Office of

Inspector General of Nebraska Child Welfare

Annual Report

2018-2019

The OIG thanks and acknowledges the Nebraska Legislature and legislative staff for continuing to provide support and advice, particularly the Executive Board, Health and Human Services and Judiciary Committees. In addition, the Public Counsel goes above and beyond in assisting the OIG—we are grateful to work within the Ombudsman's Office. A most sincere and heartfelt appreciation for all of the time, talent, and counsel that has been offered by all.

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September 15, 2019

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

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Nebraska Abuse and Neglect Hotline
1-800-652-1999

National Suicide Prevention Lifeline
1-800-273-8255

Nebraska Family Helpline
1-888-866-8660

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September 15, 2019

Dear Governor Ricketts, Justices of the Nebraska Supreme Court, and Members of the Nebraska Legislature:

It is my honor to submit to you the 2019 Annual Report of the Office of Inspector General of Nebraska Child Welfare (OIG). This report provides an account of the OIG's activities over the past fiscal year. We thank the youth, parents, relatives, foster parents, front line staff, supervisors, administrators, private providers, professionals, and others who worked with our office and brought their concerns to our attention. We take their trust in our work most seriously.

Since beginning operations, the OIG has witnessed positive changes to the systems serving Nebraska's children and families. As we begin our 8th year, we continue our work providing accountability related to multiple governmental agencies—in licensed day cares and group homes; those receiving services through the DHHS, those held in juvenile detention; and those at the Youth Rehabilitation and Treatment Centers. Of the 590 cases the OIG received as intakes this year, the majority have been handled competently by system professionals with no major violations of policy or law.

Of the system improvements made in the past year, it is important to highlight one DHHS policy change that is significant. The child abuse and neglect hotline is now required to accept all reports made by medical professionals for investigation (initial assessment) if the identified child is age five or under. We are encouraged that now all such medical professional concerns will be assessed, especially as these children are not yet school age, and a medical professional may be the only ones outside of the family to see and recognize possible child abuse and neglect.

Emerging and Continuing Topics

Amid improvements and changes to the child welfare system, there is still substantial work to do. At present time, there are many efforts underway that, taken all together, provides an uneasiness

permeating across our state regarding the welfare of children. Topics contributing to this unease and discomfort include, but are not limited to:

- The recent increase in serving families through non-court cases instead of court cases;
- Parent and children drug testing protocol change;
- Proposed regulation changes (currently in the formal promulgation process) to expand Alternative Response program eligibility and to related processes;
- The lack of services statewide, including a lack of individualized services for high risk youth with complex needs;
- The federal Family First Prevention Services Act set to be fully implemented in Nebraska starting October 1;
- Whole proposed changes to DHHS child welfare regulations (currently in the formal promulgation process), most of which are stricken in their entirety;
- Ongoing significant facility, staffing, and programming issues with the YRTCs; and
- The Eastern Service Area transition in case management provider occurring until the end of the calendar year and the associated pending litigation.

In addition, on August 16th, DHHS announced the resignation of Children and Family Services Director Matt Wallen, which became effective September 8. Things like pending litigation and changes in CFS leadership could make high-stakes transitions and changes more challenging than under normal circumstances.

Our system will require diligence on the part of all of us as improvements are identified and acted upon. It is critical that continuity of care is maintained for the children and families of the state no matter the outcome of a host of modifications.

Finally, there must be analysis of qualitative measures as whole system changes are made. It is not enough to simply note that Nebraska has fewer state wards, for example. In addition, we need to dig deeper and ask whether children are safer and more stable because of these changes. In every case, we should welcome lessons learned in order to continually adjust and improve. We must insist on great expectations for all of Nebraska's children, youth, and families, no matter their struggles.

As always, I genuinely appreciate your support of transparency, and of the search for truth in government and in the administration of our child welfare and juvenile justice systems. It is a privilege to serve as your Inspector General of Nebraska Child Welfare.

Thank you for your time and attention to this report.

Very sincerely,

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OVERVIEW

The Office of Inspector General of Nebraska Child Welfare (OIG) provides accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, identification of systemic issues, and recommendations for improvement.

Housed within the Nebraska Legislature, the OIG investigates: complaints and allegations of wrongdoing by agencies and individuals involved in these systems; deaths and serious injuries of system-involved children; system-wide looks at concerning topic areas; and other critical incidents related to children involved with the child welfare and juvenile justice system. The OIG has no authority over the operations of agencies administering the child welfare and juvenile justice system. Instead, investigations and reviews function as part of the Legislature's oversight of these important state functions.

Each year, the OIG is required to publish an Annual Report. The report must provide a summary of the OIG's investigations, including the recommendations it has made and their implementation status.[1] The following summarizes the work of the OIG from July 1, 2018 to June 30, 2019 and provides updates on OIG recommendations to child welfare and juvenile justice agencies and divisions made in prior years.

[1] Neb. Rev. Stat. § 43-4331.

OIG RECOMMENDATION HIGHLIGHTS

An Inspector General's job is to make recommendations. The Office of Inspector General of Nebraska Child Welfare Act[2] sets forth that the Office of Inspector General (OIG) is to assist in improving operations of Nebraska's child welfare and juvenile justice systems, and that is done through recommendations based on investigations coupled with interviews, case specific document review, and research and analysis. Recommendations by the OIG are made both informally and formally. A full list of recommendations and the status of each, appears at the end of this report.

Recommendations Made in FY 2018-19

The OIG made several formal recommendations during FY 18-19 based on investigations into child deaths and serious injuries. Full summaries of such investigations can be found on page 26.

DHHS ***accepted*** two formal recommendations. These recommendations were made as part of an investigation of a child death in a foster home:

- Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS, with no timeframes, are lifted.

- Create a policy regarding placement disruption plans with specific reference to where such plans should be located and found on N-FOCUS.

DHHS ***rejected*** five formal recommendations. These recommendations were made as part of an investigation into infant deaths and serious injuries born to families involved in a CPS case:

- Develop Policy and Procedure for caseworkers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.

- Clarify the definition of "change in circumstance" as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.

- Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.

- Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.

- Implement trauma-informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.

[2] Neb. Rev. Stat. §§43-4301 – 43-4332.

Recommendations Acted On in FY 2018-19

Statutory Caseload Compliance

Over the years, recommendations made by the OIG relate to caseloads and workloads for frontline child welfare staff. One example of such a formal recommendation is:

- Meet the statutorily required caseload standard for initial assessment and ongoing case management.

Front line professionals have extremely challenging jobs. They are charged with making crucial decisions about children's safety, engaging struggling parents and families, and ensuring youth have access to the care, services, loving and supportive relationships that they need to succeed. Front line workers frequently require those who take on this enormous task to respond to the urgent needs of children and families every day of the week and all hours of the day and night.

A skilled and stable child welfare workforce is key to successful outcomes for children and families and the child welfare system as a whole, especially when more and more is expected of this workforce. This is achieved when front line staff have manageable caseloads and workloads, when they are well-trained and educated, and when turnover is minimized. Increasing the professionalization and stability of the child welfare workforce has received significant attention in Nebraska in recent years from the Legislature, DHHS, and others. Efforts to improve the child welfare workforce through better training, education, recruiting, and retention show promise.

DHHS has been making progress in addressing these recommendations, but the caseload limits set forth in statute have not yet been reached. Efforts by DHHS continue in achieving manageable caseloads and workloads.

DHHS believes they have enough full-time employee positions to meet Child Welfare League of America caseload standards. Turnover has been decreasing with DHHS reporting (July 2019) an average 3% monthly turnover rate. Though caseload numbers are better than in the past (DHHS reported 91.9% statewide in compliance as of July 2019), DHHS continues to be out of compliance with statutorily required caseload standards. A monthly caseload report can be found on their website. DHHS called a working group of internal and external stakeholders to look at the current caseload standards.

A caseload initiative at DHHS is underway. The initiative counts caseloads by the number of children (as opposed to number of families), and it incorporates worker skill level. It is being tested in the field. Based on this initiative, DHHS hopes to propose new statutory language to the caseload requirement in Nebraska law for the 2020 Legislative Session.

Residential Child-Caring Agency Regulations

Several OIG recommendations are related to improving licensed residential child-caring agency regulations. Specifically, the OIG recommended that regulations include requirements on: how medications (including psychotropic medications) are dispensed and monitored; medical record-keeping and documentation; and consents for treatment.

DHHS had new residential child-caring agency regulations drafted, and the formal promulgation process is now underway. A public hearing on the new regulations was held in August 2019.

Recommendations Completed in FY 2018-19

Several OIG recommendations were **completed** by DHHS:

Improve Home Study Process

- To help ensure quality home studies across the state, DHHS is entering into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts will begin November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.

Provide stronger supports for kinship and relative foster families

- Pre-service online training for foster parents is being offered to relative and kinship placements in order to get more placements licensed. As a foster child's needs are identified, the relative and kinship foster placement will receive specialized training accordingly.

  The Nebraska Foster and Adoptive Parent Association provides specialized training, Kinship Connection, across the state. Nebraska received Kinship Navigator funds available through the Family First Prevention Services Act—U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska's Kinship Navigator program will begin October 1, 2019.

Collect data on high and very-high risk cases that do not accept services and implement more promising approaches to family engagement.

- DHHS has collected data on high/very-high risk families declining services and has seen a slight increase in the acceptance of services.

  DHHS has implemented Safety Organizing Practice (SOP), a family engagement model, over the past 6-12 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement.

Revise regulations to require infant safe sleep training before granting a child care license.

- LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted.

Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.

- Public Health has reported sharing information with both CFS and Probation in a more timely way, and, when possible, conducting joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing. DHHS reports that it shares information on licensing actions and has been coordinating effectively on investigations.

Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.

- LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS has created a new Critical Incident Reporting form accordingly. The form will be utilized statewide by September 2019.

End the practice of screening law enforcement reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.

- DHHS reports that CFS Central Office Administrators and other staff review every "Does Not Meet Definition" screen. DHHS analyzed reasons why intakes were being re-screened and adopted definitions. The CQI team performs qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, are following proper practice and policy.

Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.

- DHHS reports that the Hotline Administrator reviewed the intake process, and QA staff put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed to ensure appropriate use of policy and discretionary overrides. So far this year, of the over 1700 intakes that have been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.

Adhere to policy on out of home assessments and enhance quality assurance

- DHHS has developed new protocols to complete out of home assessments when the child is placed at a DHHS facility.

- DHHS is in the process of developing new policy on out of home assessments for all other placements. The process will engage front line workers who complete these assessments in

creating the new policy. Part of the analysis will focus on how involved Central Office will be in these assessments.

Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation. Review and revise training on child sexual abuse for DHHS staff. Include a component on child sexual abuse prevention in foster and adoptive parent training. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.

- DHHS has contracted with Project Harmony to develop the curriculum for developmentally-appropriate education to prevent sexual abuse and exploitation within the child welfare system. A 3-module training was developed:

    1. Darkness to Light
    2. Sexual Health, Behaviors, and Abuse of Children
    3. Bringing it Home: Managing Sexual Abuse and Behaviors.

Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.

- DHHS has revised contracts with child-placing agencies to better align caregiver and child needs. Specific training for foster parents will be provided based on the specific child's needs. A request for proposals has been developed for resource families. The family's voice and choice is being incorporated into these revisions. Caseworkers are utilizing Safety Organized Practice across the state. Many of these strategies are incorporated into Nebraska's performance improvement plan (PIP).

Strengthen foster care licensing to remove inappropriate and unsuitable homes.

- DHHS has enhanced the application process for foster parenting to better screen foster homes, and DHHS has issued an RFP for home studies in order to improve the process. DHHS has made modifications to regulations, which are presently in the promulgation process, to comply with more stringent foster care, adoptive, and guardianship model licensing standards.

  When currently licensed foster parents apply to renew their license, they will have to be in compliance with the new requirements—complete the updated application, home study, compliance checklist, and the like. Those not in compliance with the new regulations will no longer remain as a licensed foster parent.

Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.

- Public Health reports that goal timelines have been developed and implemented. LB 59 was passed into law during the 2019 Legislative Session, which requires that investigatory reports made under the Children's Residential Facilities and Placing Licensure Act be issued 60 days after the determination is made to conduct the investigation, except that the report may be filed within 90 days if an interim report is filed within 60 days.

OPERATIONS OF THE OFFICE OF INSPECTOR GENERAL 2018-2019

The following section of the Annual Report provides information on the operations of the Office of the Inspector General (OIG) during FY 2018-2019. This includes cases reviewed by the OIG in the past fiscal year as well as death and serious injury investigations that were opened.

Cases Reviewed by the Office of Inspector General

The work of the OIG is wholly determined by the intake information that it receives. Information generally comes to the office in the form of a "critical incident report" from the Department of Health and Human Services (DHHS) or the office of Juvenile Probation, complaints from the public, reports/requests for information and copies of grievance findings from DHHS.

During the fiscal year of 2018-2019 (FY 18-19) starting July 1, 2018 through June 30, 2019, the OIG received 590 total intakes comprised of:

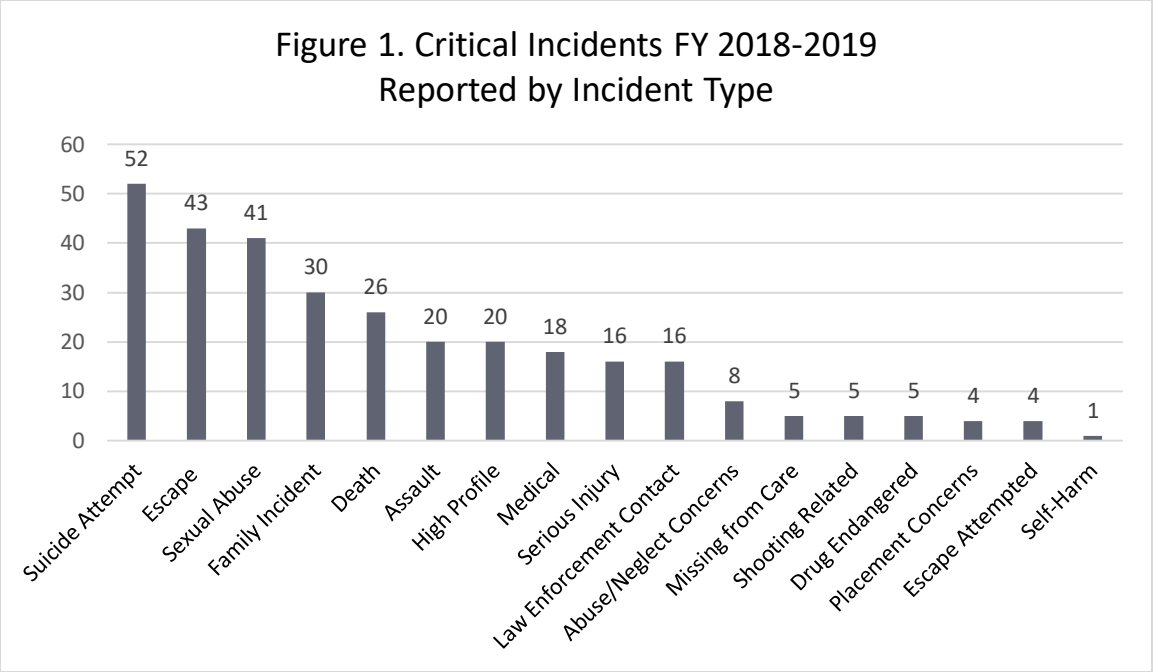
1. 317 Critical Incident Reports;
2. 226 complaints;
3. 37 reports of or requests for information; and,
4. 10 grievances and accompanying findings from DHHS.

After a review of the initial intake, the OIG conducts a preliminary investigation, including a document review, on every complaint, critical incident, and grievance finding. Based on the preliminary investigation, the OIG then determines whether a full investigation is justified or required by statute and what additional actions may be appropriate.

Critical Incidents Received by the OIG

Critical incident reports bring a range of issues to the OIG's attention. Figure 1. shows the general type of incidents included in the 317 reports involving 313 youth that were reported to the OIG in the past year. Twenty-one youth were involved in multiple incidents.

After review of the critical incident, the OIG categorizes each into various categories.



Of the 317 critical incidents reported to the OIG:

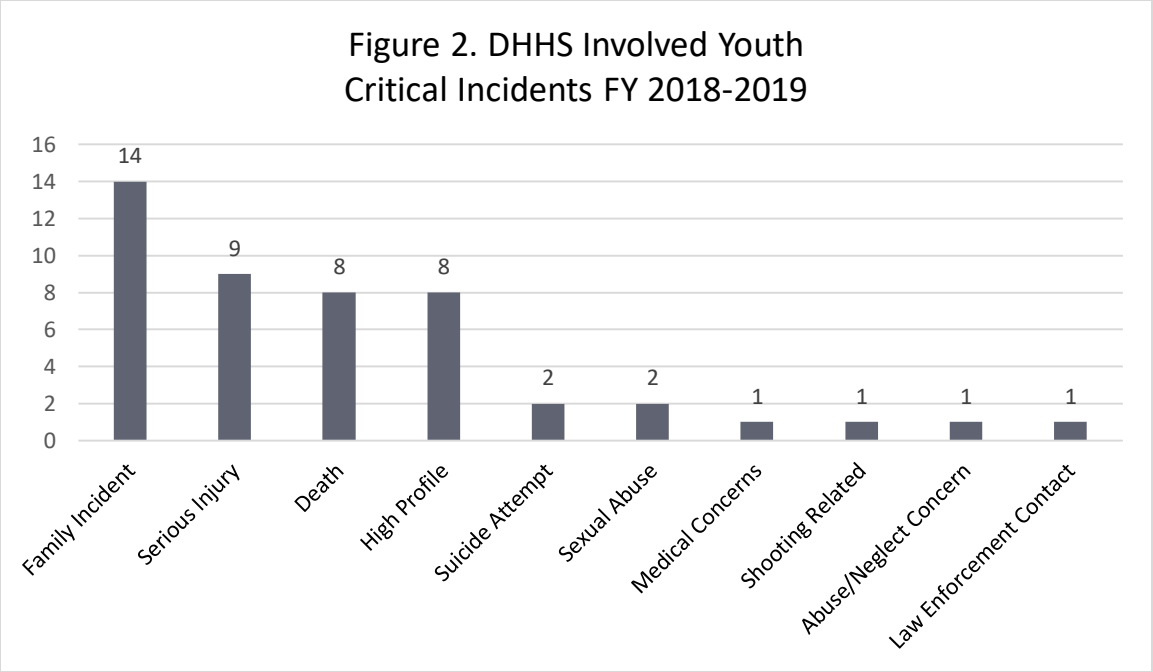
1. 243 reported by DHHS;
2. 71 reported by Probation; and
3. 3 reported by Other.

