

**WARNING: THIS REPORT INCLUDES CONTENT THAT CONTAINS
DISTURBING MATERIAL REGARDING THE ABUSE OF CHILDREN,
INCLUDING DETAILS PERTAINING TO CHILD SEXUAL ABUSE**

OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE



Summary

REPORT OF INVESTIGATION

Sexual Abuse of State Wards, Youth in Adoptive or
Guardian Homes, & Youth in Residential Placement

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A Note about the Content of this Report

The following report is a summary of the Office of Inspector General of Nebraska Child Welfare's (OIG) investigation into incidents where children who were state wards, placed in licensed facilities, or placed in adoptive and guardian homes were sexually abused. Readers should be advised that some of the report's contents are disturbing.

Every effort has been taken to keep the identities of child victims confidential, the OIG has included details about cases of sexual abuse in an effort to be transparent about what was discovered in this investigation and why specific recommendations were made.

Throughout the report, individuals - both child victims and perpetrators - will be referred to with false initials. The names of placements, private providers, and local government agencies have also been removed. When possible, dates of events have been removed.

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INTRODUCTION AND EXECUTIVE SUMMARY

Created in 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) is charged with providing an independent form of inquiry and review of the actions of individuals and agencies responsible for the care and protection of children in the Nebraska child welfare and juvenile justice systems. The OIG carries out this charge through investigations into concerning incidents and allegations of wrongdoing and improper performance. In all of its investigations, the OIG must identify recommendations for system improvement.¹

Over the years, the OIG has received numerous reports related to the sexual abuse of children involved with or adopted from the child welfare system or involved with the juvenile justice system.

A continuing flow of these types of sexual abuse reports caused the OIG to open an investigation into what was being done to prevent and respond to sexual abuse of youth in state care. For purposes of this report, “youth in state care” will refer to children served by the Nebraska Department of Health and Human Services (DHHS) either as a state ward, or a child placed at a state-run facility or a private residential facility licensed through the Division of Public Health. As part of this investigation, the OIG reviewed cases of children who were sexually abused while in state care, and cases where children were sexually abused in the adoptive and guardian homes in which the state had placed them.

The OIG’s investigation was announced in December 2016. A final report of investigation was issued to DHHS in October 2017. The following summarized final report of investigation is being released pursuant to *Neb. Rev. Stat.* §43-4325, “in order to bring awareness to systemic issues.” All confidential details have been removed from this summary report, and information on DHHS’s response to the OIG’s recommendations has been added. An explanation and general timeline of the OIG’s investigative process can be found in Appendix B.

Background on Child Sexual Abuse

Child sexual abuse remains a widespread problem in the United States. Recent estimates show that 1 in 10 children will be subject to sexual abuse involving sexual contact before the age of 18, either by an adult or another youth.² Child sexual abuse is generally understood to include everything from child rape and molestation, sexual touching, and coercing or persuading a child to engage in any type of sexual act to exposure to pornography, voyeurism, and communicating in a sexual manner by phone or Internet. In an estimated 90 percent of cases, children are sexually abused by someone they know and trust.³

Between 2013 and 2016, there were 1,284 substantiated victims of child sexual abuse in Nebraska.⁴ While DHHS does not track how many of those victims were involved with the child welfare system, national research indicates that youth in this system are at higher risk of experiencing sexual abuse and exploitation than their peers in the general population. Exact numbers of child sexual abuse victims are difficult to calculate because many victims do not report sexual abuse or wait for long periods of time before disclosing. Available research indicates that false reporting of child sexual abuse is extremely rare

¹ The Office of Inspector General of Nebraska Child Welfare Act, *Neb. Rev. Stat.* §§43-4301 to 43-4332.

² Townsend and Rheingold, *Estimating a Child Sexual Abuse Prevalence Rate*, 21.

³ Finkelhor and Shatuck, *Characteristics of Crimes against Juveniles*, 5.

⁴ DHHS CFS Administrator, email message to OIG, Feb. 17, 2017. Data was provided by DHHS and further analyzed by the OIG.

– occurring in only 4 to 8 percent of cases.⁵

The impact of child sexual abuse can be lifelong - placing survivors at heightened risk for physical and mental health diagnoses, increasing the likelihood they will encounter academic problems and engage in risky behaviors, and even negatively impacting lifetime earnings.

Findings and Recommendations of the OIG Investigation

Through its investigation, the OIG identified cases of child sexual abuse of state wards, of youth in residential facilities, and of youth reaching permanency through the child welfare system. The OIG used these cases as a starting point in identifying systemic issues that hinder DHHS and the child welfare system's ability to appropriately prevent and respond to cases of child sexual abuse.

Throughout the report, the OIG also makes recommendations to DHHS for system improvements, in addition to identifying action items for the child welfare system as a whole. Of the 18 recommendations made, DHHS has accepted 11. Recommendations and action items are detailed in each section of the report. The OIG has also added DHHS's response to each recommendation and action item. A full list can be found in Appendix A.

Cases of Child Sexual Abuse

The OIG identified 50 children who were victims of sexual abuse that had been substantiated by DHHS or the courts, or where the case was court pending. Substantiated cases are those where it has been determined sexual abuse occurred. Court pending sexual abuse cases are cases that have been investigated and enough evidence exists that sexual abuse occurred that a juvenile or criminal court action was filed. The outcome of such juvenile or criminal proceeding has not yet been determined.

Twenty-seven victims were in state care at the time of their sexual abuse and 23 were sexually abused in an adoptive or guardian home in which the state had placed them. The 23 youth who were sexually abused in adoptive or guardian homes were no longer involved in the child welfare system when the abuse was reported, although for some the sexual abuse they experienced began before permanency was achieved.⁶ All of the sexual abuse allegations were reported to DHHS between July 2013 and October 2016.

The OIG also identified, reviewed, and analyzed some sexual abuse allegations of children in state care that were listed as unfounded or were never investigated. Under Nebraska law, all reports of child abuse or neglect not classified as court substantiated, court pending, or agency substantiated are to be considered unfounded.⁷ Although these allegations were not substantiated, at times correctly, the cases nonetheless illustrated concerns about how the child welfare system was functioning. Seven of these cases are highlighted in the report.

The OIG reviewed and gathered information on each case of sexual abuse to identify trends and systemic issues. Each case is summarized in the report.

The victims and cases identified by the OIG should not be considered a comprehensive list of children who were sexually abused while in state care or in adoptive and guardian homes. That number remains

⁵ Everson and Boat, "False Allegations of Sexual Abuse."

⁶ These adoptions or guardianships were finalized between 2003 and 2015.

⁷ Neb. Rev. Stat. § 28-720.01.

unknown, in large part due to the reluctance of child victims to report sexual abuse, as well as the issues this investigation documented with reporting, investigating, and substantiating sexual abuse.

From its efforts to identify sexual abuse cases, the OIG recommended that DHHS:

1. Create a system to collect and review cases when allegations of sexual abuse of children and youth served by CFS's child welfare and juvenile justice programs arise. DHHS rejected this recommendation.

Systemic Issues Identified

Through its investigation, the OIG identified systemic issues in a number of areas. In each of these areas, the OIG also made recommendations and identified action items to address shortcomings.

Attitudes towards sexual abuse of youth in state care

The OIG came across system professionals and caregivers who had problematic attitudes towards child sexual abuse and children who have spent time in the state's care.

- At times, children's sexual abuse disclosures were dismissed and never reported. In these cases, caregivers and professionals often assumed children were lying or "acting out" because they were troubled.
- Some children were exposed to continuing sexual abuse through professional and system inaction after concerns were noted.
- Some children were blamed by caregivers and system professionals for causing the sexual abuse that they suffered.

These attitudes contributed to many of the errors and issues that left the child welfare system unable to effectively prevent and respond to child sexual abuse of youth in its care.

The OIG identified fostering a culture of zero-tolerance for child sexual abuse as a child welfare system action item.

Reporting and screening child sexual abuse allegations

There were issues with how child sexual abuse allegations were reported to and screened by the DHHS Child Abuse and Neglect Hotline (Hotline).

1. Although it violates state law to fail to call the Hotline or law enforcement, some adults and system professionals who were aware of child sexual abuse allegations did not report them to the proper authorities.
2. If and when a report reached the Hotline, the use of overrides (a certain process to screen out reports) allowed some child sexual abuse cases to go without investigations and left children vulnerable to ongoing abuse.
3. Instances were discovered where reports of youth sexually abusing other youth were incorrectly determined to not meet the definition of child sexual abuse at the Hotline.
4. The Hotline has a practice of screening law enforcement only reports as "Does Not Meet Definition" when the allegation continues to meet DHHS's definition of child sexual abuse. This practice is not authorized in DHHS policy, masks the number of child sexual abuse allegations,

and creates opportunities for errors to occur.

The OIG recommended that DHHS:

2. End the practice of screening law enforcement only reports as “Does Not Meet Definition” when the allegation continues to meet DHHS’s definition of child sexual abuse. DHHS recommended modification of this recommendation.
3. 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 accepted this recommendation.
4. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff. DHHS accepted this recommendation.

The OIG also identified two child welfare system action items:

- Examine strategies to improve child abuse reporting; and,
- Ensure law enforcement follows their statutory duty to share child abuse reports with DHHS.

Investigations of child sexual abuse

There were several areas surrounding the investigations of child sexual abuse allegations that need improvement.

- Despite requirements in state law, not all allegations of child sexual abuse were investigated by DHHS or law enforcement. Further, DHHS was not assessing for risk of harm and providing needed services in all child sexual abuse cases.
- DHHS investigations of child sexual abuse at residential facilities, called “out of home assessments,” were not being conducted according to DHHS policy, leaving issues at these facilities unresolved.
- Across the state, some child sexual abuse cases were difficult to substantiate due in part to limitations in gathering evidence and poor coordination in multidisciplinary investigations.
- Child sexual abuse substantiations were inconsistent across Nebraska, even when evidence of child sexual abuse is present. This was due to differences in court practice and a lack of guidance by DHHS to accurately and uniformly apply a preponderance of the evidence standard.

The OIG recommended that DHHS:

5. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement. DHHS accepted this recommendation
6. Create a process to fulfill DHHS’s statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone. DHHS rejected this recommendation.
7. Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases. DHHS accepted this recommendation.
8. Adhere to policy on out of home assessments and enhance quality assurance. DHHS accepted this recommendation.

The OIG also identified two child welfare system action items:

- Clarify the *Child Protection and Family Safety Act*; and,
- Improve multi-disciplinary coordination in child sexual abuse investigations.

Workforce ability to prevent and respond to sexual abuse

High caseload, workload, and workforce turnover contributed generally to DHHS being unable to effectively prevent, identify, and respond to sexual abuse of youth in state care.

- Timeframes for completing child sexual abuse investigations were missed in a number of cases, sometimes by years. The OIG found 184 DHHS investigations and 1,350 law enforcement only investigations reported between 2013 and 2016, where timeframes were not met.
- Ongoing cases suffered as turnover and high workload made it difficult to identify signs that sexual abuse was occurring or made it difficult to provide effective case management to children who had been abused.
- The OIG also identified that the DHHS workforce was many times uncomfortable with discussing child sexual abuse.
- Not all staff were prepared to give youth while in state care the information they need about child sexual abuse to help them stay safe and know who they can talk to if something concerning does occur.

The OIG recommended that DHHS:

9. Meet the statutorily required caseload standard for initial assessment and ongoing case management. DHHS accepted this recommendation.
10. Review, modify, and enforce the process for gathering information and making findings in law enforcement only cases. DHHS accepted this recommendation.
11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation. DHHS accepted this recommendation.
12. Review and revise training on child sexual abuse for DHHS staff. DHHS accepted this recommendation.

Child sexual abuse in foster, adoptive, and guardian homes

Thirty-seven of 50 sexual abuse cases identified by the OIG occurred in foster, adoptive, or guardian homes. The OIG identified several deficiencies with how homes are chosen and prepared to care for children.

- Completion of home studies alone is not adequate to ensure that placements are safe and suitable for children.
- A shortage of appropriate placements created pressure to put children in homes that may have met minimum standards for placement but had suitability concerns.
- Foster and adoptive parent training did not include key information on preventing and reporting

child sexual abuse. In many instances, foster and adoptive parents were not able to respond appropriately to sexual abuse allegations or protect children.

The OIG recommended that DHHS:

13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements. DHHS accepted this recommendation.
14. Strengthen foster care licensing to remove inappropriate and unsuitable homes. DHHS accepted this recommendation.
15. Include a component on child sexual abuse prevention in foster and adoptive parent training. DHHS rejected this recommendation.

The OIG also identified improving foster home recruiting as a child welfare system action item.

Child sexual abuse in residential facilities

The OIG identified three substantiated child sexual abuse cases in residential facilities - two in privately-run facilities one at a state-run facility. The OIG also reviewed a number of concerning sexual abuse cases at a wide range of facilities that were never substantiated.

- The Division of Public Health, which licenses most residential facilities through the *Children's Residential Facilities and Placing Licensure Act*, did not have the capacity to adequately investigate and respond to sexual abuse allegations at residential facilities.
- The standards established for facilities related to sexual abuse are inadequate to minimize the risk of child sexual abuse.
- Where the U.S. Department of Justice's Prison Rape Elimination Act Juvenile Facility Standards had been implemented, staff took appropriate steps to respond to allegations and incidents of sexual abuse.

The OIG recommended that DHHS:

16. Ensure adequate staffing for residential-child caring agency licensing operations. DHHS rejected this recommendation.
17. Adopt clear internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes, rules and regulations at residential child-caring agencies. DHHS recommended modification of this recommendation.
18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies. DHHS recommended modification of this recommendation.

The OIG also identified a child welfare system action items:

- Move licensing of residential child-caring and child-placing agencies from the Division of Public Health to the Division of Children and Family Services.

BACKGROUND ON CHILD SEXUAL ABUSE

While there is no universal definition, expert organizations and practitioners generally consider child sexual abuse to include both contact and non-contact sexual acts either between an adult and a child or two children, when one exerts power over the other. Child sexual abuse is generally understood to include everything from rape and molestation, sexual touching, and coercing or persuading a child to engage in any type of sexual act to exposure to pornography, voyeurism, and communicating in a sexual manner by phone or Internet.⁸

DHHS has adopted a definition of child sexual abuse that includes, “any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, child, vulnerable adult, or other person.”⁹

The rate of child sexual abuse declined between 1990 and 2010 in the United States.¹⁰ Recent estimates show that it remains a widespread problem, however. An estimated one in 10 children will be subject to sexual abuse involving sexual contact before the age of 18, either by an adult or another youth.¹¹

There is no single set of characteristics common to perpetrators of child sexual abuse. In 90 percent of cases, perpetrators of sexual abuse are known to and trusted by the children they abuse and their families. In about 30 percent of cases, children are abused by family members.¹²

The consequences of child sexual abuse include a heightened risk for mental health problems, including posttraumatic stress, anxiety, and suicide attempts.¹³ Children with a history of sexual abuse are also more likely to engage in risky behaviors, including substance abuse and breaking the law, and encounter academic problems.¹⁴ Studies show that adult survivors of child sexual abuse are more likely to need medical treatment for physical and mental health problems, have lower lifetime earnings, and lower reported life satisfaction.¹⁵

In Nebraska, there were 1,284 substantiated victims of child sexual abuse between 2013 and 2016.¹⁶ These children had sexual abuse allegations reported, investigated, and substantiated (found to have occurred) by either the court system or DHHS.

