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SPECIAL REPORT OF INVESTIGATION

The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center

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TABLE OF CONTENTS

Introduction 1
Executive Summary 2
Critical Incident & Scope 4
Conducting the Investigation 5
YRTC Background 8
Overview of Youth Committed to YRTC-Geneva 10
Timeline of Events 20
Findings 30
Recommendations 46
Appendices 55
- Appendix A: August 16, 2019 letter to CEO Smith from IG Rogers 56
- Appendix B: August 29, 2019 letter to IG Rogers from CEO Smith 60
- Appendix C: November 9, 2019 ███ letter to CEO Smith from IG Rogers 63
- Appendix D: December 12, 2019 ███ letter to IG Rogers from Bo Botelho 66
- Appendix E: Juvenile Room Confinement Policy and Procedure 68
- Appendix F: DHHS Response to Recommendations 71

INTRODUCTION

The following report is the culmination of a joint investigation of the Youth Rehabilitation and Treatment Center at Geneva (YRTC-Geneva) conducted by the Office of Public Counsel and the Office of Inspector General of Nebraska Child Welfare (OIG). At the time the investigation was initiated in August 2019, Julie Rogers was the Inspector General of Nebraska Child Welfare (IG). During the middle of the investigation, IG Rogers was confirmed as Public Counsel\Ombuds by the Nebraska Legislature, a position she began at the end of January 2020. Jennifer Carter was appointed as Inspector General and started in her role at the beginning of September 2020.

The Office of Public Counsel, also known as Ombudsman's Office or Ombuds, promotes accountability and improvement in public administration, in part by making recommendations for changes that will strengthen agency effectiveness. Further, the Office of Public Counsel expressly investigates cases of any juvenile committed to the custody of a youth rehabilitation and treatment center (YRTC).[1]

Within the Office of Public Counsel is the Office of the Inspector General of Nebraska Child Welfare. The OIG provides accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, identification of systemic issues, and recommendations for improvement. The primary aim of the OIG's investigations and reviews is improving operations through identification of systems issues and needed policy changes.

The work of the Office of Public Counsel and the OIG is wholly determined by the information that it receives whether through complaints from the general public or from critical incident reports by state agencies. The investigations of either office rely on the information to which each office has access by statute and the information provided by those persons interviewed.

During this investigation, there were dozens of examples of hardworking, dedicated staff that sacrificed their time to ensure that they made space to be interviewed, oftentimes for hours, and that the appropriate and requested documents were provided in a timely manner.

[1] Neb. Rev. Stat. §81-8,245 (11)(a).

EXECUTIVE SUMMARY

On August 12, 2019, the Department of Health and Human Services (DHHS) informed the Office of Public Counsel and the OIG about a serious development that arose at YRTC-Geneva. In response to that development, and out of a concern for the safety of the youth, DHHS made plans for changes that would alleviate some of the immediate concerns and dangers, beginning with the reduction of YRTC-Geneva's census. The circumstances ultimately led to the relocation of all of the female youth to the Youth Rehabilitation and Treatment Center at Kearney (YRTC-Kearney) one week later. After learning the details of the crisis situation involving 35 state wards, a formal investigation was initiated to analyze the extent and manner of the deterioration at YRTC-Geneva and to understand how the campus came to deteriorate to such an extent that it required closure.

This investigative report outlines the events leading up to the youth being moved to YRTC-Kearney, describes actions taken in conducting the investigation, gives background on the YRTCs, provides a timeline related to YRTC-Geneva from 2015 to August 2019, presents findings after careful analysis, and makes recommendations for YRTC system improvement.

Background

Juvenile courts in Nebraska may commit a youth to a YRTC as part of an intensive supervised probation, provided that youth has exhausted all levels of probation supervision, as well as options for community-based services. When any juvenile is committed to a YRTC, that juvenile becomes a state ward and is considered to be in the legal care and custody of DHHS for the purposes of obtaining health care and treatment services.

Juvenile offenders are a special population with a statistically high rate of Adverse Childhood Experiences (ACEs). ACEs refer to a group of specific childhood experiences researchers have identified as risk factors for chronic disease and dysfunction in adulthood. ACEs not only increase the chances of involvement in the juvenile justice system but increase the risk of re-offense. Youth involved in the juvenile justice system have roughly three times more ACEs than youth in the general population and are thus more likely to experience substance abuse issues, self-harm behaviors, and school-related problems. By the time youth reach the juvenile justice system they are generally in need of secondary prevention and intervention.

At the time of the Geneva crisis, 33 out of the 35 youth placed at the facility (94%) had a documented trauma history such as being abused or neglected or both. Fourteen had at some point in their childhood been a ward of the state due to abuse or neglect. All 35 youth were diagnosed with a behavioral disorder, a mental health disorder, or both. Many of the youth also had multiple out-of-home placements including group homes, shelters, detention centers, foster care, and psychiatric residential treatment facilities.

Findings and Recommendations

The failures of leadership related to YRTC-Geneva occurred at multiple levels, on multiple fronts, and in ways that were complexly intertwined, with each compounding the consequences of the next. This reflects a failure by leadership to plan, to problem solve, and to dedicate the resources necessary to provide the legally required care for the youth at YRTC-Geneva. The failure of leadership led to management, staffing and training issues, lack of programming and treatment, and the deterioration of the cottages. Each of these elements is required to effectively meet the mission of YRTC-Geneva and the needs of the girls. As a result of these failures, the youth at YRTC-Geneva experienced varying levels of trauma. It was clear after interviewing all the youth, many of them were exposed to or experienced some sort of traumatization or re-traumatization during their commitment at YRTC-Geneva during the crisis.

The investigation found:

1. The leadership at the Department of Health and Human Services, Office of Juvenile Services, and at YRTC-Geneva failed to ensure that YRTC-Geneva had the necessary management, staffing, programming, treatment, and facilities to care for the youth in its custody, as evidenced by:
    - Key management positions in the administration at YRTC-Geneva were not appropriately staffed or were left vacant;
    - Lack of staff and training for staff;
    - Failure to provide programming and treatment; and,
    - The youth were living in an uninhabitable environment.

2. Youth placed in the care and custody of DHHS for treatment and rehabilitation at YRTC-Geneva were exposed to varying levels of trauma during their commitment to the facility.

The following recommendations were made to DHHS for system-wide improvement:

1. Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.
2. Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.
3. Implement a fully digital case management system.
4. Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.
5. Implement evidence-based programming consistently throughout the YRTC system.
6. Implement a trauma-responsive environment across the YRTC system.

DHHS accepted all recommendations, except for recommendation number two, which was rejected.

Critical Incident & Scope

On Monday, August 12, 2019, DHHS Chief Executive Officer (CEO) Dannette Smith and Dr. Janine Fromm, DHHS Executive Medical Director, briefed IG Julie Rogers and Deputy Public Counsel for Institutions, Jerall Moreland, about the crisis that had arisen at YRTC-Geneva. CEO Smith and Dr. Fromm described the problem as three-tiered: (1) the acuity of the girls was significant; (2) staffing issues included double shifts and significant overtime and inexperienced staff filling important roles; and (3) the deterioration of the facilities had led to at least two residential buildings being shut down. With two residential buildings closed, CEO Smith outlined a plan to immediately reduce the census at YRTC-Geneva to safely house and serve the girls. After initially attempting to move some girls to the Lancaster County Youth Services Center (the detention center), on Monday, August 19, 2019, all of the girls at YRTC-Geneva in the custody of DHHS Office of Juvenile Services (OJS) were moved to YRTC-Kearney.

Scope of Investigation

This report is focused on the events, circumstances, and decisions that led to the crisis at YRTC-Geneva in August 2019.

It is important to note and acknowledge that over the course of the last 16 months there has been constant and significant change within the YRTC system in response to the crisis at Geneva, leading to a multitude of complaints, allegations, and issues. In addition to the investigation into the deterioration of YRTC-Geneva, the Ombudsman's office and the OIG have been monitoring and responding to each of these issues as they have arisen in various ways. Many of these issues were communicated to and handled informally with DHHS leadership and administrators. Many issues are ongoing, and the Ombudsman's Office and OIG remain engaged on those issues.

This report, however, does <u>not</u> address the subsequent changes and issues that arose after the girls were moved from YRTC-Geneva. Rather, it is focused solely on understanding the factors that led to the crisis at YRTC-Geneva which required the removal of the girls and the closure of the facility.

What follows is a summary of key events, decisions, and leadership changes leading up to the crisis in August 2019 and the findings and recommendations based on an analysis of those instances taken together as a whole.

CONDUCTING THE INVESTIGATION

The Office of Public Counsel promotes accountability and improvement in public administration, in part by making recommendations for changes that will strengthen agency effectiveness. By performing this function, and by publishing reports of its findings and recommendations, the Office of Public Counsel, also known as the Ombudsman's Office or Ombuds, also helps to promote public accountability of the agencies of state government and performs a legislative oversight function. Further, the Office of Public Counsel expressly investigates cases of any juvenile committed to the custody of a youth rehabilitation and treatment center.[2]

Within the Office of Public Counsel is the OIG. The OIG specifically provides independent investigation and performance review of Nebraska's child welfare and juvenile justice systems. The primary aim of the OIG's investigations and reviews is improving operations through identification of systems issues and needed policy changes. The Office of Inspector General of Nebraska Child Welfare Act (Neb. Rev. Stat. §§43-4301 – 43-4331) sets out duties for the OIG, including investigating, "allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations," of DHHS.[3]

The work of the Office of Public Counsel and the OIG is wholly determined by the information that it receives in order to know what issues and problems to investigate. Unless an agency proactively brings an issue to the attention of the Office of Public Counsel, it more frequently receives complaints about state agencies from citizens and did receive three complaints regarding YRTC-Geneva in FY18-19: two from girls about school suspension and one regarding a youth wanting her 60-day notice to go home. Information generally comes to the OIG in one of two ways; in the form of a "critical incident" report from DHHS or complaints made directly to the office by individuals. The OIG received 20 critical incident reports involving female youth committed to YRTC-Geneva in FY18-19. Eighteen incidents involved youth escapes and one was a sexual abuse report that happened prior to the youth's commitment to YRTC-Geneva. One incident involved a youth who attempted suicide. The OIG did not receive any complaints regarding YRTC-Geneva during this time period.

Below is a detailed explanation of the Office of Public Counsel's and the OIG's jointly conducted investigation into the deterioration of YRTC-Geneva:

August 12, 2019: Then Inspector General (IG) Julie L. Rogers and Deputy Public Counsel for Institutions, Jerall Moreland, were briefed by DHHS CEO Smith, and Dr. Fromm, DHHS Executive Medical Director, about significant problems at YRTC-Geneva.

- The problems were described as three-tiered: 1) the acuity of the girls was significant, 2) the facility had staffing problems that included many double shifts and overtime as well

[2] Neb. Rev. Stat. §81-8,245 (11)(a).
[3] Neb. Rev. Stat. §43-4318 (1)(a).

as several important roles being filled by unseasoned staff, and 3) the deterioration of the facility, namely, two buildings had been shut down and much of those problems had been caused by the girls pulling sprinklers.

- The immediate plan to help alleviate the situation was to:
    - Remove the most disruptive girls with the most criminogenic tendencies by transferring four of the youth to the Lancaster County Youth Services Center (also known as Lancaster detention) and four to the Dickson security unit at YRTC-Kearney;
    - Ensure that there were no more than 20 girls at YRTC-Geneva because the facility was operating with only two living units;
    - Bring in staff from the Hastings Regional Center's Juvenile Chemical Dependency Program and YRTC-Kearney;
    - Onboard six new staff to start September 2 and hold a job fair at YRTC-Geneva;
    - Begin the process of consistent evaluation and clinical services by getting an understanding of each girl's prescriptions and mental health diagnosis so they can get the treatment they need; and
    - Contract for psychiatric services with Boys Town Psychiatry and Richard Young Behavioral Health Center.
- By the end of that day, four girls were transported to Lancaster detention and none were transferred to the Dickson security unit.

August 13, 2019: IG Rogers and Mr. Moreland visited the four girls who had been transferred to the Lancaster County Youth Services detention center where they were housed with the rest of the detention population. Each youth was interviewed separately. The interviews made clear that each youth had no idea why they had been moved to detention.

August 14, 2019: IG Rogers and Mr. Moreland visited YRTC-Geneva, took a tour of each building, and met with and interviewed administrators, staff, and youth. Staffing issues were apparent, administrators were distressed, youth were observed to be not engaged in any constructive activities, and the living cottages were observed to be in extreme disrepair, including the rooms used for room confinement.

August 15, 2019: IG Rogers and Mr. Moreland spoke with several people about the YRTC-Geneva situation and next steps. This included the Department of Administrative Services (DAS) to discuss the urgent nature of getting all of the cottages repaired; family members of the girls who had reached out with their concerns about their daughters' safety and well-being; and DHHS administrators, staff, and DHHS CEO Smith about the urgent need to get professionals (like health inspectors) into the utilized living units to assess whether it was safe for the girls and staff to be in, let alone living and sleeping in, those buildings in their condition. The four girls at Lancaster detention were court ordered back to YRTC-Geneva. Transport stopped at YRTC-Geneva, and then took them to YRTC-Kearney instead of Geneva, where they were housed in the Dickson security unit.

August 16, 2019: IG Rogers sent a letter to CEO Smith outlining immediate concerns and making recommendations for short-term actions. (See Appendix A and B). Mr. Moreland spent the day at YRTC-Geneva in order to further understand the situation.

August 19, 2019: All of the girls were moved to the YRTC-Kearney campus. Geneva staff went with the girls to help with the transition. The girls were separated from the male youth on campus.

In addition to this knowledge and activity, between August 12th and August 19th, the Office of Public Counsel and OIG received several complaints about the dire conditions of YRTC-Geneva that led up to opening this investigation.

During the investigation information was gathered from sources, including the following:

1. Over 65 interviews including current and former staff of YRTC-Geneva, OJS, DHHS, DAS, parents of the girls, and 24 youth who had been at YRTC-Geneva during the summer of 2019 and youth who had been at YRTC-Geneva prior to the summer of 2019;
2. More than 1,000 emails regarding YRTC-Geneva pertaining to issues such as education, staffing, maintenance and repair of buildings, leadership changes, and timing of events;
3. Review of data related to YRTC-Geneva including critical incidents, assaults, Performance-based Standards, staff turnover and vacancy, use of psychotropic medications, provisions of individual therapy, and use of room confinement;
4. American Correctional Association audit reports and Prison Rape Elimination Act audit reports;
5. Nebraska law related to YRTC-Geneva and DHHS rules and regulations, administrative regulations and operational memoranda;
6. Case files of 35 youth committed to YRTC-Geneva over the summer of 2019;
7. Numerous video reviews of the sprinkler pull events in various cottages during the summer of 2019;
8. Various reports and documents such as YRTC-Geneva Annual Reports, OJS Annual Reports, trainings and staffing documents, work orders, and contracts; and
9. Research into best practices surrounding juvenile justice facilities for girls.

YRTC Background

YRTCs are residential facilities serving youth ages 14-18 in Nebraska's juvenile justice system. Before 2020, there were two YRTCs—one serving only boys in Kearney and one serving only girls in Geneva. Until recently, YRTC-Geneva had a rated capacity of 82 youth. Their annual operating budget was approximately $8.6 million for FY 2019.[4]

Juvenile courts in Nebraska may commit a youth to the Office of Juvenile Services (OJS) for placement in a YRTC as part of an intensive supervised probation, provided that youth has exhausted all levels of probation supervision, as well as options for community-based services.[5]

OJS was created in 1994 as a separate division of the Department of Correctional Services (DCS), with a director appointed by the governor and charged with oversight of the two YRTCs. OJS was tasked with meeting and addressing the unique needs and developmental differences of youth. In 1997, OJS was transferred from DCS to DHHS.

When any juvenile is committed to OJS, that juvenile becomes a state ward and is considered to be in the legal custody and care of DHHS for the purposes of obtaining health care and treatment services.[6] The department has the "authority, by and with the assent of the court, to determine the care, placement, medical services, psychiatric services, training, and expenditures on behalf of each juvenile committed to it."[7]

Since 1998, the Office of Juvenile Services Act (Neb. Rev. Stat. § 43-401 to 43-424) has laid out a number of basic requirements for DHHS with regard to YRTC-Geneva and YRTC-Kearney. Nebraska law requires that programming and treatment at the YRTCs address:

- Behavioral and mental health conditions and needs;
- Drug and alcohol addiction;
- Education and special education;
- Health and medical needs;
- Individual, group, and family therapy; and,
- Case management and structured programming aimed at reintegrating youth into their families, communities, and schools.

OJS must determine the level of treatment for each juvenile, using risk and needs assessment tools, a case management protocol that balances accountability, treatment, and public safety, and a case management system for all juveniles committed to OJS.[8] Treatment services and programs

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[4] Department of Health and Human Services Office of Juvenile Services Annual Legislative Report: SFY 2019. https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/488_20190916-162916.pdf.
[5] Neb. Rev. Stat. §43-247.02(2).
[6] Neb. Rev. Stat. §43-408(1).
[7] Neb. Rev. Stat. §43-285(1).
[8] Neb. Rev. Stat. §43-406.

OJS provides through the YRTCs include "individualized planning," "structured programming," and "a strong academic program."[9] Other services include classes in behavior management, job skills, and other age and developmentally appropriate programming that will assist youth as they reintegrate into their communities. Programs and treatment services must address concerns such as drug and alcohol addiction, health and medical needs, and "behavioral impairments, severe emotional disturbances, sex offender behaviors, and other mental health or psychiatric disorders."[10] Youth participate in family team meetings – which may include their probation officers – and work to transition back to the community.