DHHS Involved Youth: 47

The OIG defines a family or youth as involved with DHHS under the following circumstances: an intake was received at the Hotline, there is an Initial Assessment investigation, an Alternative Response case, or a non-court case. The type of involvement is either active at the time of the critical incident or within the previous twelve (12) months of the incident. Table 1. indicates the number of critical incident reports at each level of DHHS-Children and Family Services Division (CFS) involvement. Figure 2. Provides data on the types of incidents reported.

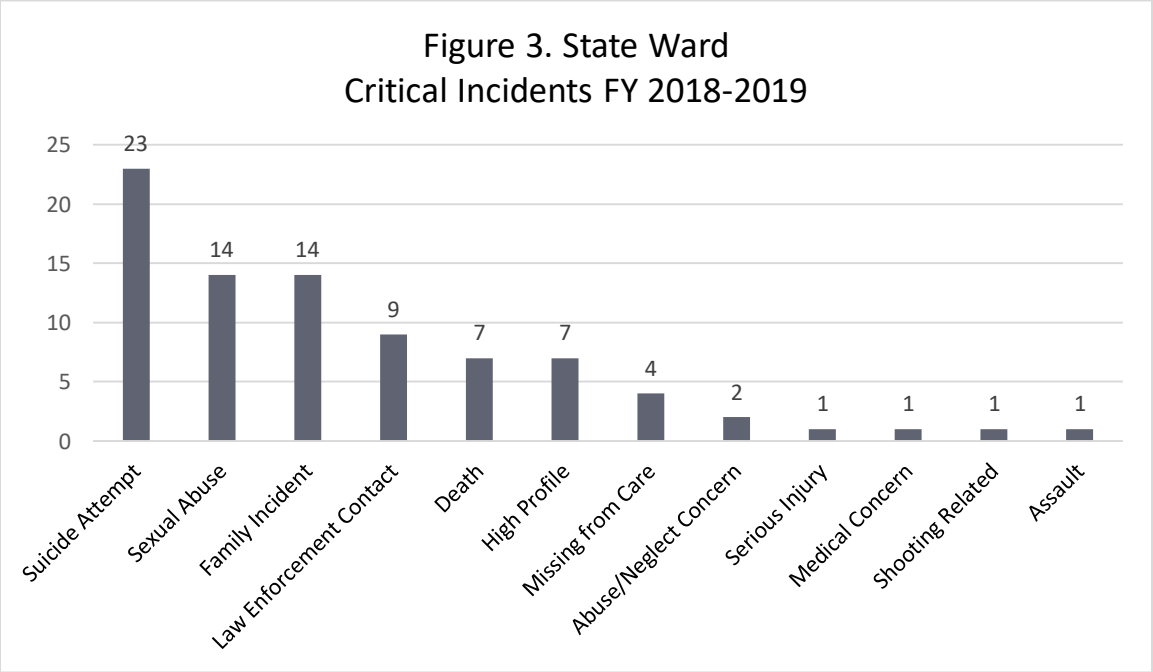
Table 1. **DHHS Involved Youth**
Critical Incidents FY 2018-2019

DHHS Involvement Point	Total
Intake	30
Initial Assessment	9
Alternative Response	2
Non-Court case	6



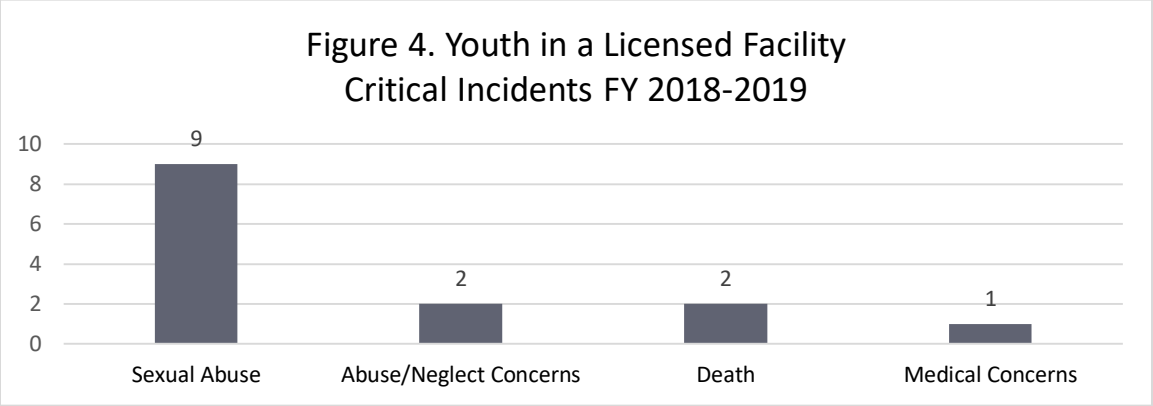
State Wards: 84

The State Ward category includes youth who, at the time of the incident, were court ordered to be under the care, custody and control of the Department of Health and Human Services.



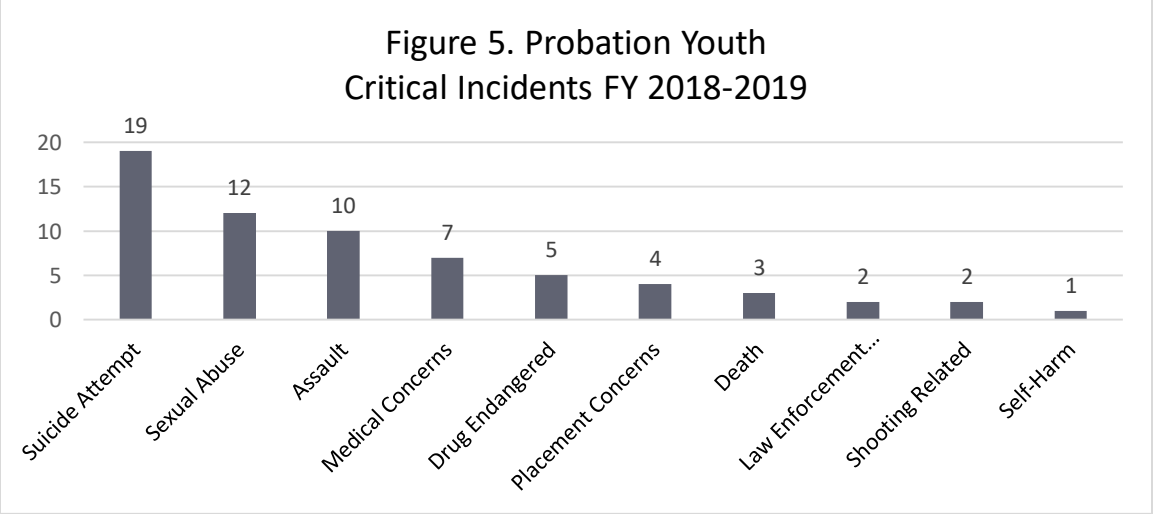
Youth in a Licensed Facility: 9

This category involves youth who were placed or being cared for in a Nebraska licensed facility (group home, daycare, etc.) during the time of the incident. These youth do not have any DHHS or Juvenile Probation involvement.



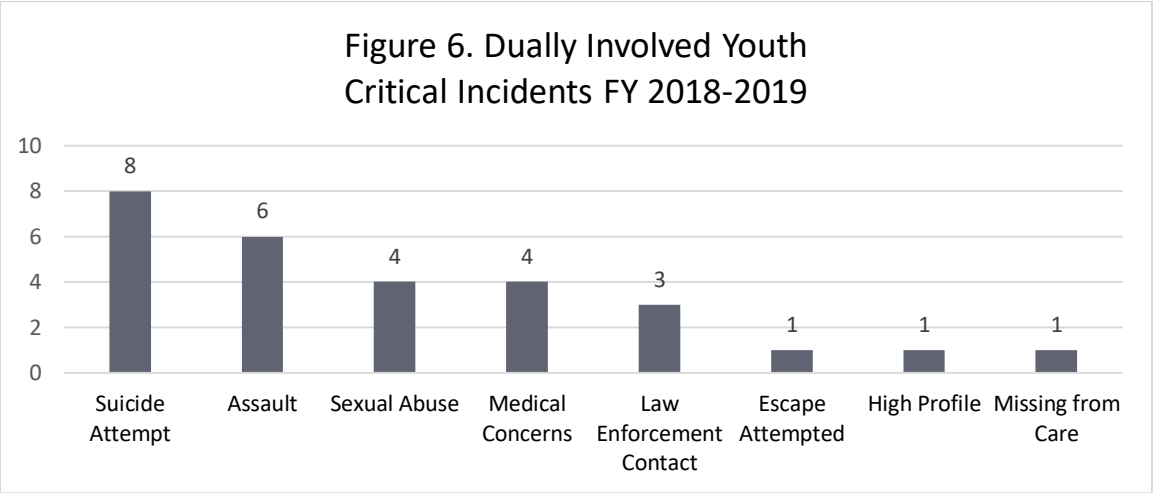
Probation Youth: 65

Probation youth include those who, at the time of the incident are supervised by Juvenile Probation, but not placed at the Youth Rehabilitation and Treatment Centers (YRTCs).



Dually Involved: 30

This category involves youth who are involved with Juvenile Probation and the Department of Health and Human Services in some manner.



Youth Rehabilitation and Treatment Centers (YRTCs): 55

The YRTC category includes youth who are committed to the Youth Rehabilitation and Treatment Center (YRTC), which is operated by the Department of Health and Human Services-Office of Juvenile Services Division (OJS). Youth in this category could be supervised by probation, tribal court, and/or CFS. All youth at the YRTC are considered OJS wards. There are two YRTC campuses: one in Kearney, Nebraska for male youth and one in Geneva, Nebraska for female youth.[3]

Table 2.

YRTC-**Geneva** Critical Incident Reports, FY 2018-2019

Escape	13
Escape (off campus)	5
Suicide Attempt	1
Sexual Abuse	1

Table 3.

YRTC-**Kearney** Critical Incident Reports, FY 2018-2019

Escape	19
Escape (off campus)	6
Attempted Escape	3
Sexual Abuse	3
Assault	2
Suicide Attempt	1
Medical Concern	1

[3] Though the YRTC-Geneva campus is not operational at the time of this report, it was during the FY 2018-19 reporting period.

Both facilities underwent a Prison Rape Elimination Act (PREA) audit in October 2018 and both facilities achieved compliance with PREA standards. All juvenile facilities covered under the PREA standards must be audited once every three years. The full audit report for both facilities was released in November 2018, and can be found on the Nebraska Department of Health and Human Services' website.[4]

In the spring of 2019 new programming was implemented at YRTC-K. Dr. Jerry Van Winkle, resident psychologist, created "The Phase Model" that identifies vulnerable youth, typical youth, and youth who repeatedly violate the rules and who have serious mental health issues. The youth are assigned a program according to their classification. The program scores youth on a number of issues to measure the youth's progress. If the youth makes progress, they are given rewards or privileges. The Phase Model integrates evidence based interventions, for example motivational interviewing, moral reconation therapy (MRT), and aggression replacement training (ART). There are a total of five phases the youth must complete.

The YRTC-K's newly constructed fence was completed this summer. The 10 foot high chain-link fence does not enclose the entire perimeter of the YRTC-K property, but instead creates a barrier around the buildings. Since the fence was completed, at the time of this report, there have been eight escapes from the facility. While there's been a focus on preventing escapes, YRTCs continue to struggle with adequate staffing, youth engagement, and programming.

Nebraska will always need youth placements—after all other options, usually private entities that either can not accept the youth into their program or that have not succeeded in serving the youth, have been exhausted. Without YRTCs, and without alternative options created to accommodate the specific youth's high needs, these youth would likely be sent to out-of-state facilities, could remain in detention facilities, or end up in the adult prison system.

DHHS, with Casey Family Programs, hosted a Visioning Session in July about the YRTCs and included cross-system government, judicial, and non-profit sector stakeholders. The purpose of the meeting was to develop a shared vision and desired future state for children served by YRTCs and to outline how to achieve that future desired state. A draft implementation plan is being created, and the group is expected to reconvene in order to determine strategies.

In August 2019 the OIG received information regarding the programming, mental health services, staffing, and physical deterioration of YRTC-G that prompted all of the youth committed to YRTC-G to be moved to, and placed at, YRTC-K. The OIG has begun a full investigation into the situation and the investigation is ongoing.

[4] http://dhhs.ne.gov/Youth%20Facility%20Documents/YRTC%20Geneva%20PREA%20Audit%20Report.pdf#search=PREA and http://dhhs.ne.gov/Youth%20Facility%20Documents/YRTC%20Kearney%20PREA%20Audit%20Report.pdf#search=PREA

Death and Serious Injury

The OIG is required to investigate death and serious injury of system-involved youth who are: (1) placed in out of home care (2) currently receiving or have received child welfare services from DHHS in the past twelve months (3) currently receiving or have received services from the Juvenile Services Division of Probation in the past twelve months (4) the subject of a child abuse investigation (Initial Assessment) in the past twelve months. The OIG is not required to investigate deaths that occurred by chance. Serious injury is defined as, "injury or illness caused by suspected abuse, neglect, or maltreatment which leaves a child in critical or serious condition."[5]

Of the 26 reported child deaths in FY 2018-2019, four had sufficient contact or involvement in the child welfare or juvenile justice system to merit opening an investigation.

Table 4. Opened Investigations of Child Deaths during FY 2018-2019

Total	Cause of Death	System Involvement
1	Suicide	State Ward
1	Homicide	Juvenile Probation
1	Sudden Unexpected Infant Death	Public Health Licensing Daycare
1	Suicide	Public Health Licensing Residential Facility

Of the 16 serious injuries reported in FY 2018-2019, three met the requirements to open an investigation.

Table 5. Opened Investigations of Child Serious Injuries during FY 2018-2019

Total	Cause of Serious Injury	System Involvement
1	Severe Maltreatment	State Ward
2	Physical Abuse	DHHS Involved

[5] Neb. Rev. Stat. §43-4318 (2).

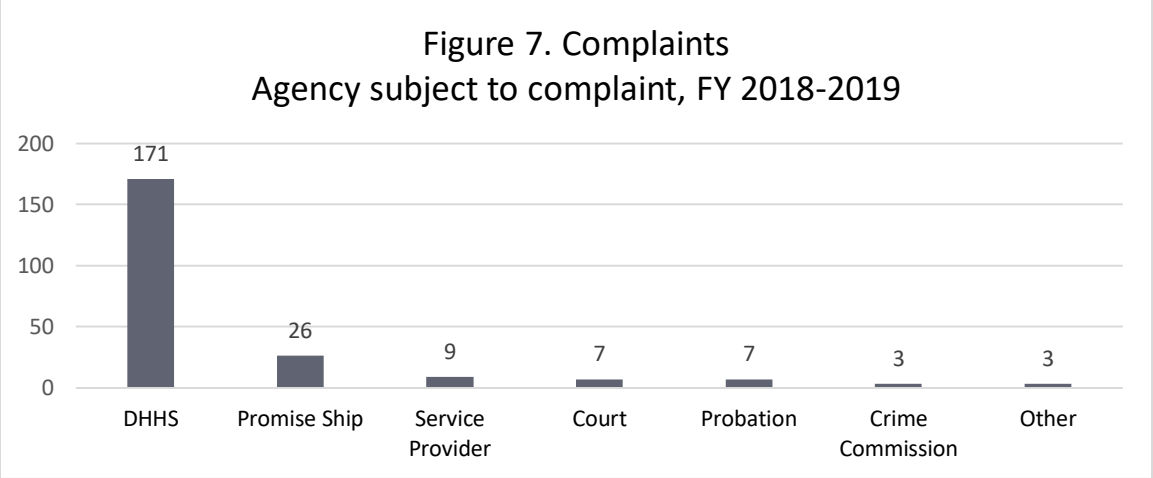
Complaints

The OIG receives complaints and investigates "allegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations"[6] by:

- DHHS;
- Juvenile Services Division (Probation);
- The Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) juvenile justice programs;
- Private child welfare agencies, foster parents, licensed child care facilities, and contractors of DHHS and Juvenile Probation; and
- Juvenile detention and staff secure detention facilities.

In the past year, the OIG received 226 complaints. The OIG responds to and investigates complaints by employees, administrators, foster parents, biological parents, grandparents, family members, attorneys, and the general public about various aspects of the child welfare system, the juvenile justice system, and DHHS Licensure Unit as it pertains to children and youth.

The agencies and issues varied and represented all areas and points in the system. If a complaint is received about an area outside of the OIG's jurisdiction, then a referral is made when appropriate.



Complaints are multifaceted and most encompassed more than one specific incident or concern. For FY 2018-2019, more than half of the complaints generated were inclusive of two or more issues. Examples of types of issues received in complaints were sorted into the following categories:

- Case Management
- Child Safety
- Initial Assessment
- Hotline
- Removal from Home
- Contact and Visitation
- Permanency
- Laws/Policy/Procedure
- Placement
- Financial
- Licensing
- Non-Court cases

[6] Neb. Rev. Stat. §43-4318 (1)(a).

Alternative Response Cases

The OIG is tasked with reviewing and investigating critical incidents and complaints related to Alternative Response (AR), a pilot project that began in 2014.[7] Alternative Response was implemented by DHHS to change the way the system responds to some child welfare and neglect reports. Alternative Response is approved until December 31, 2020. Use after that date will require action by the Nebraska Legislature during the 2019 Legislative Session.[8] The OIG must report on any AR cases it reviews in its Annual Report.[9] This year, the OIG received one complaint and two critical incidents related to AR. The OIG conducted a preliminary review of each case, which did not result in a full investigation.

The following issue was reported to the OIG concerning AR:

- An intake was accepted for AR after a youth fell and hit his head and started to have a seizure. The youth was transported to the ER. It was reported this was the second fall within two months. There were concerns about the living conditions of the home and the youth's hygiene. After speaking with all members of the household, the children were found to be safe. The family was already participating in some services for the children. The complaint to the OIG centered on information that was confusing to the parents provided by the caseworker. The parents declined any further services. The AR case was closed.

The following critical incidents were reported to the OIG concerning AR:

- An intake was accepted for AR after a youth called a suicide prevention hotline with suicidal ideation because of abuse happening in the home. While the caseworker was speaking to law enforcement regarding another case this AR intake was discussed. It was agreed that despite this being an AR case, law enforcement would conduct a welfare check based on the allegations. After the law enforcement officer completed a welfare check of the youth and spoke to school officials, the officer went to the family home and spoke to the mother. Two days later, the law enforcement officer and the caseworker discussed the case. The caseworker went to the family home and spoke with the youth and the mother. The caseworker found the youth safe in the home. That same night, after an argument between the youth and the mother, the youth attempted suicide by consuming a large amount of prescription medication (critical incident). She was taken to the hospital. After her recovery, the mother arranged for the youth to attend counseling and continued medication management. The mother declined any additional services offered by DHHS. The AR case was closed.