There are currently no numbers available on how many of the 1,284 victims of child sexual abuse had child welfare involvement. There are no comprehensive estimates of the prevalence of sexual abuse of children in the child welfare and juvenile justice system available either nationally or in Nebraska. However, studies suggest that youth in these systems are particularly vulnerable to sexual abuse and exploitation.

In the United States, research estimates that youth living without either parent (including foster care or a residential facility) are 10 times more likely to be sexually abused than youth living with both parents.¹⁷

⁸ Townsend and Rheingold, *Estimating a Child Sexual Abuse Prevalence Rate*, 26-27.

⁹ Intake Screening Policy and Procedures Manual, March 2012, DHHS CFS, 19.

¹⁰ Finkelhor and Jones, *Have Sexual Abuse and Physical Abuse Declined*, 3.

¹¹ Townsend and Rheingold, *Estimating a Child Sexual Abuse Prevalence Rate*, 21.

¹² Finkelhor and Shatuck, *Characteristics of Crimes against Juveniles*, 5.

¹³ Devries et al., “Childhood Sexual Abuse,” e1332.

¹⁴ Darkness to Light, *Consequences*, 1-2.

¹⁵ Fergusson et al., “Childhood sexual abuse.”

¹⁶ DHHS CFS Administrator, email message to OIG, Feb. 17, 2017.

¹⁷ Sedlak, et al., *NIS-4*, 5-32.

This is consistent with research from other countries, which indicates that youth in foster care and in residential facilities are at higher risk for child sexual abuse than the general population.¹⁸ Youth in state care have also been found to be particularly vulnerable to sex trafficking.¹⁹

Available numbers of child sexual abuse victims both in the child welfare system and the general population are likely an undercount. The majority of child sexual abuse incidents are never reported. Research studies estimate that only 38 percent of child victims disclose sexual abuse. Many of the children who disclose sexual abuse share the information with friends and peers, instead of adults or authorities, lessening the likelihood of official reports being made. Some child victims don't disclose abuse until years later and some never do.²⁰

Some reports of child sexual abuse reported to authorities are not investigated, even though available research suggests that a small fraction (between four and eight percent) of child sexual abuse disclosures are false.²¹ From 2004 to 2009, child protective services agencies across the United States investigated about 55 percent of the child sexual abuse reports they received.²² Between 2013 and 2016 in Nebraska, the percentage of reports accepted for a DHHS investigation or assessment was lower - about 36 percent.²³

Reports do not get investigated by DHHS for a variety of reasons. Reports may not meet the definition of what is considered to be child sexual abuse. Furthermore, in Nebraska, DHHS has a policy of only investigating and assessing sexual abuse cases when the alleged perpetrator is part of the child's household or has continued access to the child. DHHS has determined that in these situations there is a continuing risk of harm to the child. All other child sexual abuse reports are referred to law enforcement for a criminal investigation. However, depending on the report, law enforcement may not investigate.

Even when child sexual abuse reports are investigated, it is often difficult for the county attorney's office to prosecute the perpetrator or for DHHS to substantiate the incident. The evidence that can be gathered in cases of sexual abuse is often limited, since physical evidence usually cannot be collected. The disclosure and cooperation of the child victim, who often has a relationship with the perpetrator, must be relied on. Given these limitations, prosecution and substantiation rates for child sexual abuse tend to be low.²⁴

¹⁸ Euser, et al., "The Prevalence of Child Sexual Abuse."

¹⁹ Bounds, et al., "Commercial Exploitation of Children."

²⁰ London et al., "Disclosure of Child Sexual Abuse."

²¹ Everson and Boat, "False Allegations of Sexual Abuse."

²² Sedlak, et al., *NIS-4*, 17.

²³ DHHS CFS Administrator, email message to OIG, Feb. 17, 2017. From 2013 to 2016, DHHS accepted 5,646 sexual abuse calls for investigation out of 15,741 sexual abuse calls received.

²⁴ Walsh, et al., "Prosecuting Child Sexual Abuse," 2-3.

ANALYZED CASES OF SEXUAL ABUSE

The OIG analyzed cases involving alleged sexual abuse of youth in state care and youth in adoptive and guardian homes gathered from a variety of sources - critical incident reporting provided by DHHS and Juvenile Probation, reports to the Child Abuse and Neglect Hotline (Hotline) provided by DHHS, and other cases the OIG discovered in the course of its investigation. These cases were used to identify errors and systemic issues that impact the child welfare system's ability to prevent and respond to sexual abuse of youth in its care.

Through its review, the OIG identified **50 child victims** of sexual abuse whose cases were reported to DHHS between July 1, 2013 and October 31, 2016. Twenty-seven children were sexually abused while in the state of Nebraska's care, either as state wards or living in a residential facility, and 23 youth who were former state wards were sexually abused while in the care of the adoptive or guardian homes in which the state had placed them. This section provides summaries about each of the 50 children and the sexual abuse they underwent. The ages of children at the time of the report of sexual abuse are noted. To protect the identities of victims, initials are used and do not correspond with actual initials.

In order to be included in the OIG's count of victims, the sexual abuse allegation had to be listed as substantiated or court pending by DHHS.²⁵ Forty-eight of the 50 victims were identified through a list of Hotline reports provided by DHHS. Two victims were not included in that list, due to errors or delays in entering information by DHHS staff in the field. The OIG discovered those cases through a review of a critical incident and a media report, respectively.

The OIG also identified cases of sexual abuse involving children in state care that were unfounded or that were not investigated, but revealed concerning errors or systemic issues. Seven of these cases are included in this report. These cases are also summarized in this section.

SUBSTANTIATED AND COURT PENDING SEXUAL ABUSE CASES

YOUTH IN STATE CARE

The OIG identified **27** child victims who were sexually abused while in state care. All 27 cases were reported to the Hotline between July 1, 2013 and October 31, 2016. Twenty-three of these children were state wards, three youth were both state wards and supervised by Probation, and one youth was supervised by Probation alone but placed in a residential facility licensed by DHHS. In seven of 27 cases, youth were sexually abused by an individual who did not live in the family home.

Case Summaries

T.A., N.A., and Y.A. - 8, 10, and 12 years old

T.A., N.A., and Y.A., sisters, originally became state wards due to allegations of methamphetamine use and domestic violence by their parents. When the juvenile court case was closed four years later, the girls had been living with their father, V.A., his girlfriend, R.D., and her children for over a year. Eight months after the first case closed, T.A., N.A., and Y.A. again became state wards after physical abuse of Y.A. by R.D. All of the children were removed, but days later were placed back in the home with a safety plan.

²⁵ For a child sexual abuse allegation to be substantiated, DHHS gathers evidence to make a finding that the sexual abuse more likely than not occurred. This includes both allegations substantiated because of a juvenile or criminal court decision, and allegations substantiated based on DHHS's review alone.

Eight months after they entered state care for the second time, T.A. and N.A. disclosed sexual abuse, including oral sex, fondling, and digital penetration by their step-brothers, C.D. (age 17) and J.A. (age 20). Both girls had mental health diagnoses and were taking multiple psychotropic medications at the time. T.A. also said that she had witnessed her sister, Y.A., who had a seizure disorder and was missing part of her brain, being sexually abused as well. T.A. said the abuse had been going on for about two years. During the investigation of the case, it was also discovered that C.D. and his sister, G.A., were being sexually abused by V.A. (age 33). T.A. also disclosed sexual abuse by her father, V.A. Prior to closing the first child welfare case, multiple reports related to sexual acting out of children in the home and inappropriate sexual contact between V.A. and his step-children had either not been investigated or closed without substantiation.

V.A. has not been criminally charged for sexual abuse. The report of V.A. sexually abusing C.D. and G.A. is agency substantiated. J.A. was convicted of Attempted 1st Degree Sexual Assault of a Child and sentenced to 10-15 years in prison. C.D. was convicted of Child Abuse and sentenced to 3-5 years in prison. The reports against J.A. and C.D. are listed as court substantiated.

R.O. and K.O., and M.E. - 10, 11, and 8 years old

R.O. and K.O., brothers, became state wards due to homelessness, lack of food, and hygiene issues. Both boys had developmental disabilities, including low IQs, and had been diagnosed with fetal alcohol syndrome and a variety of mental illnesses. For seven months, R.O. and K.O. lived in a licensed foster home. After moving to their aunt's home in another state, the boys were engaging in inappropriate sexual activities with each other. They disclosed that their former foster mother's son, or foster brother, age 14, had sexually abused them, including oral and anal sex and making the boys watch pornography. During the investigation, M.E., a different state ward placed in that licensed foster home for extended respite care, also disclosed that the foster brother had made her watch pornography and had unsuccessfully tried to sexually touch her as well. The foster brother was adjudicated in juvenile court for child abuse and was placed on probation. DHHS staff told the OIG that the foster brother was a victim of sexual abuse by an adult who is facing criminal charges. However, the OIG found no record of the foster brother's sexual abuse being reported to the Hotline. The foster brother was initially placed on the Central Registry, but later expunged for good cause. The report is agency substantiated.

F.C. – 16 years old

F.C. was adopted from the child welfare system at four years old, and then re-entered it at the age of 11 for uncontrollable behavior. Four years later, he was placed at a licensed foster home, which cared for a number of teenage male state wards. Three months after moving in, another state ward placed in the foster home, D.V. (age 18), stuck his finger into F.C.'s anus while he was fully clothed. F.C. also reported that D.V. had entered his bed while he was sleeping and started to sexually touch him. At the time of the abuse, besides F.C. and D.V., there were three teen boys living in the home as foster youth. D.V. had been removed from his family home and put in foster care for sexually perpetrating on his younger brothers. D.V. was convicted of 3rd Degree Assault and placed on probation for 18 months. The report is court substantiated.

L.N. and P.N. - 4 and 6 years old

L.N. and P.N. were placed in the relative foster home of Y.F. and D.F., their great-grandparents, after having been removed from their mother's care due to unsanitary conditions in her home. Two months later, a report was made that P.N. had disclosed sexual touching by her uncle, S.N. (age 19), who also

lived with Y.F. and D.F. The uncle, S.N., disclosed that he engaged in oral and vaginal sex with P.N., kissed and sexually touched her, and had shown her pornography. S.N. also admitted to sexually touching L.N., by rubbing his penis on multiple occasions. During the investigation, it was also discovered that P.N. had told her great-grandmother of the abuse, but that she did not believe her. S.N. was convicted of 1st Degree Sexual Assault and Attempted 1st Degree Sexual Assault of a Child and sentenced to 15-20 years in prison. The report is court substantiated.

R.G. - 15 years old

R.G. became a state ward because of his own behaviors. R.G. was hospitalized a number of times for mental health issues and spent time in shelters and detention centers, before returning home to his mother. Prior to becoming a state ward, R.G. disclosed that an older couple had given him drugs and that the woman had engaged in sexual activities with him, but the case was categorized as unfounded. While at home, his uncle's ex-girlfriend, H.A. (age 24), started sexually abusing R.G., including engaging in sexual intercourse with him on a number of occasions. Shortly after the abuse was discovered and reported, R.G. was removed from his home to a detention center and then admitted to a psychiatric residential treatment facility. H.A. was convicted of Contributing to Delinquency and placed on probation for 12 months. The report is agency substantiated.

V.H. - 13 years old

V.H. entered state care due to parental substance abuse and domestic violence. An attempt at reunification with her mother failed 3 years later, and she was placed in a relative foster placement with her grandmother. While placed with her grandmother, V.H. met registered sex offender P.D. (age 38) through a neighbor and they exchanged cell phone numbers. Over that summer, P.D. sent V.H. inappropriate text messages and nude pictures, and convinced her to send him nude pictures as well. P.D. sexually assaulted V.H. The messages were discovered and reported. About a year later, while V.H. was placed in a psychiatric residential treatment facility for mental health treatment, she disclosed that during the summer of 2013, a man who attended her church, T.B. (age 19), had also sexually touched her and tried to coerce her into having sex. P.D. was convicted of Enticement with Electronic Device and 1st Degree Sexual Assault and sentenced to 11-17 years in prison. The report is court substantiated. T.B. was convicted of 3rd Degree Sexual Assault and was sentenced to probation for two years. The report is court substantiated.

M.U. - 18 year old

M.U. became a state ward after violating the law. The following year, she was placed at a group home after a brief stay in detention. M.U. went on a weekend home visit from the group home. While at home, her older brother, T.U. (age 25), came into the bathroom behind her, groped her, and put his hands under her clothing and underwear. M.U. punched him and ran away. While investigating M.U.'s report, police also discovered that T.U., who was reportedly schizophrenic, had been abusing his younger sister, Y.U. (age 8) and physically threatening his mother and other members of the family. T.U. was charged with Terroristic Threats, Use of a Deadly Weapon to Commit a Felony, and 3rd Degree Sexual Assault of a Child. The Court found T.U. not responsible by reason of insanity for all three charges and committed T.U. to a public institution. As of August 2017, the intake listed the sexual abuse report as court pending.

B.A. and F.A. – 7 and 8 years old

B.A. and F.A. were removed from their home, along with their 1-year-old sister, for physical abuse. Soon after they were placed in an approved relative foster home with their grandparents, N.O. and J.U. Around a year after removal, B.A. disclosed that whenever his grandmother was out, J.U. (age 63), his

grandfather, would instruct the children to take off their clothes. J.U. would then begin touching the children on their legs and bottoms. On further investigation, F.A. disclosed that J.U. had engaged in vaginal sex with her, digitally penetrated her on multiple occasions, and inappropriately massaged and touched her, including during bath time. It was also discovered that the children were being disciplined with belts by their grandfather. The OIG did not find any criminal charges pending. The report is agency substantiated.

A.L. - 11 years old

A.L., along with her two brothers, became state wards, due to concerns about their parents' substance abuse. The children remained placed at home, where her grandparents also lived. About a year later, A.L.'s mother was arrested, and A.L. disclosed that she did not want to stay in her home because her grandfather (age 65) had been inappropriately touching her. During the investigation, A.L. stated that twice during the preceding week her grandfather had lain down next to her on the couch, lifted her shirt, pinched her nipples, and rubbed her thigh and genital area. A.L. did tell her mother before her mother's arrest. The mother did not report the abuse, but told A.L. to stay away from her grandfather. The grandfather was convicted of Attempted 3rd Degree Sexual Assault on a Child and Child Abuse and sentenced to up to 2 years in prison. The report is court substantiated.

Y.N. - 13 years old

Y.N. and her sister, had been state wards due to domestic violence and substance abuse in their home. The girls were adopted from the child welfare system by T.N. 5 years later. They were removed from T.N.'s home a little less than 2 years after adoption, due to physical abuse. That case successfully closed 7 months later. However, six months after the initial case closure, Y.N. and D.N. were again removed from T.N. due to physical abuse. They were placed in the licensed foster home of A.S. (age 38) and M.S. Within 2 months of placement, the Hotline received a report that Y.N. had disclosed that A.S. was having sex with her. The children were removed from the foster home, but during an interview that month Y.N. denied any sexual contact with A.S.

