OFFICE OF

INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

Report of Monitoring

Subject: Critical Incidents in Licensed Child Cares in Fiscal Year 2024-2025

Report Date: October 30, 2025

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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 requires the Department of Health and Human Services (DHHS) to report to the OIG "all cases of death or serious injury: (i) Of a child . . . in a child care facility or program . . ."[1] The OIG Act also mandates that the OIG investigate those serious injuries or deaths occurring in a child care facility when the office determines the death or injury did not occur by chance.[2] To determine if a full investigation is warranted, the OIG thoroughly reviews each of these incidents reported by DHHS and the subsequent investigations of both DHHS' Division of Children and Family Services (CFS) and Children's Services Licensing (CSL) through DHHS' Division of Public Health.

Scope

The OIG's in-depth review into how CFS and CSL handled the incidents which do not require a full investigation is the focus of this report. This report will not include incidents that will require a full investigation by the OIG. Any full investigation will result in a separate investigative report.

Both CFS and CSL conduct investigations into alleged abuse and neglect that occurs in licensed child cares; however, each agency conducts its investigation for different purposes. CFS investigates to determine if abuse or neglect did occur and if the alleged perpetrator of the abuse or neglect should be formally placed onto the Child Abuse and Neglect Central Registry (Central Registry). CSL conducts its investigation to determine if the child care or licensee violated any rules and regulations as defined in the Nebraska Administrative Code (NAC). Typically, the CFS and CSL investigations are conducted at the same time to share both information and resources between the entities.

[1] Neb. Rev. Stat. § 50-1806(2)(a)(i), previously Neb. Rev. Stat. § 43-4318.
[2] Neb. Rev. Stat. § 50-1806(1)(b), previously Neb. Rev. Stat. § 43-4318.

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

Background

Children's Services Licensing

Children's Services Licensing is responsible for processing child care provider applications; granting licenses for child care providers; conducting annual inspections; completing complaint investigations; conducting compliance checks; enforcing regulations; taking action against providers who violate regulations; 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 and ensures the providers are following regulations and safety codes. If a provider has violated a regulation or is out of compliance, the Inspection Specialist will work with the provider to correct the situation in a timely manner. When necessary, Inspection Specialists have the authority to implement various disciplinary actions against a child care provider. 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 several different types of unlicensed and licensed day care providers in Nebraska. Unlicensed providers can provide daycare to three or fewer children. To care for more than three children, the daycare must be licensed. A Family Child Care Home I is a licensed provider that can 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. There are also licenses for Preschools and School-Age Only Centers, which can be combined with other licensed centers.

Children and Family Services

Children and Family Services is responsible for investigating allegations of abuse and neglect of children within licensed child care homes and facilities. The CFS Specialist (CFSS) who is 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 they determine that an individual did so by a preponderance of the evidence gathered, that person 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 CSL and law enforcement when they are also investigating the allegation.

Summary

Throughout Fiscal Year 2024-2025, CSL, through DHHS' Division of Public Health (PH), reported a total of 23 serious injuries and deaths to the OIG that occurred within licensed child care homes and facilities.

One of these 23 incidents is not included in this report, as the serious injury was a bite from a bat that was not investigated by CSL or CFS due to occurring entirely by chance. Of the remaining 22, CFS accepted 21 for assessment, with one not meeting the definition for an investigation. Of those 21 investigated, 11 were determined to be unfounded for child abuse or neglect. Two investigations were agency substantiated, as it was found that the child care provider was at fault for the injury to the child. Four investigations were listed as court pending due to legal charges being filed against a child care provider or a staff member at a child care center. There were four OHAs that did not have a finding listed within the reviewed OHA.

CSL investigated all 22 incidents included in this report. Fourteen cases were substantiated as being out of compliance with licensing regulations and required corrective action from the child care.