- An intake was accepted for AR when a youth was found unresponsive after consuming a large amount of prescription medication, and subsequently placed on life support at the hospital. The intake alleged the youth and the parent were arguing all weekend and emotional abuse was happening in the home. Two days later, the assigned caseworker received information the youth passed away (critical incident). The caseworker received a timeframe exception to meet with the family. After meeting with all members of the family, the caseworker found the other children in the home safe. Services were offered to the family, but the parents declined. The AR case was closed.

[7] Neb. Rev. Stat. §28-712.01.
[8] Neb. Rev. Stat. §28-712.
[9] Neb. Rev. Stat. §43-4331.

JUVENILE ROOM CONFINEMENT
2018 REPORT SYNOPSIS

The OIG released its second annual report on the use of juvenile room confinement in December 2018.[10] The report examined juvenile room confinement in Nebraska between July 1, 2017 and June 30, 2018.

Based on its definition in Nebraska law, juvenile room confinement is an umbrella term.[11] Different facilities keep youth involuntarily alone by using practices which may be known as segregation, restrictive housing, special management, isolation, seclusion, disciplinary confinement, time-out, and room restriction, among others.[12]

Nebraska juvenile facilities reported a total of 2,686 incidents of juvenile room confinement during FY 17-18. The OIG believes this number is an undercount of actual incidents of juvenile room confinement, due in part to the fact that there was no way to verify the accuracy of the room confinement reports submitted by juvenile facilities.

Of the 33 reporting facilities, data measures were calculated on the use of room confinement at the seven facilities that reported more than 10 instances of room confinement during FY 17-18.

Nebraska Department of Correctional Services (NDCS)

The Nebraska Department of Correctional Services (NDCS) operates facilities that house people convicted of crimes in Nebraska's criminal courts and sentenced to prison terms. While most of its inmates are over 19 years of age (the age of majority in Nebraska), some NDCS inmates are minors housed at the Nebraska Correctional Youth Facility (NCYF).

FY 17-18	Incidents/ individual	% ending in 4 hours	% ending in 8 hours	Median duration (hours)	Age range (years)	Longest incident (hours)	Shortest incident (hours)
NCYF	34/18	0	0	240	17-18	7152	24

10 https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/650_20181214-092041.pdf

11 Neb. Rev. Stat. § 83-4,125 states, "Room confinement means the involuntary restriction of a juvenile to a cell, room, or other area, alone, including a juvenile's own room, except during normal sleeping hours."

12 Individual facilities have specific definitions and practices for each type of room confinement. These practices are discussed in detail in sections on types of facilities in the full report.

DHHS Youth Rehabilitation and Treatment Centers (YRTCs)

The DHHS Office of Juvenile Services (OJS) operates two Youth Rehabilitation and Treatment Centers (YRTCs) in Kearney (boys) and Geneva (girls) that serves youth in the juvenile justice system, ages 14 through 18.

FY 17-18	Incidents/ individual	% ending in 4 hours	% ending in 8 hours	Median duration (hours)	Age range (years)	Longest incident (hours)	Shortest incident (hours)
YRTC-K	1099/125	8.5	16	20.75	14-18	125.5	1.25
YRTC-G	726/56	54	59	2.25	14-18	119	1.25

Juvenile Detention Facilities

The Nebraska Jail Standards Board, housed at the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission), has the authority over the four juvenile secure and staff secure detention facilities in Nebraska. Douglas County Youth Center (DCYC), Lancaster County Youth Services Center (LCYSC), Northeast Nebraska Juvenile Services Center (NNJSC), and the Patrick J. Thomas Juvenile Justice Center (PJTJJC). These facilities have primarily housed youth under 18 after initial arrests, youth who are sent to detention after probation violations, and youth awaiting placement while on probation.

FY 17-18	Incidents/ individual	% ending in 4 hours	% ending in 8 hours	Median duration (hours)	Age range (years)	Longest incident (hours)	Shortest incident (hours)
PJTJJC	75/36	72	100	3.25	14-17	8	1
NNJSC	84/48	93	98	1.5	13-18	14.5	1.25
LCYSC	276/89	97	99	1.75	12-18	13	1.25
DCYC	392-174	<1	<1	57.5	11-18	262.5	2

The OIG recommended the following actions to reduce the use of room confinement for each of the various agencies:

Individual facilities:

- Revise facility policies to reflect best practice.
- Focus on workforce development.
- Create a Juvenile Room Confinement Reduction Plan and include technical assistance and oversight.
- Publicly report information on the use of room confinement, including seclusion.

Nebraska Department of Correctional Services:

- Provide additional details in NDCS rules and regulations on restrictive housing as it relates to best practices and youth under age 19.
- Specifically adopt time limits for inmates in restrictive housing under age 19.
- Conduct a study on youth who spend particularly long periods of time in room confinement.

Nebraska Department of Health and Human Services-Office of Juvenile Services (YRTCs):

- Develop and implement a strategic plan to reduce room confinement.
- Change OJS rules and regulations to align with best practices.

Nebraska Department of Health and Human Services-Public Health Division:

- Update licensing rules and regulations to reflect juvenile room confinement reporting requirements.

Nebraska Jail Standards Board:

- Clarify definitions of different forms of room confinement within Juvenile Detention Jail Standards.
- Update Jail Standards to reflect room confinement reporting requirements.
- Update Jail Standards to eliminate the use of room confinement for disciplinary purposes.

INVESTIGATIONS

The Office of the Inspector General (OIG) is statutorily obligated to investigate deaths and serious injuries of Nebraska children and youth who were:

- Being taken care of at a licensed facility, such as a day care or group home;
- The subject of an abuse or neglect assessment (also referred to as an investigation) in the previous twelve months, but the family did not receive services through DHHS;
- Engaged in an alternative response case, voluntary, or non-court case, and received services through their DHHS involvement, but were not involved in a formal court case;
- Involved in a juvenile court case and DHHS had custody of the child, also known as being a state ward;
- Placed at a Youth Rehabilitation and Treatment Center;
- Placed at a juvenile detention center;
- Supervised by juvenile probation.

FY 2018-2019 Juvenile Probation Investigations

Suicidal Behavior of Probation-Involved Youth Investigation

In April 2018 the OIG gave notice to, and met with, the Administrative Office of Probation (AOP) regarding an OIG investigation focused on identifying systemic issues related to the identification and/or response to suicidal behavior of juveniles under the supervision of juvenile probation, and what, if any, improvements in the system were needed. The OIG was looking into fifteen reports of suicide attempts and three reports of death by suicide of juvenile probationers as part of the investigation.

Youth suicide is a significant problem, representing the second leading cause of death among youth ages 10-19 nationwide in 2016. During this same period, the suicide rate in Nebraska for youth 10-19 exceeded the national average.[2] Additionally, risk factors for suicide are considered to be more prevalent among youth in, entering into, or having been in the juvenile justice system[13]. The sudden loss of freedom that placement on probation and the additional restrictions creates potential situational risk factors for suicidal behaviors that the juvenile justice system must be prepared to process.[14]

The OIG conducted research, analyzed juvenile probation's policies and procedures, reviewed individual probation cases, and started conducting interviews with juvenile probation staff across the state. In June 2018, the AOP abruptly stopped interviews. Relevant data requests were denied. Consequently, a proper and full investigation could not be completed, and in the fall of 2018 the OIG

[13] National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice Task Force – Suicide Research Workgroup. (2013). Suicidal ideation and behavior among youth in the juvenile justice system: A review of the literature. Washington, DC: Author.
[14] QPR Institute, Ask a Question, Safe a Life (1995 – Revised 2016), Paul Quinnett, Ph.D.

discontinued the investigation.

Continuing through FY 2018-19, the OIG has not received needed and proper access to information nor people within the AOP in order to carry out investigatory and statutory responsibility under the Office of Inspector General of Nebraska Child Welfare Act.

FY 2018-2019 DHHS Investigations

The following sections provide more detail on the full investigations that were completed[15] during FY 2018-2019. All recommendations made are based on today's Nebraska child welfare system and identified issues that need addressed presently. In the cases where no recommendations are made, the incident either revealed no issue about the administration of an agency or the agency had already made systemic changes to address the issues found.

The OIG has taken note of any child welfare themes and issues reflected in each investigation. The OIG will track them as part of its effort to identify systemic issues and consider them as topics for future investigations as necessary and appropriate.

[15] The deaths and serious injuries occurred between 2014 and 2018.

SUMMARIES OF INVESTIGATIONS COMPLETED IN FY 18-19

Death of a 14-month-old State Ward

The following report summarizes the OIG investigation into the death of 14 month-old toddler due to blunt force trauma. The injuries were described to be consistent with abusive head trauma. At the time of incident, the toddler was a state ward placed in foster care.

Critical Incident

A 14-month-old was in the care of his foster mother. She reported that he began vomiting after his bath, and then collapsed; he seemed to have a seizure. After he stopped breathing the foster mother said she put him in cold water and started slapping him and beating him to cause him to breathe. She called 911. After taken to a hospital, he was declared brain dead.

A physician with expertise in child abuse, reported that his injuries were consistent with abusive head trauma.

Child Welfare History

The toddler's older sister became a state ward because of parental drug use and domestic violence. She was placed in a foster home. The mother underwent treatment for methamphetamine addiction while she was pregnant, and while the sister was a state ward. The baby was born, and the foster parents were at the hospital for the birth. The baby remained in the mother's care. The plan was to transition the older sister back to the care of the mother.

The month after the baby was born, DHHS noted that the mother had successfully completed her treatment program and was capable of caring for both of her children. The older sister was reunited with the mother and baby. The mother and her children became close with the foster parents, often spending weekends with them. The court case was closed.

About six months later, the mother was stopped for driving erratically and was arrested. In the car were open containers of alcohol, drug paraphernalia that tested positive for methamphetamine, an unrelated man in the possession of possible stolen goods, and the two children, now age 2-years-old and 11-months-old.

The children were taken into emergency custody and placed with DHHS. Both children tested positive for methamphetamine exposure.

The children were placed with the prior foster family. The DHHS caseworker observed that the 2-year-old and 11-month-old clearly knew the foster parents, and seemed comfortable with them. The child-placing agency worker reported that she was contacted at about 9 a.m. the next morning by the DHHS on-call caseworker. The child-placing agency worker went to the foster home that day. Neither worker reported knowledge of a disruption plan in place on the foster home.

Medical records from the following month indicated that the foster mother asked physicians about the then 12-month-old's inconsolable crying. She was concerned that exposure to methamphetamine in utero may have had an effect on his personality and

development. Physicians did not report any medical concerns with the child. The child-placing agency reported that both the foster mother and foster father expressed concern about the then 13-month-old's tantrums. The family was reminded of their right to respite care and on-call support.

The foster parents used respite care a week later. The approved caregivers for the weekend were the foster mother's sons and one of the son's fiancée. The fiancée and son had two young children of their own. The fiancée reported in a police interview that she was the primary caregiver during this time and that the 13-month-old was an easy baby to care for.

A couple weeks later, the child-placing agency worker and the caseworker visited the foster home and reported the home conditions appeared normal. The caseworkers reported things were going well with the children. They said the foster parents treated the two children like their own grandchildren. In a police interview, the foster father indicated that he thought of them as his own children.

A day later, the foster mother was home alone all day with the two children. The foster mother said that she fed the children dinner that evening, and then gave them a bath. The 14-month-old began to vomit immediately after the bath. At some point, his eyes rolled back in his head and he appeared to have a seizure. He stopped breathing. The foster mother put him in cold water and started slapping him and beating on him to cause him to breathe. She then called 911. EMTs arrived within about 5 minutes. The toddler was taken to the local hospital. The physician noted retinal hemorrhages in both eyes. Head and neck CTs indicated brain swelling and right side subdural hematoma. He had a low core body temperature. The hospital medical professionals believed the injuries were the result of "non-accidental trauma," and were similar to those associated with shaken baby syndrome.

The toddler was then transported to another hospital. The physician who examined him stated the evidence indicated that he had experienced at least one episode of shaking or significant rotation with an impact. The doctor said that the pattern of injury was not associated with normal care, short falls, or resuscitation injuries, and "represents abusive head trauma." The toddler was pronounced brain dead, and the autopsy indicated the cause of death as blunt force trauma. The foster mother told police she intended to induce his breathing and those efforts resulted in the injuries. She said the other noted injuries were the result of the toddler playing with his older sister. She also claimed that he had seemed to feel unwell all day.

The foster mother was not criminally charged with the toddler's death. The child-placing agency withdrew support from the foster home. DHHS agency-substantiated the physical abuse, and the foster mother was placed on the Central Registry. The foster home's license was not renewed about a year later, and there is a note in the foster family's file to not place children in their home.

Findings

Almost one year prior to the toddler's death, the foster parents received foster placement of a sibling strip of children, ages 10, 4, 3, and 1. The foster parents gave the child-placing agency official notice to have the children removed within three days of their placement. The foster parents expressed frustration because they believed they had not been given sufficient information about the children. The foster parents said that the four-year-old child had behavior issues and the one-year-old did not sleep throughout the night. They asked that the children be removed immediately. The child-placing agency staff members reminded these foster parents that they were required to give 14-days' notice. The foster parents were offered respite care for the children.

The child-placing agency recommended a disruption plan[16] for the foster home. Although the foster parents complained about the behaviors of the children they fostered, the child-placing agency was concerned about their lack of understanding of normal child behaviors. For example, a one-year-old may not sleep through the night for a variety a reasons, including experiencing a new environment. The child-placing agency staff did not believe the sibling strip of children had been given an adequate opportunity to adjust to their new living arrangement. The child-placing agency recommended additional class training for the foster parents. The disruption plan established that no more than two children could be placed with the foster family at a time, nor could children under the age of two or those with behavior issues. DHHS then placed a hold on the foster home as they reviewed the disruption plan. The sibling strip was moved out of the foster home.

Days later, DHHS approved the foster home's disruption plan but removed the HOLD on the home. Though there was a disruption plan, it was meaningless without some type of HOLD. The disruption plan itself was available on N-FOCUS as a scanned document, and a brief discussion of the plan was available in the narratives section.

Protection and Safety Procedure Memo #6-2016 refers to placement holds in foster homes. The Foster Care Resource Development staff (FCRD) in this case appropriately put a HOLD on the foster home after the child-placing agency recommended a disruption plan. The type of placement HOLD used was "Consult with RD (Resource Development) Staff" which is used when "RD has documented information about a foster home which should be reviewed and shared prior to a placement. For example, a home may have experienced disruptions with a certain type of child(ren) and does best with a specific age group." That was the situation with this foster home.

Even though FCRD inappropriately removed the "Consult with RD Staff" HOLD after the disruption plan was put into place, access to the disruption plan was available on N-FOCUS as a scanned document, if the on-call caseworker had time to peruse the scanned documents. Even so, a disruption plan mean nothing without a HOLD.

In determining placement of the two child, DHHS and the child-placing agency staff disagreed on the timeline about when and whether conversations took place during the early morning hours of the mother's arrest.

[16] A disruption plan refers to any emergency placement change in the foster care system. Some disruption plans refer to adoptions that are terminated before they are finalized. Foster children are often subjects of disruptions because of their behaviors. Disruptions are not always behaviorally based, however. Foster parents may experience circumstances in which a placement needs to be disrupted: for example, a foster parent may suffer a serious illness, and request a change in placement.

There is also much documented about whether or not the DHHS on-call caseworker or the child-placing agency overnight staff should have or should not have allowed the placement at that moment. Since the HOLD was lifted previously, the on-call caseworker would see nothing presently preventing placement and the child-placing agency's overnight worker would be expected to simply state whether the home was available, which it was. The disagreement about what happened those early morninghours does not matter because without a HOLD on the home, there would have been no reason not to place the children with that particular foster family, especially considering the family's prior relationship.

Recommendations

The OIG is tasked with making recommendations in reports of investigation.[17] Recommendations are intended to address any systemic issues that the report identifies. Based on the issues identified in this case, the OIG recommends that DHHS take the following steps:

I. Clarify DHHS policy by adding specific processes to address how and when foster placement holds with no timeframes are lifted.

The OIG recommends clarifying Protection and Safety Procedure Memo #6-2016**.** There is currently a "Time Frame" section for 3 types of placement holds: Complaint Under Investigation, CPS Investigation, and Corrective Action.[18] These holds must be resolved within 30 days.

However, the following types of holds do not have a time frame: Agency Decision, Consult with RD Staff, License Renewal in Process, License Suspended, and Provider Requested. In the case of the foster home, "Consult with RD Staff" was the relevant issue; the HOLD should not have been removed. The OIG recommends DHHS add language to clarify which of these placement HOLDS should not be removed, and include specific steps on when and how each type of placement HOLD can be lifted.

II. Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.

The OIG recommends adding a policy on disruption plans including how and why disruption plans are created, the child-placing agency's role in disruption plans, how and when DHHS approves disruption plans, how disruption plans relate to placement holds, and where disruption plans should be located in N-FOCUS.

In the reviewed case of this report, it is possible that the relationship the children had with the foster family would have been given priority despite a disruption plan and lifting of the hold. However, workers and supervisors should have had more complete information about the foster home at the moment of placement, as well as opportunities to consider additional oversight of the placement.

DHHS accepted all recommendations. See letter dated July 17, 2019.

[17] Neb. Rev. Stat. §43-4327.

[18] Protection and Safety Procedure #6-2016, p. 2.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

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

From: Dannette R. Smith
Chief Executive Officer
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301 Centennial Mall South, P.O. Box 95026
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RE: Response to Investigation – [redacted] (October [redacted], 20[redacted] – December[redacted], 20[redacted])

Date: July 17, 2019

The Department of Health and Human Services (DHHS) has reviewed the report submitted on June 26, 2019, regarding [redacted]. The Department appreciates the time and thought put into reviewing this case and the accompanying recommendations. DHHS accepts the recommendations and will be making necessary changes to existing policies and standard work instructions.

Infants Born with Current Family CPS Involvement Death or Serious Injury

The following incorporates investigations into four death or serious injury cases of an infant born into an existing Child Protective Services (CPS)[19] case while an older sibling(s) was placed out of home.[20]

In each case, there was substantiated abuse and/or neglect of a young child by the parent(s) that resulted in out of home care. Following the removal of this child, a new baby was born into the family while the CPS case involving the older sibling(s) was open. The new sibling was left in the care and custody of the parent(s) only to then suffer serious injury or death due to abuse.