The DHHS chief executive officer appoints an Office of Juvenile Services Administrator (OJS Administrator) to perform the administrative duties and oversee programs.[11] The duties of the OJS administrator include managing facilities, staff, and budgeting, as well as coordinating programs, services, and counseling.[12] Each YRTC has a Facility Administrator (FA) who is responsible for and oversees the operation of the facility.

The number of youth being served at the YRTCs has declined in recent years due to legislative changes. In 2013, LB 561 passed which placed new limits on admissions to the YRTCs, in addition to other major restructuring of the juvenile justice system aimed at making it more rehabilitative and effective. Since July 2013, Nebraska law has required all community-based resources be exhausted prior to sending a youth to a YRTC.[13]

In addition, LB 464, passed in 2014, both required that YRTCs develop and begin implementing evidence-based programming and altered the type of youth who could be sent to YRTC by reducing the number of youth prosecuted in adult criminal court in Nebraska. Beginning January 1, 2015, youth formerly prosecuted as adults in criminal court for lower-level felony offenses (IIIA and IV) and 16-year-olds prosecuted for misdemeanors in adult court then had their cases filed in juvenile court.[14] In 2016, charges against 17-year-old misdemeanants were also required to originate in juvenile court.[15] Instead of heading to adult jails and prisons, some of these youth stayed in juvenile court and were committed to a YRTC.

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[9] Neb. Rev. Stat. §43-407.
[10] Neb. Rev. Stat. §43-407(2)(a).
[11] Neb. Rev. Stat. §43-404(2).
[12] Neb. Rev. Stat. §43-405.
[13] Neb. Rev. Stat. §43-286 (1)(b)(iii).
[14] Neb. Rev. Stat. §43-246.01
[15] Neb. Rev. Stat. §29-1816.

Overview of Youth Committed to YRTC-Geneva

Trauma among Youth in the Juvenile Justice System

Adverse childhood experiences (ACEs) refer to a group of specific childhood experiences researchers have identified as risk factors for chronic disease and dysfunction in adulthood. An ACE score measures the cumulative effect of traumatic stress exposure during childhood.[16]

Juvenile offenders are a special population with a statistically high rate of ACEs. ACEs not only increase the chances of involvement in the juvenile justice system but increase the risk of re-offense. Youth involved in the juvenile justice system have roughly three times more ACEs than youth in the general population and are thus more likely to experience substance abuse issues, self-harm behaviors, and school-related problems. By the time youth reach the juvenile justice system they are generally in need of secondary prevention or intervention or both. A fundamental tool in secondary prevention is the implementation of Trauma-Informed Care (TIC).[17]

Demographic Analysis of Youth at YRTC-Geneva during the Investigation

The OIG analyzed demographics of the 35 OJS female youth committed to YRTC-Geneva as of August 5, 2019. All of these youth were adjudicated as OJS wards and were from 10 different counties covering all DHHS Service Areas and three different Tribes. Nine of the 35 youth had one or more commitments to YRTC-Geneva prior to their current placement at the facility. Thirty-three out of the 35 youth (94%) had a documented trauma history of being abused, neglected, or both. Ten of the youth were dually adjudicated as state wards due to abuse and neglect, and fourteen had at some point in their childhood been a state ward. Four youth were in the legal custody of a tribe. All 35 youth were diagnosed with a behavioral disorder, a mental health disorder, or both. Twenty-seven out of 35 youth were prescribed one or more psychotropic medication. One youth was committed to YRTC-Geneva for over two years. Table 1 provides further demographic details.

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[16] Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[17] Baglivio, Michael T; Epps, Nathan; Swartz, Kimberly; Huq, Mona Sayedul; Sheer, Amy; et al.Journal of Juvenile Justice; Arlington Vol. 3, Iss. 2, (Spring 2014): 1-23.

Table 1. Youth Demographics as of December 2019

Youth by DHHS Service Area/Tribal

Tribal	Western	Central	Northern	Eastern	Southeast
4	7	3	3	7	11

Youth's Age at Time of Commitment

Fourteen	Fifteen	Sixteen	Seventeen	Eighteen
5	9	9	7	5

Youth by Race/Ethnicity

African American	African American/Caucasian	Caucasian/Hispanic	Native American	Native American/Hispanic	Caucasian
7	5	3	7	1	12

Common Mental/Behavioral Diagnosis

Conduct Disorder	Alcohol/Cannabis Use Disorder	Disruptive Mood Dysregulation Disorder	Depressive Disorder	Oppositional Defiant Disorder	Post-Traumatic Stress Disorder (PTSD)
20	24	10	12	15	10

Youth's Age at Time of Discharge

Fifteen	Sixteen	Seventeen	Eighteen	3 days or less prior to Nineteen
2	7	7	2	3

Geneva YRTC Youth Summaries[18]

Below are descriptions of each of the girls including when they were placed on probation, their placement history, and documented diagnosis while at YRTC-Geneva.

These youth would have all committed a law violation under Nebraska Juvenile Code that resulted in being placed on probation by a judge. Nebraska law requires all community-based resources to be exhausted prior to ordering a youth to a YRTC.

A.M.

A.M. was placed on probation in 2016. She has been placed in group homes, shelter, detention centers, foster care, a psychiatric hospital and a psychiatric residential treatment facility. A.M. has experienced generational trauma and chronic trauma within her family structure. She was committed to YRTC-Geneva in October 2018 at the age of 15 years old. She was diagnosed with Disruptive Mood Dysregulation, Conduct Disorder, and Borderline Intellectual Functioning.

B.K.

B.K. was made a tribal ward in 2016 due to physical abuse and drug abuse by her parents. She was placed on probation in February 2018. She has been placed in tribal kinship homes, detention centers, shelters, group homes, and psychiatric hospitals. B.K. was committed to YRTC-Geneva in February 2018 at the age of 14 years old. She was diagnosed with Oppositional Defiant Disorder, Alcohol Use Disorder, Cannabis Use Disorder, and Major Depressive Disorder. She was discharged in September 2019 at the age of 16 years old.

B.D

B.D. has a history of being a tribal ward dating back to 2007 through 2009 and then again in 2016 to 2019 due to neglect. B.D. was placed on probation in September 2018. She has been placed with tribal relatives, shelters, group home, detention, and a psychiatric residential treatment facility. She was committed to YRTC-Geneva in July 2019 at the age of 17 years old. She was diagnosed with Alcohol Use Disorder, Cannabis Use Disorder, Conduct Disorder, Adjustment Disorder, and Aggressive Behavior.

B.L.

B.L. was a tribal ward for a few months in 2003. She then became a state ward from 2003 to 2006. B.L. was placed in a guardianship. She was again a tribal ward in 2015 after the guardianship disrupted. She was placed on probation in August 2016. She has been placed in foster care, emergency shelters, and detention. She was missing at least three times. She was committed to YRTC-Geneva in September 2018 at the age of 15. She was diagnosed with

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[18] Initials of involved youth have been altered to protect their identity.

Alcohol Use Disorder, Oppositional Defiant Disorder, Impulsive Control Disorder, and Cannabis Use Disorder.

C.N.

C.N. was a state ward from 2004 to 2006 due to neglect. The family also worked a non-court case for a few months in 2011 due to neglect. C.N. was placed on probation in May 2018. She has been in a foster home and in detention. She was committed to YRTC-Geneva in May 2019 at the age of 15 years old. She was diagnosed with Depressive Disorder, Conduct Disorder, and Cannabis Use Disorder. She was discharged in October 2019, at 15 years old.

D.E.

D.E. was placed on probation in July 2017. She has been placed in a psychiatric residential treatment facility. She was committed to YRTC-Geneva in July 2019 at the age of 15 years. D.E. reported a history of physical and emotional abuse by her parents during the initial intake. She was diagnosed with Depressive Disorder, Conduct Disorder, Cannabis Use Disorder, PTSD, Hallucinogen Disorder, Alcohol Use Disorder, and as Bipolar. She was discharged in September 2019, at 16 years old.

D.A.

D.A. was a state ward from 2004 to 2005 due to parental drug use and neglect. D.A. was adopted and eventually was placed on probation in April 2017. She was placed in a detention center and had psychiatric hospitalizations before being committed to YRTC-Geneva in June 2018, at the age of 14 years old. D.A. was diagnosed with Major Depressive Disorder with Anxious Distress, Cannabis Use Disorder, Alcohol Use Disorder, and Oppositional Defiant Disorder.

D.M.

D.M. was physically abused and neglected as a child. She has a history of being sexually assaulted multiple times. D.M. was placed on probation in October 2013. She was placed in detention facilities, group homes, and was missing at least once before being committed to YRTC-Geneva in April 2017 at the age of 16 years old. She was discharged March 2018. She was diagnosed with Conduct Disorder, Cannabis Use Disorder, PTSD, Alcohol Use Disorder, Bipolar, ADHD, and Anxiety Disorder. Her second commitment to YRTC-Geneva started in January 2019. She was discharged in August 2019, one day before her 19th birthday.

D.G.

D.G. was removed from her family home because of parental substance abuse in 2011. She has a history of physical abuse, neglect, and multiple sexual assaults. She was again made a state ward in 2017 after her parent became terminally ill. She was placed on probation in May 2017. She has been placed in foster homes, group homes, detention centers, and psychiatric residential treatment facilities. She was committed to YRTC-Geneva in April 2019 at the age of 17 years old. She was diagnosed with PTSD, Disruptive Mood Dysregulation, Conduct Disorder,

Cannabis Use Disorder, Alcohol Use Disorder, and Parent-Child Relational Problem. D.G. was discharged in October 2019 at the age of 17 years old.

E.C.

E.C. was placed on probation in December 2015. She spent time in detention centers, group homes, jail, and foster homes. Her first commitment to YRTC-Geneva was from May 2016 to December 2016. E.C. was made a state ward and removed from her family home due to neglect in 2017. Her second commitment to YRTC-Geneva was from October 2017 to December 2018. Her third commitment to YRTC-Geneva was in April 2019 at the age of 17 years old. E.C. was diagnosed with Oppositional Defiant Disorder, Adjustment Disorder, Cannabis Use Disorder, and Alcohol Use Disorder. E.C. was discharged in October 2019 at the age of 17 years old.

H.T.

H.T. was a state ward from 2013 to 2014 due to physical abuse, domestic violence, parental substance abuse, and truancy. She has a history of being sexually assaulted multiple times. H.T. was placed on probation in November 2017. She has been in foster care, group homes, a psychiatric hospital, and a psychiatric residential treatment facility. She was committed to YRTC-Geneva in June 2019 at the age of 17 years old. She was diagnosed with Persistent Depressive Disorder, PTSD, Oppositional Defiant Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Opioid Use Disorder, and ADHD.

J.A.

J.A. was placed on probation in June 2017. She has a history of being sexually assaulted multiple times. She had been in a detention center, a psychiatric residential treatment facility, shelters, and group homes. She was placed at YRTC-Geneva in October 2018 at the age of 14 years old. She was diagnosed with Depressive Mood Disorder, Reactive Attachment Disorder, PTSD, and Cannabis Use Disorder.

J.D.

J.D. was made a state ward from 2004 to 2007 due to neglect. J.D. was again made a state ward and placed in foster care in 2017 as she was being sexually abused by her brothers. She was placed on probation in December 2017. She has been in psychiatric residential treatment facilities, group homes, psychiatric hospital, detention centers, and in foster care. She was committed to YRTC-Geneva in March 2019 at the age of 16 years old. She was diagnosed with Adjustment Disorder with mixed Disturbance of Emotions and Conduct. She was discharged in September 2019 at the age of 16 years old.

J.T.

J.T. was made a state ward from 2007 to 2009 due to neglect. She was again made a state ward due to neglect from 2010 to 2014. J.T. was adopted by a relative after parental rights were terminated. J.T. was placed on probation in April 2016. She has been placed in detention centers, foster homes, group homes, psychiatric hospitals, and psychiatric residential treatment facilities.

She was committed to YRTC-Geneva in May 2018 at age 15 years old. She was diagnosed with Conduct Disorder, Disruptive Mood Dysregulation, and Cannabis Use Disorder. She was discharged in August 2019 at the age of 16 years old.

K.M.

K.M. was removed from her parents due to abuse and neglect. She was adopted at the age of 7 years old. K.M. was placed on probation in August 2016. She has been placed in detention facilities, group homes, and psychiatric residential treatment facilities. Her first commitment to YRTC-Geneva was in December 2017 at the age of 14 years old. She was discharged in August 2018. She was diagnosed with Conduct Disorder. K.M. was committed to YRTC-Geneva a second time in October 2018. She was discharged in August 2019 at the age of 15 years old.

K.N.

K.N. has a history of parental neglect. She was placed on probation in February 2017. K.N. was placed in detention facilities, shelters, and group homes. She was committed to YRTC-Geneva in January 2019 at the age of 16 years old. She was diagnosed with Oppositional Defiant Disorder and Anxiety Disorder.

K.J.

K.J. was made a state ward after her parents were incarcerated in 2015. K.J. has been placed in foster homes, group homes, and psychiatric residential treatment facilities. She was placed on probation in May 2018 and committed to YRTC-Geneva the same day at the age of 16 years old. She was diagnosed with PTSD, Depressive Disorder, Cannabis Use Disorder, Alcohol Use Disorder, Conduct Disorder, and ADHD. K.J. was discharged in August 2019, at the age of 17 years old.

L.T.

At some point L.T. was removed from her biological family due to abuse and neglect. Their parental rights were terminated. L.T. was adopted in 2010 and then made a state ward in 2016 due to behavioral issues. L.T.'s adoptive mother relinquished her parental rights in early 2017. L.T. spent time in foster homes, detention facilities, psychiatric residential treatment facilities, and group homes. She was placed on probation in August 2018. She was committed to YRTC-Geneva in November 2018 at age 16 years old. She was diagnosed with ADHD, PTSD, Bipolar Disorder, Reactive Attachment Disorder, Conduct Disorder, and Disruptive Mood Dysregulation. She was discharged in October 2019 at the age of 17 years old.

N.K.

N.K. was made a state ward from 2006 to 2007 due to abuse and neglect. She was placed on probation in September 2015. N.K. had been placed in foster homes, detention facilities, psychiatric hospitals, group homes, and psychiatric residential treatment facilities. Her first commitment to YRTC-Geneva was from December 2016 to June 2017. Her second commitment was from August 2017 to April 2018. N.K.'s third commitment started in June 2019 at age 18

years. N.K. was diagnosed with PTSD, Disruptive Mood Dysregulation, Cannabis Use Disorder, Adolescent Antisocial Behavior, Major Depressive Disorder, and Social Anxiety Disorder. She was discharged in October 2019, three days before her 19th birthday.

N.L.

N.L. became a state ward in 2016 because of neglect. She was placed on probation in January 2017. She has been placed in psychiatric residential treatment facilities, group homes, psychiatric hospitals, foster homes, and detention centers. She was committed to YRTC-Geneva in July 2019 at the age of 17 years old. She was diagnosed with Conduct Disorder, ADHD, Cannabis Use Disorder, and Alcohol Use Disorder.

P.A.

P.A. experienced domestic violence in her prior relationship. She became a mother in 2017. She was placed on probation in March 2018. She has been placed in group home. P.A. was committed to YRTC-Geneva in April 2019 at the age of 18 years old. She was diagnosed with Major Depressive Disorder, Cannabis Use Disorder, and Oppositional Defiant Disorder. She was discharged in September 2019 at the age of 18 years old.

P.O.

P.O. was made a state ward and removed from her biological family due to abuse when she was 5 years old. At the age of 9 years old she was adopted. In 2018 she was made a state ward again and removed due to suspected sexual abuse. She was placed in detention facilities, shelters, foster homes, and psychiatric residential treatment facilities. P.O. was placed on probation in 2016. She was committed to YTRC-Geneva in November 2018 at the age of 16 years old. She was diagnosed with ADHD, Oppositional Defiant Disorder, Disruptive Mood Dysregulation, and Conduct Disorder.

R.A.

R.A. was adopted by relatives in 2007 due to parental neglect. She was made a state ward in 2016 due to her mental health issues. R.A. was placed on probation in August 2018. She was placed in foster care, shelters, detention facilities, and psychiatric residential treatment facilities. R.A. was committed to YRTC-Geneva in August 2018, at the age of 17 years old. She was diagnosed with Conduct Disorder, Major Depressive Disorder, and ADHD.

R.R.

R.R. has a history of being physically abused. She is also a victim of sexual assaults and reportedly of prostitution. R.R. was placed on probation in August 2016. She was placed in detention facilities, psychiatric residential treatment facilities, shelters, and group homes. R.R. was committed to YRTC-Geneva in July 2018 at the age of 15 years old. She was diagnosed with Conduct Disorder, PTSD, Methamphetamine Use Disorder, and Cannabis Use Disorder. She was discharged in August 2019 at the age of 16 years old.

R.H.

R.H. was made a tribal ward in 2014 due to parental drug use and neglect. She was placed with her maternal grandparents. She has also been placed at a group home and shelter. At the age of 15 her first commitment to YRTC-Geneva was in April 2018 through October 2018. R.H. was diagnosed with Cannabis Use Disorder, Alcohol Use Disorder; Generalized Anxiety Disorder, and Oppositional Defiant Disorder. She was re-committed in March 2019 at age 16 years old. She was discharged in September 2019 at 17 years old.

S.D.