Throughout that summer and fall, A.S. found ways to stay in touch with Y.N. – showing up at her school, using Facebook, driving by foster homes, and giving her cell phones. After Y.N. admitted that A.S. had sexually abused her repeatedly, including oral and vaginal intercourse on a frequent basis, she continued to have contact with him and would sneak out of her foster homes to meet him. That fall, Y.N. discovered she was pregnant and a DNA test proved A.S. had impregnated her, and he was arrested and convicted of two counts of 1st Degree Sexual Assault of a Child and sentenced to 100-160 years in prison. The report is court substantiated.

R.Z. - 17 years old

R.Z. became a state ward due to both abuse and neglect and his own behaviors. After entering the child welfare system, R.Z. experienced a number of placement changes including stays in foster homes, shelters, detention centers, a psychiatric residential treatment facility, and a few months where he was missing from care. He was admitted to a psychiatric residential treatment facility before stepping down to Group Home Q, licensed by Public Health as a residential child-caring agency. A shift manager at Group Home Q, age 31, began to groom and sexually abuse R.Z. while he was at the group home, including engaging in sexual intercourse with him on several occasions. The shift manager was convicted of 1st Degree Sexual Assault of a Protected Person and sentenced to probation for five years. The report is court substantiated. Public Health did not complete an investigation into Group Home Q related to this incident.

Z.C. – 18 years old

Z.C. became a state ward due to physical abuse and was placed in the licensed foster home of G.T. and R.T. There had been two prior investigations of R.T., the foster father, sexually abusing foster children by fondling them at the time that Z.C. was placed in the home. Both allegations had been unfounded. 3 years after being placed with G.T. and R.T., Z.C. moved out of the home and started college,. Once there she disclosed that R.T. (age 63) repeatedly fondled her. Z.C. had disclosed the abuse to her foster mother in the past, but she did not report the allegation because she thought Z.C. was a liar. A few months after reporting the sexual abuse, Z.C. was hospitalized after drinking alcohol and overdosing on prescribed psychotropic medications. R.T. was convicted of 3rd Degree Assault and sentenced to probation for two years. The report is court substantiated.

K.N. - 4 years old

K.N. entered the child welfare system with her brothers due to parental substance abuse and domestic violence. The children were placed with their maternal grandparents. During a visit with their father, their half-brother, D.J. (age 17), asked to come over and visit with his siblings overnight. The next morning, K.N. disclosed that D.J. had undressed in front of her, undressed K.N., and touched her genital area. The abuse was immediately reported to the Hotline. According to DHHS records, D.J. admitted to the sexual abuse in juvenile court. The report is agency substantiated.

B.L. - 15 years old

B.L. was charged with theft and was placed on Juvenile Probation. B.L. was placed at Group Home Z licensed by Public Health as a residential child-caring agency. Five months later, B.L. was written up for being disrespectful by saying that M.O. (age 36), a female staff member, had performed oral sex on him. That same month, M.O. was officially written up by her supervisor for being alone with youth, B.L. in particular, in their rooms for long periods of time. No report was ever made to the Hotline.

Two months later, when rumors about M.O. having sexual contact with B.L. resurfaced, Group Home Z conducted an internal investigation and concluded there was no substance to the rumors. Again, no report was made to the Hotline. Another two months after that, a report was made to that M.O., who was pregnant, was having sex with B.L. M.O. was then fired from Group Home Z the following month. M.O. was criminally charged after B.L. was found to be the father of her baby.

Public Health took no disciplinary action against the group home for this incident. M.O. was convicted of 1st Degree Sexual Assault and sentenced to 10-16 years in prison. The report is court substantiated.

W.C. – 17 years old

W.C. became a state ward, after a prior guardianship from the child welfare system disrupted. W.C. was also on Juvenile Probation. W.C. had multiple mental health and substance abuse diagnoses. Over the course of the following year, W.C. spent almost five months missing from care, in addition to spending time in group homes, shelters, and detention centers. A year after becoming a state ward, he was placed in the foster home of K.B. and C.B., who had adopted his younger half-siblings. The following month, a police officer patrolling an empty parking lot discovered K.B. (age 46), who was intoxicated at the time, believed to be having sex with W.C. in a car. W.C. denied that sexual contact had occurred when interviewed. He told authorities that he and K.B. had just been sitting in the car talking after they left the home because of an argument with other family members about her spending too much time with him. K.B. is charged with 2nd Degree Sexual Assault of a Protected Person, Child Abuse, and Tampering with

Physical Evidence. As of August 2017, the trial was pending and the intake listed the sexual abuse allegation as court pending.

I.L. - 16 years old

I.L. entered the child welfare system with her sisters due to parental substance abuse and domestic violence. The children were placed in the relative foster home of their grandfather. Seven months later, it was discovered that I.L. was using stolen phones and that two adult men, S.V. (age 28), and another man, who was unable to be identified, were exchanging inappropriate pictures and messages with I.L. S.V. was convicted of two counts of Enticement by Electronic Device and Contributing to the Delinquency of a Child and sentenced to probation for five years. The report is court substantiated.

K.M. -15 years old

K.M. entered the child welfare system due to parental substance abuse. After being placed at a few foster homes, he returned home on a trial home visit. K.M. remained a state ward when police were looking for K.M. in connection with a report of shots fired. They interviewed his acquaintance, G.F. (age 34), in an attempt to locate him, and she told police that she had been having sexual intercourse with K.M. every day for over two months. G.F. was convicted of Child Abuse and sentenced to two years of probation. The report is court substantiated.

C.O. - 18 years old

C.O. became a state ward due to substance abuse issues. He was placed in a number of group homes and shelters before being sent to a state-run residential facility later that year because of issues with running from placement and continued drug use. C.O. was spending large amounts of time in room confinement for his behaviors, and his mental health was deteriorating.

C.O. was exhibiting regular self-harming behaviors, using glass and other items he found to cut himself. That month he was assigned a new therapist, S.M. (age 28). C.O. had therapy with S.M. at least once a week, with sessions sometimes lasting a few hours, throughout the summer. Despite the time spent in therapy, C.O. continued to have self-harming and aggressive behavior. He was then arrested and transported to jail for assaulting a staff member. Shortly after his arrest, video footage was found of S.M. having sexual contact with C.O. during six separate therapy sessions in one month including kissing, mutual masturbation, and sexual touching and massage. Videos from earlier sessions were not available, so it was unclear how long the abuse had been occurring. C.O. declined to be interviewed for the investigation. S.M. was charged with 2nd Degree Sexual Abuse of a Protected Person and sentenced to 30 days in jail and four years on probation. The report is court substantiated.

L.Y. - 16 years old

L.Y. became a state ward due to physical abuse. While placed in a foster home it was reported that she had been having sexual conversations with two adult men, S.I. (age 33) and C.H., through the internet and her phone. It was also reported that S.I. had had sex with L.Y. in the community and also in L.Y.'s foster home. During the investigation, L.Y. disclosed oral and vaginal sex with S.I. and that she had also been exchanging nude photographs with W.R. (age 20) the son of one of her former foster parents. After the sexual abuse was discovered, L.Y.'s foster mother wanted her immediately removed. S.I. is charged with 1st Degree Sexual Assault of a Child and Enticement by Electronic Device. As of August 2017, the trial was pending and the intake listed the sexual abuse allegation as court pending.

N.N. - 10 years old

N.N. and her sister, V.N., were removed from their biological mother due to physical abuse, medical neglect, and parental drug use. Four years after her original removal, N.N. was placed in the licensed foster home of C.E. and L.E. V.N. was placed there a few months after N.N. Numerous reports of physical abuse of the children by C.E. and L.E. were called into the Hotline. V.N. was removed from the home nine months after being placed there. However, DHHS found the foster home conditionally suitable and safe from N.N. on review. N.N. stayed in the placement for an additional 14 months, before another report of physical abuse was received. This time DHHS concluded the foster home was unsuitable, but did not substantiate allegations of physical abuse. N.N. was removed from the home. The agency supporting the foster home terminated their contract. However, DHHS did not formally close the home until eight months later.

One month after being removed from C.E. and L.E.'s home, N.N. disclosed sexual abuse by L.E. (age 66) while she had been placed with him. L.E. was charged with three counts of 1st Degree Sexual Assault on a Child. An additional three victims – 2 family members and V.N. - have reported sexual abuse by L.E. since that time. He now faces five counts of 1st Degree Sexual Assault on a Child and one count of 3rd Degree Sexual Assault on a Child. As of August 2017, the trial was pending and the intake listed as court pending.

Q.U. - 14 years old

Q.U. came into state care along with her younger sister. Shortly after their removal from the home they were placed in a kinship foster home with P.Z. Prior to her entry into the child welfare system, there had been reports that Q.U.'s mother was encouraging her to have sex with older men in return for drugs. Fourteen months after placement, Q.U. was hospitalized due to a suicide attempt, and P.Z. reported that she and Q.U. had been receiving threatening messages from S.E. (age 25). When police interviewed Q.U., she told them that she and S.E. had a sexual relationship and that P.Z. knew about and encouraged it. In interviews, Q.U. disclosed that she and S.E. had sex three times and that P.Z. had put her in situations where other men had inappropriately touched her as well.

S.E. was sentenced to 16-20 years in prison for two counts of attempted sexual assault of a minor. P.Z. was sentenced to 2 years in prison for two counts of child abuse. DHHS entered a finding of court substantiated for this report.

YOUTH IN ADOPTIVE AND GUARDIAN HOMES

The OIG identified 23 child victims of sexual abuse who had been adopted or placed in guardianships from Nebraska's child welfare system. These children did not have open child welfare cases when sexual abuse allegations were reported to the Hotline - between July 1, 2013 and October 31, 2016. In a number of cases, children reported that the sexual abuse while they were still state wards.

Case Summaries

W.D. and E.D. – 11 and 13 year olds

W.D. and E.D., along with their older brother X.D., were adopted from Nebraska's child welfare system by D.D. Prior to adoption, there were some indications that all three children were sexual abuse victims before becoming state wards. Three years after adoption was final, the Hotline received a series of reports alleging inappropriate sexual behavior by the children. A few investigations were conducted, but no

services were offered to the family. Six years after the first Hotline report, E.D., who has a diagnosed developmental disability, disclosed that X.D. (age 15) had sex with her and her sister and that her mother knew about it. In interviews, it was discovered that X.D. had sexually abused his siblings, and that W.D. and E.D. were kissing, fondling each other, and engaging in oral sex. Because D.D. was aware of these behaviors, the children were removed from her care and re-entered the child welfare system. The report was agency substantiated.

R.R. - 14 years old

R.R. was placed in a guardianship with her grandparents, D.G. and B.G. Eighteen months later, R.R. called the police because her grandfather, D.G. (age 68), had threatened to hurt himself if she didn't sit on his lap, and she was worried for him. R.R.'s father had committed suicide prior to her guardianship. When police responded, R.R. disclosed them that earlier that day she had tried on her homecoming dress and her grandfather came into her room, watched her remove the dress, and then, while she was topless, hugged her, fondled her breasts, and made sexual comments to her. When B.G., the grandmother, was informed of the incident, she blamed R.R. for removing her dress. B.G. refused to have any more contact with R.R., so the guardianship disrupted and R.R. re-entered the child welfare system. D.G. was convicted of Child Abuse and sentenced to probation for twelve months. The report is court substantiated.

M.C. - 15 years old

M.C. was adopted, along with his brother, by J.C. Nine years later, J.C., a licensed foster parent, accepted placement of T.E. (age 18), M.C.'s half-sister, who was a state ward due to both delinquency and abuse and neglect and had been in the system for seven years. M.C. was hospitalized after a suicide attempt. While he was in the hospital, sexually explicit messages between T.E. and M.C., detailing sexual contact including oral, vaginal, and anal sex. were discovered and reported. The sexual abuse was occurring in the home when J.C. was sleeping. The report is agency substantiated.

J.R. and N.R. - 17 and 18 years old

B.R. and H.R. were licensed as foster parents and an extended family home for those with developmental disabilities. J.R., who had diagnosed developmental disabilities, was placed with the family. B.R. and H.R. became her guardians and later adopted her. N.R., originally removed from her mother because of sexual abuse by her mother's boyfriend, was also placed with the family.

Four years after being adopted, N.R. had her older brother take her to the hospital after H.R. (age 47) sexually assaulted her. N.R. reported that H.R. had been sexually abusing her for the four years and forcing her to have intercourse for two years. N.R. had told B.R., the adoptive mother, of the abuse in the past, but B.R. refused to believe her. During the investigation, R.R., a child who was privately adopted, also disclosed sexual abuse by H.R. that had gone on for years. She had also told B.R. about the abuse, but B.R. had called her a liar. Based on these disclosures, all of the children were removed and became state wards. J.R. did not disclose sexual abuse by H.R. in the initial investigation, but did so later while in foster care. H.R. was convicted of 1st Degree Sexual Assault and Child Abuse and sentenced to 95-100 years in prison. The report is court substantiated.

H.H. - 13 years old

H.H. and her two brothers were adopted by S.H. and D.H. About six years later, the Hotline received a call that H.H. had disclosed sexual abuse by her adoptive father, D.H. (age 53), and that S.H., the adoptive mother, knew but was not reporting it and blamed H.H. for throwing herself at D.H. During the

investigation, H.H. disclosed that the sexual abuse had been occurring for about a year and included fondling, sexual touching, and vaginal penetration. H.H. and her brothers were removed and taken into the state's care. D.H. was convicted of Attempted 1st Degree Sexual Assault and sentenced to 4-10 years in prison. The report is court substantiated.

D.X. - 15 years old

J.X. became her sister D.X.'s guardian. Six years later, D.X. disclosed that J.X.'s boyfriend, Y.E. (age 30), had sexually abused her over the course of a year. The abuse occurred when J.X. was not at home and included inappropriate touching, fondling, and massages. J.X. was not aware of the abuse and after D.X. disclosed, she believed her and took action to keep her safe. Y.E. was convicted of Disturbing the Peace and sentenced to a \$500 fine. The report is agency substantiated.

L.T. and A.T. - 17 and 19 years old

A.T. was placed into a guardianship with S.T. from Nebraska's child welfare system. S.T. then privately adopted A.T. S.T. also adopted L.T. and his brother from the Nebraska child welfare system. Nine years after being adopted, L.T. entered the juvenile justice system because he had sexually abused a 10-year-old developmentally disabled girl in the community. A few months later, A.T. disclosed that his father had been sexually abusing him, and the police were contacted. During the investigation, it was revealed that S.T. (age 47) had sexually abused A.T. for 13 years, pre-dating his adoption, and L.T. for at least four years. The sexual abuse included watching pornography, fondling and masturbation, and forced oral sex. The boys' adoptive mother did not know about the abuse, so no child welfare case was opened after the abuse was discovered. In the years since the abuse was discovered, L.T. was placed in a public institution. S.T. was convicted of two counts of 1st Degree Sexual Assault on a Minor and sentenced to 60-80 years in prison. The report is court substantiated.

A.N. - 17 years old

A.N. was adopted from the child welfare system by B.N. and G.N. Twelve years later, a report that the adoptive dad, G.N. (age 52), was sexually abusing A.N. was called into the Hotline. The investigation revealed that G.N. had been inappropriately hugging and kissing A.N. at least daily for about three years, which he told DHHS investigators was to help prepare her to be a good wife. The adoptive mom, B.N., was aware that the inappropriate kissing and hugging were occurring. A.N. also reported that G.N. had recently begun to inappropriately touch her, including massaging her breasts, bottom, and genitalia. B.N. refused to believe A.N. was sexually abused, and A.N. re-entered the child welfare system. G.N. was not criminally charged. The report is agency substantiated.