Child protection practices occur in multifaceted settings that can be complex to navigate; under the circumstance where an infant is born to a CPS-involved family with another child in an out of home placement, the complexity is amplified. Accurately integrating information from the existing case with factors indicative of infant vulnerability is vital to the decision making process. It becomes central to identifying safety threats, evaluating risk for future maltreatment, and when formulating suitable interventions on behalf of the infant. The reviewed cases provided insight into:

- The need to increase the awareness of infant vulnerability in case management, specifically infants under the age of one year; and,
- The necessity to re-examine the decision making process and the application of critical thinking skills in complex child protection services scenarios, particularly those involving families with a pregnancy during an open CPS case.

The OIG found that the infant, who later died or was seriously injured, was kept at home with the CPS-involved parent(s) with no additional services, that parent progress in the sibling CPS case was mischaracterized, and that caseworkers and supervisors assigned to the case at the time of the serious injury or death of the baby did not have sufficient support in addressing trauma.

The vulnerability of children is generally accepted. Empirical research identifies both the increased vulnerability of newborns/very young infants, and of those born into families involved with child protective services; highlighting why these children should be the focus of great concern.

- Children who had an older sibling referred to CPS in the year before their birth were highly correlated with factors that predicted injury, death and hospitalizations;[21]

[19] For the purposes of this report, CPS is used to refer the specific functions of the Department of Health and Human Services Division of Child and Family Services that pertain to child protection.

[20] Data on this specific population—babies born into an existing CPS case where an older sibling was placed out of home—is not easily produced by DHHS as data is not tracked in that way. Interviews conducted by the OIG indicated anecdotally that cases, with a child or children are placed in out of home care and a new baby is born, are not rare, but at the same time, do not happen at a high frequency.

[21] Vaithianathan et al., "Injury and mortality among children identified as at high risk of maltreatment. Pediatrics 141(2). (2018) p. 5.

- Infants are more than twice as likely to die of maltreatment as children who are between the ages of one and two years old, thus, the greatest risk factor for death by maltreatment is infancy;[22] and,
- Newborns are uniquely at risk because they are fragile, non-verbal, and entirely dependent on others for their care; while caregivers face additional responsibilities, time management issues and sleep deprivation.[23]

CASE SUMMARIES

The following four case summaries describe the critical incident—either death or serious injury—of the infant, the family's CPS involvement and prior history for each case included in the report.

All names of those involved have been changed to maintain confidentiality.

ANGELA J.

SERIOUS INJURY - AGE: 6 MONTHS

Critical incident

Angela J. was brought to the hospital by her parents, Brenda and Collin J., where doctors found a subdural hematoma on Angela's head. She also had two healing leg fractures. It was noted that Angela had a total of four bruises on her lower jaw at the time of admittance.

Collin later confessed that he shook Angela on previous occasions, and on this day, he had shaken and dropped her. Collin was charged, plead no contest to Felony Child Abuse-Serious Injury, and was sentenced to three years on probation.

At the time of Angela's birth, her mother, Brenda, was involved in an open CPS case with her oldest daughter Debra. Five days after the birth of Angela, Brenda voluntarily relinquished her parental rights to Debra, thus removing her as a participant in the case plan.

Child Welfare History

Brenda J. is the biological mother of four children; Debra, Elliot, Angela and Fiona.

Debra was born to Brenda J. when she was 16-years-old. Debra's father was 60-years-old.

A non-court case was initiated after the birth due to concerns for Debra as Brenda did not have necessary items to care for a newborn, Brenda's poor physical hygiene at the time of the birth, and an observed lack of bonding between Brenda and Debra. Services addressed the unsanitary living conditions, parenting skills, and meeting the physical needs of a newborn. Within six weeks of agreeing to the voluntary case, the family started to resist engagement with the case plan. The case closed within six months as the family was no longer willing to continue working with non-court support services.

[22] Child Welfare Information Gateway, Child Abuse and Neglect Fatalities 2016: Statistics and Interventions. July, 2018. p. 3. (Accessed January 25, 2019). https://www.childwelfare.gov/pubpdfs/fatality.pdf.

[23] Corkin at al,"Predictors of Mothers' Self-Identified Challenges in Parenting Infants. Journal of Child and Family Studies: 27. (2018) 667. Doi:10.1007/s10826-017-0903-5.

Two years later Elliot was born to Brenda J. Ten days after his birth, Elliot presented at a well child checkup severely dehydrated and in kidney failure. Doctors at the hospital determined that Elliot was suffering from severe dehydration and starvation as a result of abuse/neglect. Debra and Elliot were both made state wards.

Brenda was unable to make sustained case plan progress, and was never able to demonstrate she had developed the necessary skills to care for the children and meet their basic needs in a consistent manner.

Brenda and Collin J. married, and ten days later Brenda gave birth to Angela. An intake was accepted alleging Brenda and Collin did not have the supplies necessary to care for a newborn and that Brenda had two children currently not in her custody or care.

Elliot had been placed in the care of his biological father. Brenda relinquished her parental rights to Debra.

A juvenile petition was filed a week after the birth of Angela. An affidavit indicated that Brenda had voluntarily relinquished her parental rights to Debra, the older sibling, five days after the birth of Angela stating she was "unable to provide for Debra." Additional information in the document indicated that Collin had reported that he was diagnosed with ADHD and Bipolar Disorder and was not currently seeking treatment, and that the couple intended to leave the state and relocate where Collin had obtained employment.

Angela was made a state ward and was placed in the home with her parents, contingent on their adherence to a Safety Plan that was initiated by CPS at the time of her birth.

Multiple documentation narratives from this period indicate that Brenda and Collin were having difficulty following through on utilizing community resources, and maintaining a legal source of income along with providing safe and stable housing – but in general were maintaining at a minimal standard.

The juvenile petition was dismissed when Angela was three months of age, due to the family maintaining their income and housing and there were no further incidents of concern towards the care of Angela.

An intake concerning Angela was accepted when she was four months old, alleging physical neglect of Angela by both her parents. The report included concerns of trash, dirty and moldy dishes, food laying around, and dirty clothing scattered throughout the home.

Angela was found to be SAFE in the care of her parents based on the meeting of her physical needs and the condition of the home at minimal standards. Angela was also found to be at HIGH risk for future maltreatment, and the parents were offered a non-court case. The parents declined to participate in the non-court case.

At six months of age, Angela was seriously injured by her father.

GRACIE S.

DEATH – AGE: 1 MONTH

<u>Critical incident</u>

Gracie S. was found non-responsive and limp in her crib and was brought to a hospital. A CT scan of Gracie found multiple fractures to both sides of the skull, multiple areas of bleeding inside the skull and brain, in conjunction with small bruises on her head and some swelling at the sight of the skull fractures.

Doctors specializing in child abuse reported that Gracie's injuries had no other explanation other than child abuse. Gracie had been severely shaken, and her head was either slammed or crushed. Several days later life support was removed and Gracie S. died.

Heather S., Gracie's mother, was arrested and plead no contest to Felony Child Abuse. Heather admitted to shaking Gracie and dropping her on two occasions. Heather was sentenced to prison for 60-70 years.

Heather S. had an open CPS case involving Gracie's older sibling, Lucas, at the time of the critical incident.

Child Welfare History

Heather S. is the biological mother of Kevin, Lucas, and Gracie.

Lucas was born to Heather S. and Jeff M.

At one week of age, Lucas was seen in the emergency room due to blood in his mouth. He was admitted to the neonatal intensive care unit. No explanation for the injury was determined. At three weeks of age, Lucas was again taken to the emergency room with two bruises on his forehead. Heather reported that her foot had slipped on the stairs while carrying the infant which resulted in him falling out of her arms. The following day Lucas was admitted to the hospital due to bright red blood in his stools. At six weeks of age, Lucas was taken into the emergency room by his parents with facial bruising. Heather reported that three days prior she had tripped and fallen over the family dog while carrying Lucas. A skeletal survey indicated that Lucas had a bone fracture. Lucas was made a state ward.

Heather admitted to investigators that she was having a hard time dealing with the stresses of caring for a newborn, and that on the day of the final incident Lucas wouldn't stop crying. Heather told officers that she had hit Lucas because he was "crying too much" and that she had pulled him out of a bassinet by yanking his arms. Heather plead guilty to Felony Child Abuse and was sentenced to prison for 18 months to 2 years.

For eight months following her release from prison, Heather made little progress on meeting case plan goals and complying with court orders, and later informed her caseworker that she was pregnant. Heather maintained contact with Lucas, via fully supervised parenting time occurring one or two times a week for 2-3 hours each.

Heather relocated to a new area of the state three hours away from her then current residence. Though she lived in a new service area, she continued case management with her original caseworker's office. She attended family team meetings via phone and drove once a week to have fully supervised two to four hour parenting time sessions with Lucas.

Gracie S. was born to Heather S. eleven months after her release from prison. At the time of Gracie's birth, an intake was accepted by the Hotline for the physical neglect of Gracie. The intake noted the mother had a prior history of abuse to an older sibling.

Gracie was assessed for safety while still in the hospital after her birth. Gracie was found to be safe in the care and custody of her mother. A Risk Assessment for Heather S.'s household was completed. The final risk level was HIGH and the planned action was to recommend for ongoing services. Despite the HIGH risk to Gracie, follow up with Heather did not occur. Voluntary services were not offered, and further monitoring of Heather's ability to safely parent Gracie was not initiated.

Two days after Gracie suffered injuries as a result of abuse by her mother, which would ultimately be the cause of her death, the court terminated jurisdiction over the case involving

Lucas and relieved DHHS of responsibility. Five days after Lucas' case close, Gracie was removed from life support and died.

Michael G.

Death – Age 4 months

Critical incident

Four-month-old Michael G. was found unresponsive in the family home and died.

Michael's mother, Nancy G., gave conflicting accounts of events to law enforcement investigating the death. She recounted finding Michael in his bouncer with his face in a pillow, then stated she had found the infant laying on his stomach on the couch with Paul A., Michael's father. Then once at the police station, Nancy was heard by officers telling an unknown person on the phone that she woke up and found Michael laying in the bed next to her with blue lips.

Nancy had a blood alcohol concentration (BAC) of .225 and Paul a BAC of .062. Nancy's continuous alcohol monitor (CAM) placed as part of her conditions of probation was removed five days prior to the death of Michael.

At the time of Michael's birth, Nancy had an open CPS case involving Nancy's older son, Robert. Six weeks prior to the death, the case involving Robert closed and a juvenile petition alleging the neglect of Michael by Nancy was filed. At the time of Michael's death, the petition was awaiting disposition; Michael had not been made a state ward.

Child Welfare History

At the age of 15, Nancy became a state ward due to an incident of domestic violence between her mother and herself; Nancy had a (BAC) of .183 at the time of the incident. Nancy had 14 placements after being made a state ward. Her juvenile history contains multiple references to heavy alcohol consumption and self-reported binge drinking starting at 13 years of age. Nancy aged out of the system after transitioning to independent living.

Nancy G. is the biological mother of Robert, Steve and Michael.

When Robert was two-years-old an intake was accepted due to a homicide in the family home in which he was present. A juvenile petition was filed and Robert was made a state ward. Nancy successfully completed her case plan, and the juvenile court case was closed. Four months later, another intake was accepted by the Hotline alleging domestic violence between Nancy and her mother in the presence of Robert.

Law enforcement officers arrested Nancy for outstanding warrants and charged her with child abuse and neglect. Her BAC at the time was .292, making her too intoxicated to safely care for Robert. The Safety Assessment found Robert SAFE, however a juvenile petition was filed in conjunction with the incident but did not request that Robert be made a state ward. The Guardian ad Litem later requested Robert be made a state ward and placed with the non-custodial parent. For the second time in four years, Robert was made a state ward.

Nancy reported at a team meeting that she was pregnant. About the time she was five months pregnant with Michael, Nancy began to stabilize and make progress in the case involving Robert. However, there were

concerns about the presence of Paul A. (father to Michael) around Robert due to his history of drug/alcohol use, violence, and the generally unstable nature of his relationship with Nancy.

When Michael G. was born an intake alleging the physical abuse of the newborn was accepted due to Nancy being involved with CPS. A Safety Assessment found Michael SAFE based on the baby testing negative for all substances at birth, Nancy sufficiently providing for all physical needs of the newborn, and resumed well child checks with medical professionals. A Risk Assessment was completed and scored HIGH. The Risk Assessment conclusion stated, "This case will remain open as it relates to Robert until a custody and parenting agreement can be established, however at this time there appears to be no safety threat for Michael." Service authorizations continue to provide family support for monitoring of overnight parenting time for Robert.

In the following month Nancy had multiple contacts with law enforcement, one of which included an accepted intake by the Hotline due to Nancy caring for Robert and Michael in an extremely inebriated state. The completed Safety Assessment found Michael to be CONDITIONALLY SAFE; the resulting Safety Plan included family support in the home two hours per day, Michael would attend daycare on a regular basis, and Nancy would consistently meet with her therapist and continue drug/alcohol testing via Probation. Visits between Nancy and Robert reverted back to fully supervised.

A hearing for the case related to Robert was held a few weeks later. It was noted that Nancy had missed drug tests, was not attending AA, had two contacts with law enforcement during the month prior, and had relapsed in her sobriety. The judge signed a bridge order that granted Robert's biological father full custody, thus closing out the CPS case. Nancy was only allowed fully supervised contact with Robert. A few days after this hearing a juvenile petition was filed based on the earlier incident of Nancy caring for Michael while intoxicated.

The juvenile case involving Michael was adjudicated and a hearing was scheduled for disposition. Michael was left in the care and custody of his mother. Within 60 days of the petition being filed, four-month-old Michael G. was found unresponsive in his home and died.

Tammy D.

Serious Injury – Age: 1 month

<u>Critical incident</u>

Tammy D. was admitted to a hospital with brain bleeds, bruising on her face and abdomen, and a dislocated elbow. A skeletal scan later revealed a healing fracture of the femur.

Tammy's father, Weston D., had brought Tammy to the emergency room claiming he had dropped her while trying to swaddle the newborn. During the police investigation Weston admitted to shaking her on at least two occasions and to shaking and dropping her just prior to bringing her to the emergency room.

Tammy was taken into protective custody and made a ward of the state. Weston was convicted of 1st Degree Assault and sentenced to 12-24 years in prison. Tammy's mother, Abbie D., was convicted of Child Abuse and sentenced to 1 year in jail.

At the time of Tammy's injuries, her parents were involved in an open CPS case stemming from the abuse of her older sibling, Bruce D.

Child Welfare History

Abbie and Weston D. are the parents of four children; Donna, Clara, Bruce and Tammy.

Weston took his then three-week-old son, Bruce D., to the hospital for increased fussiness and trouble breathing. While there, staff noticed a suspicious red mark on his left arm. The mark was described as red, three inches long, the width of a ballpoint pen tip, extending from the elbow two inches toward the wrist, and one inch toward the shoulder. The mark was determined by medical professionals to be a bruise.

Due to the unexplained bruise and because hospital staff were aware that the D. family had lost an infant daughter (Clara) the year before to Sudden Infant Death Syndrome (SIDS), law enforcement and the Hotline were notified.

When questioned about how the bruise occurred, Weston indicated he was not sure. He stated he thought it might have happened because he swaddled Bruce too tightly. Medical staff specializing in child abuse concluded that the injury was not consistent with Weston's explanation.

The Safety Assessment found Bruce to be UNSAFE. Despite this, Bruce's older sibling, Donna, age 3 ½ years, was found SAFE, she was not made a state ward and continued to live in the home with her parents. Bruce was removed from the parental home and was placed with his paternal grandparents.

Fully supervised visitation was implemented for Weston four times a week. Weston was also given the opportunity to see Bruce in the evenings, when supervised by the foster parents. Abbie was allowed to care for Bruce from seven in the morning until three in the afternoon during the week without supervision.

Three months after the case was opened, Abbie told the caseworker that she was pregnant. Documentation for the next eight months described the parents' engagement as varying between unwilling to participate in services to unmotivated to progress past superficial engagement. Intensive Family Preservation was discontinued due to services not being utilized appropriately: Weston missed the majority of parenting time. Abbie became difficult to work with, refusing to communicate with providers and not following through on referrals. The parents also indicated that they were willing to engage in mental health services, but would not follow through with scheduling and/or attending sessions. During this same time period, Abbie and Weston become resistant to reunification with Bruce. Tension was evident between the parents and the caseworker. The parents consistently requested that the infant, Bruce, stay in out of home placement for the duration of Abbie's pregnancy, and the caseworker attempted to increase the amount of time Bruce was in the home and move towards a projected date for case closure.

At the time of Tammy's birth, her older sister, Donna, remained in the home with Weston and Abbie while Bruce continued to be placed in out of home care with his grandparents. A Safety Assessment completed due to Tammy's birth found the newborn SAFE.

Court reports and other documentation illustrated that while there was concern for the parent's ability to cope with two children under the age of one year and an older child with special needs, there continued to be a drive for a reunification in the very near future.

Three weeks later, Tammy was seriously injured by her father.

FINDINGS

The infants subject to the critical incident, whether death or serious injury, were each born into a family with a history illustrating that the parents had not had much time parenting the older siblings during their infancy. Reasons for the limited parenting ranged from parental choice to adoption placement to alternate caregivers, death, or system involvement that included removal from the home.

Decision-Making Within CPS

Central to the CPS process are the many decision-making points included in gathering and accurately assessing information, identifying the causes of maltreatment, and implementing services. This is to eliminate such causes of maltreatment while strengthening the family's ability to protect and care for their children.

The Child Welfare Information Gateway defines the process of structured decision-making as an approach to child protective services that uses clearly defined and consistently applied decision-making criteria applied to screening for a child abuse and neglect investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. The approach also utilizes child and family needs and strengths that are identified and considered when developing and monitoring progress toward a case plan.

The Structured Decision Making System® (SDM) was developed within the National Council on Crime & Delinquency's Children's Research Center. The system is a suite of assessment tools employed with the objectives of identifying critical decision points, increasing the reliability of decisions, increasing the validity of decisions, targeting resources to families at highest risk, and using case-level data to inform decisions throughout the agency. According to the National Council on Crime & Delinquency's website, their model "combines research with best practices, offering workers a framework for consistent decision making, and offering agencies a way to target in-demand resources toward those who can benefit most."

SDM was implemented statewide within the Nebraska Child and Family Services Division (CFS) in July 2012 for child protective services (CPS) casework. The purpose of implementing the system was to utilize an evidenced-based model that would consistently guide decision making within CFS with respect to child safety, risk of future maltreatment and planning for child permanency.