S.D. became a state ward in March 2019 due to parental domestic violence and physical abuse. She was placed on probation in June 2019. She was previously placed in foster homes and detention centers before being committed to YRTC-Geneva in July 2019. She was 15 years old. S.D. was diagnosed with Oppositional Defiant Disorder, Attention Deficit Hyperactive Disorder, and Disruptive Mood Dysregulation.

S.S.

S.S. was placed at two group homes and a detention center before being committed to YRTC-Geneva in September 2017. She was 15 years old. S.S. has a history of physical abuse. She was diagnosed with Oppositional Defiant Disorder and Alcohol Use Disorder. She was discharged in August 2019 at 17 years old.

S.A.

S.A. was removed from her biological family due to neglect as an infant, and was adopted before the age of 2 years old. N.S. is a victim of sexual abuse. She was placed on probation October 2014. She had previously been placed at a shelter and a group home. Her first commitment to YRTC-Geneva was from January 2018 to September 2018. S.A. was diagnosed with Conduct Disorder. Her second commitment started in February 2019 at the age of 17 years old. N.S. was discharged in August 2019 at age 18 years old.

S.N.

S.N. was made a state ward in 2013 due to abuse and neglect. Her parents no longer maintain their parental rights. She was placed on probation in March 2016. S.N. has been placed in foster homes, detention centers, shelter, and group homes. S.N.'s first commitment to YRTC-Geneva was from October 2017 to August 2018. She was diagnosed with Oppositional Defiant Disorder, Conduct Disorder, Cannabis Disorder, and Alcohol Use Disorder. Her second commitment to YRTC-Geneva started in August 2019 at the age of 18 years old.

T.A.

T.A. was made a state ward in 2003 due to neglect. She was adopted in 2005. T.A. was again made a state ward October 2011 at the age of 9 years old. Her adoptive parents could not handle her behaviors. T.A. was placed on probation in May 2016. She has had a long placement history including: foster placements, detention centers, psychiatric residential treatment facilities, group homes, and shelter. In May 2018 T.A.'s adoptive parents relinquished their parental rights. Five days later she was committed to YRTC-Geneva at the age of 15 years old. T.A. was diagnosed with Conduct Disorder, Attention Deficit Disorder, Disruptive Mood Dysregulation, Aggressive Behavior, Adjustment Disorder, and Post-Traumatic Stress Disorder. T.A. was discharged in September 2019 at the age of 16 years old.

W.A.

W.A. was placed on probation in September 2018. She had previous placements at detention centers and a group home. W.A. was committed to YRTC-Geneva in June 2019 at the age of 16 years old. W.A. denied any history of abuse during the initial assessment. She is diagnosed with Conduct Disorder, Alcohol Use Disorder, and Cannabis Use Disorder.

W.N.

W.N. was a prior state ward in 2009 due to neglect. She was placed on probation in December 2016. W.N. has previously been placed in detention centers, shelters, and group homes. W.N.'s first commitment to YRTC-Geneva was February 2018 to August 2018. She is diagnosed with Conduct Disorder, Attention Deficit Hyperactive Disorder, Disruptive Mood Dysregulation, Alcohol Use Disorder, Cannabis Use Disorder, and Oppositional Defiant Disorder. Her second commitment started in November 2018 at the age of 16 years old.

W.J.

W.J. was adopted around the age of two years old due to neglect. There is no record of her being a state ward in Nebraska. She reported abuse by her adoptive father. W.J. was placed on probation August 2014. She has a prior history of being placed at detention centers, shelters, group homes, foster home, and psychiatric residential treatment facilities. W.J. was committed to YRTC-Geneva in November 2018 at the age of 18. She was discharged in May 2019. She was diagnosed with Hallucinogen Use Disorder, Disruptive Mood Dysregulation, Conduct Disorder, and Cannabis Use Disorder. She was discharged to a youth shelter and was kicked out in less than a month. She was told to go live in a homeless shelter. That placement did not work out so she was taken to a detention center. Her second commitment to YRTC-Geneva started in June 2019. She was discharged in October 2019, one day before her 19th birthday.

W.S.

W.S. has a long history of being a tribal ward dating back to 2003. She was placed in a guardianship for a few years but this disrupted. W.S. has been placed in relative placements, shelters and detention centers. She was committed to YRTC-Geneva in January 2017 at the age of 14 years old. W.S. is diagnosed with Fetal Alcohol Spectrum Disorder, Suicidal Ideation, Self-Injurious, Aggressive Behavior, Depressive Disorders, Attention Deficit Hyperactivity Disorder, Anxiety Disorder, and Oppositional Defiant Disorder. W.S. only had one visit from a relative during her 2+ year commitment at YRTC-Geneva. She was discharged in August 2019 at the age of 16 years old.

W.L.

W.L. was a state ward in another state. She moved to Nebraska to live with relatives who eventually adopted her. She was placed on probation August 2017. W.L. was committed to YRTC-Geneva in February 2019 at the age of 16 years old. She was diagnosed with a Learning Disability, Oppositional Defiant Disorder, Depressive Disorders, and Alcohol Use Disorder. W.L. was pregnant while at YRTC-Geneva. She was discharged in August 2019 at the age of 17 years old.

TIMELINE OF EVENTS

How did the situation at YRTC-Geneva deteriorate to the point that the facility had to be shut down? To answer that question, it is important to analyze the events and circumstances occurring prior to the closure as a whole and not in isolation. Through the process of investigation, a relevant timeline was established beginning in 2015 and culminating at the August 2019 critical incident. The investigation found that while the timeline began as early as 2015, in May 2019 the deterioration of the facility began occurring at a brisk pace.

2015

In September 2015, the Facility Administrator at YRTC-Geneva, Dan Scarborough, was also made interim Facility Administrator at YRTC-Kearney. Mr. Scarborough would maintain his dual role for seven months with assistance from the Facility Operating Officer (FOO) at Geneva. The FOO retired from the position at Geneva in December 2015. A long time YRTC-Geneva employee who had, in 2014, received an "Employee of the Year" award from the DHHS CEO, then became the Facility Operating Officer at Geneva.

2016

Mr. Scarborough managed his duties at both the Geneva and Kearney facilities through the first four months of 2016. Mark LaBouchardiere was named facility administrator for the Kearney facility in April, allowing Mr. Scarborough to return to his duties as the full-time Facility Administrator of YRTC-Geneva. It was reported to the OIG that Mr. Scarborough felt he was stretched thin and inadequately serving both facilities when required to split his time between YRTC-Kearney and YRTC-Geneva.

In June of 2016 the OIG released the report of investigation: *DHHS Administration Allowed Conditions at the Youth Rehabilitation and Treatment Center – Kearney to Deteriorate*.[19] The report found data measures worsened under the interim administration; that no appropriate plan for operations under the interim administration were developed; the OJS Administrator was unable to fulfill job duties; and, youth at YRTC-Kearney were subject to conditions that violated the law.

Mr. LaBouchardiere steered YRTC-Kearney for seven months before being named the OJS Administrator in November 2016. Trevor Spiegel was named as the new YRTC- Kearney Facility Administrator after Mr. LaBouchardiere's advancement.

Mr. Spiegel began his tenure with YRTC-Kearney in 2008. He had been named as the Facility Operating Officer four months prior to taking over the YRTC- Kearney Facility Administrator

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[19] https://nebraskalegislature.gov/FloorDocs/104/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20160914-113017.pdf

position. As the FOO, Mr. Spiegel managed the operations of the Kearney facility including food service, laundry and maintenance.

2017

During 2017, YRTC-Geneva's full-time Licensed Clinical Psychologist and Program Director began training staff on a new behavioral incentive program, "Youth Rehabilitation and Treatment Center—Geneva: Programming, Privileges, and Treatment," also known as "levels." The behavior program developed by the Licensed Clinical Psychologist, in close coordination with YRTC-Geneva's FOO, was created specifically for Geneva and included the implementation of a gender specific "level system" for youth placed at the Geneva facility. The model was based on other jurisdictions' models for girls in the juvenile justice system, in addition to the understanding that the girls' trauma had to be addressed. In general terms, a level system is when an individual moves up and down through various established levels contingent upon specific behaviors. The youth learns to exhibit desired behavior in order to obtain access to privileges and preferred items assigned to each level and to avoid behaviors that result in the loss of a level, thus those behaviors do not result in gaining privileges. The Clinical Psychologist provided training and re-training on the level program for all YRTC-Geneva staff monthly.

In July 2017 DAS took over maintenance duties at the YRTC facilities from DHHS. This change resulted in consolidated maintenance management through the DAS office in Lincoln.

In December 2017, the American Correctional Association (ACA) gave YRTC-Geneva a perfect score for compliance with its standards for the first time in the facility's history. A press release by DHHS indicated that the facility had scored 100% compliance on 38 mandatory requirements and 333 non-mandatory measurements.

Shortly after Geneva received the perfect score for compliance, the YRTC-Geneva FOO started splitting her time and assigned duties between YRTC-Geneva and Whitehall in Lincoln.

2018

In January 2018, Mr. LaBouchardiere, OJS Administrator, was named as the new DHHS Facilities Director over all DHHS facilities including the Regional Centers, Whitehall, Beatrice State Developmental Center, and the YRTCs. Trevor Spiegel, the YRTC-Kearney Facility Administrator, was in turn named OJS Administrator. Mr. Spiegel was first made the interim administrator, and then named the permanent OJS Administrator in April 2018.

In April 2018, YRTC-Geneva's Licensed Clinical Psychologist and Program Director left the position at YRTC-Geneva. The Clinical Psychologist at YRTC-Kearney was informed that the Licensed Clinical Psychologist position at YRTC-Geneva would not be filled and instead he would be required to manage essential duties at the Geneva facility in addition to maintaining YRTC-Kearney Program Director responsibilities. The YRTC-Kearney Clinical Psychologist was not able to conduct the same trainings and quality assurance of the YRTC-Geneva levels program that had been previously maintained by the YRTC-Geneva Psychologist.

The 2016-2017 YRTC-Kearney Annual Report explained that as the Clinical Psychologist for YRTC-Kearney, the position was responsible for the overall supervision of the Mental Health Department and also provided psychological consultations and evaluations on an as-needed basis. The Clinical Psychologist was also responsible for updating procedures and ensuring mental health and substance abuse compliance with the ACA and Prison Rape Elimination Act (PREA) standards. The report also stated that the position was required to assist with developing and conducting annual trainings on programmatic material.

Within six months of the Licensed Clinical Psychologist's departure from YRTC-Geneva, the Facility Operating Officer at YRTC-Geneva also resigned, leaving the YRTC-Geneva Facility Administrator to manage the Geneva campus with only a part-time licensed clinical psychologist working from YRTC-Kearney and no operating officer.

Both YRTC-Kearney and YRTC-Geneva underwent PREA Audits in 2018. For three days, beginning October 2nd, auditors completed the on-campus audit of YRTC-Geneva. The auditing process included a review of files and selected physical plant inspections in addition to random youth and staff interviews. The PREA auditors accessed footage from 93 cameras on campus, conducted interviews of 10 youth and 12 staff, reviewed files pertinent to PREA from the prior 12 months, viewed every sleeping room and toilet/shower area and inspected the LaFlesche and Sandoz cottages. The Sacajawea and Burroughs cottages were under construction, repair or both at the time of the audit and therefore were not inspected. As a result of the audit it was found that YRTC-Geneva was in compliance with staff to youth ratios with very few exceptions. Both the Kearney and Geneva facilities would later (November 2018) be notified that they had passed the PREA audit with perfect scores. In addition to passing the PREA audit, both facilities would also be accredited again by the ACA by the end of 2018.

In October, the CEO of DHHS, Courtney Phillips, left for a position in another state. Governor Pete Ricketts appointed Bo Botelho to the DHHS Interim CEO position. He served in this position from October 15, 2018 to February 25, 2019. Prior to working for DHHS, Mr. Botelho was the Chief Operating Officer for DAS, and had also served DAS as the deputy director, general counsel and as the legislative liaison.

On October 14, 2018, the first incident of a youth breaking a fire suppression head (sprinkler head) off the interior sprinkler system occurred in the living quarters of Pod A at the LaFlesche cottage.

During 2018 YRTC-Geneva was subject to five calls to the Child Abuse and Neglect Hotline (Hotline). In cases where allegations of abuse or neglect are made within the parameters of an agency providing care in a facility setting, the allegations are investigated by a worker from the Division of Children and Family Services. The worker assesses the safety and risk to the youth using an Out of Home Assessment (OHA) tool as prescribed by protocol.

In June, October, and November of that year, the Hotline received the following intakes alleging abuse at the Geneva facility:

- June 12, 2018: Allegations of physical abuse of a youth by two staff members;
- June 29, 2018: Allegations of physical abuse of a youth by two staff members;
- October 1, 2018: Allegations of physical abuse of a youth by a staff member;
- November 21, 2018: Allegations of physical abuse of a youth by an unknown staff; and,
- November 24, 2018: Allegations of physical abuse of a youth by a staff member.

In all instances of accepted intakes, investigations and assessments were conducted. The youth were found to be safe and the allegations unfounded resulting in the cases being closed.

2019

January – March

During the first three months of 2019, one of the living pods in LaFlesche cottage was shut down completely due in part to an issue with the sewer system. Other areas of the cottage were also in need of repairs due to sustained damage. Concerns about issues related to staffing, the faltering levels program, and inconsistent school attendance by the girls began to surface.

In February, Dannette Smith was appointed the new CEO of DHHS.

A DHHS Compliance Specialist conducted an internal investigation into allegations that school staff were intentionally utilizing the scoring component of the level system as a means to provoke students and remove them from programing during school hours. As a result of the investigation, a member of facility administration, a member of administration from the school, and a member of the school professional staff were put on Performance Improvement Plans.

In February, the administration from the Hastings Regional Center (HRC) was asked to provide people from their staff to cover shifts at YRTC-Geneva. When HRC administration agreed, external staff began to flow into the facility. The relief staff assigned to Geneva began to report concerns to HRC administration. They noted their apprehension about the lack of structure at YRTC-Geneva, the negative impact poor or nonexistent programming was having on both youth and staff, and serious issues of physical safety for both staff and youth. Overtime for Geneva staff for the month of February was 1,142.25 hours, the additional staff from other facilities brought that total down to 991.5 hours in March.

During this period the Hotline received two calls alleging abuse/neglect within the facility.

- February 14, 2019: Allegations of physical neglect of a youth by unnamed staff.
- February 20, 2019: Allegations of physical abuse of a youth by a staff member.

Both of these calls to the Hotline were not accepted for investigation due to the allegations not meeting the definition of abuse or neglect as set forth in policy.

April – June

CEO Smith began conducting “huddle calls” with YRTC administrators twice a week in April. These huddle calls were expanded in May to daily cadence meetings between the CEO and YRTC administrators. For a period of time in June, the cadence calls occurred three times a day. After about a week, the cadence calls were reduced to two times per day.

The remaining living pod in LaFlesche was closed at the beginning of April. This left the YRTC-Geneva campus with three remaining cottages available to house the youth. DAS’s State Building Division (SBD) received the first bid for LaFlesche cottage repairs, on April 4, 2019. OJS and SBD had their first phone conference to discuss the timeline of repairs to the cottage on April 29. A follow up phone call was conducted on May 8, 2019, to discuss the timeline for repairs to LaFlesche. A third follow up phone call to again discuss the timeline of repairs was held between the two offices on May 28.

DHHS Chief Operating Officer and General Counsel (Mr. Botehlo), DHHS Facilities Director (Mr. LaBouchardiere), and OJS Administrator (Mr. Spiegel) along with the YRTC-Geneva Facility Administrator toured the YRTC-Geneva facility on April 16. The COO visited the facility a second time on May 17 – this time accompanied by CEO Smith. The CEO and COO visited the facility together a second time at the end of May.

YRTC-Geneva staff had 914.25 hours of overtime in April, 1,205 hours in May, and 1,499.92 hours in June.

On May 6, 2019, then acting Inspector General, Julie Rogers, emailed CEO Smith to clarify leadership roles within the YRTCs, establish the designated contact person for the OIG, and express concern for the lack of leadership consistency within the YRTC system. CEO Smith later responded to IG Rogers to confirm that DHHS Facilities Director Mr. LaBouchardiere would be focusing on the Lincoln Regional Center until further notice and that the OJS Administrator and both YRTC Facility Administrators at Geneva and Kearney would no longer be reporting to the DHHS Facilities Director, but instead would report directly to her (CEO Smith).

On May 24, the Licensed Clinical Psychologist and Program Director serving both YRTC-Kearney and YRTC-Geneva, submitted a letter of resignation effective August 2019.

On May 28th, youth broke a sprinkler head for the second time, this time in the Burroughs cottage. DAS employees, the YRTC-Geneva Facility Administrator, and a representative from Nebraska Fire Sprinkler assessed the damage. It was decided that no rooms in the cottage would be taken out of service at that time.

On May 31, OJS Administrator Spiegel was directed to report to YRTC-Geneva on a daily basis and was to manage the day-to-day operations of the facility “hand in hand” with CEO Smith. The OJS Administrator was also expected to provide group supervision for facility administrators at YRTC-Kearney and Whitehall. OJS Administrator Spiegel and CEO Smith were in daily phone contact from this point on throughout the rest of summer 2019.

In late spring, staff from the HRC were being sent to assist the Geneva facility by covering shifts. HRC administration and staff exchanged emails as concern for staff burnout due to travel and feeling unsafe at the Geneva facility grew. In addition, frontline staff from the outside facilities continued to report issues with lack of programing for youth and training for relief staff. In an email between HRC administrators, one noted: "I don't want to lose good staff because they don't feel secure in what they are doing…they are being assigned to the most difficult living unit and the Geneva staff hang out in an office."