D.S. - 12 years old

G.P. and C.P. became guardians of their niece D.S. and her sisters. Nine years later, the Hotline received a report that D.S. told her that her uncle G.P. (age 37) had recently begun removing her bra and touching her breasts. D.S. confirmed the sexual abuse in an interview. At the time of D.S.'s sexual abuse, G.P. and C.P. were licensed foster parents. D.S. and her sisters re-entered the child welfare system after the disclosure, since C.P. refused to care for them any longer. G.P. was convicted of 3rd Degree Sexual Assault on a Child and sentenced to probation for two years. The report is court substantiated.

T.I. - 17 years old

T.I. entered the child welfare system because of sexual abuse that was occurring in his home. Four years later, he was placed in the licensed foster home of L.I. (age 58), who had been a foster parent to teen boys for 13 years and also worked professionally with youth in the juvenile justice system. A report that L.I. had been strip searching the boys in his care was unfounded a few months before T.I. was placed there. Two and a half years after T.I. was adopted by L.I., T.I. reported sexual abuse by L.I. to the police. T.I. reported that L.I. had been paying and coercing T.I. to perform sex acts. T.I. reported that he had let L.I. perform sex acts on him, including masturbation. After T.I. disclosed the abuse, no child welfare case was opened since L.I. signed a power of attorney that gave his sister the ability to care for T.I. L.I. was convicted of Solicitation of a Minor and sentenced to probation for 3 years. The report is court substantiated.

R.A. – 12 years old

J.V. and E.V. took guardianship of their grandchildren, R.A. and her brother as part of a child welfare case. Six years later, R.A. disclosed that her uncle, R.C. (age 25), who lived in their house had been coming into her bedroom at night and touching her below the waist. R.A. told her grandmother, E.V. about the abuse, but E.V. did not report. After the sexual abuse was reported, J.V. and E.V. ended their guardianship of R.A. and her brother because they did not believe that the abuse had occurred. R.C. was convicted of 3rd Degree Sexual Assault of a Child and sentenced to 2 years in prison. The report is court substantiated.

Y.M. - 17 years old

Y.M. and her siblings were adopted by M.M., who they had been placed with for two years. Two months after being adopted, Y.M. disclosed that M.M. (male age 58) had performed oral sex on both Y.M. and her friend. M.M. had been giving alcohol to Y.M. and her friends before the abuse occurred. After the disclosure, the children re-entered the child welfare system. M.M. is charged with two counts of 1st Degree Sexual Assault, 1st Degree Sexual Assault of a Protected Person, Child Abuse, Contributing to the Delinquency of a Minor, and Procuring Alcohol for Minor. As of August 2017, the trial was pending and the intake listed the sexual abuse allegations as court pending.

Y.G. - 12 years old

Y.G. and her older siblings, L.G. and N.G., were adopted by A.G. and S.G. Eight years later, Y.G., who is diagnosed with developmental delays, reported that her brother L.G. was sexually abusing her. The abuse included vaginal and anal sex. The home was an active foster home at the time the abuse was reported. Since then, L.G. (age 14) admitted to sexually abusing multiple children: biological siblings, adoptive siblings, foster children, children in the church's nursery, and children in the Girl Scout program. L.G. was adjudicated in juvenile court for Disturbing the Peace and placed on juvenile probation. The report is agency substantiated.

N.L. and F.L. - 12 and 14 years old

N.L. and F.L. were adopted by J.L. and H.L. Five years later, F.L. ran away from home and disclosed that her adoptive father, H.L. (age 62), had been sexually abusing her for over two years. During the investigation, both girls disclosed sexual abuse by H.L., including fondling, touching their genital areas,

and inappropriate kissing. F.L. had told her adoptive mom, J.L., about the abuse when it first occurred, but J.L. ignored the disclosure. The children were removed from the home and re-entered the child welfare system. H.L. is charged with 3rd Degree Sexual Assault on a Child. J.L. is charged with Child Abuse. As of August 2017, the trial was pending and the intake listed the sexual abuse allegations as court pending.

S.K. – 14 years old

S.K. was adopted by her grandmother, V.K. Five years later, S.K. was hospitalized for suicidal ideation. While at the hospital, S.K. told staff that her uncle, J.K. (age 33), had sexually abused her when she was 12. S.K. reported that J.K. used to give her drugs and then sexually touch her. She told her grandmother about the abuse, and while she initially seemed to believe her, she later called S.K. a liar and a slut. After the sexual abuse was reported, S.K. was removed from V.K.'s care. J.K. was convicted of two counts of 3rd Degree Sexual Assault on a Child and sentenced to 6-10 years. The intake is court substantiated.

B.H. and L.A. - 11 years old

B.H. was adopted by G.H. and M.H., who also became guardians of L.A. and her brother. Nine years after her adoption, B.H. told her grandmother that her adoptive father, M.H. (age 60), was sexually touching both her and L.A. for approximately the past year. M.H. would come into their bedroom and rub their breasts, bottoms, and genital areas, make them touch his penis, and rub his penis on them. The girls had both told the adoptive mom, G.H., in the past, but she had not reported the abuse to the authorities or taken action to protect the children. The children re-entered the child welfare system after the abuse was reported. M.H. is charged with two counts of 3rd Degree Sexual Assault on a Child and has an active warrant for his arrest. The report is court substantiated for the sexual abuse of E.H. and court pending for the sexual abuse of L.A., who was not included in the juvenile case.

E.L. - 14 years old

E.L. was placed with her aunt, who then became E.L.'s guardian. Six years later, E.L. disclosed to her aunt that years earlier her uncle, F.G. (age 36) had sexually abused her, performing oral sex, fondling her, and showing her pornographic images. Her aunt refused to believe her, said she would get F.G. a lawyer, and kicked E.L. out of the home. E.L. was hospitalized for suicidal ideation the next day and re-entered the child welfare system. The OIG could not find criminal charges against F.G. As of August 2017, the intake listed the sexual abuse allegations as court pending.

L.W. - 11 years old

L.W. was placed in the kinship foster home of N.I. and L.O. A year later, N.I. and L.O. became L.W.'s guardians. Three months later, L.W. was living at a boarding school for children with developmental disabilities. After she attempted to kiss another student, L.W. disclosed that L.O. (age 39) had taught her how to kiss. During the investigation, L.W. said that L.O. had shown her pornography, forced her to perform oral sex, and penetrated her vaginally. L.W. and the other children in the home were removed and re-entered the child welfare system. The OIG did not find criminal charges filed on L.O. The report is agency substantiated.

UNFOUNDED CASES AND CASES NOT INVESTIGATED

In the course of its investigation, the OIG reviewed and analyzed cases involving alleged sexual abuse of youth in state care that did not meet the criteria to be included in the OIG's list of substantiated victims, but revealed important systemic issues. The seven cases that are summarized below are included because they are cited in the findings of this investigation. All of the sexual abuse allegations in these cases were reported during the same time period as the cases of the identified victims, July 2013 to October 2016.

Case Summaries

N.T. - 16 years old

N.T. entered the child welfare system due to parental drug use. He had been involved in the child welfare system in South Carolina in the past and prior to his removal, N.T. experienced physical, emotional, and sexual abuse. Four years later, N.T. was adopted. N.T. then re-entered the child welfare system one year after being adopted, because he was sexually abused his adoptive sister. N.T. had eight placements before being placed at Group Home Z three years after re-entering the child welfare system.

While at the group home, N.T. reported another youth, D.R., came up behind him and shoved the handle of a golf club six inches into his anus. DHHS Division of Children and Family Services (CFS) was assigned to complete an investigation of the incident called an out of home assessment (OHA). N.T. was interviewed at a child advocacy center, where he disclosed that D.R. and other youth had been physically aggressive towards him - punching him and grabbing him - in the lead up to the sexual abuse. N.T. reported that staff had not intervened. The sexual abuse allegations were unfounded two months after the report, though the OHA was not finalized for over two years. Public Health never completed a licensing investigation, although there were issues with supervision and access to medical care documented in the OHA.

The group home discharged N.T. due to uncontrollable behaviors. Since then N.T. has been in numerous placements, including a psychiatric residential treatment facility in another state, where he was sexually abused by a staff member. N.T. also engaged in sex with two younger females while placed at the facility. N.T. has since aged out of the child welfare system. As of August 2017, N.T. was facing a Class II felony charge for aiding and abetting a robbery.

N.T.'s case is further discussed in the OIG's sections on the failure to follow policies on OHAs, inconsistent substantiations of sexual abuse cases in Nebraska, the failure to complete investigations in a timely manner, and Public Health's lack of action on incidents at Group Home Z.

J.O. - 16 years old

J.O. was made a state ward due to parental drug use, domestic violence, and physical abuse. She was initially placed with a relative. About a year later, she was placed at a residential facility. A report was made to the Hotline regarding a sexual abuse complaint that law enforcement was investigating. J.O. reported that she was playing truth or dare with her roommates, E.R., L.F. and C.V. One of the youth was dared to do "something sexual" to J.O. Reportedly, E.R. held down J.O.'s hands while L.F. penetrated J.O.'s vagina with her fingers. The law enforcement report to the Hotline also stated that the three youth would be in court for their actions and L.F. would be moved from the facility. The Hotline screened this report as not meeting the definition of child abuse and no findings or Central Registry entry were made.

However, L.F. was adjudicated for 3rd Degree Sexual Assault.

This case is cited in the OIG's analysis of problems with screening at the Hotline. It is also an example of a sexual abuse allegation at a licensed residential facility which was never investigated by Public Health.

A.X. – 13 years old and W.K. - 14 years old

A.X. was placed on juvenile probation and was made a state ward later that same year. She went on the run from her placement and was then detained. W.K. was placed on juvenile probation and went on the run from his placement so he was also detained at the same residential facility.

Within two weeks of being placed there, the detention center made a report to the sheriff's office regarding a possible sexual assault. An employee at the detention center was playing cards with the residents when A.X. asked to use the restroom. A resident tried to distract staff to allow W.K. and A.X. to meet. During this time W.K. went into the female restroom. After another resident reported seeing W.K. leave the girl's bathroom, staff interviewed A.X. who reported that W.K. digitally penetrated her and she gave him oral sex, but she did not want to. When A.X. was interviewed by the sheriff's office she said she felt pressured and did not think anything sexual was going to happen. The sheriff did not share the report with the Hotline, even though Nebraska law requires law enforcement to share all child abuse reports with DHHS. As it was never reported, the incident was never screened to see if a DHHS investigation was appropriate.

This case is cited in the OIG's analysis of problems with reporting of sexual abuse allegations.

G.R. - 15 years old

G.R. became a state ward after breaking the law and repeatedly running away from home. Initially she was placed at home, but continued to run away and spent time in detention centers and group homes. A year later, while placed at a group home, G.R. disclosed that her step-father, A.S., had been sexually abusing her. The report was screened as Does Not Meet Definition by the Hotline and never investigated. G.R.'s juvenile justice involvement and stay in out-of-home care continued and she was sent to a residential facility. Later that year, a report that A.S. was sexually abusing his foster child, Y.N., was investigated. Around that time, G.R.'s mother, M.S., asked her if anything had ever happened with A.S. Although she initially denied it to her mother, G.R. later disclosed that A.S. sexually abused her. G.R. said that she told her mother about the abuse when she first entered the juvenile justice system, but M.S. did not believe her. G.R.'s allegations were accepted for investigation, but the report was unfounded.

A month after disclosing sexual abuse by A.S. again, and a month before G.R. was scheduled to be discharged home from the residential facility, G.R. ran away from the facility and was missing from care for four months. After returning to the facility, G.R. disclosed that while missing from the facility, she had been repeatedly raped by her boyfriend, W.A., and confined to the bedroom against her will. The Hotline screened the report as "Does Not Meet Definition." W.A. was a former ward who had been sexually abused by his cousin and while in foster care and had sexually abused his sisters, N.L. and F.L. who are included in the OIG's victim data, as they were later sexually abused by their adoptive father.

G.R.'s case is further discussed in the OIG's sections on the use of overrides and screening Hotline calls, and on suitability concerns in foster homes.

N.Z. - 13 years old

N.Z. was placed on Probation at the age of 12 due to aggressive behavior towards his mother. N.Z. was then placed in out of home care after violating the terms of his probation. After stays in a detention center, foster home, and shelter, N.Z. became a resident of a group home. Six months later, the Hotline received a report that a staff member had been seen kissing N.Z. Since N.Z. did not disclose any abuse, the sexual abuse allegations were not substantiated.

This case is further discussed in the OIG's sections on the failure to follow policies on Out of Home Assessments, investigations of abuse in residential facilities.

H.E. - 17 years old

H.E. was placed on Probation for truancy. She was placed at a shelter, but returned home a month later. However, she was then charged with a misdemeanor and sent back to the shelter. She was hospitalized twice at an emergency behavioral health unit that year. Then H.E. was being transported back to the shelter after a weekend visit home. Another youth in the transportation van, S.P., allegedly grabbed her, tried to kiss her and tried to put his hand down her pants repeatedly, although she told him no. The Hotline screened the report as "Does Not Meet Definition." This intake was one of 13 the OIG found which alleged H.E. had been sexually abused. None of the reports have been substantiated and it appears that many of these allegations were never investigated by either DHHS or law enforcement.

H.E.'s case is further discussed in screening errors at the Hotline and the failure to investigate allegations of sexual abuse.

L.S. - 15 years old

L.S. was placed on probation at the age of 12 for disturbing the peace. After a series of Probation violations, L.S. was placed at Group Home Z. Later, while at another residential facility L.S. disclosed that he had been sexually abused by a staff member from Group Home Z. The staff member had already been criminally charged with sexually abusing R.Z., another resident, when L.S. disclosed. In a CAC interview, L.S. disclosed that the staff member had groomed him, bribing him with snacks, cigarettes, and outings, and then began sexually abusing him, which included sexual touching and oral sex on numerous occasions. Nine months after it was reported, DHHS listed the case as unfounded.

This case is cited in the discussion of inconsistent substantiations of sexual abuse cases in Nebraska and Public Health's lack of action on incidents at Group Home Z. It is also an example of the failure to conclude investigations in a timely manner.

Recommendation to DHHS

1. 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.

The OIG recommends DHHS create a system to monitor reports of alleged sexual abuse involving children served by CFS's child welfare and juvenile justice programs. The OIG further recommends that DHHS administrators review information on the collected reports on a regular basis, so they can stay informed about the scope of sexual abuse and related issues occurring in the child welfare system and appropriately analyze trends. While the current Critical Incident Reporting process alerts administrators

of some sexual abuse cases, reporting is not consistent and the information gathered through critical incidents is limited.

A review of critical incident reports from July 2013 through October 2016 revealed that many sexual abuse cases identified by the OIG did not have a corresponding critical incident report. Creating a system to collect and review sexual abuse allegations would ensure that DHHS is able to track how often these issues are occurring in Nebraska's child welfare system and appropriately respond.

DHHS Response:

DHHS rejects this recommendation.

DHHS has an Intake system that collects the information on all types of allegations. Current IA protocols allow for the review of all allegations and provide information to analyze the data to determine any systemic issues.

The Child Advocacy Centers receive notice of every sexual abuse report and have the ability to contact the Hotline or law enforcement to recommend and discuss these intakes.