Most of the findings within this report center on decision-making within CPS.

THE INFANT (WHO LATER DIES OR IS SERIOUSLY INJURED) IS KEPT AT HOME WITH THE CPS-INVOLVED PARENT(S) WITH NO ADDITIONAL SERVICES.

The parents in these CPS cases were nearing case closure in the sibling's case when the infant was born. These case closures included such factors as the sibling(s) not in the home full time, if at all, and the parents having supervised or monitored parenting time. These situations did not equate with demonstrating the ability to safely and protectively parent a very young infant full time, in the home, without formal supports.

The S., G., and D. cases provide examples of a new baby being inserted into an established case similar to an addendum, versus a change in the composition of the family dynamics and

therefore necessitating the need to re-evaluate the current case plan and services. Services in place to address safety and risk of the sibling placed out of home did not adjust for the new baby in the home.

FLAWED USE OF SDM TOOLS COUPLED WITH A LACK OF CRITICAL THINKING SKILLS LED TO CASE PLANS AND SERVICES THAT DID NOT ADEQUATELY INCORPORATE THE NEWBORN INTO THE FAMILY HOUSEHOLD.

A review of SDM assessments in the four cases revealed that assessments for the newborn often conflicted with information contained in case documentation of the older sibling, were not reflective of the change in family circumstances (the birth of a new baby), and contained inaccurate information. The errors in the use of the SDM tool coupled with the underutilization of critical thinking skills led to case plans and services that did not adequately incorporate the newborn into the household.

While SDM is intended to guide child protection decisions, they alone are not enough to assure safety and risk are being assessed accurately or that adequate services are being put into place. The foundation of the tool must be rooted in well-developed critical thinking skills.

MISCHARACTERIZATION OF PARENT PROGRESS IN SIBLING CPS CASE

Within these cases, there is a dissonance between characterizations of progress and case narratives, and other information. Reports and assessments stated the parents had made progress in an area when collateral information and formal service provider updates stated otherwise. Statements of progress often contradicted the body of other documents and assessments completed during the same time period.

This mischaracterization of parent progress and engagement in the existing case was then used as important information in determining the subsequent safety and future risk of maltreatment of the new baby.

ALL AVAILABLE INFORMATION RELATED TO PREVIOUS MALTREATMENT OF A SIBLING BY THE CAREGIVER AND THEIR PROGRESS IN AN OPEN CPS CASES WAS NOT CONSIDERED WHEN ASSESSING SAFETY OF THE INFANTS.

The primary function of assessing for safety is to determine if an immediate threat to the safety of a child exists and, if present, whether the threat is or can be addressed through interventions allowing the child to remain in the home or whether removal from the home is necessary.

The OIG found that when considering the infant's safety, all available information was not incorporated, including historical information found in law enforcement reports, therapist reports, and previous SDM assessments.

It is critical that all previous reports and information be analyzed and taken into consideration. The history of the family is important because it provides critical information on the pattern of behaviors and provides indicators of past trauma that may impact the parent's ability to safely parent their child. Several examples of this were evidenced in the process of case reviews.

In the J. case, an intake for the physical neglect of Angela was accepted when she was four months old [60 days prior to her serious injury]. The assessment evaluated the physical living

conditions of the home and the availability of formula and diapers for the baby. While these observations were applicable to the current intake, the assessment did not include information from previous CPS cases with Angela's siblings Debra and Elliot. Brenda had voluntarily relinquished her parental rights to Debra just days after Angela's birth, stating she could not care for Debra, and the case involving Angela's older brother Elliot had a permanency plan recommendation of "reunification with father" and a District Court Order of Custody limiting Brenda's contact with the child.

The Safety Assessment found Angela to be SAFE, but in the assessment there was no reference to a previous juvenile court petition that had been filed in regards to Angela at the time of her birth, history of abuse/neglect of siblings, the mother's failure to demonstrate an ability to provide proper parental care without assistance from others, and the secondary caregiver's history of mental health issues.

In the S. case, an intake for physical neglect had been accepted at the time of Gracie's birth. The Safety Assessment documented the ability of Heather to meet the newborn's immediate physical needs, stating that no safety threats applied due to clean clothing and health needs being met. Assessment narratives did not integrate information from Heather's CPS case history, including Heather stating in reference to her older son, Lucas, she "had a hard time dealing with the stress of caring for a newborn," and that she had hit him because he was "crying too much," Heather's incarceration for twelve months due to physical abuse of Lucas at the age of six weeks, and Heather's participation in fully supervised parenting time with Lucas only once a week for three hours at the time.

The G. case detailed that the Safety Assessment completed at the time of Michael's birth found the newborn to be safe based on his testing negative for all substances at birth, his mother resuming scheduled well baby checkups with a pediatrician, and his mother being observed as providing for all physical needs of the infant. There was no mention of historical information with CPS, including Michael's older sibling being out of home over 15 months. During this interval, all Reunification Assessments completed in the prior twelve months scored at a final risk level of HIGH and a safety decision of UNSAFE if returned to the care and custody of his mother.

In the D. case, the Safety Assessment completed two weeks after the birth of Tammy found her to be SAFE. It was focused on the safety threat identified in her older sibling (Bruce)'s case, and did not address behavior of the parents that included a lack of engagement in referenced services, or their refusal to begin transitioning Bruce back into the home full time. Four months before Tammy's birth, Bruce's foster parents continued to have concerns for his safety. The foster parents noted that he goes to visits with the mom, Abbie, and within hours of drop off Abbie is calling asking about pick up. Additional narratives from within 90 days of Tammy's birth stated that the parents were still not fully engaged in therapeutic services.

THERE WAS A DISPROPORTIONATE RELIANCE ON RECENT INFORMATION IN COMPARISON TO THE AVAILABLE CUMULATIVE INFORMATION OF THE FAMILY'S HISTORICAL AND CURRENT CPS CASE.

Research indicates that capturing abuse and neglect information from the point of the index child's initial intake is not sufficient. Research highlights the importance of understanding that abuse is a symptom of parent/family dysfunction, not the unique experience of an individual child.

The CPS involved families had been working with caseworkers and service providers during pregnancy and at the time the new baby was born. A review of documentation and SDM Assessments revealed that when evaluating the progress of the caregivers in relation to assessing safety and risk, the previous 30-90 days of information was prioritized opposed to the whole CPS history of the family.

Interviews with case managers, supervisors and administrators associated with the cases consistently included comments inferring parents were being evaluated based on the status of the sibling's case, which did not include seeing the newborn as a change in circumstances that created a new dynamic and environment for the family.

In all of the cases, parents had been recently resistant to meaningful engagement with services, and demonstrated a pattern of inconsistent progress. Had a more comprehensive evaluation of the circumstances taken place, patterns of behavior germane to the addition of a baby to the household may have been more evident.

This dynamic creates the necessity for workers and supervisors to be vigilant in thinking critically about whether or not to remove an infant from a home that already has a young child in foster care. As the OIG reviewed safety assessments associated with this investigation, it found that with few exceptions, the safety decision for the infant was primarily based on meeting the immediate physical needs of the baby.

ONCE THE IMMEDIATE PHYSICAL SAFETY OF THE INFANT WAS DETERMINED, RESPONSES TO THESE CPS-INVOLVED FAMILIES, WHICH WERE ASSESSED AS HAVING A HIGH LIKELIHOOD OF MALTREATMENT, DID NOT RESULT IN PRIORITIZED SERVICE COORDINATION FOR THE NEWBORN.

The Risk and Prevention Assessments inform the caseworker of the risk of harm and helps determine whether ongoing services are needed. These assessments identify families who have very high, high, moderate, or low probabilities of abusing or neglecting their children in the future. By completing the risk or prevention assessment, the caseworker obtains an objective appraisal of the likelihood that children in the household will experience maltreatment in the next 12-18 months.

DHHS policy and procedure pertaining to Risk or Prevention Assessments indicates that the purpose of the assessment is to inform the decision on whether or not to open an ongoing services case, specifically stating that if the level of risk is scored as high or very high and/or the family meets one or more criteria, an ongoing case will be opened. In addition to guiding the case status decision, policy states that the risk level helps the caseworker prioritize the intensity of service coordination provided to each family.

In cases subject to this report, the family's risk level was HIGH, and there lacked an appropriate response; such as the implementation of ongoing case management services specifically addressing the risk to the infant still in the home, and/or supervisor consultations to determine whether or not to request a filing by the county attorney.

In the S. case, the Risk Assessment completed after the birth of Gracie indicated the final level of risk for future maltreatment to be HIGH with a planned action to recommend for ongoing services.

A narrative created three weeks after the birth of Gracie stated that the Service Area supervisor and caseworker reviewed the intake for final risk scoring and planned action stating:

The current allegations are of physical neglect by Heather S. to Gracie S. Allegations state that Heather has a child that is not in her care and she still has supervised visits with. Also, the mother has a court substantiated charge for child abuse when her other child was an infant. Found as a result of this investigation, the findings will be entered as UNFOUNDED. The family's final risk level was high. The final risk level was high due to the current neglect incident, the prior investigations of abuse or neglect, the family's previous ongoing case, the prior injury to a child, the age of the youngest child in the household, and the primary caregivers past and current mental health problem. The plan is to keep this case as an ongoing case.

Gracie was not made part of the current ongoing case nor was a new ongoing case opened in the new Service Area.

In the G. case, the Risk Assessment completed after the birth of Michael scored HIGH due to the current report of neglect, the four prior neglect investigations, and the primary caregiver having a history of alcohol and mental health problems. The Risk Assessment conclusion stated:

This case will remain open as it relates to Robert until a custody and parenting agreement can be established, however at this time there appears to be no safety threat for Michael.

This response focused only on the older sibling and did not address the risk of future maltreatment to the newborn.

In the D. case, there was no Risk or Prevention Assessment completed for Tammy between the date of her birth and the date of her serious injury.

REUNIFICATION ASSESSMENTS COMPLETED FOR THE SIBLINGS PROVIDED INFORMATION THAT WAS MISLEADING, INCORRECT, OR CONFLICTING.

The purpose of the Reunification Assessment is to inform the decision of whether a child is recommended for reunification with a caregiver or if a change to the permanency plan goal should be recommended. The caseworker will conduct the Reunification Assessment on any ongoing case in which at least one child is in out of home placement with a goal of reunification. The assessment evaluates risk, parenting time, and safety issues, and is utilized in ongoing cases in which at least one child is in out of home placement. If families have effectively reduced risk, have achieved at least acceptable parenting time, and the home is SAFE or CONDITIONALLY SAFE, reunification can be recommended by the CFS Specialist.

The Reunification Assessment consists of four parts, the results of which are used to reach a permanency plan goal and to guide decisions about whether or not to return a child home: (1) Risk Reassessment; (2) Parenting Time Evaluation; (3) Safety Reassessment; and, (4) Permanency Plan Recommendation.

When assessing the newborn for safety and risk, information from the older siblings' Reunification Assessments would have been considered. The OIG found information that was conflicting, misleading or inaccurate in these Reunification Assessments.

For example, in the G. case, the Reunification Assessment completed four months prior to the birth of Michael found Robert at HIGH risk for future maltreatment and UNSAFE should his care be returned to his mother. The assessment stated that Nancy demonstrated few new skills and minimal participation in pursing outcomes. An active safety threat was identified – that the

caregiver does not, cannot, or will not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care. The permanency plan recommendation was to maintain in care while pursuing reunification with the biological father and a concurrent plan for adoption. The conclusion narrative stated that Nancy continued to be unable to provide a safe and stable home for her son and to have cycles of doing well and then making poor choices while other narratives in the assessment stated that "Nancy has had a good stretch of progress and has asked for overnight monitored parenting time."

The Reunification Assessment completed within eight days of Michael's birth scored the final risk level as HIGH and the safety decision as UNSAFE with a permanency recommendation of Family Preservation with the biological father. The "Caregiver Progress with Case Plan" indicated that Nancy demonstrated few new skills consistent with case plan outcomes or with addressing critical needs with minimal participation in pursing outcomes.

In the D. case, the Reunification Assessment for Bruce was completed within the same time frame as Tammy's birth indicated that the final risk level was LOW and the safety decision was SAFE.

The initial risk level was incorrectly marked as having been MODERATE, resulting in an inaccurate risk level. The Caregiver Progress with Case Plan section was scored as both parents demonstrating new skills consistent with case plan outcomes, and successfully changing behavior to improve ability to protect and care for children. Parenting time frequency for Weston was scored as routine, with adequate quality and overall as ACCEPTABLE. These responses conflicted with case narratives that indicated Weston was having very little contact with Bruce, that the parents had only very recently displayed any kind of engagement in mental health services, and that the parents had resisted increasing the time Bruce was in the home.

CASE PLANS AND SERVICES EXCLUDED THE NEWBORN AND THE IMPACT HIS/HER BIRTH WOULD HAVE ON THE FAMILY.

The SDM Family Strengths and Needs Assessment (FSNA) is intended to assist in the collection of information used to drive the development of an individualized case plan and effective service array. In these cases a gap was found between the FSNA, case plans and services when considering the addition of an infant to the household.

A review of FSNAs completed between the time of the intake for the older siblings and the time of the serious injury/death of the infants revealed that the infant and the change in the family dynamics was not integrated into the evaluation of strengths or needs related to the family. Case plans remained the same as prior to the birth of the new sibling, with goals and services showing no adjustment in substance.

FSNA documentation did not indicate that caregivers were experiencing an increased or extraordinary need in the area of parenting skills, as would have been evidenced by having a child in out of home care. In the S. and G. cases, FSNAs for the households were completed six months prior to the birth of the infants and updated FSNAs were not completed prior to the infants' deaths.

WORKERS AND SUPERVISORS ASSIGNED TO THE CASE AT THE TIME OF THE SERIOUS INJURY OR DEATH DID NOT HAVE SUFFICIENT SUPPORT IN ADDRESSING TRAUMA.

Trauma related to the serious injury or death of a child does not only affect those who love them, but frontline caseworkers and supervisors can be affected by trauma as well. In addition to the potential of experiencing trauma as a caseworker, is the exposure to vicarious trauma. Vicarious trauma has a clinical basis in trauma theory, and is strongly correlated with PTSD experiences. Vicarious trauma is experienced through contact with traumatized people or through material that contains graphic images of trauma. Although any person can experience vicarious trauma, inexperienced caseworkers and those who have survived some form of personal trauma themselves are at particular risk.

As part of this investigation, the OIG interviewed caseworkers and supervisors involved with all of the reviewed cases. The interviews revealed that front line staff were personally affected by deaths and serious injuries of these children. Regardless of their position as front line staff or supervisors, they reported feeling supported by co-workers of an equal position, but they did not feel the same type of support by their supervisors or the administration. They also reported that while the Employee Assistance Program offered by DHHS was not "unhelpful" it did not help them in a way they found useful, especially specific to their experience through a death or serious injury on their caseload. One person indicated that as a result of the outcome of the case, they needed a significant amount of individual therapy that they sought out on their own, and had they not done so they would have not been able to continue working in the field.

There is a statistically significant path between vicarious trauma and intent to leave the organization among child welfare professionals. Critical incidents, such as those investigated by the OIG, have an emotional impact on the caseworkers who must continue to confront the incident.

RECOMMENDATIONS

The OIG is tasked with making recommendations in reports of investigation. Recommendations are intended to address any systemic issues that the report identifies. Based on the issues identified in the above cases, the OIG recommended that DHHS take the steps detailed below.

I. Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.

As a result of this investigation, the OIG found that the CFS workforce is not consistently addressing issues that arise when a newborn is added to a family that already has a child in out of home placement. The circumstances created by this event are unique. Existing policy and procedure, which typically manages cases in a linear fashion, may not easily integrate a new baby into an already established case.

The varied CFS responses in the four reviewed cases demonstrated that there exists confusion about assessing for the safety and risk of a newborn. As one administrator pointed out when speaking to the assessment of safety, "Assessing safety in the hospital should include talking to the medical staff to be sure everything is okay, it might be followed up in the home, but it's not always followed up on with contact in the home." The OIG observed that the confusion surrounding the assessment of newborns

was not limited specifically to when the child is added to a household that includes an out of home placement of a sibling and has been receiving ongoing case management services.

The OIG recommends that DHHS implement policy and procedure to explicitly address pregnancy and the birth of child into a family currently involved with CFS. The function of the policy should be to address issues unique to the pregnancy and birth of a new baby in each individual case.

As an example, the state of Oregon produced a protocol document specific to providing guidelines to be used when a pregnancy or new birth is a factor in a report of child abuse, a CPS assessment or during ongoing case management. The guidelines were meant to assist staff in addressing child safety in those circumstances by outlining additional considerations and steps to take. Included in the protocol is the utilization of a "Pregnancy or New Baby Staffing". The purpose of the staffing is to discuss history and current circumstances in order to make decisions about a plan for the least intrusive intervention for the family without compromising safety of the newborn. The staffing is not intended to replace the need to involve the family in planning, but instead offers an opportunity to use critical thinking and allow for alternative perspectives to be considered.

A greater understanding of risk indicators may provide insight into the appropriate assistance, intervention, and prevention efforts required specifically by families with new born infants. The need for this was best demonstrated when a supervisor told the OIG, "A family may not be where they need to be at for an older child who is ambulatory, and running around – it may not be safe. With a baby it's different, they're not ambulatory and can sit in a crib or bassinet and are fine."

II. Clarify the definition of "change in circumstance" as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.

DHHS Protection and Safety updates describe "change in circumstances" in reference to Safety Assessments in several location in multiple documents. For example, in PSP #5-2018 (Initial Assessment]), the CFS Specialist is directed to assess safety "whenever new information becomes available or family conditions change," (p. 5), and then goes on to clarify that additional safety assessments are only required when . . . "there is a change in family conditions (ex: when someone new moves into the home" (p. 5). Nearly identical language is expressed in earlier documents as well. A newborn is a stressful addition to any family dynamic, and is the individual in the family who is least able to advocate for themselves, thus representing a significant change in circumstance.

Pregnancy and the birth of a baby should be a named change in circumstance. Further, specific timelines and guidance as to what assessments should be completed due to a change in circumstance should be added.

III. Include the following factors to when a mandatory supervisor consultation is required: when a parent has voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.

A caregiver who has previously relinquished parental rights or who has concluded a CPS case due to a change in custody in district court may have engaged in behavior similar to those parents who had their parental rights terminated.

As currently written, DHHS Policy and Procedure requires caseworkers to consult with their supervisor when a family has scored HIGH or VERY HIGH on a Risk Assessment and there has been a previous termination of parental rights. The OIG recommends expanding this requirement to include situations when (1) a caregiver has voluntarily relinquished parental rights or (2) a caregiver has had a previous CPS case that resulted in the child being reunified with a parent other than the caregiver subject to the current intake.

