in a facility; background on the YRTCs' purpose, structure, staff roles, and internal compliance process; and an explanation of abuse and neglect investigations conducted by DHHS.

Findings

The OIG-CW made the following findings, summarized here and explained in more detail in this report,[2] as a result of this investigation:

1. **The culture at YRTC-Kearney normalized inappropriate staff behavior, which the facility failed to sufficiently address.**

Four former staff members have been criminally charged for sexual abuse of youth at YRTC-Kearney. Three other allegations were internally substantiated by Compliance to have occurred. Moreover, even though the majority of the sexual abuse allegations reviewed in this investigation have been determined to be unsubstantiated or unfounded, the number, breadth, and consistency of the allegations, along with the similarity to patterns of behavior seen in prior years, demonstrates a pervasive culture at YRTC-Kearney that normalized and insufficiently addressed behavior extending from boundary violations to inappropriate relationships and sexual abuse.

To be very clear, the OIG-CW does not find that all staff or administration at YRTC-Kearney engaged in or condoned this inappropriate staff conduct. On the contrary, it is clear that many staff members are committed to the safety, care, and rehabilitation of the youth. However, the patterns of behavior seen both in this investigation and in prior years, along with an inadequate response from the facility with regard to supervision, disciplinary action, and a failure to recognize and address broader systemic issues, have resulted in a problematic culture at YRTC-Kearney.

[2] The full explanation of the findings can be found at pgs. 54–75.

2. **Internal compliance investigations are necessary, but they are not sufficient to determine if abuse or neglect has occurred at the YRTCs.**

It is critical to recognize that much of the behavior alleged by the youth at YRTC-Kearney in the past year would and should be considered abuse. These youth are not only minors, but they are protected individuals under the law while at the YRTC and are committed to the care and custody of OJS and DHHS for rehabilitation and treatment. Many of these youth come to the YRTC with significant behavioral and mental health challenges, and often with trauma. It is the staff's role and duty, as is outlined in DHHS' policies, to maintain professional boundaries with the youth.

Compliance investigations and reviews are necessary to provide independent oversight of concerns reported within the facility, including sexual abuse, harassment, and assault allegations. However, the OIG-CW found that Compliance investigations and reviews are limited in two key ways. First, the focus of Compliance investigations is ensuring adherence to law and policy and the administration of the facility, and not on youth as potential victims of abuse. In its response to this report, DHHS notes that Compliance investigations are not intended to determine whether abuse and neglect occurred. By contrast, an Out of Home Assessment (OHA) is conducted by DHHS' Division of Children and Family Services (CFS) to determine if abuse and neglect has occurred at a facility. An OHA is a more complete and multi-faceted assessment, containing a more in-depth and complete picture of how the youth is doing in the facility. OHAs were previously conducted at the YRTCs until 2019. While there is significant overlap between behaviors that would amount to a policy violation and behaviors that would amount to abuse, there is an important distinction between a Compliance investigation to determine whether there have been violations of policy and an investigation to determine whether abuse has occurred. The former is oriented to the proper administration of the facility, while the latter is oriented towards the well-being of the youth.

Second, fact-finding is limited by Compliance's process and jurisdiction, making it harder to determine if an incident actually occurred. The OHAs are not subject to those same limitations in fact-finding.

3. **Without abuse and neglect investigations at the YRTCs, staff who abuse youth may not be placed on the Nebraska Child Abuse and Neglect Central Registry and can continue to work with youth elsewhere.**

The Nebraska Child Abuse and Neglect Central Registry (Central Registry) is maintained by DHHS and contains a record of all persons who have been found responsible for child abuse or

neglect. A person can be placed on the Central Registry by the courts, through, for example, a criminal conviction, or by DHHS, if DHHS determines, through an abuse and neglect investigation, that the abuse can be "agency substantiated" by a preponderance of the evidence. One of the primary implications of being placed on the Central Registry is on employment and volunteer opportunities. Any person appearing on the Central Registry may be denied employment or the opportunity to volunteer with youth. This process and the Central Registry serve as an essential safeguard to prevent perpetrators of abuse and neglect from having direct access to other youth and continuing their abusive conduct in any other setting.

Critically, Compliance at the YRTCs does not have the authority to place staff on the Central Registry even if an incident is substantiated. Currently, YRTC employees are only placed on the Central Registry for abuse of youth if there is a successful criminal conviction. CFS, however, does have the authority to place staff on the Central Registry when abuse and neglect is substantiated through an OHA. As a result, a critical safeguard for the safety of youth is lost when OHAs are not conducted at the YRTCs. DHHS should not apply a different standard to its own employees than it applies to every other person who allegedly abuses or neglects a child in their care.