SYSTEMIC ISSUES IDENTIFIED

ATTITUDES TOWARDS SEXUAL ABUSE OF SYSTEM-INVOLVED CHILDREN

Throughout its investigation, the OIG found evidence that child sexual abuse is not consistently treated with the seriousness it deserves. Through documentation reviews and interviews, the OIG repeatedly found system professionals and caregivers with harmful attitudes about and perceptions of both child sexual abuse and children in the state's care.

The section below highlights the most prevalent and concerning attitudes towards sexual abuse of children in the state's care that the OIG discovered.

The OIG found evidence that some system professionals and caretakers failed to believe children's reports of sexual abuse, blamed them for causing the sexual abuse in the first place, or minimized what was happening. These attitudes may have contributed to the child welfare system being unable to appropriately prevent, identify, or respond to child sexual abuse in many of the cases identified and reviewed by the OIG.

***“You're a liar.”** – Adoptive Mother, after her daughters told her of ongoing sexual abuse by their adoptive father²⁶*

Available research indicates that false reports of sexual abuse by children are extremely rare, occurring in only four to eight percent of cases.²⁷ Nonetheless, the OIG found that parents, caretakers, and professionals, are often dubious when youth disclose, and seem to be unaware of how unlikely fabricated allegations are.

In some cases, disbelief led these adults to not report the sexual abuse to the proper authorities, allowing it to continue. In 18 of the 50 cases at least one caregiver was aware of sexual abuse allegations, but failed to report it appropriately.

In other cases, the people who didn't believe the child *were* the authorities. The OIG found evidence that in a number of cases when DHHS or law enforcement dismissed reports it was because they believed children were being dishonest. Unfortunately, this left children vulnerable to ongoing abuse.

***“Oftentimes kids make false allegations of sexual abuse because they have been traumatized”** – CFS Specialist, Initial Assessment describing what makes sexual abuse difficult to investigate*

The OIG found that professionals and caretakers were particularly skeptical of sexual abuse disclosures when the child or youth was system-involved. For younger children, sexual abuse disclosures were often treated as a symptom of the abuse or neglect they had suffered prior to entering the child welfare system and assumed to be false. In some cases, disclosures were even assumed to be a recollection of sexual abuse that occurred in the past and never fully investigated.

²⁶ Statement found in DHHS records.

²⁷ Everson and Boat, “False allegations of sexual abuse by children and adolescents.”

R.R. disclosed that her adoptive father, H.R., was sexually abusing her. When the CFS Specialist interviewed her, she did not disclose again because, “[...] she had told enough people about it already tonight.” Law enforcement and the CFS Specialist took R.R. to the family home and then determined that R.R. was, “bringing back the past sexual abuse from a previous foster parent and blaming it on [H.R.] as she was very upset that evening.” After R.R.’s sister disclosed a year later, R.R.’s allegation was substantiated.

One child advocacy center told the OIG that sexual abuse allegations tend to be dismissed if children or families are well-known to the child welfare system, “Children may not be believed if they have a ‘history’ of past behaviors or law enforcement contacts or if they are members of ‘certain’ families, known to the community as ‘trouble.’”

“I was more concerned with the kid perpetrating on her.” - Direct Care Staff Member, Group Home Z describing his reaction to learning a female staff person had sexually abused B.L.

The OIG also found cases where the victim of child sexual abuse was considered to be the perpetrator, aggressor, or instigator of their own abuse by system professionals, caretakers, or community members. For some youth in the juvenile justice system, disclosures were treated as another example of the child breaking the rules, defying authority, seeking attention, or causing trouble.

This was especially common in cases where young men in the juvenile justice system were sexually abused by adult female staff. After C.O. was sexually abused at a residential facility, the facility administrator shared that he had to work with staff to ensure they understood that C.O. was the victim. He also shared that he had been confronted in the community by residents outraged by the incident, not because a youth had been sexually abused by a staff member, but because the facility had, “let this youth hurt this lady and her family.”

Another example, when B.L. initially told staff and youth that a female staff member at Group Home Z where he was a resident had performed oral sex on him, staff confronted him about the allegation and then wrote him up for making the allegation, which they thought was false.

Group Home Z staff shared with the OIG that they had noticed a pattern of this staff member spending time alone with B.L. and were concerned for the staff member’s safety, not for B.L.’s. One frontline staff person shared his perception of the sexual abuse with the OIG: “It shook me up, because I was there and I tried to warn her as many times as possible – dozens of times. Knowing who she was, she had a family and a daycare she had run before. [...] My concerns was [sic] he’s a hormonal teenager who’s going to try and manipulate to try and find a time when he can take advantage of her, when there’s no staff around. [...] I told her that he’s grooming her. This is inappropriate for a kid to do to a staff, and you need to put an end to this. [...] I never thought it would be consensual. I thought I was supposed to protect her.”

Blaming youth for causing their own sexual abuse at the hands of adults was not isolated to young men in the juvenile justice system. The OIG found instances where parents and caregivers thought teenage girls were responsible for adult men molesting them because they had acted in a provocative manner or put themselves in a situation where they should have expected to be sexually abused.

According to DHHS narratives, H.H.’s adoptive mother blamed her daughter’s “raging hormones” for DHHS being involved with the family. DHHS noted, “[The mother] stated that [H.H.] was to blame because she sat on a man when she had no underwear on.” In a different case, 14-year-old R.R.’s

grandmother and guardian told her the sexual abuse was her fault, “because [R.R.] should have known better than to take her dress off in front of [the grandfather].”

Child Welfare System Action Item

1. Foster a culture of zero-tolerance for child sexual abuse in the child welfare system.

Many system professionals and caretakers of youth in the child welfare system do not understand the dynamics of child sexual abuse, don’t take allegations seriously, or incorrectly blame children for the abuse they suffer.

The entire child welfare system – DHHS staff, private service providers, residential facility staff, foster and adoptive parents, law enforcement and legal professionals – must do all they can to ensure that there is absolutely zero tolerance for sexual abuse of youth in the state’s care. Agencies must adopt accurate training for staff that teaches about the prevalence of child sexual abuse, the heightened vulnerability of children in out-of-home care, and actions those in the system can take to prevent child sexual abuse and also respond appropriately when a child discloses. The OIG further recommends that agencies adopt clear zero tolerance policies for sexual abuse and harassment to ensure that each and every allegation is taken seriously, reported to the proper authorities, and examined internally so improvements can be made.

DHHS Response

DHHS absolutely agrees that it is imperative to foster a culture of zero tolerance for child sexual abuse and will continue to do so.

REPORTING AND SCREENING CHILD SEXUAL ABUSE ALLEGATIONS

Appropriate reporting and screening of child sexual abuse allegations is essential to ensuring that allegations are investigated and action is taken to protect children. A number of child sexual abuse cases the OIG reviewed raised concerns about whether Nebraska's system for reporting and screening cases of child sexual abuse was functioning as intended.

The OIG subsequently examined whether child abuse reporting was occurring as intended in state law and whether the Child Abuse and Neglect Hotline (Hotline), operated by DHHS, was responding adequately to sexual abuse reports and following statutes, policies, and procedures.

Background Information on Sexual Abuse Reporting and Screening in Nebraska

In Nebraska, everyone is required to report suspected child abuse or neglect, including sexual abuse and exploitation, to either law enforcement or the DHHS Hotline. DHHS and law enforcement are subsequently required to share any child abuse reports they receive with each other and both entities are charged with conducting investigations of child abuse and taking action to protect children.²⁸ Since the Hotline is centralized, DHHS has a standard protocol for sharing every report with the appropriate law enforcement agency.

In addition to receiving and sharing child abuse reports, the Hotline is responsible for screening these reports to see if they meet the definition of child abuse and require an investigation (called initial assessment) by DHHS child welfare staff or an investigation by local law enforcement. Screening includes both initial screening and the process of re-screening reports if additional information is received by the Hotline that indicates changes should be made. The Hotline also serves as a gateway to alerting other DHHS Divisions to issues at facilities that they license and oversee, allowing them to conduct investigations of their own if they determine the report warrants it.

The Hotline uses an Intake Screening Policy and Procedures Manual that was adopted in 2012 to screen reports. The manual was developed as part of DHHS's adoption of Structured Decision Making®. This manual includes information on when reports should be accepted, what priority response time they should be assigned, as well as when overrides should be used to not accept a report that meets the definition of abuse.

Every year, the Hotline receives over 30,000 calls alleging child abuse or neglect.²⁹ From 2013 through 2016, about 12 percent of those calls dealt with allegations of child sexual abuse.³⁰

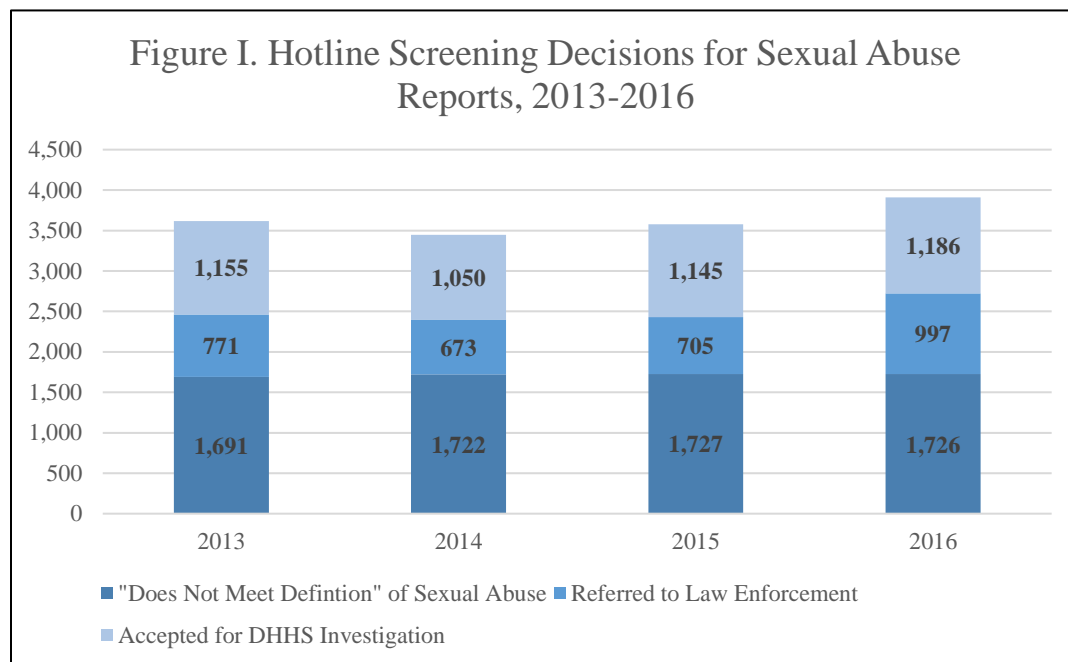
Of the 15,741 sexual abuse reports received by the Hotline between 2013 and 2016, 43.6 percent were screened "Does Not Meet Definition," and were not referred for an investigation by either law enforcement or DHHS. A little less than 36 percent of sexual abuse reports were accepted for a DHHS investigation and an additional 20 percent of reports had no DHHS investigation but were referred for a law enforcement investigation (see Figure I).³¹

²⁸ Neb. Rev. Stat. § 28-711.

²⁹ DHHS CFS, *Child Abuse and Neglect*, 7.

³⁰ DHHS CFS Administrator, email message to OIG, Feb. 17, 2017. According to DHHS data, the Hotline received 129,933 calls between 2013 and 2016. 15,741, or 12.1 percent related to sexual abuse.

³¹ DHHS CFS Administrator, email message to OIG, Feb. 17, 2017. There were 15,741 reports that alleged child sexual abuse was occurring between 2013 and 2016. The chart does not include reports listed as unable to identify or



The results of reports accepted for investigation by both DHHS and law enforcement are captured by DHHS and substantiated cases are entered into the Nebraska’s Central Registry, which tracks perpetrators of child abuse and neglect.

Hotline staff told the OIG in interviews that appropriately screening sexual abuse reports is challenging. First, often when people report sexual abuse allegations to the Hotline they have limited information on what occurred or even who the perpetrator was. According to Hotline staff, child victims may not share much information and reporters can be unsure of what to do or ask when a disclosure occurs.

Secondly, allegations are often complicated. Limited information on both allegations and the dynamics surrounding it makes it more difficult to determine whether an allegation should be accepted by DHHS or referred to law enforcement and how quickly DHHS field staff need to respond. A Hotline supervisor said, “To staff a sexual abuse case, it takes me longer. [...] They can be so convoluted and [...] sometimes they’re not the best reporters because they don’t have names and you don’t know where those people live and whether they have access [to the child].”

Findings

Allegations of child sexual abuse are not always reported to or shared with the Hotline.

If sexual abuse is never reported to the authorities, appropriate action cannot be taken to investigate the abuse or protect the child. During the investigation, the OIG found repeated instances where sexual abuse allegations were not reported to either DHHS or law enforcement. The failure to report child sexual abuse

placement concerns – a total of 82 reports. Accepted for DHHS Investigation includes reports screened accept for initial assessment, accept for out of home assessment, accept for placement assessment, and multiple reporter.

is a crime under Nebraska law and is punishable by up to three months imprisonment and a \$500 fine.³² Nonetheless, the OIG found examples of caregivers, foster parents, and residential facility staff having been told by children that sexual abuse had occurred but failing to report it to either law enforcement or the Hotline. In the sexual abuse cases identified as part of its investigations alone, the OIG found 18 children whose caregivers, including parents, foster parents, and residential facility staff, were aware of sexual abuse allegations, but did not report them.

In the case of B.L., a 15-year-old placed at Group Home Z, who was repeatedly sexually abused by a female staff person, numerous staff and administrators failed to report their concerns to appropriate authorities over the course of at least five months. Group Home Z staff who worked with the female staff person said they repeatedly spoke with her about having inappropriate boundaries with B.L. and reported concerns to supervisors, but never alerted the authorities. Administrators conducted an internal investigation when rumors that the female staff person had been performing oral sex on B.L. surfaced at the residential facility, but no one alerted law enforcement or DHHS. It was only two months afterwards, when a community member called the Hotline, that an investigation into the sexual abuse began and the female staff person no longer had access to B.L.

The OIG also found evidence of cases where law enforcement investigated or received reports of child sexual abuse, but failed to share the report with the Hotline. Nebraska law requires law enforcement to share child abuse reports with DHHS by the next working day.³³ However, both interviews with Hotline staff and cases the OIG found indicate that this is not happening consistently. If law enforcement does not share reports with DHHS, appropriate safety assessments and interventions cannot be put into place, and no finding on the Central Registry can be made.

For example, F.L. briefly ran away from her adoptive home and disclosed that she was being sexually abused. The sexual abuse was initially reported to the county sheriff, however the sheriff's office took no immediate action and did not share the report with DHHS. Four days later, the same reporter called the Hotline to report the abuse, given the lack of action, and the report was accepted as Priority 1 – requiring a response within 24 hours. For the four days between the initial report to law enforcement and the call to DHHS, F.L. and her sister, N.L., remained in the home with the man who was sexually abusing them.