Interviews with DHHS Administration indicated that the primary function of a mandatory consultation point is to assist the worker in identifying complex issues, and to assure that DHHS policy and procedure is correctly applied to the situation. In addition, Administration stated that it is the responsibility of the supervisor to provide guidance and support to front line workers as they develop assessment and case management skills. One administrator interviewed as part of the investigation stated, "SDM alone doesn't adequately incorporate siblings. It requires more staffing with supervisors and admin to say here is what I know and going over SDM can we say that this child is going to be safe if we don't intervene." The OIG would suggest that in both of the situations described above, there may be historical information and a pattern of behavior that would require assistance from a more experienced supervisor when assessing.

IV. Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.

Central to the protective service process are the many decision-making points included in gathering and accurately assessing information, identifying the causes of maltreatment and implementing services to eliminate them while strengthening the family's ability to protect and care for their children.

The OIG became aware that SDM logic training is typically left to the front line supervisor. As one administrator reported during an interview, "Refresher SDM logic training is informal between supervisor and worker." When interviewed, front line workers and supervisors consistently stated that they feel additional training in SDM logic is needed. The review of SDM assessments related to these cases raised a number of questions as to how well CFS staff understand (1) the purpose of the tool, (2) how to utilize it in the decision making process, or (3) how to integrate critical thinking skills within the process of using the assessments to guide decision making.

The OIG recommends that caseworkers and supervisors be required to complete additional SDM logic training, including the identification of safety threats, and the use of the FSNA in case plan development.

As referenced in the November 2016 Case Reading Report by NCCD's Children's Research Center, Nebraska DHHS was advised that staff would benefit from a safety assessment logic refresher. According to them, it was "the biggest shortcoming in terms of SDM system fidelity in Nebraska . . . It would help workers avoid getting stuck in technically supportable interpretations that nonetheless clearly miss the intent of the item . . . Providing training on using the SDM system to organize clear and concise case notes may strengthen documentation and help reduce workload by at least somewhat reducing the paperwork burden" (A2-A3).

As part of this investigation, the OIG interviewed staff and administration from the Center on Children, Families and the Law (CCFL). CCFL is part of the University of Nebraska-Lincoln, and has been providing Child Protection and Safety Training for DHHS since 1987.

As of March 2019, the training program consists of 14 weeks of in person and online learning that trains more than 200 new child welfare employees each year. Training includes modules for learning to assess safety and well-being, engaging families, child development, understanding the effects of trauma on children and their families, and developing case plans.

CCFL training staff identified the ability to allow the SDM tools to guide decision making instead of using the tools to confirm a decision already made as an important element of these training modules. They indicated that it is both a skill and a mindset that needs consistent reinforcement.

V. Implement trauma informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.

Interviews with DHHS Administration indicated that responses to traumatic work related events are generally handled at the office level and left to the discretion of supervisors. Interviews with supervisors and administrators associated with the reviewed cases produced relevant examples of workers significantly affected by the trauma of the serious injury or death and unable to maintain their positions in the aftermath. One supervisor shared, "After the incident the worker's job performance declined and was being addressed by administration . . . she just couldn't do the job and quit." Another administrator noted that while, "There is nothing specific in policy or procedure for workers experiencing the trauma of a death or serious injury . . . sometimes they just can't do the job anymore." The OIG recommends that an organized response to traumatic events be implemented, include training for supervisors with front line worker input. Workers who believe they have the ability to influence their environment are less likely to experience burnout.

Vicarious trauma is experienced through contact with traumatized people or through material that contains graphic images of trauma. Although any person can experience vicarious trauma, young case workers and those who have survived some form of trauma themselves are at particular risk.

There is a statistically significant path between vicarious trauma and intent to leave the organization among child welfare professionals. Workers who leave mean a loss of experience to the entire organization, through loss of institutional knowledge, historical experience, and critical thinking skills. Understanding and providing coping mechanisms for these feelings is extremely important because of caseworker mental and physical health. In a profession which relies on judgement that can come only through experience, losing human capital can have wide-ranging impacts on the system as a whole.

The costs of training caseworkers is high, but repercussions of caseworker turnover carry additional costs. Shifting caseloads among remaining workers may add to their stress and risk of burnout. High worker turnover has implications for quality, stability, and consistency of services to children and families. Changes in caseworkers mean that the children they serve in the child welfare system are less likely to achieve permanency. Children report that feelings of trust and stability with their caseworkers are important to them. Caseworker turnover affects every family on the caseload.

Organizations tend to set expectations for how workers experience trauma. Successful leadership acknowledges and normalizes trauma by giving workers opportunities for self-care, counseling, and time off. Not all recommendations carry costs. For example, supervisors may vary caseloads so trauma cases are distributed, conduct weekly meetings or conversations with affected workers, promote

voluntary meetings among others who have had the same experiences, and encourage workers to use their earned vacation time.

DHHS Response:

DHHS rejected all recommendations. See letter dated July 24, 2019.

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Pete Ricketts, Governor

Date: July 24, 2019

To: Julie L. Rogers
Office of Inspector General of Child Welfare
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Lincoln, NE 68509-4604

From: Dannette R. Smith
Chief Executive Officer
Department of Health and Human Services
301 Centennial Mall South, P.O. Box 95026
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Re: Response to Investigation – Infant Death or Serious Injury with Family Involvement in CPS

The Department of Health and Human Services (DHHS) has reviewed the report submitted on June 28, 2019, regarding Death or Serious Injury with Family Involvement in CPS. The Department appreciates the time and thought put into reviewing these cases, one of which took place in January 2014. DHHS rejects these recommendations for the following reasons.

Recommendations (Roman numerals) I – IV are all related and therefore should be addressed together. The Division of Children and Family Services (CFS) currently has a protocol outlining when family circumstances change and the requirement to reassess for safety. The protocol language is intentionally broad because there is no way to list every possible scenario that may constitute a change in family circumstances.

CFS is currently working with a national organization to research other states procedures when CPS is working with families and there is an infant death or serious injury, and subsequently determine if there needs to be any changes or updates to procedure, or training for teammates and supervisors. CFS will not make changes to protocols that are not thoroughly researched and consistent with industry best practice. It is important to also understand the consequences and impact to families and CFS teammates. As you know CFS has a Program Improvement Plan strategy to review some of our existing SDM tools. Changes resulting from those activities will include updated training on the tools, enhanced critical thinking skills, and additional education to CFS Specialists and Supervisors where these types of issues can be addressed.

CFS has also recently made changes to improve our system in response to concerns about young children, aged zero (newborn) to five years old. Effective June 24, 2019, CFS changed the intake procedure to

require a CFS response (to accept the intake) to any report made from medical personnel that involves a child from newborn to five years old (even if the report would not be accepted based on other SDM Intake criteria). We ask our teammates to conduct SDM Safety and Prevention Assessments on these families and determine if there are any community or CFS referrals for services that can be provided to assist and strengthen the families' protective capacities.

CFS is also training staff in Safety Organized Practice (SOP). SOP is a set of tools that will assist workers and supervisors to engage with families and clearly articulate the reason for CFS involvement. We are finding that the information gained through the use of these tools provides the worker, family, and the family's network a deeper understanding of when parents and caretakers have demonstrated protective actions, and what was going on in their lives at that time, and what everyone is worried about, and then how can we move forward. We believe these tools will improve engagement with families and result in children being safer and families and their networks clearly understanding the reason for CFS involvement and what behavioral changes need to be demonstrated over time.

Your recommendation (Roman numeral) V was implemented in May 2019. Nebraska is working with the Quality Improvement Center for Workforce Development (QIC-WD) to implement interventions to address secondary traumatic stress (STS) among frontline workers and supervisors. The CFS intervention is expected to increase self-awareness of STS, build skills and abilities to cope with and manage STS, and demonstrate the agency's support for the well-being of frontline teammates. A rigorous evaluation of the intervention will be conducted to answer pertinent questions about how ability to cope with regular stressors can be managed and whether improved resilience skills can decrease turnover. CFS and the QIC-WD are using implementation science to guide the rollout of the interventions and track lessons learned throughout the process. The intervention includes two components which will be implemented over the course of one year.

OIG Comment on DHHS Response:

In the response to the report, DHHS did not address the specific problems raised in the investigation such as caseworkers needing more checkpoints with supervisors to help in difficult cases, caseworkers needing better guidance to address the stresses of pregnancy and child birth in the families they are working with, and both caseworkers and supervisors needing regular SDM logic training.

While DHHS continues its ongoing efforts such as the implementation of the Child and Family Services Review Program Improvement Plan (PIP) as submitted through the Children's Bureau, the thought put into potential procedures to work with families when there is an infant death or serious injury, and training staff in the tools of Safety Organized Practice, these general efforts do not speak to the specific needs of the system identified by thoroughly reviewing brought to light by this investigation. The expected broad outcomes such as updated training, enhanced critical thinking, and more education are good things for caseworkers and supervisors. However, caseworkers and supervisors need more than these generalities when faced with complex cases such as these.

While the investigation of infant death or serious injury with family involvement in child protective services did not result in any specific findings or recommendations pertinent to the intake procedure, the changes to the particular policy is important. The OIG is encouraged by DHHS's June 2019 change to intake procedure as described in the response.

Finally, DHHS points to recommendation V. as being implemented in May of 2019. *CFS Strong* is the new Nebraska QIC-WD intervention[24] to address secondary trauma stress among frontline workers and supervisors. The intervention has not yet been fully implemented among all staff. Two curricula are part of the *CFS Strong* intervention. The first is Resilience Alliance, which is to help staff identify, understand, and address ways child welfare professional's work and related secondary traumatic stress affects them personally and professionally. This 24-week intervention did begin in May 2019, but since there is a 2-year evaluation component that is using a control group—not all DHHS caseworkers and supervisors are going through the training. The others do not get the benefit of these supports until after the evaluation. The second part of *CFS Strong* is the Restoring Resiliency Response Model which includes protocols for group-based debriefing sessions following a traumatic event. This Restoring Resiliency Response Model is planned for implementation in 2020.

[24] https://www.qic-wd.org/sites/default/files/NE%20Site%20Profile.pdf

2 ½ YEAR-OLD NON-COURT CASE DEATH

The following summarizes the OIG investigation into the death of a two-and-one-half-year-old due to drowning. At the time of the incident, the father and step-mother were engaged in a non-court case with CPS. The OIG made no recommendations to DHHS as a result of this investigation.

Critical Incident

A priority one intake was accepted by the Hotline alleging the physical neglect of the toddler and five siblings.

The intake reported the toddler had been left unattended in a bathtub filled with an estimated ten inches of water for approximately three minutes by his step-mother. Upon returning to the bathroom she found the toddler underwater and unresponsive. The toddler was transported to the hospital, revived after 21 minutes and observed by medical staff to have injuries suspicious in nature. The intake noted injuries including petechiae[25] on the forehead, scratch marks on the shoulder, ring worm on the back, and what appeared to be a bite mark on the lower leg. After being placed on a ventilator, the toddler was declared brain dead and was removed from life support six days later. The medical examiner ruled the death was attributed to the drowning incident.

Police officers on scene reported the living conditions were unsanitary. Their report noted foul odors, dried vomit on a child's mattress, dirt/debris on bed sheets, fecal matter on the floor (presumed to be from the family pet), mouse droppings in the pantry and moldy food. The following day all six children in the home, ages one year of age through 13 years of age, became wards of the state due to lack of proper parental care and unsafe/unsanitary living conditions.

The step-mother was charged with felony child abuse and sentenced to a term of three years' incarceration.

Child Welfare History

The two-and-one-half-year-old was born with Down Syndrome (Trisomy 21) and was physically and developmentally delayed. He was small for his age and could not yet walk. He had a history of heart issues, skin condition(s) and fluid in the inner ear which was thought to have contributed to a hearing loss. He had become involved with the Texas child welfare system due to neglect by his biological mother and her husband. His biological father was given custody and the family ended up residing in Nebraska.

After three intakes (alleging neglect—two of the children acting out sexually, unsanitary conditions of the home, children's poor hygiene, children's unaddressed medical conditions, and the oldest missing school while caring for his five siblings in unsafe conditions) at the Hotline, the parents agreed to a non-court case with CPS. Services put into place included: family support to assist in maintaining a sanitary home, feeding the children properly, maintaining age appropriate schedules, getting older children to school on time, scheduling and attending medical appointments for the children, completing a parenting class, and applying for state benefits.

During the first 60 days of the non-court case, a case plan was written with the goal of the parents maintaining a safe and sanitary home

[25] As defined by the Mayo Clinic, Petechiae are pinpoint, round spots that appear on the skin as a result of bleeding. The bleeding causes the petechiae to appear red, brown or purple; commonly appearing in clusters and may look like a rash.

while providing appropriate supervision of the children.

The couple maintained minimally adequate parenting. The documents noted that there was concern about their inconsistency in following through with services, their ability to meet the needs of all the children, and truancy issues for their oldest. In general, the parents were putting forth minimal effort with consistent redirection from the family support worker needed to maintain the cleanliness of the home and meet the medical and educational needs of the children, but progress was being made.

The case was staffed by the local county multi-disciplinary (1184) team. The team discussed the concern for minimal progress by the parents as evidenced by a lack of engagement with services in addressing developmental delays of three of their children and the hearing loss of a fourth child, continued truancy issues for their oldest child, and an absence of effort to arrange counseling for two of the children who had been sexually abused. The team also noted the parent's reluctance to obtain birth certificates from out of state which were required to secure educational services, state medical coverage and food assistance. At the time, DHHS's position was that there was no need for a juvenile petition. As a result of the meeting, the case was flagged for review for filing by the County Attorney's Office, and the case was scheduled for a follow up review by the team in four weeks.

In the three weeks between the team staffing and the incident leading to the death of the two-and-one-half-year-old, the parents maintained a minimally acceptable level of cleanliness in the home due in part to the efforts of a grandmother. Engagement in services continued to be superficial with missed EDN and therapy appointments being a continued source of concern.

On the day of the critical incident, the family support worker and the caseworker assigned to the case were in the home. Documentation characterized contact as routine and the condition of the home as cluttered. Later that evening the step-mother left the toddler unattended during a bath; she stated to law enforcement that when she returned to the bathroom she found the toddler in the water and unresponsive; the toddler never regained consciousness and died six days later.

8-YEAR-OLD, 6-YEAR-OLD, & 15-MONTH-OLD SIBLINGS WITHIN TWELVE MONTHS OF CPS INVOLVEMENT SERIOUS INJURY

This summarizes the OIG's investigation into the serious injury of three siblings as a result of an car accident caused by their father's drunken driving. At the time of the incident two of the siblings had been the subjects of an initial assessment and the remaining sibling had been a state ward with case closure all within the prior 12 months. The OIG made no recommendations to DHHS as a result of this investigation.

Critical Incident

Three children (siblings) ages 8 years, 6 years, and 15 months had been seriously injured when the vehicle their father was driving went through a red light and was T-boned by an oncoming vehicle. After impact, the father drove away from scene of the crash with his injured children still in the back seat of the vehicle. After law enforcement located the vehicle, the father was administered a breathalyzer, and it was determined that he was over the legal limit; he was arrested.

All three children were taken to the hospital. The 15 month-old had minor injuries and was kept in the hospital overnight for observation. The six year-old was unresponsive and found to have a brain bleed with brain trauma. The oldest sibling was unresponsive and was in the worst condition of the three children. The crash ultimately caused the oldest child to suffer severe brain damage leaving the child in a persistent vegetative state. All three children were made wards of the state.

Child Welfare History

The youngest sibling was made a state ward and placed into foster care at six weeks of age due to the mother not being able to meet the child's immediate/basic needs along with not being available to provide care due to alcohol abuse. At the time the infant was made a state ward, the biological father was unknown.

Within the approximate same period of time, the older two children where living with their biological father (later identified as the father of the involved infant) and subject to an intake by the Hotline for investigation. The allegations included that the two children were caring for themselves due to their father's alcohol abuse. The father had a significant history of DUIs. The two children were found to be safe and in moderate risk of future maltreatment, therefore the investigation was closed. This was followed by a second intake involving the children; alleging the sexual abuse of one of the children by a family member. Again the children were found to be safe in the care and custody of their father.

DNA testing confirmed the infant's paternity, and the father became a party to the juvenile case. The infant was placed with the father and the juvenile court case closed.

Sixty days after the court case closed and ten months after the investigation into the sexual abuse of the older sibling closed, the three children were seriously injured as a result of their father's drunken driving.

12-YEAR-OLD FORMER STATE WARD DEATH

The following summarizes the OIG investigation into the death of a 12 year-old due to acute exacerbation of bronchial asthma. A juvenile court case that had made him a state ward had been closed for two months. The OIG made no recommendations to DHHS as a result of this investigation.

Critical Incident

The 12-year-old boy collapsed in his home and became unresponsive; his father performed CPR. He was transported to a hospital and was declared brain dead three days later, then taken off the respirator at the request of his parents. The cause of death was listed as "acute exacerbation of bronchial asthma."

Child Welfare History

The oldest of five children, the 12-year-old boy suffered from severe bronchial asthma.

DHHS received an Abuse and Neglect Hotline intake which alleged unsanitary living conditions in the family home and physical neglect of the children. The children were removed from the family home by law enforcement due to unsafe living conditions. The children were made wards of the state and placed in a relative foster home.

The child's pulmonologist provided a letter to DHHS outlining medical concerns. The doctor stated that due to his medical condition, the child required housing that was consistently

appropriate—clean and smoke-free. The physician urged timely administration of medication under parental supervision, and expressed concerns about the presence of cockroaches and of the effects of second-hand smoke.

The parents were directed to relocate to a new home. The cleanliness of the new home generally met minimal standards, the parents cooperated with the case including working with a family support worker. Once overnight and weekend visits began, the Visiting Nurses Association (VNA) completed walk-throughs weekly and advised the parents on health conditions and routines.

The five children were returned to the parents' home 9-months after being removed. Over the next two months, the family had multiple walk-throughs of their home, including a visiting nurse who came to the home weekly. Within 90 days, the family was doing well enough that the juvenile court case was closed. One week later the child was hospitalized for asthma exacerbation. Two months after case closure the child collapsed in the home and later died of acute exacerbation of branchial asthma.

11-MONTH-OLD IN A LICENSED FAMILY CHILDCARE HOME DEATH

The following summarizes the OIG's investigation into the death of an 11-month-old infant due to Sudden Unexpected Infant Death (SUID) at a licensed family childcare home. No recommendations were made to DHHS as a result of this investigation.

