OFFICE OF INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE



Report of Monitoring

Subject: Critical Incidents in Licensed Child Cares

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Jennifer A. Carter, Inspector General Meghan Svik, Assistant Inspector General

> State Capitol, P.O. Box 94604 Lincoln, NE 68509-4604 402-471-4211 (Office) 855-460-6784 (Toll Free) oig@leg.ne,gov

Jurisdiction

The Office of the Inspector General of Nebraska Child Welfare (OIG) provides oversight and accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, system monitoring and review, and recommendations for improvement.

The Office of Inspector General of Nebraska Child Welfare Act mandates that the OIG investigate any serious injury or death of a child occurring in a child care facility when the office determines the death or injury did not occur by chance.¹

Scope

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 in Fiscal Year 2023-2024 (FY 2023-2024). None of the incidents included in this report warrant further investigation under the statutes governing the OIG.

Background

For the OIG to determine if a child care incident occurred by chance or is required to be investigated, the OIG conducts a thorough review of each incident and subsequent investigations conducted by both Children's Services Licensing—through the Nebraska Department of Health and Human Services' (DHHS) Division of Public Health (PH)—and DHHS' Division of Children and Family Services (CFS).

As described in more detail below, both CFS and Children's Services Licensing conduct investigations into alleged abuse and neglect that occurs in licensed child cares. However, each agency conducts its investigations for different purposes. CFS investigates to determine if abuse or neglect occurred and if the alleged perpetrator of the abuse or neglect should be placed on the Child Abuse and Neglect Central Registry (Central Registry). Children's Services Licensing investigates to determine if the child care or licensee violated Nebraska's statutes or any rules and regulations defined in the Nebraska Administrative Code (NAC). Children's Services Licensing may then take action ranging from requiring a child care to make simple corrections, taking formal corrective action, placing the child care's license on probation, or revoking the license if warranted. Typically, the CFS and Children's Services Licensing investigations are conducted at the same time to share information and resources. Children's Services Licensing may not complete their investigation process until CFS has made a child abuse finding determination. In many cases, this is done to ensure that disciplinary decisions take into consideration the child abuse determination.

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¹ Neb. Rev. Stat. § 43-4318 (1)(b).

Children's Services Licensing

Children's Services Licensing is responsible for the following duties related to licensed child cares in Nebraska: processing child care provider applications; granting licenses for child care providers; conducting annual inspections; completing complaint investigations; conducting compliance checks; enforcing regulations and state statutes; taking action against providers who violate regulations or statutes; educating providers; and providing parents with information regarding child care providers.

A Child Care Inspection Specialist (Inspection Specialist) conducts inspections and investigations of any licensed child care provider. They ensure providers are following regulations, state statutes, and safety codes. If a provider has violated or is out of compliance with a regulation or statute, the Inspection Specialist will work with the provider to correct the situation in a timely manner. Inspection Specialists have the authority to implement various disciplinary actions against a child care provider when necessary. Inspection Specialists are also expected to coordinate with CFS, law enforcement, or both when allegations of abuse or neglect against a child care provider are reported.

There are six different types of unlicensed and licensed child care providers in Nebraska. Unlicensed providers can provide childcare to three or fewer children. A Family Child Care Home I can provide care for at least four but no more than eight children. A Family Child Care Home II can provide care for at least four but no more than twelve children. A Child Care Center provides care for more than thirteen children. A licensed Preschool is a partial day early education program for children aged 3 and older that provides primarily education services where children do not nap and are not served a meal. School-aged programs care for 13 or more children that are age kindergarten to 13 years of age.

Children and Family Services

CFS is responsible for investigating allegations of abuse and neglect of children within licensed child care homes and facilities. While CFS also investigates incidents in unlicensed child cares, this report focuses specifically on licensed child care settings. The CFS Specialist (CFSS) assigned to a report of alleged child abuse and neglect will complete an Out of Home Assessment (OHA). This assessment determines if any individual within the child care perpetrated maltreatment against a child in their care. Should the CFSS find that an individual was responsible for any maltreatment based on a preponderance of the evidence gathered, that individual will be placed on the Central Registry and be unable to continue to work with children. The CFSS can also recommend action to assure child safety and reduce the risk of harm within child care homes or facilities. A CFSS conducting an OHA is expected to coordinate with Inspection Specialists from Children's Services Licensing and law enforcement when they are also investigating the allegation.

Summary

Throughout FY 2023-2024, Children's Services Licensing, through DHHS' Division of Public Health, reported incidents that occurred within licensed child care homes and facilities to the OIG, as required by Neb. Rev. Stat. § 43-4318 (1)(b).

There was a total of 20 incidents that occurred in a child care setting reported to the OIG in FY 2023-2024. One of these 20 is not included in this 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.

Children's Services Licensing 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, to more detailed plans set forth by Children's Services Licensing 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 (SIDS). 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 completed by CFS, and complaint investigations completed by Children's Services Licensing. 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 OHA's were less thorough due to 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 Children's Services Licensing, the investigations were thorough and detailed. In many, 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 Children's Services Licensing 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 Children's Services Licensing 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 has no formal recommendations regarding the investigative processes within CFS and Children's Services Licensing. Although not all investigations were exemplary, the OIG's overall review determined that the work was done well and collaboratively within DHHS.