Fourteen-year-old boy W.K. allegedly sexually assaulted 13-year-old girl A.X. at a detention center, which was licensed by Public Health at the time. The OIG received notice of the incident from Probation, but could not find a corresponding Hotline report. The OIG confirmed that the county sheriff conducted an investigation, but never shared the report or results of its investigation with DHHS. Although law enforcement concluded that the sexual contact between the youth was consensual in their report, by law it still should have been shared with DHHS. Furthermore, the investigation narrative indicates that there were issues with a lack of supervision at the residential facility, which may have been looked into by both the Division of Children and Family Services or Division of Public Health, had they known about it.

A DHHS administrator told the OIG that the Hotline, “finds out [about] a lot of cases over [through] the newspaper, the media,” especially cases related to child enticement and pornography. Hotline staff then have to create intake reports based on media stories, since they have no corresponding police reports. Since media stories are usually related to criminal charges or arrests, sometimes there are serious delays in DHHS screening these cases to see if there may be a need for a child welfare intervention. For

³² Neb. Rev. Stat. § 28-717.

³³ Neb. Rev. Stat. § 28-711.

example, if someone is charged with child pornography and lives with a number of young children, a safety assessment may be warranted.

A DHHS Administrator told the OIG that DHHS staff has been speaking with law enforcement agencies across the state with the Attorney General's Office to try to improve law enforcement agencies' sharing reports with DHHS: "We're trying to make sure that law enforcement gets that information back to us. [...] If they're doing an investigation that has to do with child abuse and neglect, even historical child abuse and neglect, [we're trying to make sure] that they share that report with us." She indicated that the Hotline has seen some improvement in law enforcement sharing reports, but that there are areas of the state and law enforcement agencies who continue to violate the law. This limits the Hotline's effectiveness and the timeliness of DHHS's response to sexual abuse reports.

The Hotline's use of overrides resulted in sexual abuse cases never being referred for a DHHS investigation, putting children at continued risk.

During its review of cases, the OIG found reports where the use of overrides at the Hotline resulted in sexual abuse reports never being investigated. The use of overrides to not accept abuse reports is allowed in the Hotline Intake Screening Manual for a number of reasons: the case is being referred for a law enforcement investigation alone; there is insufficient information to locate the family; the alleged victim is no longer a minor; the allegation was already investigated; the report is not credible, according to collateral contacts; and at the discretion of staff, with supervisory approval.³⁴

The OIG found a number of cases where the use of overrides prevented needed investigations and left children vulnerable to future sexual abuse.

For example, 15-year-old G.R. was involved in the juvenile justice system for runaway behavior and placed in a group home. She told another youth that she had sex with her step-father and the group home made a report to the Hotline. Hotline staff, with supervisory approval, used a discretionary override to not accept the report for investigation because the reporter and a collateral contact to G.R.'s probation officer told them about, "[G.R.'s] history of attention seeking behaviors and dishonesty." G.R.'s disclosure was never investigated.

At the time of the report, G.R.'s mother and step-father were in the process of becoming licensed foster parents. A year and a half after G.R.'s report, the Hotline received a report that A.S. was sexually abusing his 13-year-old foster child, Y.N. That same month, G.R., who was still placed out of home, again disclosed sexual abuse by A.S. A.S. was arrested and later sentenced for sexually abusing Y.N. Had G.R.'s initial disclosure been appropriately investigated, there is a strong likelihood that A.S. would have been unable to become a foster parent.

When the OIG shared this case with a DHHS Administrator during interviews, she acknowledged that this report had been incorrectly screened out: "If someone calls and makes a statement, 'I had sex with my stepfather,' I'm not going to call the Probation officer to determine what they know about it." She told the OIG that the staff member who screened the report had previously worked as a probation officer or in the juvenile justice field. She indicated that this can be a challenge as they tend to have a "philosophically different" approach to reports than staff with a child protection background.

R.R. alleged in four separate reports that she was being sexually abused by her adoptive father, H.R. The first report in June was investigated and R.R. initially recanted her account when interviewed by DHHS

³⁴ Intake Screening Policy and Procedures Manual, March 2012, DHHS CFS, 5.

and law enforcement (the interview was not conducted at a child advocacy center). The subsequent three reports were made in October and November of that year after R.R. had entered the juvenile justice system and was placed in out of home care. The reports were screened out by the Hotline using an override specified in policy. Because the allegation had already been assessed, DHHS policy indicates it should not be accepted. A year later, N.R., R.R.'s adoptive sister, disclosed sexual abuse by H.R. and the report was investigated. H.R. has since been sentenced to 95 to 100 years for sexually assaulting both N.R. and R.R. An additional adoptive sibling, J.R., later disclosed that she had also been sexually abused by H.R.

In this case, Hotline staff followed policy on not accepting reports that have already been investigated. However, given how rare false reports of child sexual abuse are and the repeated disclosures, the OIG believes that relying on the prior investigation in this instance was misguided. The decision left R.R. and her siblings vulnerable to continued sexual abuse.

While overrides may be appropriate in many cases, when dealing with sexual abuse allegations, using them can cause serious cases to be overlooked. In at least two instances, overrides resulted in a missed opportunity to discover and prevent future sexual abuse.

The Hotline incorrectly screened some cases of youth sexually abusing other youth as “Does Not Meet Definition.”

The OIG found some errors in screening decisions where there were allegations of youth sexually abusing other youth.

In the case of youth on youth sexual abuse allegations, the lack of information reported is further complicated by grey areas where staff must ultimately use judgement on which situations meet the threshold of needing a sexual abuse investigation by DHHS or law enforcement. One example staff cited was confusion over what constitutes normal sexual behavior by children that seems to be consensual. If the behavior is deemed “inappropriate,” and there is information that a parent is not appropriately intervening, then DHHS would investigate. If the parent is appropriately responding, then no investigation is necessary. While some guidance is provided to staff in the Intake Manual on making this determination, it cannot cover all situations. Staff told the OIG that they do not always feel they have the knowledge to confidently screen these reports.

The Hotline also receives reports about children under 12 who sexually abuse others, but are too young to be charged with that offense in juvenile court or labeled perpetrators on the Central Registry. According to the Hotline staff, reports like these often involve youth in different households. In those situations, policy specifies that DHHS does not investigate, instead referring the intake to law enforcement for investigation. Staff said that when law enforcement communicates that they are not investigating the allegation further, this leads some staff to incorrectly screen these reports as not meeting the definition of abuse and neglect from the start.

The OIG also found through interviews and case reviews that there is confusion about how age impacts screening sexual abuse allegations. Youth age 16 and over can consent to sexual activity by Nebraska law and by Hotline policy. The question of whether consent existed, based on limited information, then becomes a factor in making screening decisions and staff must determine whether the sexual act was consensual or not. The OIG found a number of examples where Hotline staff did not correctly use the Intake Screening manual for allegations of non-consensual sexual contact involving older youth.

In one case, Probation sent a critical incident to the OIG about an attempted sexual assault in a transportation van. Seventeen-year-old H.E. was being transported to her placement in a van with another youth, a 15-year-old boy. H.E. reported that he verbally harassed her and grabbed her. He repeatedly tried to kiss her and tried to put his hand down her pants, although she told him no. The Hotline screened the report as not meeting the definition of sexual abuse because, “There is no information that there is any abuse and neglect occurring. The children are close in age, will not have further contact nor do they reside together.” However, by Hotline policy, the report should have been screened for law enforcement investigation since it was a non-consensual sexual act involving a child. The age of the victim has no bearing when the act was not consensual.

A similar error was made in screening a report by 17-year-old G.R. that she while on the run from a residential facility, she had been confined to a room and repeatedly raped by her boyfriend. A Supervisor incorrectly screened the report as “Does Not Meet Definition.” The Supervisor recorded the reason for her decision: “Upon further review, this intake will be updated to does not meet definition as this is a situation of rape versus child sexual assault due to the ages of the victim and perpetrator.” The supervisor erred in this case, since the Intake Screening manual includes in its definition of sexual abuse, “involving [...] a child 16 and older who does not consent.”³⁵ This report should have been screened for a law enforcement investigation.

By policy, DHHS would not have investigated in either of these cases. However, the incorrect screening meant that DHHS did not follow up to learn whether an investigation was being conducted and what the results of law enforcement’s investigations were. A chance was missed to enter findings on the Central Registry.

The practice of screening sexual abuse allegations that should be investigated as “Does Not Meet Definition” is not authorized or explained in DHHS policy.

When a report to the Hotline meets the definition of sexual abuse adopted by DHHS to merit an investigation, DHHS can decline to investigate the report themselves under certain circumstances pursuant to DHHS policy. In many cases, the Hotline refers the report for a law enforcement investigation. The Intake Screening tool allows this to occur for three reasons: “Family and perpetrator reside in another state, but incident occurred in Nebraska; alleged victim is now an adult, but was a child at the time of alleged sexual abuse; or, the alleged perpetrator is not a member of the child’s household and no longer has access to the child.”³⁶

Screening the report for a law enforcement investigation does not guarantee that an investigation will occur. According to the Hotline Administrator, law enforcement agencies across the state may respond very differently to similar reports: “We also know in 93 counties, and all of LPDs (local police departments), [...] it’s different. [a town in western Nebraska] PD may say I’m gonna go out and look at this situation, where [a bigger city in the eastern part of the state] might not even touch it.” When and how law enforcement investigates an abuse allegation as well as a particular department’s resources reportedly varies greatly from jurisdiction to jurisdiction, which may impact a decision about whether and to what extent they will investigate reports they receive. Furthermore, as in the case of young children, DHHS’s definition of sexual abuse may not constitute a crime that law enforcement usually investigates or that a county attorney can prosecute in criminal court.

³⁵ Intake Screening Policy and Procedures Manual, March 2012, DHHS CFS, 19.

³⁶ Intake Screening Policy and Procedures Manual, March 2012, DHHS CFS, 5.

As stated earlier, around 20 percent of all sexual abuse reports were shown to be screened for a law enforcement investigation between 2013 and 2016. This number is an undercount of reports that should have been screened as law enforcement, however.

Hotline staff reported to the OIG that when local law enforcement indicates that they are not investigating a report or occasionally when they have discontinued an investigation, the Hotline's practice is to screen reports as "Does Not Meet Definition." The OIG did not find this practice explained or authorized in DHHS policy or in Protection and Safety Procedures. Instead, policy requires DHHS field staff to follow up on law enforcement only reports and enter a finding of "Unfounded" if an investigation was not pursued.³⁷

One impact of this practice is lessening the workload for DHHS field staff. Once a report is screened as "Does Not Meet Definition," DHHS staff have no further obligation to follow up with law enforcement to see what the outcome of the case is or make Central Registry findings.

However, it also leads to systemic issues when it comes to child sexual abuse cases. The practice masks the number of sexual abuse reports that should be investigated according to DHHS policy but are not. Effectively, an unknown number of child sexual abuse reports in Nebraska are not being investigated by either DHHS or law enforcement.

The OIG also found that screening law enforcement reports as "Does Not Meet Definition," creates an opportunity for investigated cases to be missing from DHHS data and the Central Registry. The OIG found a number of sexual abuse reports investigated by law enforcement that were incorrectly screened as "Does Not Meet Definition" by Hotline staff.

Sixteen-year-old J.O., a state ward, was digitally penetrated by her roommate at a residential facility, during a game of truth or dare. The report was initially called in by the residential facility. After the police department sent investigative reports to the Hotline, Hotline staff incorrectly determined that law enforcement was discontinuing its investigation. The report was therefore screened as "Does Not Meet Definition" and DHHS staff had no further responsibility to update the case. In this case, charges were filed on the youth involved in the incident, L.F. She was adjudicated for the sexual assault in juvenile court. However, since the report was screened out, there was neither confirmation in DHHS records that an assault on one of their wards occurred nor an opportunity to make Central Registry findings on the youth perpetrator.

N.N. disclosed that she had been sexually abused by her former foster father, L.E., while in foster care. Hotline staff initially screened the report for a law enforcement investigation. However, they then received information that the report was not going to be investigated by law enforcement. Staff then rescreened it as "Does Not Meet Definition." Although the Hotline documented that no investigation was occurring, this was not accurate. Court records show that L.E. was criminally charged for sexually abusing N.N. However, it was not until three months later, that the intake was rescreened *again* to show that a law enforcement investigation had taken place and that charges were pending.

The practice of screening allegations which meet DHHS's adopted definition of sexual abuse as "Does Not Meet Definition," creates confusion, masks the number of actual sexual abuse allegations, and leads to important information being missing from DHHS's system and the Central Registry.

³⁷ Central Registry Entries, DHHS CFS Protection and Safety Procedure #31-2016 (adopted Sept. 22, 2016).

Recommendations to DHHS

2. End the practice of screening law enforcement only reports as “Does Not Meet Definition” when the allegation continues to meet DHHS’s definition of child sexual abuse.

The OIG recommends that DHHS end the practice of screening reports referred to law enforcement as “Does Not Meet Definition.” Screening these reports as “Does Not Meet Definition” because law enforcement has declined to investigate or discontinues an investigation of a child sexual abuse report, masks the number of sexual abuse reports that are never investigated in the state. Furthermore, as the OIG found, it creates an opportunity for cases where an investigation did end up occurring to be missed. The report should be left as screened as law enforcement only, even if they do not conduct an investigation.

DHHS Response:

DHHS recommends modification of this recommendation to reflect the following: “Review the practice of screening Law Enforcement reports as Does Not Meet Definition when the allegation continues to meet DHHS ’ definition of child sexual abuse. ”

3. 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.

False reports of child sexual abuse are rare and youth are often afraid to disclose. When reports are made that meet the definition of sexual abuse of a child, they should be investigated. The OIG found cases where the use of overrides to decline to investigate sexual abuse led to further sexual abuse of children. The OIG recommends that DHHS review eliminating the option of overriding to not accept a sexual abuse report for DHHS investigation that meets the definition of sexual abuse. While overrides that refer reports to law enforcement for investigation are appropriate, the OIG believes that eliminating overrides that use prior investigations, or concerns about the reliability of the report to deem it not worthy of investigation, could help ensure that sexual abuse cases are not overlooked.

DHHS Response:

DHHS accepts this recommendation.

4. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.

Hotline staff and supervisors shared with the OIG that sexual abuse cases can be some of the most complicated and time consuming to screen. Supervisors in particular indicated that they spent a good deal of time meeting with staff to discuss sexual abuse reports and support them in making appropriate screening decisions. All of the staff interviewed indicated that additional training on child sexual abuse, especially cases involving youth sexually abusing other youth, would be helpful. Sex trafficking training is required yearly, but is specific to that topic and does not cover other child sexual abuse circumstances in an in-depth manner. The OIG recommends that training at the Hotline be enhanced to include this information.

DHHS Response:

DHHS accepts this recommendation.

Child Welfare System Action Items

2. Examine strategies to improve child abuse reporting.

In this report, as well as past reports, the OIG has identified cases where Nebraska’s law on reporting child abuse and neglect is not being followed, allowing cases of sexual abuse to go unaddressed.

The OIG recommends that the State of Nebraska undertake an analysis of whether the mandatory reporting law is working as intended and strategies that could be implemented to improve child abuse reporting, including training and enforcement mechanisms. Assessing other state’s strategies to ensure appropriate reporting occurs may be beneficial and could lead to child abuse reporting improvements in Nebraska.³⁸

DHHS Response:

DHHS is working on an on-line process for reporting child abuse and neglect. We are also working to enhance the DHHS web page for Child Abuse and Neglect Reporting to include topics such as “Identifying Signs of Abuse,” “Reporting Abuse and the Investigation,” “Process,” “Mandatory Reporting,” and “Information for Professionals (Law Enforcement, Medical and Education).”