Critical Incident

An 11-month-old infant was found unresponsive in a play pen in a licensed daycare home. The infant was transported to the hospital, and was pronounced dead shortly after arrival. The daycare provider reported that she had checked on the infant several times over the span of three hours and had observed the infant lying on his stomach with a fleece blanket balled up in one corner of the play pen in a "pillow" like fashion, and that when she went to wake him he was sweaty and warm to the touch. Autopsy results declared the cause of death as: Sudden Unexpected Infant Death (SUID), in association with the face having been covered by a blanket.

Public Health History

A review of Public Health records indicates that the provider was licensed as a family childcare home in 2009. The daycare home began an extended history of being out of compliance with various licensure regulations starting in early 2009. Violations included being over capacity and out of ratio starting in 2011, and being past due on annual in-service training. At the time of the infant's death, licensed daycare providers licensed before May 20, 2013, were required to complete safety training that included safe sleep by May 20, 2016. The provider completed the safety training *Safe with You,* 3 weeks after the death occurred in her home. Safe sleep training emphasizes that no items, including blankets or pillows, are to be in an infant's sleeping area and the infant should be placed on his or her back to sleep.

Several issues surrounding SUID were addressed in the OIG *Report of Investigation: Sudden Unexpected Infant Death, 2013-2015*, dated April 12, 2016, with recommendations made to DHHS. [26] With the passage of LB 717 in the spring of 2018, Neb. Rev. Stat. §43-2606

[26] The death of this infant was not reported to the OIG when it occurred, therefore it was not part of the April 2016 report of investigation. The OIG found documentation of this death when reviewing other records after that report was final.

was revised to require daycare providers complete a pre-service orientation that includes information on sudden unexpected infant death syndrome and safe sleep, prior to being granted a provisional license.

5-MONTH-OLD STATE WARD DEATH

The following summarizes the OIG's investigation into a five-month-old state ward's death, due to medical complications related to DiGeorge Syndrome. No recommendations were made to DHHS as a result of this investigation.

Critical Incident

As the foster mother was feeding the baby a bottle, she noticed the baby was not drinking. The foster mother called 911 and tried to resuscitate the baby. Paramedics transported the baby to the hospital, where she was pronounced dead. The cause of death was listed as medical complications of DiGeorge Syndrome.

Child Welfare History

The parents became involved with DHHS when their first born child was removed from the home and made a state ward due to failure to thrive. He was seven months old at the time and weighed 9 pounds.

When the parents had another child, a Hotline call was made due to the parents having a child who was already a state ward. The baby was born medically fragile, with DiGeorge Syndrome and associated congenital heart disease. DiGeorge Syndrome is a disorder caused by a defect in chromosome 22 and results in the poor development of the body along with the risk for failure to thrive.

The Initial Safety Assessment found the baby SAFE, and following a surgical procedure and recovery period, she returned home with her parents with initial weekly home health care visits to monitor her weight gain. At two-months-old, the baby was categorized as failure to thrive, her feeding schedule was adjusted, and weekly home health visits were resumed. One month later, the baby was hospitalized due to insufficient weight gain. She returned home with home health visits and frequent office visits for follow-up checks. Eventually, at four-months-old, the baby was placed in foster care due to the parents not following medical instructions regarding the feedings.

STATUS OF OIG RECOMMENDATIONS

Reports of investigation issued by the OIG contains recommendations for systemic reform and/or case-specific action. The OIG's annual report is required by Neb. Rev. Stat. § 43-4331 to detail recommendations and the status of implementation of recommendations.

The table below contains a summary of all recommendations made by the OIG in its investigative reports. The recommendations are numbered based on the year and order the recommendation appeared in an annual report. For example, the first recommendation appearing in the 2015 Annual Report is numbered 15-01.

Each recommendation is assigned an implementation status by the OIG based on information provided by the subject agency. The definitions of each status are:

Rejected: The agency rejected the recommendation as part of the original investigation.

Incomplete: The agency has not taken relevant action to address the recommendation.

No Further Action: The agency has taken relevant action to address the recommendation, but has no plans to take additional necessary action to address the recommendation.

Progress: The agency has taken relevant action to address the recommendation and has plans to take additional necessary action to address the recommendation.

Complete: The agency has taken all relevant and necessary action to address the recommendation.

OIG Recommendation	Agency	Implementation Status
15-01. Adopt federally mandated mental & behavioral health policies.	DHHS - CFS	**No Further Action** In April 2016, DHHS adopted most required policies, including use and oversight of psychotropic medications and guidelines on updating medical information. These have been updated and are currently found in Protection and Safety Procedure #13-2017. DHHS does not plan to adopt a mental health or trauma screening tool. DHHS will use the Family Strengths and Needs Assessment for this purpose. However, there is no guidance given to staff on how this tool can be used as a trauma or mental health screening.
15-02. Expand training on mental and behavioral health.	DHHS - CFS	**Complete** DHHS has added in-service training on these topics, and added suicide prevention training to

OIG Recommendation	Agency	Implementation Status
		topics covered in New Worker Training. In July 2017, an updated mental health desk aid was made available to all staff.
15-03. Expand quality improvement and assurance related to mental and behavioral health and psychotropic medications	DHHS- CFS	**Complete** DHHS updated its N-FOCUS system in March 2015 to allow for easy record keeping on medications, health care appointments, and medical conditions. Information entered is now reviewed by administration and at Continuous Quality Improvement (CQI) meetings.
15-04. Improve Home Study Process	DHHS-CFS	**Complete** To help ensure quality home studies across the state, DHHS is entering into contracts with accredited licensed child-placing agencies in Nebraska to complete all home studies. The contracts will begin November 2019. An updated home study template and quality assurance tool were developed as part of the process to improve home studies.
15-05. Provide stronger supports for kinship and relative foster families	DHHS-CFS	**Complete** Pre-service foster parent online training is being offered to relative and kinship placements in order to get more of such placements licensed. As a foster child's needs are identified, the relative and kinship foster placement will receive specialized training accordingly. The Nebraska Foster and Adoptive Parent Association provides specialized training, Kinship Connection, across the state. Nebraska received Kinship Navigator funds available through the Family First Prevention Services Act—U.S. Department of Health and Human Services Administration on Children, Youth and Families (ACF) to develop, enhance, or evaluate kinship navigator programs. Implementation of Nebraska's Kinship Navigator program will begin October 1, 2019.
15-06. Ensure "Absence of	DHHS-CFS	**Complete**

OIG Recommendation	Agency	Implementation Status
Maltreatment in Foster Care" is as accurate as possible		Since May 2016, DHHS has listed the number of maltreatment cases that have been "court pending" between 8 and 12 months in its CQI reports. This better captures cases of maltreatment that may not be counted in the federal measure because they are awaiting court action, usually because the crime is particularly serious.
15-07. Develop and provide training to frequent reporters and law enforcement on Child Abuse and Neglect Hotline.	DHHS-CFS	**No Further Action** In the fall of 2015, the League of Municipalities distributed DVD training modules on child abuse and neglect reporting and investigations to local law enforcement agencies, developed with DHHS assistance. DHHS provides training on child abuse reporting and the hotline to groups on request. No training for other frequent reporters – schools, medical professionals, etc. has been produced or made easily available.
15-08. Create a protocol for asking for and receiving photos at the Child Abuse and Neglect Hotline.	DHHS-CFS	**Complete** In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."
15-09. Assess availability of training, information, and programs designed to prevent child abuse within immigrant communities.	DHHS-CFS	**Complete** DHHS is currently developing a quarterly report to review information captured by N-FOCUS to develop outreach strategies in immigrant communities. Substantive collaboration between DHHS and Bring Up Nebraska has been developed as means of furthering strategies to collect consistent, statewide data, provide funding, and prioritize culturally appropriate and competent prevention service delivery. In May 2018, DHHS partnered with the Nebraska Coalition to End Sexual and Domestic Violence and funded a Community Engagement Coordinator position to collaborate with local and tribal domestic violence programs and community based organizations to address family violence

OIG Recommendation	Agency	Implementation Status
		issues in racial and ethnic minority populations and underserved populations.
15-10. Adopt and implement standards for transporting youth to and from the Youth Rehabilitation and Treatment Centers.	DHHS-CFS	**Complete** On July 1, 2017, DHHS's "Secure Transportation" service definition for transport to and from YRTCs became effective.
15-11. Increase and improve resources, tools, and support for PREA implementation at YRTC-Geneva.	DHHS-CFS	**Complete** In July 2015, a full-time Central Office PREA Manager position was created to oversee PREA implementation at both YRTCs. In 2016, a compliance team that oversees PREA and other key issues at both facilities was put in place. OJS is currently planning for the next round of PREA audits. Both YRTCs underwent a PREA Audit in the fall of 2018. The final PREA Audit reports were released on November 18, 2018 which found compliance with PREA standards at each facility.
15-12. Provide increased guidance for culture change at YRTC-Geneva	DHHS-CFS	**Complete** In the fall of 2016, daily calls between the facility and OJS administrator, as well as the compliance team of both facilities were put into effect. Work is ongoing to standardize processes and policies at both YRTCs. Changes have been made to YRTC-Geneva's organizational structure to allow the psychologist to directly supervise therapists.
15-13. Make clarifications to policies governing sexual abuse and harassment at YRTC-Geneva	DHHS-CFS	**Complete** In August 2015, DHHS updated Administrative Regulation 115.17 to clarify reporting of incidents, investigation protocol, training, and other PREA-related topics. YRTC-Geneva made changes to OM 115.17.5 in August 2015 to clarify facility specific policy and procedure. Work to standardize policies and procedures at both YRTCs is ongoing.

OIG Recommendation	Agency	Implementation Status
15-14. Clarify Hotline policy and procedure when receiving a report of sexual assault	DHHS-CFS	**Complete** The Hotline updated its guidebook and also gave staff direction and reminders on selecting the correct law enforcement agency. The OIG reviewed intakes about YRTC-Geneva for the 2016-17 fiscal year and identified only one error.
16-01. Implement training on the medical aspects of child abuse.	DHHS-CFS	**Complete** CCFL consulted with Dr. Bleicher as a medical expert for curricula review in August and September 2017. The following recommendations were made: • Spiral fractures in toddlers and young children are often activity related but the same fracture in the arms (especially infants) are highly suspicious of abuse. References made to spiral fractures need to be clarified (revision meeting scheduled for 12.05.17) • Incorporate the article Bruising Characteristics Discriminating Physical – help to distinguish accidental from abusive injuries (revision meeting scheduled for 12.05.17). **02/02/18** This training has been created and trained for the first time with the 1117 training group.
16-02. Adopt policy on photographing injuries during Initial Assessment.	DHHS-CFS	**Complete** In February 2016, DHHS adopted Protection and Safety Procedure #5-2016, "The use of Photographs from Intake through Case Closure."
16-03. Develop additional training for Initial Assessment staff.	DHHS-CFS	**Complete** CCFL updated its New Worker Training in 2016 to include a more intensive focus on family engagement. Caseworker in-service training on Enhanced SDM Safety Planning, Engaging Families on Sensitive Subjects, Human Trafficking, Advanced Testifying, and Engaging

OIG Recommendation	Agency	Implementation Status
		Families in Safety and Risk Assessments have been developed and are being offered around the state.
16-04. Further define process for utilizing child advocacy centers by Initial Assessment.	DHHS-CFS	**No Further Action** After consulting with DHHS legal staff on expanding requirements on the use of Child Advocacy Centers, DHHS decided not to update the current memo to add additional cases that should be considered for a CAC interview. Instead this decision will be left to local 1184 or multidisciplinary teams. DHHS indicated they did not believe the burden for referral should be on DHHS staff alone. DHHS issued a revised memo on use of CACs, Protection and Safety Procedure #23-2017, however, none of the OIG's suggestions were incorporated.
16-05. Update and provide additional detail on response priority definitions.	DHHS-CFS	**Complete** DHHS updated its intake manual in August 2017 in Protection and Safety Update #26-2017. The updated manual provides clarification on priority response time definitions involving injuries to children under age six.
16-06. Conduct an analysis to determine whether supervisory staffing at the Hotline is adequate.	DHHS-CFS	**Complete** In September 2016, new guidelines for supervisory review of intakes (calls to the Hotline) went into effect, reducing the percentage Supervisors had to review and extending the timeframe for them to complete reviews. However, these changes were implemented without an analysis of supervisory staffing and a review of all of their responsibilities. In 2017, DHHS added a supervisor position at the Hotline and refocused supervisors on reviewing accepted reports. CFOMs were also transferred to the Hotline and now review screened out reports.
16-07. Expand quality assurance and continuous quality improvement (CQI)	DHHS-CFS	**Complete** As part of their quality assurance efforts, DHHS is

OIG Recommendation	Agency	Implementation Status
at the Hotline.		reviewing additional Hotline calls related to physical abuse allegations of children under 7 on a quarterly basis.
16-08. Increase the Initial Assessment workforce to comply with Nebraska law on caseload standards.	DHHS-CFS	**Progress** DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts of the state. DHHS has enhanced training for workers assigned to Initial Assessment. Internal discussions about additional CFS paygrades continue. The Southeast Service Area has adopted end to end teams. A caseload initiative is underway. The initiative counts caseloads by the number of children (as opposed to number of families), and it incorporates worker skill level. It is being tested in the field. Based on this initiative, DHHS hopes to propose statutory change language to the caseload requirements for the 2020 Legislative Session.
16-09. Take steps toward greater Initial Assessment workforce specialization and experience.	DHHS -CFS	**No Further Action** DHHS reports that it is not possible to specialize the Initial Assessment (IA) workforce in many rural parts of the state. DHHS has enhanced training for workers assigned to Initial Assessment. Internal discussions about additional CFS paygrades continue. The Southeast Service Area has adopted end to end teams. In other parts of the state, IA is moving to partnering caseloads between two workers.
16-10. Contract with an independent entity to perform a validation study of Nebraska's SDM Risk Assessment instrument.	DHHS-CFS	**No Further Action** DHHS contracted with the National Council on Crime and Delinquency to conduct independent case reads on SDM safety and risk assessments. The results of the case reads were fairly positive. However, this was not a validation study. There is still no research demonstrating whether Nebraska's SDM tool is accurately predicting risk or not and whether adjustments to the tool may need to be made.

OIG Recommendation	Agency	Implementation Status
16-11. Gather and analyze additional data on the prevalence of pediatric abusive head trauma and update shaken baby syndrome materials.	DHHS – Public Health	**Complete** The Child Safety Collaborative Innovation & Improvement Network (CoIIN), housed at Public Health, has developed a Crying Plan and has gathered data from Hospitals on the materials they distribute and education they provide on abusive head trauma.
16-12. Increase the capacity for the child welfare workforce to participate in pediatric abusive head trauma prevention efforts.	DHHS-CFS	**Complete** In April 2016, CFS Central Office distributed an "Under 2" packet, in English and Spanish, designed with input from the Division of Public Health, to field staff. Information about pediatric abusive head trauma is included in the packet. CFS Staff are encouraged to give out the information anytime they assess or work with a family with a very young child.
16-13. Increase the number of supervisors at the Child Abuse and Neglect Hotline and assess Hotline workload and ongoing training and supervision.	DHHS-CFS	**Complete** DHHS added a supervisor position to the Hotline and placed 3 CFOM positions at the Hotline to review screened out reports to ensure appropriate screening decisions occurred. Supervisors review all screened out reports and listen in on calls. A new process has been set up so that quality assurance staff review accepted intakes that the field wants re-screened. Hotline processes have been reviewed through the Lean Six Sigma process to improve performance. An additional staff member was also added to the Hotline to take calls. If an intake is not accepted for initial assessment, all referrals are now tracked. All CFSS trainees will begin to shadow at the Hotline.
16-14. Enhance data available on Initial Assessment and mixed caseloads at Central Office and make this information publically available on a monthly basis.	DHHS-CFS	**Complete** DHHS has developed a monthly report on CWLA caseload compliance, including initial assessment and mixed caseloads. An overall report is posted publicly on their website and updated monthly.
16-15. Collect data on high and very-high risk cases that	DHHS-CFS	**Complete**

OIG Recommendation	Agency	Implementation Status
do not accept services and implement more promising approaches to family engagement.		DHHS has collected data on high/very-high risk families declining services and has seen a slight increase in the acceptance of services. DHHS has implemented Safety Organizing Practice (SOP), a family engagement model, over the past 6-12 months. This is part of the CFS Program Improvement Plan (PIP) under Family Engagement.
16-16. Restructure the Children's Justice Act (CJA) taskforce to ensure there is a working group focused on improving child abuse investigations, especially multidisciplinary investigations. Enhance monitoring on how CJA funds are spent to ensure they are addressing systemic gaps in child abuse investigations.	DHHS-CFS	**Complete** DHHS is developing a process to improve monitoring of CJA funds. In July 2016, CJA billing was modified to an expense reimbursement document, which will require those receiving funds to provide documentation on how the funds were spent. A new contract for CJA funds with additional requirements is planned to go into effect in October 2017. The Nebraska Commission for the Protection of Children created a subcommittee to study improvements to multidisciplinary teams.
16-17. Adopt policy and procedure on checking infant sleep areas and asking about safe sleep in child welfare cases.	DHHS-CFS Private Agency: Nebraska Families Collaborative (NFC)	**Complete** In August 2017, DHHS adopted Protection and Safety Procedure #28-2017, "Mandatory Monthly Visits With Children, Parents & Out of Home Care Providers," which includes the Nebraska Safe Sleep Environment Checklist developed by Public Health and policy for workers regarding safe sleep. NFC updated the monthly Walkthrough Checklist, adding prompts to address children ages 0-5 sleeping location, the condition of the room/bed etc.
16-18. Enhance training, resources, and education available to staff, parents, and caregivers in child welfare cases on safe sleep.	DHHS-CFS Private Agency: Nebraska Families Collaborative	**Complete** DHHS training adopted for staff, under 2 packets NFC has incorporated Safe Sleeping into New Worker Training and a webinar has been created