In early June, HRC staff were mandated to report to Geneva to cover the staff shortage at the facility. HRC administrators were told the directive was not optional. The HRC administrators exchanged emails indicating that they expected to be disciplined for not "forcing" their staff to go to Geneva, but in light of their own staffing shortages and high need youth, the administrators were not willing to force their staff to provide support to the Geneva facility or to threaten them with disciplinary action for refusing to go.

On June 4, a staff member from SBD visited the Geneva facility to meet with the OJS Administrator and go over the facility task list. The OJS Administrator prioritized repairs to the LaFlesche cottage and repairs to lights in the confinement rooms in the Burroughs cottage.

On June 5, the YRTC-Geneva Facility Administrator was notified that he was no longer responsible for the Geneva facility. He was told that he was now responsible only for scheduling at the YRTCs and Whitehall. At about the same time, letters of expectation were reviewed with the Geneva staff. At the time of the review, the staff expressed the need for improved direct supervision.

A third episode of breaking a sprinkler head occurred on June 11. Youth broke the fire suppression head off a sprinkler in the east living quarters of Burroughs cottage. The east side of Burroughs was taken out of service for six days. Youth shut off the equipment being used to dry the area which prolonged the drying time.

There were eight calls to the Hotline during April, May, and June. In all instances of accepted intakes, investigations and assessments were conducted. The youth were found to be safe and the allegations unfounded resulting in the cases being closed.

- April 5, 2019: Allegations of physical abuse of a youth by unnamed staff. The caller alleges the youth was denied lunch and the use of the bathroom, causing her to wet her pants. The caller goes on to state that the youth continues to be suicidal and is not getting the help she needs.
- April 18, 2019: Allegations of emotional abuse of a youth by two staff. The caller reported the pair of staff members encouraged the youth to call them mom and dad and told her they were going to get her out of YRTC-Geneva and take care of her. The two employees were no longer employed by the facility at the time of the report due to being forced to resign for unrelated issues. It was reported that the youth became suicidal after the pair left their positions.

- April 18, 2019: Allegations of physical neglect of unnamed youth by unnamed staff. The caller alleged a youth had found worms in her food.
- April 25, 2019: Allegations of physical abuse of a youth by a staff member. The caller reported that the staff member had slapped the youth.
- April 27, 2019: Allegations of physical neglect of unnamed youth by unnamed staff. The caller reported the youth were being mistreated by staff, specifically citing an instance where a youth was alleged to have suffered a seizure while staff stood by and did not assist her.
- June 3, 2019: Allegations of physical abuse of a youth by a staff member. The caller stated the youth had been improperly restrained by the staff member and that all the white youth are sent to school and the black youth are sent to their rooms.
- June 4, 2019: Allegations of physical abuse of a youth by the same staff member named in the June 3rd allegation. The report stated that the youth had been injured while being restrained.
- June 28, 2019: Allegations of physical abuse of a youth by a staff member.

July – August

A July 18, 2019 email from the OJS Administrator in response to HRC administrator concerns indicated that the OJS Administrator believed the staffing situation at Geneva to be stabilizing, stating, "I'm planning for much less assistance, if any, by the end of August as I think our vision is much more clear by then." By August 7, it was reported by staff from other facilities that were covering shifts at YRTC-Geneva, that Geneva was functioning with eight Geneva frontline staff and that people were walking off the job in the middle of their shifts.

On July 30, a meeting was held at YRTC-Geneva that included the Director of Juvenile Placement and a Juvenile Justice Programs Specialist, of Probation Administration. The meeting's purpose was to discuss discharge planning and the status of youth. A brief tour of the campus was conducted.

In a 21-day period (July 20 - August 9) there were nine incidents where various youth continued to damage the sprinkler system. As part of the investigation, surveillance videos recorded were observed during this time period. Long periods of time were witnessed where the youth were not engaged in any type of structured activity, and instead youth roamed within the cottage with very little to no staff interaction. Some of the youth were observed playing cards, watching TV or sitting idle.

The OIG was also able to observe the time leading up to sprinkler pulls and noted that the youth would become restless and eventually progress to an agitated state. For example, the recordings showed the girls starting small altercations with each other by throwing wadded up paper. They were also seen antagonizing staff with minor rule violations such as repeatedly opening locker doors and slamming them shut. Eventually this type of restless or agitated behavior would progress to more serious behavior resulting in property damage. Staff were observed to have little interaction with youth. They were seen standing or sitting in the day room or staff office, walking in the halls, or congregating together in groups passively watching the girls.

July 20, 2019: Youth broke fire suppression head off in day room at Burroughs cottage resulting in the day room and two offices being taken out of service for seven days. SBD staff arrived at 6:45pm to manage the situation, not leaving until 12:30am the next morning.

July 24, 2019: Youth broke fire suppression head off in room 23 in Burroughs cottage. SBD staff arrived at 4:30pm and left at 6:45pm. One room on the southwest side of Burroughs was taken out of service for three days.

July 27, 2019: Youth broke off fire suppression head in Sandoz living quarters on the east side. SBD staff arrived at 6:00pm and left at 7:45pm. Three rooms and one office were taken out of service for five days. Youth shut off the equipment which prolonged drying time.

July 31, 2019: Youth broke fire suppression head off in Sandoz day room. SBD arrived at 5:45pm and left at 10:00pm. The day room was sectioned off with temporary barriers (plastic) and taken out of service for seven days.

August 1, 2019: Youth broke fire suppression head and pulled fire suppression piping out of the wall in Burroughs living quarter's west hall. SBD staff arrived at 2:00pm and left at 4:30pm. The water was cleaned up – nothing was taken out of service.

August 6, 2019: Youth broke off two fire suppression heads and piping on the north side of Burroughs rooms 22 and 23 then used the piece of piping to break glass out of two doors. SBD staff arrived at 12:40pm and left at 4:30pm. The water was again cleaned up – nothing taken out of service. On this same day, the Hotline received a call alleging the physical abuse of a youth. The reporter stated that an unnamed staff member put the youth into handcuffs and confined her to a wheelchair after being disruptive. The intake was not accepted for investigation due to not meeting definition.

August 7, 2019: Youth broke fire suppression head off in room 25 in Burroughs. SBD staff was on site cleaning up previous damage and system was off, thus there was no further damage.

August 8, 2019: There were two incidents of broken fire sprinklers. The first incident occurred when youth broke a fire suppression head in room 21 in the west hall of Burroughs. SBD arrived at 3:30pm and left at 5:00pm. Nothing was taken out of service. The second incident on that day occurred in the Sacajawea cottage. The OIG observed video surveillance from the cottage that showed just prior to pulling the piping, the youth got on top of a chair, hit a fire sprinkler with a book at least ten times while a staff member watched and did not intervene. The youth then physically pulled down fire suppression piping breaking it in two places within the ceiling. Staff had four youth help clean up the debris. It was noted that staff had the four youth take off their shoes despite ankle deep water filled with floating debris. The rest of the youth were sent to the gym. Based on interviews, the OIG confirmed that while the cottage was in a state of disarray (everything was wet, smelled of strongly of mold, and there were wires hanging down from the ceiling) the girls were forced to go back to Sacajawea cottage later that night to sleep. SBD arrived at 5:45pm and left at 11:45pm. Sacajawea day room was taken out of service for nine

days. In addition to the damage done in the day room, water traveled through the floor into the basement and saturated Geothermal systems and the air handler.

August 9, 2019: Youth broke a fire suppression head in the south bathroom in the west hall of Burroughs. SBD arrived 3:30pm and left at 5:00pm. The water was cleaned up, nothing was taken out of service.

August 10, 2019: The youth were still being housed in the gym during daytime hours due to the damage to Sacajawea but were required to sleep in the cottage at night. Through interviews and a review of video recordings, the OIG learned that on the evening of the 10th the girls were escorted back into the cottage around 8:00 p.m.—an hour earlier than usual. The ceiling was not repaired in the living area and the lights were either not working or not on. The floorboards were ripped out. Fans were running everywhere around the cottage. The cottage's air conditioning was shut off. The cottage was in disarray. The OIG observed video surveillance that showed while staff attempted to get the youth to their sleeping rooms around 9:00 p.m. the girls refused to cooperate. The youth were huddled up in a group, one carrying around a stick-like object. At least two youth physically got sick by puking into a bucket. Some youth started ripping papers up. The girls then accessed a phone in the living unit while staff observed but did not interfere. Multiple youth from within the Geneva facility called the Hotline to report their issues: girls being forced to sleep in areas with water damage that were hot, smelled bad and had visible mold growing. Other youth stated that they were being kept in rooms with damaged ceilings and that things were in a general state of disarray. The youth reporters alleged that all of the girls felt unsafe. One youth reporter stated, "Geneva is supposed to be a rehabilitation center. I've only seen a therapist three times since May 29th." The reporters were upset that there was only one licensed therapist at Geneva and the other therapists were interns. One youth recounted during an OIG interview how they felt about going back to Sacajawea that night:

> *They only had fans in there. They weren't doing anything else to fix the cottage. We were putting our concerns out there about sleeping back in that cottage. There was a youth who was pregnant and another youth with asthma. Our eyes would be poofy and red, but it went away when we left the cottage. We were getting frustrated. On Saturday night, they brought us back in the cottage around 8 p.m. instead of 9 p.m., in the family room two girls started gagging and throwing up, the carpet was all sticky. We were getting frustrated. They made us sleep there, but we just couldn't be there. We just went on strike. We wouldn't go to our rooms to go to sleep.*

About an hour later two Fillmore County Sheriff Deputies showed up at the cottage. The deputies stood with the staff and did not engage the youth. About thirty minutes later the Nebraska State Patrol arrived at the cottage as well. Staff then escorted three youth to another cottage while the officers and remaining staff got the rest of the youth into their rooms. The officers left without any citations or arrests.

August 11, 2019: The OJS Administrator, who at this time was responsible for the day-to-day operations with CEO Smith, was contacted by the Hotline about the reports. The OJS Administrator stated that he had assessed the building and was closing it. The Hotline narrative for the intakes stated the following: "Intake Closure Status: Not Accepted: Reason: This information will be forwarded to licensing." The YRTCs are not licensed through Public Health.

On August 11, CEO Smith, DHHS Executive Medical Director, and DHHS Facilities Director arrived at the facility to tour the buildings and meet with staff. At that time, DHHS Facilities Directors Mr. LaBouchardiere was brought back to working with the facilities under OJS, but his role at the time was unclear.

FINDINGS

The leadership at DHHS, OJS, and at YRTC-Geneva failed to ensure that YRTC-Geneva had the necessary and required management, staffing, programming, treatment, and facilities to care for the youth in its custody.

The failures of leadership related to YRTC-Geneva occurred at multiple levels, on multiple fronts, and in ways that were complexly intertwined, with each compounding the consequences of the next. This reflects a failure by leadership to plan, to problem solve, and to dedicate the resources necessary to provide the legally required care for the youth at YRTC-Geneva. Each of these elements is required to effectively meet the mission of YRTC-Geneva and the needs of the girls.

Key management positions in the administration at YRTC-Geneva were not appropriately staffed or were left vacant.

The investigation revealed a pattern of failing to provide appropriate staffing for key management positions at the YRTCs. In several instances, staff in key positions were asked to meet those responsibilities in more than one facility, or key positions were left vacant.

One pattern – requiring staff to hold key positions in two different facilities – was present as early as 2015 and became more prevalent in the two years before the crisis at Geneva. In September 2015, Dan Scarborough, the Facility Administrator at YRTC-Geneva, was also made interim Facility Administrator at YRTC-Kearney. Mr. Scarborough would maintain his dual role for seven months until April 2016 when Mark LaBourchardiere was named Facility Administrator at YRTC-Kearney. This required the YRTC-Geneva Facility Administrator to oversee two large and complex facilities over 100 miles apart. While both Kearney and Geneva were YRTCs, their programming, culture, facilities, and the youth they served were decidedly different.

During the time he was required to run two facilities, the YRTC-Geneva Facility Administrator had support at YRTC-Geneva from the Facility Operating Officer (FOO) at Geneva. At YRTC-Geneva, the Facility Operating Officer played a crucial role in the supervision of staff and the day-to-day operations of the facility. The FOO at that time had worked at Geneva for years, and eventually had been promoted to the Facility Operating Officer. After that FOO retired in December 2015, another long-time YRTC-Geneva employee, was hired to fill that role. The newly hired FOO was not as experienced in administration but still provided continuity and support in that key position. These vital management positions at Geneva may have helped maintain stability at Geneva while the Facility Administrator was splitting his time between two facilities.

However, even with the support of a well-seasoned FOO, it was reported to the OIG that the YRTC-Geneva Facility Administrator felt stretched thin when maintaining duties at both the Kearney and Geneva facilities and was not doing justice to either facility. The OIG's investigation of YRTC-Kearney in 2016 found that the data measures worsened at Kearney when the facility did not have a dedicated full time Administrator.

Despite the challenges of asking one person to staff two facilities, this management pattern persisted. In December 2017, the YRTC-Geneva's Facility Operating Officer, was required to start splitting time and duties between YRTC-Geneva and Whitehall in Lincoln. These facilities are not only geographically distant, but they are also very different types of facilities. While both serve youth in the juvenile justice system, the facilities are very different in terms of purpose, programming, and standards and accreditation. YRTC-Geneva served girls and Whitehall houses a sex offender treatment program for male youth. Whitehall is a Psychiatric Residential Treatment Facility (PRTF) that is licensed as a medical and behavioral health facility. YRTC-Geneva was accredited by a national correctional association and had different standards. As noted, the Facility Operating Officer position played a crucial role in the supervision of staff and the day-to-day operations at YRTC-Geneva. This important work was compromised when the FOO was required to oversee the day to day operations of two very different and geographically distant facilities.

By the early fall of 2018, less than a year after being forced to serve both facilities, the FOO resigned. The Facility Operating Officer position was never filled.

As the Facility Operating Officer position was being compromised, another key position was also lost. In early 2018, YRTC-Geneva's Licensed Clinical Psychologist and Program Director, and the person who had created the levels programming being used at YRTC-Geneva, left to work at Whitehall full-time. The Level Program created for YRTC-Geneva was not yet fully ingrained into the facility culture at Geneva at that point. Once again, this critical position was left vacant. Instead, the Clinical Psychologist at YRTC-Kearney was told to split responsibilities between YRTC-Geneva and YRTC-Kearney and serve as the Program Director at both facilities. There was frustration that the Licensed Clinical Psychologist did not spend more time at YRTC-Geneva, as his full-time job was at YRTC-Kearney.

The loss of these two key management positions had a significantly detrimental effect on YRTC-Geneva. Several administrators were of the opinion that the FOO was the glue that was holding everything together and their resignation was a critical point. With regard to the loss of the full-time Licensed Clinical Psychologist and the FOO, one administrator observed that "in a matter of four months, we lost the people who were holding the model together." In addition, the direct line staff and case managers had reported directly to the FOO. It was reported that when the FOO left, "all of that quality assurance and supervision and support—those things fell off."

By early 2019, YRTC-Geneva had no FOO and a part time YRTC-Geneva Program Director and Psychologist who was rarely physically present. In addition, in February, the OJS Administrator became concerned that many of the girls were spending more time in their cottages than in school. An internal investigation was initiated into the treatment of the girls by a school administrator and a member of the professional staff.

Though maybe not as drastic of a shift, other positions also did not get filled at YRTC-Geneva. For example, a full-time employee in charge of training was not replaced after leaving in mid-2016. Then the administrative assistant who picked up those job duties left and was not replaced. Also, DHHS human resources support for YRTC-Geneva diminished greatly when the position

assigned to handle human resources for both YRTC-Geneva and YRTC-Kearney was left vacant, resulting in major delays in dealing with staff issues.

This pattern of mismanagement extended up through DHHS in leadership positions that oversaw the YRTCs. From 2016 through 2018, the leadership at the two YRTCs, the leadership at OJS, and at DHHS was relatively stable. While in different positions of leadership, the same three people had oversight over YRTC-Geneva in the year prior to the crisis. In the months before the ultimate crisis at Geneva, some critical changes in leadership at OJS and DHHS were made swiftly.

In April 2019, CEO Smith, who began her tenure in February, became involved with the YRTCs and began huddle calls with the facility administrators from YRTC- Kearney, YRTC-Geneva, Whitehall, and Hastings Regional Center two times a week.

By May, at CEO Smith's direction, the DHHS Facilities Director, who had previously run the boys YRTC, served as OJS Administrator and still had responsibility for the YRTCs as Director of Facilities, was instructed to limit his oversight to the Lincoln Regional Center. He was no longer involved in the YRTCs. CEO Smith then became the direct report for the OJS Administrator and the two Facility Administrators at the YRTCs. By the end of the month, CEO Smith requested that the OJS Administrator be present at Geneva daily and run the facility in conjunction with her. The YRTC-Geneva Facility Administrator was still at Geneva but was no longer in charge of operations.

By June, CEO Smith was holding cadence meetings via phone three times a day with the OJS Administrator, the YRTC-Geneva Facility Administrator, and a Youth Counselor Supervisor at YRTC-Geneva. CEO Smith and the OJS Administrator would usually talk daily, sometimes multiple times per day.

This shifting of responsibilities and roles meant that there was no dedicated, full-time administrator in Geneva at the start of the summer of 2019. Rather, the OJS Administrator, and CEO Smith, who had responsibility for the entirety of the Department of Health and Human Services, were trying to run the facility in the midst of their other responsibilities.