3. Ensure law enforcement follows their statutory duty to share child abuse reports with DHHS.

The OIG found that not all law enforcement personnel followed the statutory requirement that they share information on all child abuse reports with DHHS. Nebraska should take action to study whether a widespread problem exists of law enforcement not sharing these reports and take appropriate action—through training and educational programs or other enforcement approaches—to ensure reports are shared.

DHHS Response

DHHS will communicate and work with the Crime Commission and other law enforcement entities. Current Neb. Rev. Statute 28-728 requires the County Attorney to establish protocols with assistance from the Child Advocacy Center and outlines how reports will be shared between law enforcement and DHHS.

³⁸ McElroy, *An Analysis of State Laws*.

INVESTIGATIONS OF CHILD SEXUAL ABUSE

Thorough and accurate investigations of child sexual abuse are key to protecting children. The OIG uncovered concerns related to how child sexual abuse allegations are investigated. The OIG subsequently reviewed whether DHHS was following Nebraska law and policies and procedures related to investigating child sexual abuse.

Background on child sexual abuse investigations

Nebraska's *Child Protection and Family Safety Act* (*Neb. Rev. Stat. §§ 28-710 to 28-727*) charges both law enforcement and DHHS with investigating child abuse and neglect reports, including those that allege someone is, "knowingly, intentionally, or negligently causing or permitting a minor child to be [...] sexually abused."³⁹ Under the Act, investigation is defined as, "Fact gathering related to the current safety of a child and the risk of future child abuse or neglect that determines whether child abuse or neglect has occurred and whether child protective services are needed."⁴⁰

Since 2013, DHHS has accepted around 1,100 sexual abuse reports a year for a DHHS investigation. According to regulations, DHHS conducts investigations –which they refer to as initial, placement, or out-of-home assessments – to determine whether maltreatment and allegations of abuse and/or neglect can be validated; and, what services, if any, are needed and how those can be best provided.⁴¹

These investigations are rarely conducted by DHHS alone, and often require coordination with not only law enforcement, but other experts and interested parties. Others involved in investigations include medical professionals and child advocacy centers (CACs), which coordinate multidisciplinary teams and provide specialized interviews, called forensic interviews, for children. Other DHHS Divisions – Public Health, Developmental Disabilities, and Medicaid and Long-Term Care – may also be involved when allegations involve facilities or care providers that are licensed by or providing services for those divisions.

As part of its investigative process, DHHS must gather and review evidence and make a finding about whether or not there is enough evidence present that abuse or neglect, more likely than not, occurred. DHHS policy requires this be done even in cases that law enforcement investigates alone. Substantiated cases must be entered on the Central Registry of child abuse and neglect that DHHS is required to maintain by law.⁴²

DHHS uses Structured Decision Making® (SDM) tools for reports it accepts for investigation. In the case of initial assessments, SDM tools govern the decision about whether or not a child welfare case should be opened, based on the assessment of safety and risk. In the case of placement assessments, used for foster homes, they guide the decision on whether or not the placement is safe and suitable for the children living there, and what interventions might be necessary.⁴³ Out of home assessments, conducted when allegations

³⁹ Neb. Rev. Stat. § 28-710 (2)(b)(v).

⁴⁰ Neb. Rev. Stat. § 28-710 (2)(e).

⁴¹ 390 Neb. Admin. Code, ch. 4, Chapter 4-000.

⁴² Neb. Rev. Stat. § 28-718.

⁴³ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017 (adopted Feb. 2017), 22-30. DHHS previously used Protection and Safety Procedure #16-2013 and #27-2016 to govern initial assessment. While there have been some changes between versions, many of the requirements have stayed the same.

take place in residential facilities or child care settings, are not conducted with SDM tools but require a determination about child safety and recommendations to reduce the risk of harm.⁴⁴

Findings

Investigations are not being conducted in all cases of alleged child sexual abuse, contrary to Nebraska law.

Nebraska law specifies that both law enforcement and DHHS must investigate reports of child sexual abuse, but for different reasons. When child abuse or neglect is reported, the law states: “It is the duty of the law enforcement agency to investigate the report, to take immediate steps to protect the child, and to institute legal proceedings if appropriate,” and: “The department shall investigate for the purpose of assessing each report of child abuse or neglect to determine the risk of harm to the child involved.”⁴⁵ While law enforcement is charged with investigating for the purposes of criminal prosecution or juvenile court filing, DHHS is charged with confirming findings to make a Central Registry determination and assessing risk to the child and the need for child welfare services.

Through its interviews with DHHS and document review, the OIG discovered that some child sexual abuse reports involving Nebraska children are not being investigated. When a child sexual abuse allegation involves a perpetrator and child victim who are not part of the same household and the perpetrator no longer has access to the child, DHHS’s policy specifies that they will not conduct an investigation.⁴⁶ In these cases DHHS has determined there is no risk of harm, and the allegations are instead referred only to law enforcement for an investigation.

Interviews with DHHS staff revealed that some law enforcement agencies in Nebraska do not routinely investigate every alleged child sexual abuse case that is referred to them by the Hotline. This could be for a variety of reasons. Law enforcement’s main role is to investigate a case to determine if a crime has been committed along with ensuring safety, not to determine services needed. DHHS staff indicated that cases that involve sexual abuse where the perpetrator is also a child may be especially unlikely to warrant law enforcement intervention.

When law enforcement decides not to investigate a report that DHHS referred to them involving a perpetrator in a different household, it is simply not investigated by anyone. DHHS is charged with gathering evidence on these cases and make a finding. However, if no evidence was gathered by law enforcement, it will always be unfounded. DHHS does not conduct any interviews or assessments in these cases.

DHHS is not assessing for risk of harm and providing services in all child sexual abuse cases, as required by law.

For each report of child abuse or neglect received at the Hotline, Nebraska law requires DHHS to both assess for “the risk of harm to the child involved,” and “provide such social services as are necessary and appropriate under the circumstances to protect and assist the child and to preserve the family.”⁴⁷

In the course of its investigation, the OIG discovered that DHHS is not assessing for risk of harm or providing services when reports are referred for a law enforcement only investigation. According to

⁴⁴ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017 (adopted Feb. 2017), 33-35.

⁴⁵ Neb. Rev. Stat. § 28-713.

⁴⁶ Intake Screening Policy and Procedures Manual, March 2012, DHHS CFS, 5.

⁴⁷ Neb. Rev. Stat. § 28-713 (2).

DHHS Protection and Safety Procedures, the only responsibility that DHHS has for these reports is reviewing reports to determine if there is sufficient evidence that abuse or neglect occurred and to make a Central Registry entry.⁴⁸ There is currently no process for reviewing these reports to determine whether the child is at continued risk of harm or whether services might be necessary to assist the child, as Nebraska statute requires.

Even if DHHS did review law enforcement reports to try to assess risk of harm and need for services, it would be difficult. Law enforcement investigations only gather information on whether or not a crime was committed and a child's current safety. Reviewing law enforcement's investigative reports is therefore unlikely to provide sufficient or appropriate information for DHHS to determine risk and whether or not services are appropriate.

DHHS policies on out of home assessments are not being followed.

Out of home assessments (OHA) are conducted by DHHS when there are reports of abuse and neglect that occur in child care centers and residential facilities. DHHS policy states that the purpose of an OHA is to: "Determine if abuse and neglect has occurred; Assess the safety of the children involved; Recommend action and follow through to assure child safety; and, Assess the cause of the problem and make recommendations to reduce risk of harm."⁴⁹

Currently, policy on completing an OHA is outlined in two Division of Children and Family Services Protection and Safety Procedures, #7-2014 and #5-2017.⁵⁰ Through its investigation, the OIG discovered that some DHHS staff were not following all policy established on OHAs. Unfortunately, the failure to follow these policies resulted in investigations of sexual abuse at facilities that do not adequately identify and respond to sexual abuse.

Protection and Safety Procedure #7-2014 specifically deals with out of home assessments of facilities when "allegations of a serious nature occur," including a, "sexual relationship between staff and resident(s)."⁵¹ The memo provides a way for additional DHHS specialists to be assigned to assist with the investigation to interview victims and witnesses. It also requires Central Office to create an "Out of Home Assessment Team" including assigned field and Central Office staff, representatives from other Divisions who have an interest in the residential facility, and DHHS legal staff, if appropriate.

When serious incidents occur at residential facilities, a determination about abuse and neglect must be made. Equally important, however, is a determination about safety at the residential facility and whether incidents reveal licensing issues that must be addressed by other DHHS Divisions. The process laid out in the memo presents a way for investigations and action to be appropriately coordinated across these Divisions.

In interviews, staff who have conducted OHAs told the OIG that Protection and Safety Procedure #7-2014, adopted in October 2014 to ensure, "a prompt, efficient and coordinated response," to abuse allegations at licensed facilities, is not being followed. When a supervisor was asked whether Central

⁴⁸ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017, 3, 31.

⁴⁹ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017, 33-34.

⁵⁰ Under the period of time when many cases included in the OIG's investigation were reported, DHHS's policy on OHAs was governed by Protection and Safety Procedure #16-2013 or #27-2016. Requirements for OHAs have not changed substantially between versions of the policy.

⁵¹ Collaboration in Facility Investigations of Child Abuse and Neglect, DHHS CFS Protection and Safety Procedure #7-2014 (adopted Oct. 20, 2014), 1.

Office and local teams currently utilize the protocols outlined in that memo, including the utilization of an Out of Home Assessment Team, the answer was, “No. Never.” Staff interviewed were not sure why the policy had not been implemented.

The OIG also became aware that this policy was not being followed through reviews of OHAs that were relevant to this investigation. Between November 2014 and May 2016, the DHHS Hotline accepted four different reports of abuse and neglect at Group Home Z that, by policy, required Central Office to form an OHA team. Three reports involved a sexual relationship between a staff member and youth, and one involved neglect of multiple youth. In each case, though OHAs were completed, no team was formed. The OHAs were poorly coordinated between Divisions, and ongoing issues at the residential facility were not addressed.

Furthermore, there were long delays in completing these OHAs at the Group Home Z, even though they involved serious issues that by policy should have been prioritized for a thorough investigation. A report of B.L. being sexually abused by a female staff member was not finalized for sixteen months, although B.L. disclosed much earlier and the female staff member was criminally charged with sexual abuse six months earlier.

The Hotline received a report that a female staff member had been seen kissing a male 13-year-old resident, N.Z., at a group home. By DHHS policy, Central Office should have created a team to coordinate the investigation, including both the Division of Children and Family Services (CFS) and Division of Public Health. However, no team was created. Without the team in place, local CFS staff interviewed residents and coordinated with law enforcement without Public Health or Central Office staff being included. N.Z. did not disclose any abuse, so the sexual abuse allegations were not substantiated. However, the OHA narrative revealed several concerns about the residential facility that Public Health licensing should have pursued according to regulations, including reports of residents being served moldy food.

The OIG found many examples of OHAs that were not compliant with other policy requirements, laid out in DHHS’s Protection and Safety Procedures on initial assessment.⁵² Policy on initial assessment requires CFS staff to appropriately coordinate with law enforcement and Public Health. CFS staff must also make findings about whether abuse or neglect occurred, enter findings onto the Central Registry, and determine risk of maltreatment to other children, regardless of substantiation. Policy also states, “Recommendations about changes in practice or conditions that will reduce the likelihood of maltreatment will be made.”⁵³

In the OHAs at Group Home Z mentioned above, CFS staff did not make thorough determinations on risk. They found no risk to children at the residential facility, despite concerning evidence about issues at the residential facility and a pattern of reports alleging abuse and neglect not being called into the Hotline. CFS staff also failed to make recommendations to address the frequent concerns at Group Home Z, many of which involved improper supervision and inappropriate relationships between staff and youth.

Instead, CFS staff improperly relied on limited action by Group Home Z to address problems. In the OHA on the female staff member’s sexual abuse of B.L., the assessment states that no recommendations were made because the female staff member had been fired. In an OHA conducted after a different resident from that group home, N.T., was allegedly sexually assaulted by another youth, CFS failed to make any recommendations to the group home because they believed Public Health already had addressed the

⁵² Initial Assessment, DHHS CFS Protection and Safety Procedures #16-2013, #27-2016, and #5-2017.

⁵³ Initial Assessment, DHHS CFS Protection and Safety Procedures #16-2013, #27-2016, and #5-2017, 35.

shortcomings they examined, including training for staff, limiting the number of youth at the group home, appropriate filing, and more. The assessment stated: “[...] Licensing will make the recommendations and no recommendations are provided from CFS at this time.” However, Public Health never issued a report to that group home relative to the incident. The failure to make recommendations violated policy. It also showed how little coordination there was between CFS and Public Health, although it is required.

Ultimately, the failure to follow OHA policy –coordinating concerning investigations, appropriately assessing risk, and making recommendations for residential facility improvement - left issues unaddressed and child residents vulnerable.

Child sexual abuse cases are difficult to substantiate.

Nebraska law requires DHHS to maintain a Central Registry of cases of abuse and neglect that after an investigation occurred, were determined to be substantiated.⁵⁴ The law specifies that in order to be considered substantiated, one of two conditions must be met:

- A court has entered a judgment of guilty on a criminal complaint, indictment, or information or a juvenile court adjudication has been made under *Neb. Rev. Stat.* § 43-247(3)(a) which relates or pertains to the report of child abuse or neglect;⁵⁵ or,
- DHHS determines that by a preponderance of the evidence that child abuse or neglect occurred after an investigation, although no court action occurred.⁵⁶

There are a few exceptions to these criteria for being added to the Central Registry. Nebraska law prevents minors under 12 from being placed on the Central Registry and parents whose cases have been adjudicated as abused or neglected, but through no fault of the parent.⁵⁷ Furthermore, records maintained on the Central Registry can be amended, expunged, or removed at any time upon notice to the subject of the report of child abuse or neglect and upon good cause shown.⁵⁸

Court substantiation of child sexual abuse may require a different burden of proof than agency substantiation of child sexual abuse. The burden of proof in a criminal case is *beyond a reasonable doubt*. For agency substantiation of child sexual abuse or a juvenile court adjudication, the burden of proof is *a preponderance of the evidence* – that the abuse was more likely to have occurred than not.

Whatever the evidentiary standard, the OIG’s investigation showed that substantiating child sexual abuse is difficult. Although false reports of child sexual abuse are rare, gathering evidence to prove child sexual abuse occurred is challenging, in large part due to the nature of child sexual abuse itself. DHHS staff shared with the OIG that they find sexual abuse cases particularly difficult to investigate and substantiate.

One DHHS supervisor told the OIG, “There might be an investigation where maybe we’ve been out five times on IA, and we can’t get anything concrete. Everybody knows that there’s something up, there’s something awful happening, but you can’t get there. And those are the worst. You know something is up in your gut, and there’s red flags, but you cannot get enough information.”

⁵⁴ Neb. Rev. Stat. § 28-718.

⁵⁵ Neb. Rev. Stat. § 28-720 (1)(a).

⁵⁶ Neb. Rev. Stat. § 28-720 (1)(c).

⁵⁷ Neb. Rev. Stat. § 28-720 (3).

⁵⁸ Neb. Rev. Stat. § 28-721 (1).