4. **There were numerous issues and limitations with Compliance's reviews and investigations into the sexual abuse allegations at YRTC-Kearney.**

Compliance serves a vital oversight function at YRTC-Kearney by ensuring the facility adheres to internal and DHHS policies, state and federal laws, and established best practices. In many of the cases, however, the OIG-CW identified issues that were significant enough to prevent Compliance from determining whether specific sexual abuse allegations had occurred. The primary challenges apparent in Compliance's reviews and investigations fell into three broad categories: those arising from deficiencies in how facts were analyzed and how investigations were conducted; those arising from external resource limitations and a subsequent failure to pursue alternative means of gathering facts; and those arising from focusing too closely on individual incidents rather than identifying systemic and facility-wide issues.

5. **The OIG-CW was not notified of the initial incidents in March and April 2025 as a result of Compliance's determination that those incidents were not PREA violations, which placed them outside the required notifications under the law.**

OJS is required by law to report to the OIG-CW "as soon as reasonably possible" after an instance of an "internally substantiated" PREA violation. The two incidents from March and April 2025 for which the OIG-CW did not receive notice were both determined by Compliance

to be "boundary violations" rather than substantiated sexual abuse violations under PREA. When these behaviors are determined not to be PREA violations, even if substantiated, they fall outside of the reporting requirements under the law.

Recommendations

The OIG-CW makes the following recommendations as a result of this investigation, summarized here and explained in more detail in this report:[3]

1. **DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made.**

The staff behaviors and actions alleged and detailed in this investigation amount to abuse of the youth in DHHS' care and custody. These incidents should be investigated as such. In all other facilities licensed by DHHS, CFS conducts an abuse and neglect investigation through an OHA to determine if abuse occurred at the facility. Compliance investigations are not oriented to the abuse of the youth, and, in addition, fact-finding may be limited in the Compliance process. OHAs are not subject to those same limitations. Furthermore, Compliance does not have the authority to place a staff member's name on the Central Registry, but CFS, through an OHA, does. This ensures that staff who have abused youth cannot work with children elsewhere. DHHS should hold the staff at its own facilities to the same standards to which it holds staff at other juvenile facilities. DHHS successfully conducted OHAs at the YRTCs until 2019. It should conduct them again.

2. **DHHS and YRTC-Kearney should address the culture problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth**.

There are a number of specific conditions at YRTC-Kearney that created opportunities for the alleged staff misconduct to occur and that need to be addressed regardless of how many of the allegations in this investigation are ultimately substantiated. The OIG-CW recognizes that DHHS and YRTC-Kearney leadership have begun making some changes in response to the events described in this report and that some of the improvements are reportedly already underway. Those efforts are acknowledged and encouraged. The following areas, however, warrant deliberate and sustained attention going forward: (1) enhance supervision of YPS staff; (2) increase programming and structured activities for youth; (3) strengthen surveillance and

[3] The full explanation of the recommendations can be found at pgs. 77–87.