As OJS Administrator, it was challenging to also run the YRTC-Geneva facility on a daily basis. One front-line staff noted that they could tell the OJS Administrator very much wanted to succeed but he had very little support all summer [2019].

Based on the foregoing timeline of events, it would appear that the loss of specific people integral to the YRTC-Geneva program, the requirement that several key positions oversee more than one facility, and unfilled positions vital to the functioning of YRTC-Geneva resulted in a weakening of the Geneva facility's clear, stable, and organized management.

This had an ongoing detrimental effect on YRTC-Geneva. As explored below, the failure to maintain these critical management positions exacerbated issues with staffing, programming and treatment, and the lack of staffing in turn compounded the issues with programming and treatment.

Lack of Staff and Training for Staff

The vacancies and inappropriate staffing of key management positions at YRTC-Geneva coincided with and exacerbated critical issues with staff training and retention.

As noted earlier, the YRTC-Geneva Licensed Clinical Psychologist had created the levels programming being used at the facility. When that Psychologist left YRTC-Geneva, the Level Program created by them was not fully ingrained into the facility culture. A critical piece of staff training on their programming system had not been completed. In addition, the key supervisory role of Facility Operations Officer was no longer filled after September 2018 – there was no one to assist the Facility Administrator with staff supervision, as had been in place for decades.

In a failed effort to address the supervisor vacuum left by the vacant Facility Operating Officer position, a questionable hire was made in December 2018. Instead of hiring a qualified Facility Operating Officer to fill the vacancy, a supervisor position from the Hastings Regional Center (HRC) was moved to YRTC-Geneva, and a Geneva Youth Counselor Supervisor was hired. This position was supposed to supervise those staff working directly with the youth day in and day out. According to the investigation, the newly hired Youth Counselor Supervisor created a toxic work environment. It was reported that the supervisor would bring pets (a snake and a dog) to campus, even though that was not allowed for anyone else, and that despite their problematic management style, the YRTC-Geneva Facility Administrator provided little to no supervision. Staff shared during interviews that she was a terrible supervisor, played favorites, inappropriately socialized with subordinates, did not ensure everyone had the proper training updates, gave the girls anything they asked for, and was generally not respected. “And it caused drama all over campus. And then these people started resigning because of this drama…and then all the good staff left.” “She was a disaster.”

In March 2019, still no FOO was hired, but rather a second Youth Counselor Supervisor was hired. According to the investigation, there was a clear effort to make changes at YRTC-Geneva that would make its structure mirror YRTC-Kearney’s. The Youth Counselor Supervisor position was to be working directly with the front line staff, instead of being focused on administrative duties.

In early 2019 it was clear that Geneva was beginning to have significant staffing issues related to training and supervision. In February, the administration at the Hastings Regional Center’s Juvenile Chemical Dependency Program was required to send staff to help fill in at YRTC-Geneva.

Emails from February illustrate the significant effect the lack of staff had on the programming and the facility even then. A Youth Security Supervisor from HRC who was working at the Geneva facility wrote that: “My observations are that the front line staff appear apprehensive or maybe scared to hold the girls to the program guidelines and when they do the girls have little respect to what the front line staff are saying…Also, along the same lines, these girls are running that cottage and they know it…In addition, without additional staff it was difficult to engage the girls while meeting the needs of the program at the same time.”

Even with help from other facilities, YRTC-Geneva had to utilize an enormous amount of mandatory overtime to meet their staffing needs. A Youth Security Supervisor from HRC notes in a February email to HRC administrator that there was one staff member from YRTC-Geneva who had worked an 18-hour shift. The overtime data from that time shows how heavily the facility had to rely on it:

- February 2019 - 1,142.25 hours of overtime
- March 2019 - 991.50 hours of overtime
- April 2019 - 914.25 hours of overtime
- May 2019 - 1,205 hours of overtime
- June 2019 - 1,499.92 hours of overtime

Irregularities in youth programming and safety at YRTC-Geneva continued to be the source of concern throughout the month of March. Emails exchanged between Hastings employees providing coverage at Geneva and administration from both the Hastings and Geneva facilities consistently discuss compounding problems, and varying perspectives on what the core issues are and how to address them. For example, an email chain between several administrators states, "Some of it sounds like just a good safety walk through of areas and getting things fixed, removed or processes cleaned up. Other things like the 18-24 hour shifts, the lack of responsiveness and the personal relationship issues could be more problematic on several levels."

YRTC-Geneva front line staff interviewed reported that they did not feel supported, it was crushing to see the girls have nothing to work for, they were just trying to keep things afloat, and by the end, they felt like babysitters. One staff described working three to four 16-hour shifts per week, "Getting 3 hours of sleep takes a toll on your physical and mental health. I'd be tired and grumpy."

Compounding matters, staff from other facilities consistently described a total lack of training and regularly being placed in unsafe situations when they worked at Geneva. In early June 2019, an administrator at the HRC wrote:

> *My understanding was we were going to Geneva to assist with the 2:1 situation with a girl. Staff are now complaining they are being assigned to the most difficult living unit and the Geneva staff hang out in an office. I don't know how anyone is learning anything from our staff being there if that is the case. We are throwing bodies at the problem, and I don't think we are doing it in an organized way.*

Similarly, a Hastings Youth Security Specialist emailed an administrator at the Hastings Regional Center in early June noting that untrained staff from other facilities are often left alone with 16 girls:

> *I have been talking to staff that has endured the misfortune of working in Geneva. The information is they do not give breaks or sometimes no lunch. Our staff have walked into a mess created by administration and are working being subjected to unsafe conditions. With no formal training they are given up to sixteen girls while working by themselves. I would hope you and others are stepping up to ensure safety of your staff. The FOP is aware of the situation and hopefully can fix this mess.*

In his response, the administrator shared those same concerns regarding the lack of training and how the staff from other facilities were being misused:

> *As for the training of our staff who go, I have contacted Geneva's administration multiple times asking for training, reporting that Geneva staff are leaving HRC staff with up to 16 girls while Geneva staff sit in their office. Everything that gets reported to me I contact Geneva's administration immediately to inform them as well as [the OJS Administrator and the DHHS Facilities Director].*

By the early summer 2019 it was also clear that pulling staff from other facilities was also putting a strain on the other DHHS facilities and programs and the system as a whole, not just Geneva. In a series of emails exchanged between multiple administrators and staff from both HRC and YRTC-Geneva the increased tension was notable: "I don't know how he [OJS Administrator] expects us to send people to Geneva when we can't even manage our own program." Administrators at HRC were beginning to get push back from staff assigned to work at the Geneva facility and were concerned that they would lose their own good staff because they were being forced to work at Geneva: "staff are burning out here." One administrator stated that he was "vehemently opposed sending our staff anywhere due to our own staffing shortages." He had decided that he would offer his staff overtime by working at Geneva but he would not force them to work there, even if it meant being disciplined himself, given the conditions at Geneva and the needs of his own facility.

In response to some of the concerns raised, a Youth Counselor Supervisor (YCS) at Geneva wrote an HRC administrator, noting that even with the staffing help from HRC and Whitehall, Geneva was still utilizing mandatory overtime. Instead of offering training, the YCS offered to produce "a quick guide of pertinent rules, procedures and information that staff need to know" which could be shared with HRC staff before they came to Geneva. Perhaps even more concerning, the lack of training continued even as the YCS acknowledged that "Geneva is very different than HRC and we do not have the staffing ratios that HRC has."

In July, the OJS Administrator wrote to HRC administration stating that he anticipated needing less assistance by the end of August because he believed "our vision is much more clear by then."

In an early August email exchange HRC administrators expressed their concern to each other. Stating that "it was worse than ever over there" (meaning Geneva) and that staff were "walking off the job every week."

Failure to Provide Programming and Treatment

The lack of leadership and oversight combined with untrained staff and staffing shortages predictably led to issues with programming and treatment.

According to Nebraska law, juveniles who are committed to OJS and the Youth Rehabilitation and Treatment Centers shall be afforded evidence-based programs and treatment that address behavioral impairments, mental health disorders, drug and alcohol addiction, health and medical needs, education, and counseling services in an individualized plan.[20]

According to YRTC-Geneva's annual reports from 2003-2017[21], historically, YRTC-Geneva's model of treatment included gender responsive interventions in five general areas including:

> Education: The State Board of Education approved the operation of the Geneva North School as an accredited school under the terms of the Special Purpose Agreement. Credits earned by students at Geneva North are transferable to Nebraska schools once the youth is released from the facility;
>
> Recreation Therapy: A wide variety of recreational opportunities were accessible to the youth, including outside basketball courts, and a swimming pool;
>
> Mental Health: YRTC-Geneva utilized evidence-based cognitive behavioral and skill-building programming, to include:
>
> - Aggression Replacement Training (ART)
> - Moral Reconation Therapy (MRT)
> - Thinking for a Change (T4C)
> - Dealing with Anxiety
> - Managing Your Emotions
>
> Individual therapy is also offered to youth with behavioral, mental health and substance abuse needs. Therapists at the YRTC-Geneva are trained in the Adolescent Community

[20] Neb. Rev. Stat. § 43-407.
[21] YRTC-Geneva Annual reports from 2003-2017 are available to the OIG via the Nebraska Library Commission and the current DHHS website.

Reinforcement Approach (ACRA), which is an evidence-based program for substance abuse;

Medical Services: Health Services are coordinated by registered nurses, with an on-site medical services area; and

Religious Programs: The religious programming is offered at the YRTC-Geneva through the Chapel of Hope. General oversight of the Chapel of Hope is provided by a Chapel of Hope Committee comprised of community volunteers. Participation in religious programs by the youth was voluntary.

Prior to her resignation, the YRTC-Geneva Licensed Clinical Psychologist implemented a program specific to YRTC-Geneva youth that incorporated a level system that had scoring elements for the youth's daily behavior. The program was to reinforce consistency and good behavior by the youth in all the areas of programming listed above.

However, when the YRTC-Geneva Clinical Psychologist resigned there was no one on staff who could make sure the levels program was running as intended. That included the Licensed Clinical Psychologist and Program Director at YRTC-Kearney, who was also serving in that role at YRTC-Geneva and splitting time between both facilities. YRTC-Kearney had a different program in place, therefore the psychologist from the Kearney facility was not as familiar with the ins and outs of the YRTC-Geneva program. In addition, the position was no longer full-time at YRTC-Geneva, as the psychologist continued to spend most of his time at YRTC-Kearney. As a result, fidelity to the level program started to deteriorate at the end of 2018. This led to a host of issues for staff, youth, and the facility.

In October 2018, the lack of programming was having clear effects on the girls' behavior. Damage by youth began to escalate including incidents such as:

- Youth climbed an unattended ladder and repositioned a camera;
- The need to replace the cover lens on a single camera three times in one week because of damage; and
- A youth breaking the sprinkler head and flooding sections of LaFlesche cottage.

Staff from other facilities who were required to work at YRTC-Geneva noticed the lack of programming and the effects of such. In February 2019, a Youth Security Supervisor from Hastings emailed a DHHS Administrator:

> *Also, there was minimal interaction with the girls outside of crisis as it appeared the house supervisor and one male staff were running from one problem to the other…One girl stated after the first incident that sometimes due to boredom the girls act out for something to do. It was our observation that the girls had a significant amount of down time that would contribute to the negative interactions they would have with their peers. I think it would be more helpful to have more structure in the evenings and to try to break up some of the down time.*

In February 2019, the youth were voicing their need for programming. A Youth Security Specialist II emailed a DHHS Administrator: "The girls did mention to me that they would like to see some programming for after school. Talking with the girls that do not go to school they would like something to do during school time."

During the month of February, a YRTC-Geneva staff member filed a complaint with DHHS administration alleging that the school staff were treating the youth poorly and as a result the girls were refusing to go to school. At the time, the OJS Administrator suspected that the youth were manipulating the level system in an attempt to get a better daily score. He believed the girls had figured out that the school staff were stricter about the scoring in the levels system, so they would get a better score if they stayed in the cottage and refused to go to school.

The DHHS compliance investigation concluded that Geneva North High School had a toxic environment for the youth which was being created by the school administration and staff's negative interactions with the girls. The investigation determined that less than half of the youth were attending school. The youth who refused to attend school were left in the cottages with limited access to a teacher and school materials. This violated Rule 10 under the Department of Education and could have affected the school's accreditation. The report found that the school and YRTC-Geneva did not have a plan to reintegrate youth back to into the classroom. The report made the recommendations to consult with DHHS human resources as to the actions of the school personnel, provide additional training about de-escalation and trauma-informed care to school administration and staff, and create a plan with school administration and the treatment team to reintegrate youth back into the classroom. As a result of the investigation, a member of the school administration and one member of the professional staff along with a member of facility administration were each put on a performance improvement plan. There was no clear indication that any improvement in the girls' education occurred following the investigation and subsequent performance improvement plans.

By June 2019, the OJS Administrator discontinued the level program at YRTC-Geneva. This was done with no intervention or program ready to replace the system. The youth were receiving little to no programming and treatment, now had no behavior modification plan, and their daily routine and structure was compromised.

Staff pointed out that once the levels were taken away, things went downhill fast, "And the girls, literally, were like we don't have anything to work towards anymore so what's the point? And then they just started destroying everything. Because what's the point? They are working toward nothing."

Staff also talked about the change in programming:

> *When I first started, they had scheduled rec, they'd go off campus. They'd do all sorts of stuff, like arts and crafts, volunteering…they would do so much in a day—one thing after another after another. And then, staff shortages, they had absolutely nothing to do at the end—they didn't have rec anymore, nothing specific. There'd be recs cancelled, or there'd only be open gym and that's it because people would be mandatoried as people called, and God forbid the girls get to go outside, but there was a chance they'd run supposedly.*

The OIG's review of surveillance tapes confirmed the lack of programming. The tapes showed the youth sitting around all day in the last weeks of July, and early August 2019, watching television, playing cards, or trying to find something to do. The staff would not interact with the youth unless one of them was acting out. During an interview one youth stated that when the level program was taken away and replaced with nothing, the girls did not care anymore because they were not earning privileges, and there was no motivation to try. "Staff just ignored everyone, we didn't have anything to do, it was crazy…when you needed attention that's when you misbehaved."

With all of these issues combined, the youth started acting out more and more each day. The staff were not equipped to deal with the behaviors. As camera review confirmed, staff were left to essentially babysit the youth.

The lack of engagement and training by staff led to egregious behavior and risk to the health and well-being of the youth. While observing surveillance videos, there were at least two occasions of a youth falling to the ground and being attended to by other youth. The identified youth suffers from diagnosed pseudo seizures which are stress induced non-epileptic seizures. The video showed that after each sprinkler break, the fire alarm would flash lights, chaos would ensue, and she would have a seizure.

Youth were observed trying to cover the youth's eyes and ears. Staff were observed either ignoring the seizing youth or very minimally engaging in making sure she was okay. During an incident on August 1, other youth immediately attended to her as she was seizing, helping her to the floor in the commons area, as staff watched through the office window. One staff came out of the office but did not engage or help the incapacitated youth or the other girls. Other staff walked past, ignored the medical situation, and focused on water clean-up. All of a sudden, the girls awkwardly stopped and left the youth on the floor. The speculation is that the youth were reminded of the no-touch policy. Though the nurse was seen in the building minutes before, no nurse was seen coming to check on the youth with the medical condition after it appeared she had suffered a seizure.

During an incident on August 7, the same youth seemingly suffered a seizure and two by-standing youth escorted her to a sleeping room. A staff member unlocked the door. Youth attended to her, helped her to the restroom, stayed with her, and checked on her. Staff did not. Later, she was out of her room in the hall by the front office and suffered yet another seizure,

collapsing. A youth signaled for staff. The staff went into a room at end of hall, came out, threw what looked like either a small pillow or ice pack down the hall at the group of youth attending to the afflicted youth as she was laying on the floor, and then went the other way. The youth put a pillow under the girl's head as she lay face down. Again, the youth got the girl up and took her to her room. About five minutes later, the youth escorted her down to the room confinement side of the building where all of the staff were. Staff did nothing to assist or check on the youth's health and well-being. The youth were very distraught by how staff handled their peer's medical condition. (See Appendix C and D).

It became evident that in the absence of programing (most notably, an appropriate behavior management tool such as a level system), staff were utilizing juvenile room confinement practices as a means of attempting to maintain control of the facility and the youth. They were frequently using juvenile room confinement inappropriately and out of alignment with best practices, DHHS policy, and the YRTC-Geneva Operating Memoranda. (See Appendix E).

Based on reviewed facility video footage, daily logbooks, submitted juvenile room confinement reports, and interviews with juveniles placed at YRTC-Geneva at the time of the crisis, the evidence clearly demonstrated instances of room confinement that did not include:

- An appropriate place to sleep;
- Rooms equipped with working light fixtures;
- Access to programing, including educational services;
- Physical exercise;
- Appropriate mental health services;
- The opportunity to return to the general population in the shortest amount of time possible; and,
- The use of juvenile room confinement when youth were potentially suicidal or self-harming.

Youth were required to sleep on a hard raised surface and placed in rooms that had no working lights. While in confinement the youth did not attend school for extended periods of time and did not have contact with school personnel. There appeared to be a heavy reliance on independent "packet work" in lieu of programming and school attendance. Daily log entries by staff and mental health professionals indicated confusion about which youth were potentially suicidal and needed to be more closely monitored. An entry by the psychologist stated that two youth refused to speak with him. He went on to document that one was "enjoying being oppositional" and another woke up only long enough to say she was "fine" – all of this documentation calling into question the quality of mental health services being provided. If contact with staff from medical, clinical, social work, religious or medical units was happening, it was not clearly documented.