OIG Recommendation	Agency	Implementation Status
		that is mandatory for all permanency staff. The training includes information on items that should/shouldn't be in the crib, co-sleeping, blankets, infant sleepwear, etc. This training will be completed annually by all permanency staff. NFC has attached Safe Sleep Guidelines to ages 0-5 Walkthrough Packet that is to be reviewed and/or given to the caregiver at each walkthrough when assessing non-agency/kinship homes.
16-19. Revise regulations to require infant safe sleep training before granting a child care license.	DHHS-Public Health	**Complete** LB 717 was signed by the Governor on April 11, 2018, requiring training before a daycare license is granted. Regulations regarding the change are being formally promulgated. Public Health worked with the Nebraska Department of Education to make the "Safe with You" training more accessible to providers, including in an online format, since it now must be taken prior to a license being granted.
16-20. Adopt federally mandated policies and procedures on mental and behavioral health care as soon as possible	DHHS-CFS	**No Further Action** See Recommendation 15-01
16-21. Enhance efforts to reduce caseworker turnover.	DHHS-CFS	**Complete** DHHS has made changes to job recruitment strategies, revisions to New Worker Training to make it more accessible and less travel-intensive to complete. In July 2017, DHHS implemented a supervisor training program to better ensure caseworkers are supported.
16-26. Adopt policy on joint case management and case planning when a youth is involved with both the child welfare and juvenile justice system.	DHHS-CFS	**Complete** DHHS has issued Administrative Memo 1-2018, Crossover Youth Practice Model, and, with Probation, presented the Statewide Crossover Youth Initiative Training to all case managers and juvenile probation officers.
16-27. Increase training and coordination between the Division of Children and	DHHS-CFS DHHS-Development	**Complete** Both CFS and DD participate in the Cross

OIG Recommendation	Agency	Implementation Status
Family Services and the Division of Developmental Disabilities.	al Disabilities	Divisions Solution Team. In 2017, DD helped provide information and feedback on CFS New Worker Training and developed a PowerPoint on available services for CFS staff.
16-28. Coordinate with Juvenile Probation and improve care to youth with developmental disabilities in the juvenile justice system	DHHS - Developmental Disabilities	**Complete** DD developed and disseminated a handout for probation officers and court stakeholders providing details on the Home and Community Based Waivers available to people with disabilities, presented a training at the Nebraska Juvenile Justice Association Conference, attended weekly system collaboration meetings with Probation, and deployed clinical staff to assess youth committed to YRTCs for service eligibility.
16-29. Make the OJS Administrator a Full-time Position	DHHS-CFS	**Rejected-Progress** Trevor Speigel is the current named OJS Administrator, but at the present time it is unclear whether he is acting in that capacity with regard to the Youth Rehabilitation and Treatment Centers. In addition, two facilities were added to the OJS Administrator role, according to the DHHS Division of Behavioral Health organizational chart—Hastings PRTF and Whitehall.
16-30. Close or Appropriately Restructure Full-time Secure Care Program at YRTC-Kearney in Dickson, D5	DHHS-CFS	**Complete** In 2016, DHHS ended the full-time care program in Dickson. Currently, youth can live in Dickson for a short period of time if they have had struggles in their living unit. Each youth in Dickson has a Reintegration Plan that must be developed where the youth begins participating in normal activities as soon as they are able (example - school, group meetings). YRTC-Kearney reports that youth have not stayed in Dickson for longer than three to four weeks. These changes have not been codified in policy.
16-31. Develop Continuous Quality Improvement Process at YRTCs Led by Central Office	DHHS-CFS	**Complete** In 2017, DHHS Central Office began putting together monthly data reports on Performance-based Standards at the YRTCs. They include

OIG Recommendation	Agency	Implementation Status
		information on assaults, confinements, escapes, injury, restraints, misconduct, property incidents, suicidal behavior, youth seen for medical treatment, and staff-to-resident ratio.
16-32. Develop and implement a comprehensive Strategic Staffing Plan in order to achieve appropriate staff to youth ratios while attracting and retaining qualified staff members for YRTC-Kearney	DHHS-CFS	**Complete** DHHS examined staffing at YRTC-Kearney, and calculated how many staff it needed to comply with PREA. Additional staff for YRTC-Kearney were included in the 2016 DHHS budget request and funded by the Legislature in 2017. DHHS reports that recruitment of staff at YRTC-Kearney has significantly improved.
16-33. Digitalize Records at YRTC-Kearney	DHHS-CFS	**Complete** In January 2017, the YRTCs began loading information on incident reports into an online portal, Salesforce. The system is now fully operational and allows facilities to review records of individual incidents as well as track specific incidents, including escapes, use of force, restraints, and seclusion.
17-10. Adopt a policy that requires contact with mental health professionals already involved with a family when a family gives consent.	Private Agency: Owens Educational Services, Inc.	**Complete** Owens now requires staff to contact & stay in communication with mental health professionals when a release is signed.
17-11. Implement training on suicide warning signs and prevention in youth.	Private Agency: Owens Educational Services, Inc.	**Complete** In April 2017, an LIMHP, PLADC Mental Health Practitioner trained staff company-wide on QPR (Question. Persuade. Refer.) Training for suicide prevention. This curriculum was also added to New Hire Training.
17-12. Promulgate rules and regulations related to the Children's Residential Facilities and Placing Licensure Act as soon as possible.	DHHS-Public Health	**Progress** DHHS has had a draft set of regulations with stakeholder input ready for promulgation. These regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.

OIG Recommendation	Agency	Implementation Status
17-13. Include requirements related to dispensing and monitoring medications, especially psychotropic medications, in new regulations for Residential Child-Caring Agencies.	DHHS-Public Health	**Progress** The regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.
17-14. Adopt clear requirements on medical record-keeping and documentation in regulations.	DHHS-Public Health	**Progress** DHHS draft regulations include record keeping requirements for medications and specify that facilities must adopt policies on medical record-keeping. The regulations have now entered the formal promulgation process, and a public hearing was held in August 2019.
17-15. Clarify requirements for consents for medical care, treatment, and coordination for Residential Child-Caring Agencies in regulations.	DHHS-Public Health	**Progress** DHHS draft regulations specify that facilities must adopt policies obtaining consent for medical treatment. The regulations have now entered the formal promulgation process and a public hearing was held in August 2019. DHHS is also planning to develop additional guidance for facilities on how to comply with regulations, while not adding requirements to regulations themselves.
17-16. Increase coordination with the Division of Children and Family Services and Administrative Office of Probation on Residential Child-Caring Agencies.	DHHS-Public Health	**Complete** Public Health has reported sharing information with both CFS and Probation in a more timely way, and, when possible, conducting joint visits of facilities with CFS. Efforts to effectively coordinate are ongoing. DHHS reports that it shares information on licensing actions and has been coordinating effectively on investigations.
18-01. Create a system to collect and review information about allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs.	DHHS-CFS	**Rejected - Complete** LB 1078 was signed by the Governor on April 4, 2018, requiring reporting of information on sexual abuse allegations. DHHS has created a new Critical Incident Reporting form accordingly. The form will be utilized statewide by September 2019.

OIG Recommendation	Agency	Implementation Status
18-02. End the practice of screening law enforcement reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse.	DHHS-CFS	**Complete** DHHS reports that CFS Central Office Administrators and other staff review every "Does Not Meet Definition" screen. DHHS analyzed reasons why intakes were being re-screened and adopted definitions. The CQI team performs qualitative reviews to determine whether intakes, including sexual abuse allegation intakes, are following proper practice and policy.
18-03. Review the option of eliminating overrides to not accept a sexual abuse report for investigation at the Hotline, except in the case of law enforcement only investigations.	DHHS-CFS	**Complete** DHHS reports that the Hotline Administrator reviewed the intake process, and QA staff put together data to analyze this practice. The Hotline's use of overrides to change screening decisions are reviewed to ensure appropriate use of policy and discretionary overrides. So far this year, of the over 1700 intakes that have been reviewed by the CFS Central Office staff, no sexual abuse reports have been overridden to not accept.
18-04. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.	DHHS-CFS	**Complete** DHHS has contracted with Project Harmony to create three modules related to preventing and educating about the sexual abuse of children.
18-05. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.	DHHS-CFS	**No Further Action** DHHS has created a new finding: Law Enforcement Refusal, which indicates that law enforcement is choosing to not investigate the allegation. This change in Hotline protocol has been implemented statewide. Staff at the Hotline continue to reach out to law enforcement. The Hotline Administrator has met with law enforcement across the state about the importance of communicating these investigatory conclusions with the Hotline.
18-06. Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide	DHHS-CFS	**Rejected – No Further Action** DHHS reports that this is already occurring, based on assessments and referrals that take place at the

OIG Recommendation	Agency	Implementation Status
necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.		Hotline. Hotline staff will connect families to other hotlines and the CACs when appropriate. DHHS has implemented a voluntary FAST program where families with screened out cases receive a letter asking if they want to be connected to economic assistance programs. All referrals through the FAST program are documented on NFOCUS.
18-07. Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.	DHHS-CFS	**Complete** DHHS reports that a curriculum has been developed on the preponderance of the evidence standard. Trainings for all supervisors occurred across the state beginning in April 2018.
18-08. Adhere to policy on out of home assessments and enhance quality assurance	DHHS-CFS	**Progress** DHHS has developed new protocols to complete out of home assessments when the child is placed at a DHHS facility. DHHS is in the process of developing new policy on out of home assessments for all other placements. The process will engage front-line workers who complete these assessments in creating the new policy. Part of the analysis will focus on how involved Central Office will be in these assessments.
18-09. Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.	DHHS-CFS	**Complete** DHHS has transferred the responsibility for entering findings to the Hotline for investigations conducted by law enforcement only. (Program Memo #33-2017). In May 2018, Hotline staff began addressing the backlog of law enforcement cases where no findings have been made. DHHS reports that data on outstanding law enforcement investigations is being gathered/tracked.
18-10. Meet the statutorily required caseload standard for initial assessment and ongoing case management.	DHHS-CFS	**Progress** DHHS believes they have enough FTE to meet CWLA caseload. DHHS is exploring a teaming approach to cases. Turnover has been decreasing with DHHS reporting an average 3% monthly

OIG Recommendation	Agency	Implementation Status
		turnover rate. Though caseload numbers are better than in the past (DHHS reported 91.9% statewide in compliance as of July 2019), DHHS continues to be out of compliance with statutorily required caseload standards. A monthly caseload report can be found on their website. CFS called a working group of internal and external stakeholders to look at the current caseload standards. The proposal counts the number of children on a caseload instead of the number of families. The worker's skill level is incorporated into the formula as well. This is being tested in the field. A caseload initiative is underway. The initiative counts caseloads by the number of children (as opposed to number of families), and it incorporates worker skill level. It is being tested in the field. Based on this initiative, DHHS hopes to propose statutory change language to the caseload requirements for the 2020 Legislative Session.
18-11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.	DHHS-CFS	**Complete** DHHS has contracted with Project Harmony to develop the curriculum for developmentally-appropriate education to prevent sexual abuse and exploitation within the child welfare system. A 3-module training was developed: 1. Darkness to Light 2. Sexual Health, Behaviors, and Abuse of Children 3. Bringing it Home: Managing Sexual Abuse and Behaviors.
18-12. Review and revise training on child sexual abuse for DHHS staff.	DHHS-CFS	**Complete** DHHS has contracted with Project Harmony to implement the training. See 18-11.
18-13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.	DHHS-CFS	**Complete** DHHS has revised contracts with child-placing agencies to better align caregiver and child needs. Specific training for foster parents will be provided based on the specific child's needs. A request for proposals has been developed for

OIG Recommendation	Agency	Implementation Status
		resource families. The family's voice and choice is being incorporated into these revisions. Caseworkers are utilizing Safety Organized Practice across the state. Many of these strategies are incorporated into Nebraska's performance improvement plan (PIP).
18-14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.	DHHS-CFS	**Complete** DHHS has enhanced the application process for foster parenting to better screen foster homes, and DHHS has issued an RFP for home studies in order to improve the process. DHHS has made modifications to regulations, which are presently in the promulgation process, to comply with more stringent foster care, adoptive, and guardianship model licensing standards. When currently licensed foster parents apply to renew their license, they will have to be in compliance with the new requirements—complete the updated application, home study, compliance checklist, and the like. Those not in compliance with the new regulations will no longer remain as a licensed foster parent.
18-15. Include a component on child sexual abuse prevention in foster and adoptive parent training	DHHS-CFS	**Rejected - Complete** The training that Project Harmony is implementing till also be utilized in foster and adoptive parent training. See 18-11.
18-16. Ensure adequate staffing for residential-child caring agency licensing operations.	DHHS-Public Health	**Rejected – No Further Action**
18-17. Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes and rules and regulations at residential child-caring agencies.	DHHS-Public Health	**Complete** Public Health reports that goal timelines have been developed and implemented. LB 59 was passed into law during the 2019 Legislative Session, which requires that investigatory reports made under the Children's Residential Facilities and Placing Licensure Act be issued 60 days after the determination is made

OIG Recommendation	Agency	Implementation Status
		to conduct the investigation, except that the report may be filed within 90 days if an interim report is filed within 60 days.
18-18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.	DHHS-Public Health	**No Further Action** Public Health reports reviewing PREA regulations and incorporating some standards into regulations being promulgated.
19-01. Clarify DHHS policy by adding specific processes to address how and when foster placement HOLDS with no timeframes are lifted.	DHHS-CFS	**Incomplete**
19-02. Create a policy regarding placement disruption plans with specific reference to where they should be located and found on N-FOCUS.	DHHS-CFS	**Incomplete.**
19-03. Develop Policy and Procedure for workers addressing pregnancy/birth with parents involved with the Division of Children and Family Services.	DHHS-CFS	**Rejected**
19-04. Clarify the definition of "change in circumstance" as found in current policy and procedure to include pregnancy and the birth of a baby, specific timelines and guidance as to what assessments should be completed due to a change in circumstances.	DHHS-CFS	**Rejected**
19-05. Include the following factors to when a mandatory supervisor consultation is required: when a parent has	DHHS-CFS	**Rejected**

OIG Recommendation	Agency	Implementation Status
voluntarily relinquished their parental rights, and when there is a CPS case closure due to reunification with a non-custodial parent.		
19-06. Require SDM logic refresher training for caseworkers and supervisors every 12 to 18 months.	DHHS-CFS	**Rejected**
19-07. Implement trauma informed support for workers experiencing the serious injury or death of a child on their case load above and beyond the Employee Assistance Program offered to all persons working for the State of Nebraska.	DHHS-CFS	**Rejected**

JULIE L. ROGERS
Inspector General

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July 16, 2019

Deb Minardi
Probation Administrator
1445 K Street, State Capitol, Room #1209
Lincoln, NE 68508

Dear Ms. Minardi:

The Office of Inspector General of Nebraska Child Welfare (OIG) is in the process of compiling its Annual Report which is due from our office on September 15. Neb. Rev. Stat. §43-4331 requires the OIG, in the annual report, to detail recommendations made in investigative reports and their implementation status.

Although Probation has not formally accepted any of the OIG recommendations, the OIG is committed to providing updates on all of the improvement you have made specific to these areas. To that end, we are requesting the OIG is provided information on what action, if any, Probation has taken on the recommendations. The present day *draft* of the status of probation recommendations is attached. Please provide any information related to these recommendations by **Friday, August 2**.

Please do not hesitate to let me know if you or members of your team have any questions or concerns about the updates. I look forward to highlighting the specific progress Probation is making regarding these particular recommendations in our annual report.

Respectfully,

Julie L. Rogers

Corey R. Steel
State Court Administrator

STATE OF
NEBRASKA
JUDICIAL BRANCH

Deborah A. Minardi
State Probation Administrator

August 12, 2019

Julie Rogers
Inspector General
State Capitol, P.O. Box 94604
Lincoln NE 68509-4604

Re: OIG Annual Report for 2018-2019

Dear Ms. Rogers:

This correspondence is in response to your July 16, 2019, letter to me regarding the duty of the Office of Inspector General to provide an annual report pursuant to Neb. Rev. Stat. § 43-4331. I note that there has not been an investigative report involving Probation completed by your office since the publication of your last annual report.

Your letter also indicated that "Probation has not formally accepted any of the OIG recommendations" from previous reports. In spite of this, work has been completed in many of the topic areas your recommendations covered. As you are aware, I was appointed to the position of Probation Administrator earlier this year. I have spoken at forums and highlighted my desire for Probation to make stakeholder relationships a central focus of our work. I look forward to reviewing your annual report as well as any other reports directed towards Probation.

Probation maintains a commitment to continuous quality improvement and an ongoing evaluation of our performance. Any recommendations that you provide will not only assist with this, but are also beneficial to help inform staff development topic areas for Probation employees. It is the mission of Nebraska Probation to create constructive change and improve the lives of juveniles' placed under our supervision through rehabilitation, collaboration, and partnerships in order to enhance community safety.

Sincerely,

Deborah Minardi

Deb Minardi
Probation Administrator

C: Wendy Wussow, Supreme Court Clerk

Administrative Office of the Courts & Probation
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Attachment

OIG Recommendations to Probation	Implementation Status
16-22. Adopt training and policy on supervising youth with intellectual and developmental disabilities (I/DD).	**Rejected - Progress** Probation provides the Nebraska Developmental Disabilities Access Guide to Probation Officers; to date Probation has been unable to locate a suitable training vendor and plans to coordinate with DHHS to accomplish training; there are no policies yet created, and the OIG is unaware of any action to create a policy.
16-23. Adopt policy on child welfare referrals and joint case management.	**Rejected - Complete** Probation released a policy regarding this subject. Probation has been training probation officers and DHHS caseworkers across the state with DHHS on the new joint case management policy.
16-24. Adopt policy on documentation and record keeping.	**Rejected**
16-25. Increase internal quality assurance efforts at the state level.	**Rejected**
17-01. Adopt statewide policy or protocol on what a probation officer's role is between assigning an alternative to detention and a court hearing.	**Complete** Probation approved a Predisposition Supervision Policy in September 2017. The policy sets forth the circumstances under which predisposition, court-ordered probation supervision may occur.
17-02. Adopt policy that specifies what restrictions are not appropriate for use as an alternative to detention.	**Incomplete**
17-03. Implement guidelines on when it is appropriate to use specific types of alternatives to detention.	**Incomplete**
17-04.Require a simple mental health screening during intake interviews and select a uniform tool for probation officers to use.	**Incomplete**
17-05. Adopt policy requiring probation officers to make and	**Incomplete**

OIG Recommendations to Probation	Implementation Status
document mental health referrals if an intake interview suggests that the youth has mental health needs.	
17-06. Create an acknowledgment form for youth and parents after an alternative to detention is implemented that contains information on their rights and responsibilities.	**Progress** Probation has created this form. It is unknown whether the form has been approved and implemented.
17-07. Improve communication protocols between Probation and alternative to detention providers to ensure that key information on youth is appropriately passed on.	**Incomplete**
17-08. Collect and publish data on the length of time between alternatives to detention being assigned and a court hearing taking place.	**Incomplete**
17-09. Assess whether Probation has the authority to monitor alternatives to detention.	**Complete** Probation implemented a Predisposition Supervision Policy in September 2017 clarifying the circumstances under which predisposition, court-ordered supervision may occur.