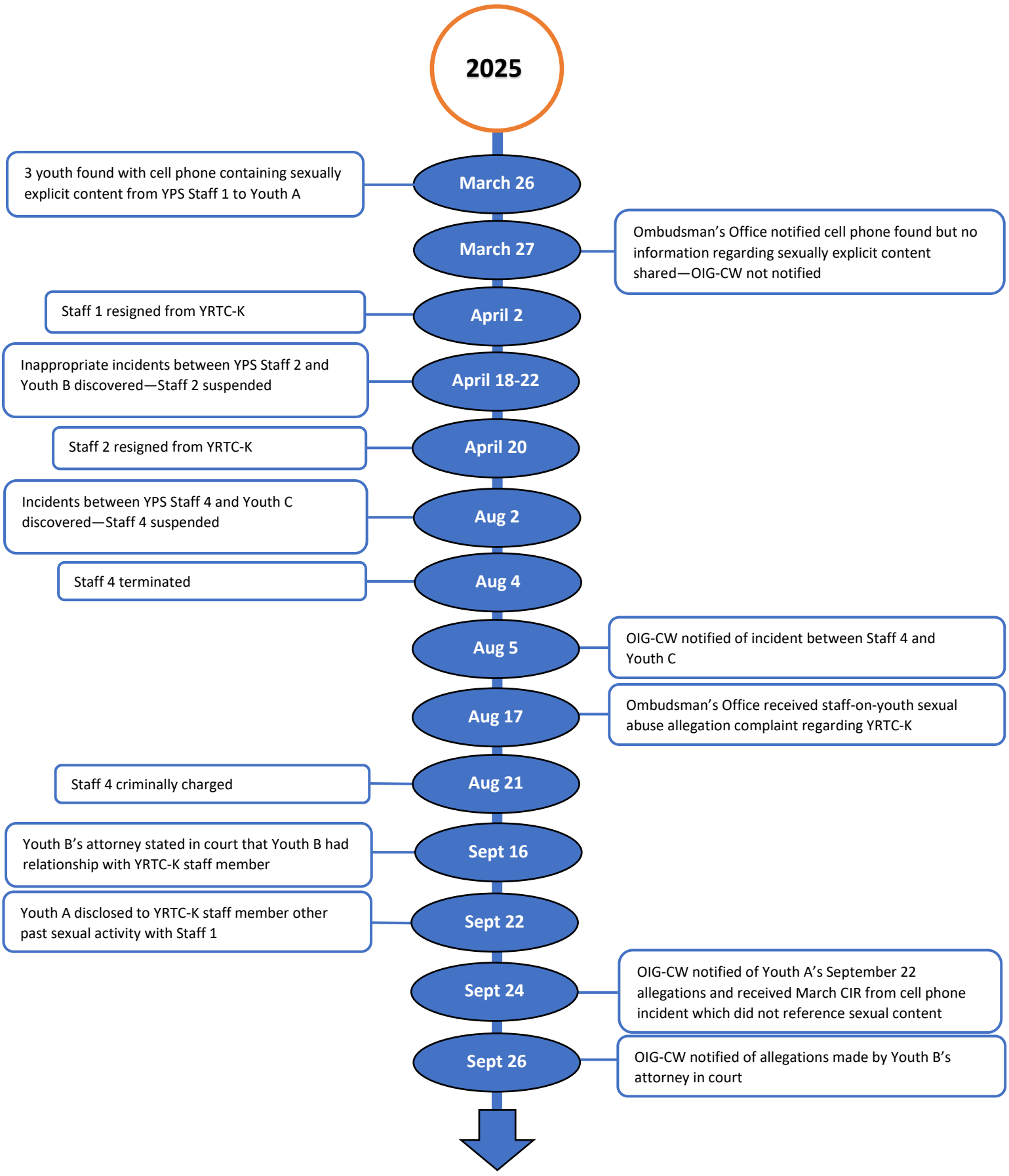
monitoring capabilities and practices; and (4) implement consistent processes for holding staff accountable for boundary concerns.

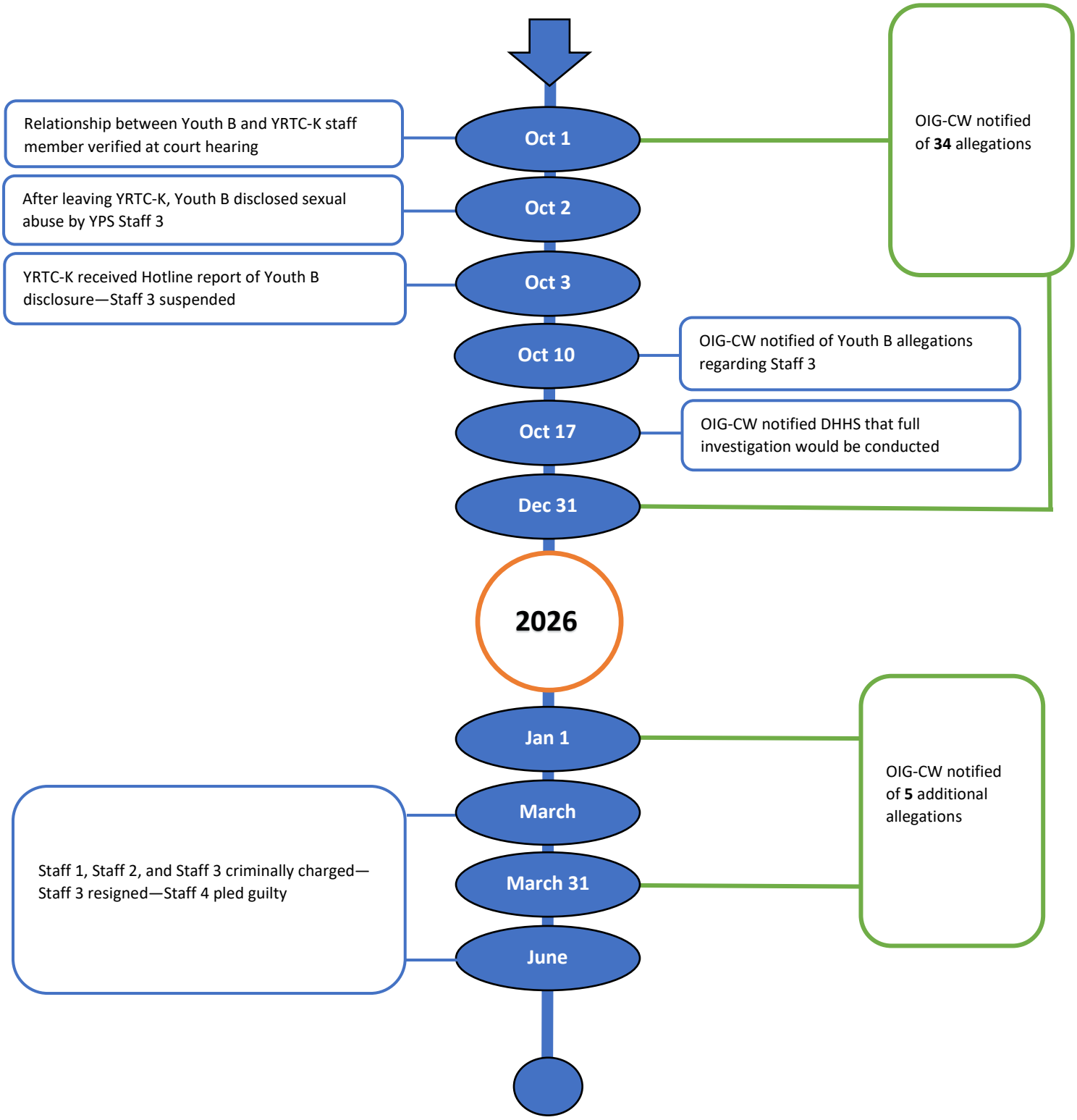
3. **DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report.**