On October 1, 2018, the Hotline received an intake alleging physical abuse to a youth by YRTC-Geneva staff. An Out of Home Assessment was conducted by a Children and Family Services Specialist (CFSS). When the CFSS went to speak with the girl regarding the allegations at YRTC-Geneva, she was suicidal and confined in a room. The CFSS wrote in the Out of Home

Assessment that she, "observed in the room, that there was exposed wires, metal from the door, and the floor was just concrete. The walls had drywall missing from it, and paint was chipping. [That she] observed the room to be hazardous not only for physical health but also mental health. Not safe for either youth or staff." It is unknown what cottage the youth was housed in at the time of the assessment.

On August 5, 2019, according to video surveillance, numerous youth came in and out of the isolation rooms in Burroughs Cottage. Some of the isolation rooms had cameras and others did not. Some rooms had lights, others did not. Some youth were given mattresses and blankets, others were not. A related concern was also noted as incidents of juvenile room confinement were being observed on video surveillance – specifically an incident where two male DAS employees (maintenance) went into one of the youth's isolation rooms without YRTC staff present. One of the male maintenance men left the other alone with the youth in the confinement room. The youth was sitting on the bed while the male DAS employee was speaking with her. It is unknown what the DAS employee was saying to the youth. During this period two YRTC staff walked by but did not intervene. After a few minutes, the male DAS employee left the room and shut the door. Approximately 30 minutes later the youth took a string and tied it around her neck and put a blanket over her head. During a routine check, a staff member looked into the door window, saw the youth and intervened. Staff responded by removing everything from the room, putting shackles on her wrists while her hands were behind her back, and then leaving the youth there alone—in the dark. Almost an hour later, staff removed the shackles but kept the youth isolated in juvenile room confinement.

The lack of programming and treatment combined with, and exacerbated by, the lack of staffing and the absence of key positions proved to be a devastating combination. The level program that was implemented in 2017 was nonexistent by the summer of 2019. The youth were not receiving any meaningful programming or mental health treatment. During the school year many youth were not attending full-time. With all of these issues compounding each other, there was a predictably negative effect on the youths' behavior. The staff were not equipped to deal with these behaviors and the result was damage to the cottages and the eventual YRTC-Geneva closure.

The Youth were Living in an Uninhabitable Environment

All of the issues with leadership, staffing, programming, and treatment were compounded by the fact that these issues were all happening in facilities that were deteriorating.

The YRTC-Geneva campus is comprised of four cottages: LaFlesche, Burroughs, Sandoz, and Sacajawea. The campus also has an administration building that includes a gym, indoor swimming pool, and classrooms; a food service building; a chapel; and a maintenance building.

LaFlesche Cottage was important to the YRTC-Geneva program, because it housed youth with higher behavioral health needs. The cottage had two pods, A and B, with 10 rooms in each pod. Burroughs, Sandoz, and Sacajawea were used to house the remainder of the girls. In addition to having youth rooms and living quarters, Burroughs had the rooms specifically utilized for juvenile room confinement.

All of the issues with leadership and staffing, and the lack of programming and treatment, resulted in an increase in the frequency and duration of negative behaviors by the youth. The facilities were being repeatedly damaged, as evidenced by internal DAS emails sent as early as October 2018:

> *This is the third day in a row of severe vandalism. Last evening a girl tore the camera off of the ceiling. The evening before we were called in because a girl in confinement was tearing the desk light off of the wall, and using the pieces to self-harm. Monday evening a girl threw a VCR or DVD player (not sure which) into a TV, and another girl kicked a hole in the library door. It is not my place to instruct DHHS staff how to stop this type of behavior, however something needs to happen.*
>
> *I am highly frustrated, that these girls are still being allowed to continuously destroy property. We do not have a plan in place yet for emergency repair work to be paid for, or materials to be ordered. . . This entire week (starting last Sunday) has been focused on damage control from the Sprinkler head disaster in LaFlesche.*

Since LaFlesche was used to house the girls with higher behavioral issues, the loss of LaFlesche was significant. The loss was not due only to damage by the girls. The LaFlesche cottage had multiple mechanical issues arise including plumbing and sewer issues. LaFlesche was shut down completely in early 2019. In 2017, DAS took over maintenance responsibilities for all state run facilities, therefore YRTC-Geneva would have to go through DAS for any repair work or maintenance. DHHS attempted to get LaFlesche cottage repaired through DAS through a series of discussions and meetings, but ultimately, LaFlesche was never repaired before the August 2019 closure.

The loss of LaFlesche created a housing issue for administration that contributed to the spiraling decline of the facility. Initially leadership appeared to struggle with making a plan for where to house youth considered to have higher behavioral needs as their main cottage was rendered unusable. When accompanied by the damage done to the remaining three cottages, leadership seemed unable to problem solve the housing issue. In an email to the DHHS Facilities Director, the OJS Administrator stated:

> *We have just under a half dozen rooms in Sacajawea that girls can't sleep in due to kicking holes in the walls. We have to be able to fix those rooms with something more than just drywall. Because of those rooms being that way, we are having to have girls sleep in Burroughs, with the most high risk girls, just to give them an area to sleep in. I know those girls have caused a lot of damage but we need to have more than 2.5 buildings for occupancy.*

In addition, the lack of programming and treatment and resulting behavior issues led to the deterioration of the buildings at a fast rate. The youth started to break sprinklers within the cottages. Each sprinkler break took hours to clean up and in some instances shut down portions

of the building or the whole building for up to a few hours to a few days. After the first sprinkler break in October 2018, there were 12 sprinkler breaks from May 28, 2019 to August 8, 2019. DHHS did not take any known proactive measures to prevent or stop these sprinkler breaks from happening.

DHHS and DAS attempted to repair damages to the buildings, like holes in the walls, lights in the rooms, broken surveillance cameras, and mold created by the water damage, but were unable to do so effectively for a multitude of reasons. The deterioration of the cottages caused even more angst and disruptive behaviors from the youth. The failure to address the deteriorating buildings led to unsafe living conditions for the youth and therefore they were moved to YRTC-Kearney on August 19, 2019.

In the months prior to the crisis at YRTC-Geneva, the deterioration of the cottages significantly impacted the safety of the youth and their overall well-being. The facilities at the YRTCs, as with most facilities, are integral to the programming and can have a profound effect on the youth served. These facilities are, or should, be built and maintained with the needs of the youth they serve in mind. As the OJS administrator stressed in an email to the DHHS Facilities Director: "There is a psychological component to this as well. If girls continue to live in areas that are damaged/look rough, they act how their surroundings look."

It is indisputable that the girls were causing the damage in the cottages. But the failure to address the girls' behavior highlights the failure of the leadership at DHHS to fulfill their statutory mandate to provide treatment and programming to the youth it serves or at the very least to occupy the youth in a productive and positive way. It is predictable that the more these youth are bored and not given the opportunity to improve themselves, the more likely it is they will act out. Leadership's narrow or myopic focus resulted in viewing the incidents of damage in isolation, giving the majority of their attention to individual repairs and assigning blame to a few youth from a specific segment of their population. They failed to look at the program as a whole and determine the root cause of the escalating negative behaviors displayed by the youth. This despite the fact that this group of professionals were considered and expected to be experts in the field of providing rehabilitation and treatment services to a population of youth with known trauma histories, accompanied with behavioral and social impairments consistent with the very behavior they were displaying.

Youth placed in the care and custody of DHHS for treatment and rehabilitation at YRTC-Geneva were exposed to varying levels of trauma during their commitment to the facility.

The failure of leadership led to management, staffing and training issues, lack of programming and treatment, and the deterioration of the cottages. As a result, the youth at YRTC-Geneva experienced varying levels of trauma.

Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope or integrate the emotions involved with that experience. Re-traumatization occurs when a situation, interaction, or environmental factor reproduces events or dynamics of prior trauma and triggers feelings and reactions associated with the original traumas.

Empirical data and research has established that adolescents with histories of ACEs and trauma often enter the child welfare and juvenile justice systems. Re-traumatization occurs when those systems are either not trauma-informed or not providing a truly trauma-informed environment in conjunction with trauma-informed programming. It can happen in obvious ways such as using restraints on a youth who has been restrained and raped, or in less obvious ways, such as shutting the door to an office in an effort to protect privacy which may trigger the youth's memory of an abuser shutting the door prior to abusing her. This is not to suggest that the YRTC-Geneva staff were aware that their behavior or the situation was replicating something about the youth's trauma history or that it was being done intentionally. Re-traumatization is often unintentional.

During an interview with a youth she said, "That's when everything went downhill when they took levels away and put us all in bright orange—it just made me feel like I'm locked up in a prison plus we couldn't go outside. They wouldn't let us on walks even." These changes affected how the youth perceived their environment and made them feel like they were in prison.

Another youth talked about her room confinement experience, "I'd stay in there 5-6 days. No one ever comes to see me in there. When I get frustrated, I harm myself."

The youth experienced "Sanctuary Harm" in that many of them had experienced severe stressors prior to placement at YRTC-Geneva and then encountered more trauma in what should have been a supportive and protective environment. Sanctuary harm is inclusive of events involving insensitive, inappropriate, neglectful or abusive actions by staff or others which takes place within a facility meant to provide care for an individual. These actions produce or exacerbate symptoms from prior trauma. As a result, the previously traumatized person experiences a whole other additional layer of trauma. Trauma on top of trauma. Causing rage, despair, and a profound lack of trust in anything or anybody having to do with the system meant to help them. Experiencing, witnessing or being confronted with actual or perceived threats of serious harm or injury to self or others can induce intense fear, helplessness, and disorganized or agitated behavior.[22]

During interviews with the youth, several scenarios were mentioned where the youth experienced severe stressors, that were confirmed throughout this investigation. One youth described how she had been through a lot of trauma in her life, and then during the summer there was "no structure and nothing to work towards." Many of the youth interviewed were convinced that "this is a set-up" and that YRTC-Geneva was purposefully trying to get them to fail. They had no idea what was going on and nothing seemed right—levels were taken away, there was no outdoor time, no programming, no groups, and therapy sporadically. They were at a loss about what they were expected to do to be successful.

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[22] Mueser K, Goodman LA, Trumbetta SL,et al: Trauma and posttraumatic stress dis-order in severe mental illness. Journal of Consulting and Clinical Psychology 66:493–499, 1998.

The lack of action by staff in response to the youth experiencing seizures was also an example of a severe stressor the youth described. They talked about when she had seizures, their view was that the staff only cared about cleaning up the building, not helping a youth who needed medical attention. The youth described how they had to take over caring for their peer because the staff would not. No staff would make sure the seizing youth was okay, but rather that was up to the youth. One girl reported getting in trouble for helping the youth and was told to leave her alone.

After the August 8th pipe break in Sacajawea cottage, the youth were required to stay in the gym during the day and were taken back to the cottage at night to sleep. The conditions of the cottage were deplorable. It smelled like mold, everything was wet, even with multiple fans running, wires were hanging from the ceiling, and the walls had holes in them. The youth expressed their concerns to staff. Some youth were getting physically sick from the odor. One youth had asthma and another was pregnant. The youth perceived this environment as a threat and acted out in an attempt to force the staff to move them. The staff continued to have the girls sleep in the cottage. One youth described it this way, "There was black mold everywhere, and it was so bad that [we] weren't even allowed in there during the day, so at night there were girls throwing up, so they turned up. It's because all those girls were super sick, and that wasn't okay."

There is no evidence that DHHS made these decisions to intentionally harm the youth, but it is clear after interviewing all the youth, many of them were exposed to or experienced some sort of traumatization or re-traumatization during their commitment at YRTC-Geneva.

RECOMMENDATIONS

The Ombuds and OIG acknowledge that much has changed at the Youth Rehabilitation and Treatment Centers (YRTCs) in the past year. There have been two different business plans proposed by DHHS altering the structure of the system. In addition, due to legislation, DHHS is now required to create a five-year plan for the YRTCs which could change the structure further. As a result, the following recommendations are not directed specifically to the YRTC-Geneva facility, but rather these recommendations are directed to the YRTC system in general as it exists today and should be considered in whatever plan or system is developed by DHHS with regard to the YRTCs.

Six recommendations were made to DHHS based on this investigation. DHHS accepted five recommendations and rejected one. DHHS's individual response is included after each recommendation. (See Appendix F).

1. **Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.**

Under Nebraska law, the YRTCs are under the jurisdiction of the Office of Juvenile Services (OJS).[23] According to Neb. Rev. Stat. § 81-3116 the Division of Children and Family Services (CFS) is responsible for administering the OJS program.

In 2018, according to the DHHS organization chart, the Office of Juvenile Services was moved to the Division of Behavior Health, with the OJS Administrator reporting directly to the newly created position of DHHS Facilities Director, not the CFS Director. The Division of Behavior Health organization chart showed OJS supervising the Hastings Regional Center. The YRTCs were not included in the organization chart. The March 2019 Division of Behavior Health organization chart indicated that OJS was expanded to include the Whitehall facility, again YRTCs were not specifically listed. These changes were made without changes in statute. By law, OJS and the YRTCs remain under the Division of Children and Family Services.

Moving OJS, thus the YRTCs, from under Children and Family Services to the Division of Behavior Health may be a logical choice considering OJS's statutory mandate to provide programs and treatment services that address behavioral impairments, severe emotional disturbances, sex offender behaviors, and other mental health or psychiatric disorders. However, it is unclear if the YRTCs were included in Behavior Health as the facilities were not present on the organizational chart anywhere. The YRTC-Kearney Annual Report for 2019-2020 conflicts with the organizational chart referenced above. It indicates that the YRTCs were under the Division of Children and Family Services.

[23] Neb Rev Stat §43-404.

Currently, the Office of Juvenile Services is not represented within the Division of Behavior Health or Children and Family Services. YRTCs are not present in either of the Divisions as well. DHHS is required by law to have an OJS Administrator. If the OJS Administrator position is vacant, it should still be represented within the DHHS organizational chart.

The changing organization of the OJS program and administrator position creates confusion as to how OJS functions and is administered within DHHS in general. It is unclear why DHHS has conflicting information about where the YRTCs are located within the agency and why there is an absence of OJS in any organizational chart.

The foundational issue surrounding where OJS is located within DHHS, and who supervises OJS, raises concern surrounding the chain of command, oversight, and management of the YRTCs.

It is recommended DHHS align all state-run juvenile programs and facilities within the same DHHS Division. The OIG recommends DHHS clarifies where OJS is located within the Department and update the organization chart to include OJS and YRTCs. In order to do so, DHHS may have to ask the Nebraska Legislature for statutory changes.

DHHS RESPONSE: Accept

DHHS would accept this recommendation and offers the following:

The Office of Juvenile Services (OJS) provides supervision to all of the 24/7 youth facilities: Whitehall, YRTC-Kearney, YRTC-Geneva, the Lincoln youth facility and the Hastings youth facility. Whitehall is licensed as a Psychiatric Residential Treatment Facility (PRTF) and falls under the Behavioral Health (BH) division. The Youth Rehabilitation and Treatment Center facilities, plus the Lincoln and Hastings facilities, fall under the Children and Family Services (CFS) division.

In order to provide programming structure, staffing support and operational consistency, the Chief Operating Officer (COO) provides direct supervision to the OJS administrator. The COO works in collaboration with the Director of Children and Family Services and the Director of Behavioral Health. The umbrella oversight methodology, while spanning both CFS and BH, allows for standardization, stabilization and consistency across all DHHS-provided youth services.

An updated organizational chart, including the OJS administrator position, is currently under review and will be released upon approval to provide clarification.

2. **Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.**

YRTC-Geneva and YRTC-Kearney are accredited through the American Correctional Association (ACA). The ACA has specific standards facilities must follow in order to be accredited. In June 2017, YRTC-Kearney passed the Standard Compliance Reaccreditation Audit with the ACA. In August 2017, YRTC-Geneva passed the audit. The YRTC-Lincoln facility which is housed in Lancaster County's juvenile detention facility is currently not accredited.

YRTC-Geneva and YRTC-Kearney are also members of the Performance-Based Standards (PbS) Project, and according to DHHS's website, the YRTC-Lincoln facility will also be participating in PbS, a national quality assurance and coaching program for juvenile correctional facilities associated with the Council for Juvenile Correctional Administrators. Comprehensive reviews and analysis occur every six months and compare data at individual facilities on specific measures to national averages. The PbS Project does not conduct onsite inspections or audits.

All YRTC facilities are required to be in compliance with PREA regulations. In November 2018, YRTC-Geneva and YRTC-Kearney passed the PREA audit. YRTC-Lincoln has not had an audit.

ACA standards, PbS, and PREA are the only external compliance measures YRTCs currently have. The standards are correctional based. The ACA and PREA onsite audits are only conducted every three years.

Additional standards and oversight of a *different* type is necessary for the YRTCs. The Division of Public Health's Licensing program enforces regulations and standards for residential child caring agencies. Licensing standards for a child caring agency include but are not limited to the following: staff qualifications and training, staff to youth ratios, facility and building requirements, health and safety requirements, discipline rules, and record keeping. This type of oversight provides for a more robust review, monitoring, and supervision of YRTC programs, activities, and policy.

These regulations and standards are to ensure the safety and well-being of youth placed in out of home care. Division of Public Health issues licenses, conducts annual inspections and complaint investigations, among other duties.