The OIG conducted an in-depth review of all of the incidents reported to the OIG in FY 2024-2025 by reviewing: the investigation documents provided by DHHS, including the intake and OHA completed by CFS and the Complaint Review completed by CSL; all prior investigations completed by CSL posted to its public website; and any provided law enforcement reports. Relevant statutes, policies, and regulations were reviewed as well. The incidents ranged from serious injuries such as broken bones, hematomas, and nursemaid's elbow, to less severe injuries such as bruises, scratches, and rug burns. Sexual abuse allegations were also investigated. In two instances, a child was left alone in a daycare van for a short time after being transported, with no resulting injuries. There was also one death that was determined to be due to illness. The incidents reported to the OIG occurred in both licensed child care homes and licensed child care centers.

Findings

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 incidents. A few OHAs were noted to be less thorough due to a lack of details, information being copied and pasted into different sections of the OHA, and the need for further explanation of the finding. In four OHAs completed, there was no finding at all.

As for CSL, many investigations were thorough and detailed, though there were a few with very little detail about the interviews and investigation. In most investigations, the scope not only pertained to the complaint being investigated, but while visiting the child care, the investigator reviewed for any and all violations of regulations present, noting these in their review document. The specific regulations being reviewed for compliance and all regulations noted to be violated are clearly identified within CSL's complaint review form. It was also noted that licensed child cares are being regularly monitored through unannounced semi-annual visits from licensing staff. It should be noted that it often takes many months for the OIG to receive the CSL written investigations after the date of the reported incident. CSL investigations can also be delayed because of a law enforcement investigation into the incident. However, in a review of CSL policies, there does not appear to be a timeframe in which these written

investigations are expected to be completed. In contrast, CFS requires that OHAs be completed within 60 days of the intake, with a few exceptions.

The OIG commends CFS and CSL for working together on the reviewed investigations, which allowed for the parties involved to only be interviewed once and 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 CSL. While not all investigations reviewed in FY 2024-2025 were exemplary, the OIG's overall review determined that the work is being done well and collaboratively within DHHS. The OIG would suggest that CSL review the timeframes in which investigations are being completed to determine if there is any room for improvement.

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

November 19, 2025

Jennifer A. Carter
Inspector General
Office of Inspector General of Nebraska Child Welfare
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Dear Ms. Carter:

Thank you for the opportunity to review the OIG Child Care Monitoring Report for FY2024-2025. The Department of Health and Human Services (DHHS), Division of Public Health (DPH), offers the following information pertaining to the work of Children's Services Licensure (CSL).

The report includes comments about the level of detail included in CSL investigative reports. While the investigations performed by the DHHS Division of Children and Family Services (CFS) can be more focused on abuse and neglect and the related details, CSL investigations must address how an incident violated child care regulations and statutes more broadly. Because CSL is required to make their reports public, the reports may not include the same level of detail as those provided by CFS.

The report also includes comments about CSL delays and timeframes for completing investigations. There are many factors that influence the length of time it takes CSL to complete an investigation. CSL must often wait for CFS, law enforcement, and/or medical examiners to complete their investigations and submit findings before CSL is able to complete their investigations. CSL Inspection Specialists are expected to complete an initial draft report within 30 days after receiving all other investigation findings. The draft report is then reviewed by supervisors to determine any negative or disciplinary actions that may be initiated. The disciplinary process which includes an appeal period for the licensee can further delay the release of investigative information.

The DHHS DPH is dedicated to continual analysis of systems and processes, applying Theory of Constraints principles. To address the OIG concerns outlined in the report, CSL will:

- Ensure consistency for Inspection Specialists throughout the state. Supervisors will provide training to review standards and continuity.
- Communicate expectations for Inspection Specialists on the status of investigations to ensure timely completion.
- Implement a plan to address investigation completion and review, especially in the event of staffing gaps, to ensure investigations are completed and reports are reviewed in a timely manner.

Sincerely,

Becky Wisell

Becky Wisell, Deputy Director
Health Licensure and Environmental Health
Division of Public Health
Department of Health and Human Services