The OIG-CW identified numerous concerns with how Compliance conducted its reviews and investigations into these sexual abuse allegations at YRTC-Kearney. The OIG-CW recognizes that Compliance's work improved in meaningful ways over the course of the period reviewed, and that the volume and highly complicated facts of allegations during this period presented genuine challenges. However, the OIG-CW identified some consistent issues that should be addressed. At a minimum, DHHS should conduct a thorough review of Compliance's investigative methods and standards, including how evidence is gathered, preserved, and evaluated; how the preponderance of the evidence standard is applied in practice; how allegations of verbal abuse are assessed in the absence of audio evidence; and how the distinction between unfounded and unsubstantiated determinations is made and applied consistently. That review should also examine Compliance's practices for identifying and addressing systemic or facility-wide concerns, including whether unsubstantiated allegations are analyzed collectively for recurring issues rather than treated solely as individual matters.

4. **The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth.**

The current statutory requirement that the YRTCs notify the OIG-CW of any “internally substantiated” PREA violations should be expanded to include any allegations of staff sexual abuse of youth, as well as boundary violations, whether or not the allegations are substantiated by Compliance. If such a requirement had been in place prior to this investigation, the OIG-CW would have been notified of some of the more serious allegations of sexual abuse of which it did not receive notice initially. In addition, such a requirement would allow for more consistent monitoring of how allegations of staff abuse are being handled by the facility and what the risk is to the youth at the facility. Ensuring that the OIG-CW is aware of the frequency of the allegations, proven or not, might also provide some indication of other challenges or concerns at the facility.


2025
March 26
3 youth found with cell phone containing sexually explicit content from YPS Staff 1 to Youth A
March 27
Ombudsman's Office notified cell phone found but no information regarding sexually explicit content shared—OIG-CW not notified
April 2
Staff 1 resigned from YRTC-K
April 18-22
Inappropriate incidents between YPS Staff 2 and Youth B discovered—Staff 2 suspended
April 20
Staff 2 resigned from YRTC-K
Aug 2
Incidents between YPS Staff 4 and Youth C discovered—Staff 4 suspended
Aug 4
Staff 4 terminated
Aug 5
OIG-CW notified of incident between Staff 4 and Youth C
Aug 17
Ombudsman's Office received staff-on-youth sexual abuse allegation complaint regarding YRTC-K
Aug 21
Staff 4 criminally charged
Sept 16
Youth B's attorney stated in court that Youth B had relationship with YRTC-K staff member
Sept 22
Youth A disclosed to YRTC-K staff member other past sexual activity with Staff 1
Sept 24
OIG-CW notified of Youth A's September 22 allegations and received March CIR from cell phone incident which did not reference sexual content
Sept 26
OIG-CW notified of allegations made by Youth B's attorney in court


Relationship between Youth B and YRTC-K staff member verified at court hearing
Oct 1
OIG-CW notified of **34** allegations
After leaving YRTC-K, Youth B disclosed sexual abuse by YPS Staff 3
Oct 2
YRTC-K received Hotline report of Youth B disclosure—Staff 3 suspended
Oct 3
Oct 10
OIG-CW notified of Youth B allegations regarding Staff 3
Oct 17
OIG-CW notified DHHS that full investigation would be conducted
Dec 31
2026
Jan 1
OIG-CW notified of **5** additional allegations
March
Staff 1, Staff 2, and Staff 3 criminally charged—Staff 3 resigned—Staff 4 pled guilty
March 31
June