Licensing is essential to care facilities because it is a way to ensure that standards for human health, safety, and care are appropriately met. Anyone who wishes to operate a child placement facility in Nebraska must be licensed. For example, Whitehall is licensed as a psychiatric residential treatment facility. However, the YRTCs, which were created to provide care, treatment, and education to youth in Nebraska, are not licensed facilities.

If YRTC-Geneva had been licensed, some issues may have been caught and addressed sooner. The October 2018 Out of Home Assessment by DHHS related to a Hotline call by one of the youth is a good example. As noted by the CFSS who conducted the Out of Home Assessment, the room where the youth was confined was observed to be "hazardous not only for the physical health but also mental health" and was not safe "for either youth or staff." If the YRTCs had

been licensed, the Division of Public Health would have been notified of the deplorable conditions at YRTC-Geneva and would have completed an investigation.

It is recommend all YRTC facilities become licensed through Division of Public Health as a Residential Child Caring Agency. The YRTC-Geneva crisis demonstrated the need for such licensing and oversight. It is important that the facilities are physically maintained in such a manner as to meet the obligation to the youth to provide for their safety and wellbeing.

DHHS Response: Reject

DHHS would respectfully decline this recommendation and offers the following:

DHHS is currently in the process of constructing a 5-year plan for the YRTCs. As a part of this review, there are discussions on the differences of several accreditation standards – American Correctional Association (ACA), Prison Rape Elimination Act (PREA), The Joint Commission (TJC) and Commission on the Accreditation of Rehabilitation Facilities (CARF) – and what is most appropriate now, and what will be most applicable and attainable in the future. Residential Child Caring Agencies standards could be added to the discussion to see if this would be an applicable license that would bring value for the YRTCs.

Licensure is a process whereby an organization can hold itself accountable to the standards set as a best practice. A premise is that adequate facilities, staffing and programming are provided in such a manner that the youth receiving care would obtain maximum benefit from the highest and best use of each of the three primary resources. DHHS took steps in 2020 to assess, improve and enhance each of these three primary resources, such that the services rendered could meet any best practice standard of care. At this time, the PRTF facilities will be accredited by TJC, utilized by healthcare and residential services around the globe. Facility leadership is also exploring the application of CARF standards to determine if this would bring the YRTCs value. Ultimately, any credentialing process necessitates additional resources and multiple overlapping credentialing processes are perceived to be redundant.

3. Implement a fully digital case management system

As required in Neb Rev Stat §43-406(4), it is recommend that DHHS Central Administration implement a digital case management system that would generate all documents electronically, making access to records faster and more transparent.

A digital case management system will assist YRTC staff when youth are moved within the YRTC system. For example, when the youth were relocated from YRTC-Geneva to YRTC-Kearney a considerable amount of time and effort was expended to transport paper charts to the Kearney facility and then to integrate the records into Kearney's file keeping system. Had the records been kept in a digital case management system, the YRTC-Kearney staff would have had complete, thorough and timely accesses to critical information about the youth as they worked to integrate them into YRTC-Kearney programs and services.

DHHS Central Administration should immediately commit resources to digitalize all existing and future facility records (including but not limited to youth intakes and evaluations, critical incidents, therapy notes, medical records, grievances and living unit logs) to make things more efficient for all YRTC staff and administrators. YRTCs currently use Salesforce to collect data, but it is not a case management system. Ensuring that Central Administration and authorized entities have real-time access to such records will enhance needed real-time oversight.

DHHS Response: Accept

DHHS would accept this recommendation and offers the following:

An electronic case management system allows for improved access, enhanced data sharing, increased safety and improved efficiency. In addition, an electronic case management system allows for clinical reviews of a youth's progress toward treatment goals and the ability to document modifications as care progresses. It also should allow for storage space economies and require less staff time to receive, store, track and retrieve records.

DHHS currently utilizes the Avatar system for digital case management. The system also allows for a structured data sets and analytics that are used for reporting and to improve operations. Until 2020, YRTC facilities used stand-alone systems, but Avatar is now used across all DHHS residential facilities. DHHS has targeted March 1, 2021, as the go-live date for full-functionality of Avatar within the youth facilities. Modifications and enhancements for added value are under review.

4. **Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.**

As evidence in the findings, Geneva's deterioration was due in part to key leadership positions being left vacant or inappropriately resourced when the duties and responsibilities of those positions were spread over more than one facility and those facilities were often geographically distant and programmatically diverse. In addition, key front-line staffing was not maintained. The YRTCs cannot appropriately and successfully serve the youth in their care without appropriate staffing at all levels.

As DHHS moves the YRTCs to a rehabilitation and treatment model, and as part of their planning effort, DHHS should assess all YRTC positions to determine their title, role, function, duties, and workload within a rehabilitative and treatment structure. DHHS should prepare a report that includes but is not limited to; workforce analysis, identified gaps within the YRTC workforce and an outline of the process they will take to retain, hire and properly train all employees.

It is imperative for the YRTC system to have well defined positions that are fully staffed with manageable workloads. As evidenced in the findings, many key YRTC positions were over extended and eventually left vacant. In addition, some existing positions do not fit into the rehabilitation and treatment model. For example, front line staff positions are currently titled "Youth Security Specialist" or "Officer of the Day" which mimics a correctional facility structure.

It is recommended that after conducting the detailed analysis of the YRTC workforce, DHHS publically report the analysis including their plan to implement appropriate staffing across the YRTC system in a timely manner.

DHHS Response: Accept

DHHS would accept this recommendation and offers the following:

DHHS remains committed to hiring, training and retaining quality staff at their facilities. The COO remains diligent in the goal of hiring the best, investing in the training and continuing education of staff, and engaging staff to bring their best each day to the care duties of our youth. Human Resources and the YRTCs are currently engaged in discussions of the entry level roles and their descriptors.

DHHS, through its consultative relationship with MYSI (Missouri Youth Services Institute), is reviewing the roles and responsibilities of positions within the care continuum. Each facility will benefit from this review for the types of staff roles and the duties of those roles.

Staffing ratios are utilized as a guide to allow the staff to meet minimum established benchmarks for quality care, and are authorized to flex up staffing if additional care is required to prevent quality, risk, or safety issues with the youth. The outcome of these efforts is a staffing plan for the appropriate number of budgeted positions across facilities to meet the care needs of our youth.

5. **Implement evidence-based programing consistently throughout the YRTC system.**

Nebraska Revised Statute §43-407 requires the YRTC system to provide evidence-based programing structured to deliver the academic and life skills necessary for a juvenile to successfully return to his or her home and community upon release. Programs and treatment services shall address behavioral impairments, severe emotional disturbances, sex offender behaviors, and other mental health or psychiatric disorders; drug and alcohol addiction; health and medical needs; education, special education, and related services; individual, group, and family counseling services.

Based on the currently proposed business plan, the youth committed to the YRTC system could potentially be placed at multiple YRTC facilities. It is imperative that each facility in the YRTC system have consistent evidenced-based programming.

In addition, the evidenced-based programing should be coupled with a trauma-responsive environment, as discussed below. To accomplish this, DHHS will need to deliberately provide trauma based training to YRTC administration and staff on a consistent basis.

DHHS Response: Accept

DHHS would accept this recommendation and offers the following:

From our time-tested utilization of Cognitive Behavioral Therapies, Rational Emotive Therapy, and Motivational Interviewing, to early adoption of trauma informed care in 2014, to the more recent implementation of the MYSI model of care, DHHS remains committed to full utilization of these evidence-based practices to provide youth with the best opportunity to maximize their time in care with DHHS. Additional clinical supervision roles have been added to the care continuum to allow for more direct clinical participation and oversight of the youth care process.

6. Implement a Trauma-Responsive environment across the YRTC system.

The YRTCs in general endeavor to operate as "trauma-informed" facilities — acknowledging the potential suffered trauma in both treatment philosophy and methodology. As defined by the Substance Abuse and Mental Health Services Administration, a trauma-informed environment is one that realizes the widespread impact of trauma; recognizes the signs and symptoms of trauma in clients and other stakeholders; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and actively resists re-traumatization within their system.

Within the trauma-informed setting exists an additional component of "trauma-sensitivity" which applies to staff who are do not have the knowledge, education level or training to implement specific Trauma Informed Care (TIC) practices or programs in a therapeutic setting. The trauma-sensitive component facilitates greater awareness of trauma and certain TIC applications that can enhance the services that are provided by those staff.[24] At the time of the crisis, YRTC-Geneva was falling short in its operation as a trauma-informed facility, including the practice of trauma-sensitivity by staff.

It is recommended DHHS go beyond providing trauma-informed services to cultivating a trauma responsive environment across the YRTC system that includes the use of research based trauma-informed programs, and all levels of staff trained in trauma-sensitivity. Trauma responsive organizations seeks to anticipate the potential existence of trauma so that its aftermath can be appropriately addressed at all levels of an organization. A trauma responsive organization operates from the position that everyone they serve has a trauma history.

According to Dr. Stephanie S. Covington and Dr. Sandra L. Bloom, well established specialists in the development and implementation of gender-responsive and trauma-informed services in both the public and private sectors, becoming trauma-responsive requires a complete rethinking of how services are provided. Each interaction within a treatment facility must be fully and carefully considered. Covington and Bloom argue that trauma-responsive organizations can only be built when everyone, all of the stakeholders, come together and agree to shared language and values for talking about, and attempt to lessen the impact of, trauma in the lives the organization touches. Covington and Bloom state that they mean everyone: the maintenance staff, the administrative team, the board members — if a person is involved in the operation of a facility in any way, no matter how small or seemingly inconsequential to the overall mission, he or she needs to buy into the organization's trauma-responsive philosophy. They acknowledge that it isn't easy, but state that it is essential for the successful application of trauma-responsive practices.

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[24] Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

While many organizations are trauma-informed, becoming trauma-responsive means looking at every aspect of an organization's programming, environment, language, and values and involving all staff in better serving clients who have experienced trauma. Accepting YRTCs as being trauma-informed is not sufficient if we are seeking to maximize the effectiveness of their charge to provide treatment and rehabilitation. It is recommend DHHS implement a trauma-responsive environment throughout the YRTC system. To accomplish this, DHHS will need to deliberately provide trauma-based training to YRTC administration and staff on a consistent basis.

DHHS Response: Accept

> *DHHS would accept this recommendation and offers the following:*
>
> *DHHS began implementation of trauma informed care system training and utilization in 2014. This training is now a standard component of the care that is provided to youth in the YRTC system. Many, if not most, of the youth that come to DHHS have experienced significant trauma, as evidenced by their admission diagnosis and needing to receive a level of care that requires court involvement and commitment. The staff are trained and receive refreshed training on how to maintain a trauma responsive environment of care. In December of 2019 the YRTCs began including an additional resource called Trauma Affect Regulations: Guide for Education and Therapy (TARGET). This best practice is yet another trauma-responsive tool for clinical use. The training has been well received by staff. Individual employee ongoing training needs are assessed and evaluated annually.*

Appendices

Appendix A: August 16, 2019 letter to CEO Smith from IG Rogers

Appendix B: August 29, 2019 response letter to IG Rogers from CEO Smith

Appendix C: November 9, 2019 [redacted] letter to CEO Smith from IG Rogers

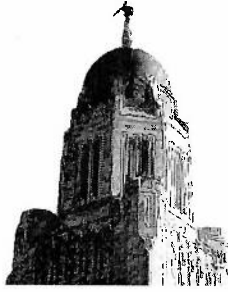
Appendix D: December 12, 2019 [redacted] response letter to IG Rogers from Bo Botelho

Appendix E: Juvenile Room Confinement Policy and Procedure

Appendix F: January 4, 2021 letter and recommendations response from CEO Smith

Appendix A: August 16, 2019 letter to CEO Smith from IG Rogers

JULIE L. ROGERS
Inspector General



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August 16, 2019

Dannette R. Smith
Chief Executive Officer
Department of Health and Human Services
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RE: Youth Rehabilitation and Treatment Center - Geneva

Dear CEO Smith,

First, thank you for reaching out and meeting with Jerall Moreland, Deputy Public Counsel for Institutions, and me on Monday morning, August 12, 2019, to explain to us in person what was happening at the Youth Rehabilitation and Treatment Center—Geneva (YRTC-G), the urgency of the situation, and your immediate plans to alleviate the problems. As you've communicated to me over the past several months, transparency is very important to you, and by taking the initiative to communicate the concerns at the YRTC-G and your plans to deal with the problems showed that you are serious about that promise of transparency. I very much appreciate that.

The information you and Dr. Janine Fromm, DHHS Executive Medical Officer, provided about what you referred to as the current "Three-Tiered Problem" includes:

1. The acuity of the girls placed there,
2. The staffing challenges (lack of staff leading to overtime and double shifts), and
3. The disrepair of the facility (water damage, holes in walls, and the like).

The plan at that time was that a "Change of Location" would be filed in each corresponding juvenile court case, and girls would begin to be transferred off of the YRTC-G campus starting at 1 p.m. and those transferred would get YRTC programming at the alternate locations. Only four girls were transported to the Lancaster County Youth Services Center that day. The goal was to get the census down to about 20 girls in order to safely manage the population.

On Tuesday, August 13, 2019, Mr. Moreland and I visited the Lancaster County Youth Services Center and spoke with several people including each of the four girls transferred there. The youth did

not know why they were at the detention center at that time. Youth reported unsanitary living conditions at YRTC-G including water damage, mold, holes in walls, and exposed wires, but also a lack of programming, including no behavioral management program—what they referred to as the "Levels". They described their days as sitting in the gym and either playing basketball, playing spades or sleeping from 7 a.m. to 9 p.m. At the detention center, the youth were receiving the same services as other youth in detention.

It does not appear that any "Change of Location" was ever filed in any of the juvenile cases.

On August 14, 2019, Mr. Moreland and I went to YRTC-G and toured the facility and every living unit with DHHS staff present. The OIG confirmed that only two living units (out of four) are being utilized and witnessed the unsanitary, questionable, and unsafe living conditions the youth have been exposed to. On that day, the on-campus census was 24 girls, with one girl on a day pass, coming back in the evening. Others were on furlough status. The OIG also confirmed that there is little to no programming taking place at the current time due to a number of factors, but mostly due to lack of staff, lack of staff training, and lack of appropriate physical space.

On August 15, 2019, (yesterday) you and I spoke about the need to get professionals (like health inspectors) into the two currently utilized living units to assess if it is truly safe for the girls and staff to be in those buildings.

Also yesterday, the OIG met with a parent of one of the youth who was transported to the detention center. The parent voiced concerns for the child's safety and well-being. The parent had yet to be informed by DHHS officials about exactly what has happened to her daughter and any plan for her daughter moving forward.

A court hearing was held, and the four girls at the detention center were ordered to be transported back to the YRTC-G. By evening, they were moved to the YRTC in Kearney. It is my understanding there will be a meeting with you and the families of those four girls later today. I will plan to attend.

Based on the conversations with multiple people since Monday, other than the absolute deterioration of the living units at YRTC-G, allegations of neglect have surfaced: inappropriate use of room confinement, over-medicating youth, youth not getting her psychotropic meds prescribed before arriving at the YRTC-G, lack of mental health care, lack of programming, lack of physical activity, PREA violations, and staff shortages. Some of these issues were raised by you on Monday morning and some were not.

DHHS currently has the care, custody, and control of over 30 youth committed to YRTC-G. The OIG firmly suggests DHHS take urgent and immediate action for the safety and well-being of **all** of the youth placed there. The OIG would suggest DHHS take the following actions immediately:

1. Create alternate plans for where the girls will safely go in the event one or two of the current living units must be shut down.
2. Contact all legal parties (parents, attorneys, county attorneys, probation officers) to apprise them of the situation.
3. Work with all parties to coordinate plans and hearings for a change in placement.
4. Notify all judges DHHS cannot serve any youth at the YRTC-G campus until all issues have been addressed.

5. Contact any and all experts available to you (Public Health Licensing Specialist, Medicaid, DAS, mold removal experts, etc.) to fully assess the safety and conditions of the living units, to address the facility issues, and form a working plan. This includes closely and frequently communicating with the Department of Administrative Services.
6. Review and analyze the current programming at YRTC-G.
7. Implement staffing plans including the training and re-training of current staff.
8. Review and analyze the current mental health program.
9. Formulate a plan that will improve behavioral programming, mental health programming, and staffing.

If the OIG can be a resource to DHHS during this time, please reach out to me or our office.

Very sincerely yours,

Julie L. Rogers

CC: Legislative Council

Appendix B: August 29, 2019 letter to IG Rogers from CEO Smith

August 29, 2019

Julie L. Rogers
Office of the Inspector General of Child Welfare
State Capitol, P.O. Box 94604
Lincoln, NE 68509

Dear Ms. Rogers:

Thank you for your letter dated August 16, 2019 outlining your concerns about the condition and placement of youth at the Youth Rehabilitation and Treatment Center – Geneva (YRTC-G). I take comfort in knowing we share these concerns so that we may continue working together toward a solution that is in the best interest of the youth and families served by YRTC-G.

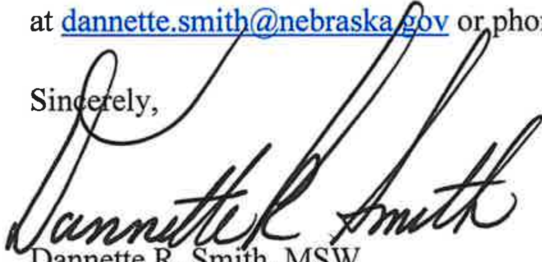
I was surprised to receive your letter considering I have been so transparent with you and others, continuously discussing the acuity of the girls at YRTC-G, the programming, and the facility, as you have acknowledged in your letter. We have discussed these issues many times in the last several months. I discussed my concerns with you in early June after leadership transitions at the facility. You attended a meeting on July 9, 2019 to talk about this very matter. I have also been on the phone with you frequently as the situation has evolved, discussing solutions and providing updates. The concerns raised are obviously not a new issue.

While I had hoped to rebuild the program before taking the present steps, the deteriorating condition and current staffing challenges made it necessary to act quickly because there was simply not time to fix the issues before relocating the youth who had been placed at YRTC-G. As you are aware, on Monday, August 19, 2019, all 24 girls were moved from the Geneva facility to YRTC-Kearney and are receiving appropriate care, programming, and security for their needs.

Nebraska law does not require a court order to change location once a child has been committed to the Office of Juvenile Services. As we did with the four girls placed at the Lancaster County Youth Services Center, notice was provided to the juvenile court judge, the legal parties, and the parent/guardian at the time the juveniles were relocated. DHHS has issued a press release notifying the public that the juveniles will be served through YRTC-Kearney to allow DAS access to the Geneva campus.

As we continue to communicate freely and regularly, I will ensure that you are kept up to date on the actions DHHS is taking to address this situation. I assure you that I will remain open and transparent. I know I can count on you to work with DHHS to help ensure Nebraska's youth continue to receive the care and support they need. Should you have any questions please do not hesitate to contact me by email at dannette.smith@nebraska.gov or phone at (402) 471-9433.

Sincerely,

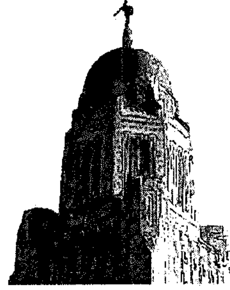


Dannette R. Smith, MSW
Chief Executive Officer
Department of Health and Human Services

cc: Legislative Council

Appendix C: November 9, 2019 [redacted] letter to CEO Smith from IG Rogers

JULIE L. ROGERS
Inspector General



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

SENT VIA E-MAIL

November 9, 2019

Dannette R. Smith
Chief Executive Officer
Department of Health and Human Services
301 Centennial Mall South, P.O. Box 95026
Lincoln, NE 68509

RE: Youth Rehabilitation and Treatment Center – Geneva Staff Treatment of Youth [redacted]

Dear CEO Smith,

As you are aware, our office is conducting an investigation into conditions at the Youth Rehabilitation and Treatment Center—Geneva (YRTC-G). Part of that investigation included spending much of the past week at the YRTC-G reviewing camera video of some incidents that happened over the summer, namely water sprinklers and pipes being broken. Though those reviews will be covered in our formal report, I thought it important to communicate to you before the final written report what we observed in our video review yesterday.

[redacted] is a youth who suffers from diagnosed pseudo seizures—non-epileptic seizures that are stress induced. In the spring of this year, because [redacted] had suffered from a longer seizure than usual, she was taken to the Fillmore County Hospital for the condition, as documented in her YRTC-G medical file.

During our video review of two water sprinkler breaks in Burroughs room confinement hallway—one on Thursday, August 1 at 1:17 p.m. and another on Wednesday, August 7 at 7:53 p.m.—[redacted] is observed in the other part of the building seemingly falling to the ground and suffering from seizures. One on August 1 (1:18 p.m.) and two on August 7 (7:54 p.m. and 8:20 p.m.).

Girls were observed trying to cover [redacted]'s eyes and ears. The video showed that after each sprinkler break, the fire alarm would flash lights. Staff were observed either ignoring [redacted] or very minimally engaging in making sure she was okay. During the August 1 incident, other youth

immediately attended to [redacted]i, helping her to the floor in the commons area, as staff watched through the office window. One staff came out of the office, but didn't engage or help [redacted] or the other girls. Other staff walk past, ignored [redacted]'s situation, and focused on water clean-up. All of a sudden, the girls awkwardly stopped and left [redacted] on the floor. We can speculate that the girls were possibly reminded that there is a no-touch policy. Though the nurse was seen in the building minutes before, no nurse was seen checking on [redacted].

During the August 7 incident, [redacted] seemingly suffered a seizure and girls on either side of her escorted her to a sleeping room. A staff unlocked the door. Youth attended to [redacted], helped her to the restroom, stayed with her, and checked on her. Staff do not. Later, [redacted] is out of her room in the hall by the front office and suffers another seizure, collapsing. A youth signals staff, staff goes into room at end of hall, comes out, and throws what looks like either a pillow or ice pack down the hall at the group of girls attending to [redacted] on the floor, and goes the other way. The girls put the pillow under [redacted]'s face. She is face down. Again, the girls get [redacted] up and take her to her room. About 5 minutes later, the girls escort [redacted] down to the room confinement side of the building where all of the staff are. Staff do nothing about [redacted]. The girls take [redacted] back to her sleeping room.

I thought it important that you were made aware of this, especially as staff are laid off and reassigned during the current YRTC transitioning. At minimum, a human resources review of the staff should be conducted to see if these staff are appropriate in working with youth after ignoring or minimally engaging to make sure a girl in their care, with a history of seizures, is okay during and after suffering a seizure. Our understanding of the staff involved that we observed in the videos are:

There were other staff and ODs in and out of Burroughs.

Please let me know if DHHS looks into these staff's actions and inactions, and if you do so, the outcome of the reviews. Thank you very much.

If the OIG can be a further resource to DHHS, please reach out to me or our office.

Very sincerely yours,

Julie L. Rogers

CC: Mark LaBouchardiere, Director of Facilities
Carl Eskridge, Acting Ombudsman

Appendix D: December 12, 2019 [redacted] letter to IG Rogers from Bo Botelho, DHHS General Counsel

December 12, 2019

Julie L. Rogers, Inspector General
Office of Inspector General of Nebraska Child Welfare
PO Box 94604, State Capitol
Lincoln, NE 68509

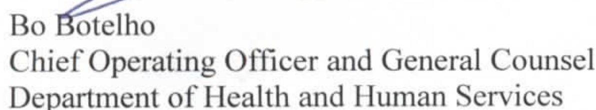
RE: [redacted] / Youth Rehabilitation and Treatment Center – Geneva

Dear Ms. Rogers:

Based on the available medical and other evidence, the Department of Health and Human Services has three primary findings after investigation of incidents involving [redacted] at the Youth Rehabilitation Treatment Center – Geneva. The first one being the staff in the immediate area of Ms. [redacted] during the epileptic events on August 1, 2019 and August 7, 2019 did not follow written seizure protocol for Ms. [redacted]. All the staff interviewed expressed an understanding that at least one employee was to stay with Ms. [redacted] during the epileptic event. They all described doing so as the way they would normally respond during such epileptic events. In the light most favorable to the staff in question, it appears that staff made poor decisions about staying next to Ms. [redacted]r because of the exigent circumstances of the sprinkler incidents. The failure to follow the other items in the seizure protocol is complicated by the fact that the staff who were interviewed all recounted being verbally instructed that those items were discontinued and the new instructions were to make sure Ms. [redacted] was in a safe place, get out of her way, and try to talk to her to bring her out of it.

The second finding concludes that during interviews, staff members stated that they had been verbally instructed that they should discontinue sing ice packs, inhalants, and an oxygen monitor. One of the nurses stated she attended an appointment with a doctor who advised these were unnecessary. However, Ms. [redacted]'s medical file lacked documentation to support the verbal instructions apparently given to staff to discontinue certain aspects of the seizure protocol. If a doctor instructed one of the nurses that certain parts of the seizure protocol could be discontinued, that should have been documented in writing in the medical file, and the communication to the staff should have been documented as well. Lastly, the file did not contain documentation of a thorough psychological or psychiatric reevaluation in 2019 or a comprehensive behavioral health treatment plan evaluating and addressing the underlying psychological issues to help prevent or at least decrease continued seizure events.

Sincerely,



Bo Botelho
Chief Operating Officer and General Counsel
Department of Health and Human Services

Appendix E: Juvenile Room Confinement Policy and Procedure

Juvenile Room Confinement Policy & Procedure

DHHS rules and regulations authorize the use of room confinement. Regulations distinguish between different types of confinement – (1.) Staff Directed Timeout, which is considered a cooling off period occurring in the juvenile's sleeping quarters lasting up to an hour, (2.) Safekeeping (Investigative, Protective, and Administrative), which involves removing the juvenile from the general population and placement in a room other than their sleeping quarters for a period up to 24 hours (safekeeping can be extended beyond the 24 hour period with administrative approval), and (3) Room Confinement, the involuntary restriction of a juvenile alone in an area other than their sleeping quarters for the purpose of helping the juvenile who is an imminent threat to herself, other persons, or the safety/security or good order of the facility bring her behavior into control, lasting for up to 5 days.[24]

YRTC-Geneva Operating Memoranda (OM) 302.1.5 outlines de-escalation strategies in addition to specific procedures on room confinement. The OM specifies that room confinement is, "to help the juvenile bring her behavior into control so that she may return to her regular program in the shortest amount of time possible, while also ensuring safety, security, and good order of the facility." It also specifies that room confinement is not to be used as a disciplinary measure.[25]

Youth Rehabilitation & Treatment Center – Geneva Operational Memorandum 302.1.5 states:

- Juveniles place in room confinement are afforded living conditions and privileges that may be earned approximating those available to juveniles in the general population, subject to safety, security and good order of the facility;
- The juvenile shall receive a bed, blanket; regular meals are to be served in room; a minimum exercise period of 30 minutes each morning and afternoon while in room confinement, and reading material, upon request;
- When a juvenile in room confinement is assessed as being suicidal, the Greenline procedures are enacted (OM 115.23.5 Mental Health Services)
- The juvenile may work on school assignments and will receive full mail privileges;
- Whenever a juvenile is placed in room confinement, the medical staff is notified and conducts a medical assessment. Unless medical attention is needed more frequently, each juvenile in room confinement will receive a daily visit from a member of the medical staff;
- The juvenile is to be visually checked every 15 minutes and such duly noted on the Safety Check form;

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24 Youth Rehabilitation & Treatment Center-Geneva Operating Memorandum 302.1.5 "Governing Juvenile Conduct."

25 Youth Rehabilitation & Treatment Center-Geneva Operating Memorandum 302.1.5 "Governing Juvenile Conduct."

- The juvenile will be visited at least once each day by personnel from administrative, clinical, social work, religious, or medical units;
- If it is determined that the juvenile is at risk to others, social services staff in collaboration with the Officer of the Day (OD), will continue to work with the juvenile to de-escalate until she is calm. Once it is determined that the juvenile is calm and no longer poses a risk to herself or others, the social services staff will assign Repair Work for the juvenile to complete; and,

If the juvenile has not de-escalated or is believed to be an imminent risk to themselves, others, or the safety, security and good order of the campus after three hours of confinement, the assigned social services staff will provide a summary to administration and designee of the juvenile's behavior during this time and the reasons why least restrictive means were unsuccessful. This information will then be used to make a decision regarding the juvenile's programming and continued confinement status.

Appendix F: January 4, 2021 letter and recommendations response from CEO Smith

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

January 4, 2021

Julie L. Rogers, Public Counsel/Ombudsman
Jennifer A. Carter, Inspector General of Nebraska Child Welfare
State Capitol, PO Box 94604
Lincoln, NE 68509-4604

RE: Special Report of Investigation: The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center

Dear Ms. Rogers and Ms. Carter:

The Department of Health and Human Services (DHHS) has received your report, *Special Report of Investigation: The Deterioration and Closure of Geneva Youth Rehabilitation and Treatment Center.* We appreciate your hard work on this report.

Attached you will find the response from DHHS on the recommendations that were provided. We look forward to working with you in the future on matters relating to the YRTCs.

Please feel free to contact me if you have any questions. I can be reached at 402-471-9433 or dannette.smith@nebraska.gov.

Sincerely,

Dannette R. Smith, MSW
Chief Executive Officer
Department of Health and Human Services

Recommendation	Response
Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.	Accepted
Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.	Declined
Implement a fully digital case management system	Accepted
Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.	Accepted
Implement evidence-based programming consistently throughout the YRTC system.	Accepted
Implement a trauma-responsive environment across the YRTC system.	Accepted

1. Clarify where the Office of Juvenile Services, overseeing the YRTCs, is housed within DHHS.

DHHS would accept this recommendation and offers the following:

The Office of Juvenile Services (OJS) provides supervision to all of the 24/7 youth facilities: Whitehall, YRTC-Kearney, YRTC-Geneva, the Lincoln youth facility and the Hastings youth facility. Whitehall is licensed as a Psychiatric Residential Treatment Facility (PRTF) and falls under the Behavioral Health (BH) division. The Youth Rehabilitation and Treatment Center facilities, plus the Lincoln and Hastings facilities, fall under the Children and Family Services (CFS) division.

In order to provide programming structure, staffing support and operational consistency, the Chief Operating Officer (COO) provides direct supervision to the OJS administrator. The COO works in collaboration with the Director of Children and Family Services and the Director of Behavioral Health. The umbrella oversight methodology, while spanning both CFS and BH, allows for standardization, stabilization and consistency across all DHHS-provided youth services.

An updated organizational chart, including the OJS administrator position, is currently under review and will be released upon approval to provide clarification.

2. Require all YRTCs to be licensed as a Residential Child Caring Agency through the Division of Public Health.

DHHS would respectfully decline this recommendation and offers the following:

DHHS is currently in the process of constructing a 5-year plan for the YRTCs. As a part of this review, there are discussions on the differences of several accreditation standards – American Correctional Association (ACA), Prison Rape Elimination Act (PREA), The Joint Commission

(TJC) and Commission on the Accreditation of Rehabilitation Facilities (CARF) – and what is most appropriate now, and what will be most applicable and attainable in the future. Residential Child Caring Agencies standards could be added to the discussion to see if this would be an applicable license that would bring value for the YRTCs.

Licensure is a process whereby an organization can hold itself accountable to the standards set as a best practice. A premise is that adequate facilities, staffing and programming are provided in such a manner that the youth receiving care would obtain maximum benefit from the highest and best use of each of the three primary resources. DHHS took steps in 2020 to assess, improve and enhance each of these three primary resources, such that the services rendered could meet any best practice standard of care. At this time, the PRTF facilities will be accredited by TJC, utilized by healthcare and residential services around the globe. Facility leadership is also exploring the application of CARF standards to determine if this would bring the YRTCs value. Ultimately, any credentialing process necessitates additional resources and multiple overlapping credentialing processes are perceived to be redundant.

3. Implement a fully digital case management system.

DHHS would accept this recommendation and offers the following:

An electronic case management system allows for improved access, enhanced data sharing, increased safety and improved efficiency. In addition, an electronic case management system allows for clinical reviews of a youth's progress toward treatment goals and the ability to document modifications as care progresses. It also should allow for storage space economies and require less staff time to receive, store, track and retrieve records.

DHHS currently utilizes the Avatar system for digital case management. The system also allows for a structured data sets and analytics that are used for reporting and to improve operations. Until 2020, YRTC facilities used stand-alone systems, but Avatar is now used across all DHHS residential facilities. DHHS has targetd March 1, 2021, as the go-live date for full-functionality of Avatar within the youth facilities. Modifications and enhancements for added value are under review.

4. Conduct a detailed analysis of the YRTC workforce and implement a plan to ensure appropriate staffing of YRTC positions at all levels.

DHHS would accept this recommendation and offers the following:

DHHS remains committed to hiring, training and retaining quality staff at their facilities. The COO remains diligent in the goal of hiring the best, investing in the training and continuing education of staff, and engaging staff to bring their best each day to the care duties of our youth. Human Resources and the YRTCs are currently engaged in discussions of the entry level roles and their descriptors.

DHHS, through its consultative relationship with MYSI (Missouri Youth Services Institute), is reviewing the roles and responsibilities of positions within the care continuum. Each facility will benefit from this review for the types of staff roles and the duties of those roles.

Staffing ratios are utilized as a guide to allow the staff to meet minimum established benchmarks for quality care, and are authorized to flex up staffing if additional care is required to prevent quality, risk, or safety issues with the youth. The outcome of these efforts is a staffing plan for the appropriate number of budgeted positions across facilities to meet the care needs of our youth.

5. Implement evidence-based programming consistently throughout the YRTC system.

DHHS would accept this recommendation and offers the following:

From our time-tested utilization of Cognitive Behavioral Therapies, Rational Emotive Therapy, and Motivational Interviewing, to early adoption of trauma informed care in 2014, to the more recent implementation of the MYSI model of care, DHHS remains committed to full utilization of these evidence-based practices to provide youth with the best opportunity to maximize their time in care with DHHS. Additional clinical supervision roles have been added to the care continuum to allow for more direct clinical participation and oversight of the youth care process.

6. Implement a Trauma-Responsive environment across the YRTC system.

DHHS would accept this recommendation and offers the following:

DHHS began implementation of trauma informed care system training and utilization in 2014. This training is now a standard component of the care that is provided to youth in the YRTC system. Many, if not most, of the youth that come to DHHS have experienced significant trauma, as evidenced by their admission diagnosis and needing to receive a level of care that requires court involvement and commitment. The staff are trained and receive refreshed training on how to maintain a trauma responsive environment of care. In December of 2019 the YRTCs began including an additional resource called Trauma Affect Regulations: Guide for Education and Therapy (TARGET). This best practice is yet another trauma-responsive tool for clinical use. The training has been well received by staff. Individual employee ongoing training needs are assessed and evaluated annually.