A caseworker who was assigned to initial assessment shared that it can be difficult to get victims to share what happened to them, “You know, just from what I’ve learned, a lot of times [the perpetrator] is usually someone they trust. They’re afraid of damaging that relationship, even though it’s already been damaged. I think most kids are afraid to disclose.”

There is often limited evidence to collect in cases of child sexual abuse. Sexual abuse usually occurs in private, ensuring there are no witnesses except for the victim and perpetrator. There is often no physical evidence that can be collected. Many times, the situation involves a child victim disclosing that something happened and the alleged perpetrator denying it. Determining whether sexual abuse occurred then hinges on weighing the credibility of each statement.

Furthermore, as many as 90 percent of child sexual abuse victims are abused by someone they know and trust. 30 percent of perpetrators are estimated to be members of a child’s family.⁵⁹ These relationships can impact child disclosures.

Given the limited evidence that can be collected and the potential trauma for child victims if a case is filed, court filings by county attorneys, especially those in criminal court, are infrequent. In 2015, only 11 percent of child sexual abuse cases that underwent a forensic interview at Project Harmony, the CAC in Omaha, were accepted for prosecution. The Bridge of Hope CAC in North Platte reported that from 2014 – 2016, there was approximately a 13 percent prosecution rate for child sexual abuse cases that they saw.

Numbers provided by DHHS indicate that only a small fraction of child sexual abuse reports are substantiated. Of the 8,792 sexual abuse reports that were screened for a DHHS or law enforcement investigation between 2013 and 2016, only 6 percent were substantiated (see Table I). An additional 5.8 percent of reports were awaiting the outcome of a court case, and may be substantiated.

| Year | Accepted for Investigation by DHHS or Law Enforcement | Agency Substantiated | Court Substantiated | Court Pending |
|--------------|--|-----------------------------|----------------------------|----------------------|
| 2013 | 2,208 | 124 | 40 | 186 |
| 2014 | 2,002 | 76 | 78 | 91 |
| 2015 | 2,119 | 60 | 56 | 106 |
| 2016 | 2,463 | 51 | 44 | 134 |
| Total | 8,792 | 311 | 218 | 517 |

⁵⁹ Finkelhor and Shatuck, *Characteristics of Crimes against Juveniles*, 5.

⁶⁰ Substantiated reports of child sexual abuse can contain more than one child victim. From 2013-2016, DHHS reported to the OIG that there were 1,284 victims of child sexual abuse, but only 529 substantiated reports. Reports accepted for investigation include reports screened as “Multiple Reporter.”

Nebraska law requires the establishment of multidisciplinary child abuse and neglect investigation teams to provide a “coordinated response by law enforcement, child advocacy centers, prosecutors, the Department of Health and Human Services, and other agencies or entities designed to protect children.”⁶¹ However, these teams do not consistently meet across the state and function to effectively coordinate investigations in all instances. One CAC told the OIG, “Due to lack of time and staff, it is sometimes difficult for MDT [multidisciplinary team] members to work the cases together which would be best practice.”

The OIG found examples of ineffective coordination and cases where investigative parties had different approaches hindering an investigation. The initial report that Y.N. was being sexually abused by her foster father, A.S., was received. It was over five months before A.S. was arrested. Between the initial report and his arrest, he continued to pursue and sexually abuse Y.N. while an investigation was ongoing, although she had been removed from his care. Concerns about the delays in law enforcement’s investigation were raised at an MDT meeting. Law enforcement then assigned a new detective to the case, which, finally led to A.S.’s arrest.

The OIG found that in some sexual abuse cases, substantiations may be jeopardized by the failure to use forensic interviews and medical exams offered at CACs. Although Nebraska state law and DHHS policy suggest (but do not require) that alleged sexual abuse victims who are under 19 years old be interviewed and examined at CACs, interviews with DHHS staff across the state indicated that some law enforcement agencies do not utilize them in every case.⁶²

In a case reviewed by the OIG, R.R. disclosed that her adoptive father, H.R., was sexually abusing her. Law enforcement chose to conduct the interview themselves, rather than arrange for forensic interviews and exams of R.R. and her siblings at a CAC. R.R. did disclose sexual abuse to the law enforcement officers, but then recanted when a caseworker tried to get her to repeat the allegation. R.R. was told that she would be taken home if she wouldn’t say anything. She then recanted and the allegations were unfounded. It was not until her sister, N.R., reported sexual abuse over a year later that CAC interviews occurred, and both N.R. and R.R. described years of sexual abuse.

Child sexual abuse substantiations, especially agency substantiations, are inconsistent across Nebraska.

Throughout its investigation, the OIG discovered that while both state statute and DHHS policy on making findings after investigations of child sexual abuse cases is consistent, actual substantiations across the state are not.

The inconsistency in substantiations of child sexual abuse can be attributed to both differences in how child sexual abuse is investigated and prosecuted in different parts of the state, leading to court substantiations, and differences in local DHHS practice when it comes to agency substantiation.

Local county attorney decision-making about whether and what type of sexual abuse allegations to file after an investigation is complete varies across the state. Even in cases where there may be enough

⁶¹ Neb. Rev. Stat. § 28-728. These are commonly referred to as “1184 Teams” in Nebraska because the bill creating such was Legislative Bill 1184, 1992.

⁶² Neb. Rev. Stat. § 28-728 (3)(d)(iii); Collaborating with the Child Advocacy Center (CAC), DHHS CFS Protection and Safety Procedure #23-2017 (adopted July 25, 2017) and #21-2015.

evidence to file in criminal or in juvenile court, the county attorney may decline to do so for some reason, like the additional trauma to the child victim.

In cases where no criminal or juvenile case is filed or where an alleged perpetrator pleads to an amended charge, CFS Specialists, Supervisors, and Administrators in the field are responsible for evaluating evidence to determine whether it is more likely than not that sexual abuse occurred. When a preponderance of the evidence suggests that child sexual abuse did occur, DHHS has a responsibility to make that finding and enter the perpetrator on the Central Registry.⁶³

DHHS staff assigned to initial assessment told the OIG that sometimes they can have a hard time gathering all the evidence that exists that child sexual abuse occurred, which makes it difficult to agency substantiate. Nebraska law restricts who can have access to records of forensic interviews conducted at CACs.⁶⁴ Although other parts of the law indicate that DHHS, as a member of an investigative team should have access, IA workers shared that CACs and law enforcement do not always share copies of videos or transcripts of CAC interviews.⁶⁵ According to staff in the field, this makes it difficult to agency substantiate cases. If DHHS chooses to agency substantiate without acquiring the transcript or video of a forensic interview, the substantiation is vulnerable to expungement. Forensic interviews are one of the most significant evidence of sexual abuse occurring that can be gathered. Without clear evidence of a disclosure, DHHS would have to remove a perpetrator from the Central Registry.

The OIG also discovered that some staff and Service Areas are more hesitant than others to use agency substantiation in cases of sexual abuse or are confused about the preponderance of evidence standard. This leads to cases where a preponderance of the evidence indicates sexual abuse occurred to be missing from the Central Registry.

Two contrasting cases illustrate the difference in agency substantiation between reports and service areas. J.R. was adopted by H.R. H.R. was charged with sexually abusing J.R.'s adoptive sisters, N.R. and R.R. J.R. disclosed that H.R. had sexually abused her months after his arrest. Since H.R. had already been charged on multiple accounts and a conviction was likely, law enforcement and the county attorney did not get involved, leaving a decision on substantiation up to DHHS. DHHS chose to agency substantiate the report based on J.R.'s disclosure.

A different approach was taken by DHHS staff responsible for making a finding in the case of L.S., a former resident of a group home. After a female staff member had been criminally charged for sexual abuse of B.L., L.S. disclosed that the same female staff member had also sexually abused him. During a CAC interview, L.S. disclosed that the same female staff member had groomed him, bribing him with snacks, cigarettes, and outings, and then began sexually abusing him, which included sexual touching and oral sex on numerous occasions. Again, because the staff member was already facing charges, law enforcement and prosecutors did not go forward with the case. In this instance, although the evidence was similar to what existed in J.R.'s case, DHHS listed the allegation as unfounded.

The OIG found additional cases where it seemed the preponderance of evidence burden was met, but no substantiation was made. For example, N.T., a youth at a group home, detailed sexual abuse by another

⁶³ Central Registry Entries, DHHS CFS Protection and Safety Procedure #31-2016 (adopted Sept. 22, 2016), 3.

⁶⁴ Neb. Rev. Stat. § 29-1926 (2)(a).

⁶⁵ Neb. Rev. Stat. § 28-730 allows sharing of documents and information with the investigative team for the purpose of investigation.

youth in a CAC interview. Although he made the disclosure and evidence seemed to support what occurred, the incident was classified as unfounded by DHHS.

Some DHHS staff do not clearly understand the differences between the evidentiary requirements for criminal prosecution or juvenile court adjudication and agency substantiation. Interviews with IA staff revealed that in some areas, unless law enforcement or the county attorney was moving forward with a court filing, they would not seek an agency substantiation on a child sexual abuse. A supervisor stated when asked about agency substantiating sexual abuse allegations, “We rarely agency-substantiate just because if law enforcement’s not moving forward, they clearly don’t have enough evidence to feel like they can move forward, therefore there won’t be any court substantiation . . . it doesn’t really rise to a level of court for evidence. We really try to think about this, if it were to go to court, would there be enough to substantiate so we aren’t putting just anyone and everyone on the Central Registry.”

In many sexual abuse cases, IA staff rely on law enforcement to take the lead in investigating to determine whether child sexual abuse occurred. Unfortunately, this reliance led some IA staff to not understand the separate roles and burdens of proof that law enforcement and DHHS must meet. The law enforcement mindset oftentimes bleeds over into IA investigations of child sexual abuse. For example, if a child changes his or her story when disclosing the sexual abuse, law enforcement (the county attorney) may determine that the evidence is insufficient to prove that child was sexually abused beyond a reasonable doubt. Depending on the totality of the evidence, however, there may be enough evidence to meet the preponderance of the evidence burden required for an agency substantiation. Even if the county attorney does believe that sufficient evidence exists to prove an allegation in court, the county attorney may choose not to proceed for other reasons such as uncooperative witnesses or avoiding further trauma to the victim. The decision of a county attorney not to move forward in a court case, in and of itself, is not sufficient to determine whether an allegation should be agency substantiated.

Recommendations to DHHS

5. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.

If there is an allegation of child sexual abuse that meets the definition of child abuse and neglect under the *Child Protection and Family Safety Act*,⁶⁶ that allegation needs to be investigated. Under the *Act*, an investigation is defined as, “fact gathering related to the current safety of a child and the risk of future child abuse or neglect that determines whether child abuse or neglect has occurred and whether child protective services are needed.”⁶⁷ If law enforcement does not investigate whether or not child sexual abuse occurred, DHHS should do so to ensure child safety, assess for risk and services, and make a determination about agency substantiation.

DHHS Response:

DHHS accepts this recommendation.

⁶⁶ Neb. Rev. Stat. §§ 28-710 to 28-727.

⁶⁷ Neb. Rev. Stat. § 28-710.

6. Create a process to fulfill DHHS’s statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse referred for law enforcement investigation alone.

For each report of child sexual abuse, the law requires DHHS to assess, “the risk of harm to the child involved,” and “[...] provide such social services as are necessary and appropriate under the circumstances to protect and assist the child and to preserve the family.”⁶⁸ However, investigations that involve a perpetrator in a separate household who no longer has access to the child, are referred to law enforcement. In those cases, DHHS is not conducting assessments or providing services.

The OIG recommends that DHHS develop and adopt a policy that creates a process for assessing law enforcement only investigations of child sexual abuse for risk of harm and need for services. Nebraska law requires more of DHHS than merely reviewing law enforcement reports to determine whether abuse occurred and whether an entry to the Central Registry should be made.

DHHS Response:

DHHS rejects this recommendation. DHHS currently assesses for risk of harm during the intake process. The Hotline takes the information (screens) and determines the next steps based on the information received. DHHS will look for opportunities to clarify the guidance to DHHS staff related to assessing these reports.

7. Provide additional guidelines and training on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.

Currently, the only guidance DHHS has established for making agency substantiations is a prompt that staff should assess available evidence to determine whether it was more likely than not that abuse occurred. The lack of additional guidelines means that there is a great deal of both flexibility and variability in how particular areas of the state handle agency substantiations of child sexual abuse. While one service area may consider a child sexual abuse allegation unfounded if the only evidence was a forensic interview with a disclosure, another may classify it as agency substantiated.

The OIG recommends that DHHS develop additional guidance on when *the preponderance of the evidence* burden is met in child sexual abuse cases. This would help ensure agency substantiations are occurring consistently across the state and that no case where it is more likely that child sexual abuse occurred than not is left off the registry because staff are unsure as to when the preponderance standard is met.

After guidance is developed, training on the meaning of the different standards of proof for intake, initial assessment, and ongoing case management staff will be important, especially to clarify both the separate and overlapping roles between DHHS and law enforcement.

DHHS Response

DHHS accepts this recommendation.

⁶⁸ Neb. Rev. Stat. § 28-713 (2).

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

The OIG found that DHHS was not following key provisions of policy on out of home assessments, including provisions that require Central Office oversight and coordination of investigations of serious allegations at residential facilities.⁶⁹ Had these policies been fully followed, investigations could have been more thorough, better coordinated, and timely. The investigations could have addressed serious concerns at facilities instead of allowing them to persist for some time.

The OIG recommends that DHHS adhere to its policy requiring coordination and Central Office involvement in Out of Home Assessments that are serious in nature. The OIG also recommends that policy be clarified on determination of safety of and risk to children at facilities, assessing underlying causes, and making recommendations. Currently these are requirements within the OHA process, but unlike other assessments used by DHHS, there is no standard tool or detailed guidance to help staff know what to look for or how to make these decisions. The OIG recommends that DHHS enhance quality assurance on OHAs to give feedback on how they are being completed and identify any areas where staff need further clarification, guidance, or training.

DHHS Response

DHHS accepts this recommendation.

Child Welfare System Action Items

4. Clarify the *Child Protection and Family Safety Act*.

The OIG found repeated instances of DHHS and law enforcement agencies failing to follow the requirements of the *Child Protection and Family Safety Act*. Although these requirements are clear when the Act is read as a whole, any ambiguity or misunderstanding leads to gaps in the investigation of allegations of child sexual abuse. The OIG recommends amending the Act to clarify the roles of DHHS, law enforcement, and county attorneys. The OIG also recommends amending the Act to use consistent terminology throughout related to investigations, assessments, and substantiation.

DHHS Response

*DHHS will work with the OIG on clarifying needed changes to the *Child Protection and Family Act*.*

5. Improve multi-disciplinary coordination in child sexual abuse investigations.

Multi-disciplinary coordination and the functioning of 1184 teams varies across the state. In cases of child sexual abuse, appropriate investigation and response requires effective coordination between DHHS, law enforcement, prosecutors, and others. The OIG recommends that Nebraska continue its ongoing efforts in coordinating investigations within multi-disciplinary teams.

DHHS Response

Since the Child Advocacy Centers are the primary entity responsible for coordinating the

⁶⁹ Collaboration in Facility Investigations of Child Abuse and Neglect, DHHS CFS Protection and Safety Procedure #7-2014 (adopted Oct. 20, 2014).

multidisciplinary teams, DHHS will continue to partner with the teams to meet this recommendation. Refer to Neb. Rev. Statute 28-728 through 28-730. The Children's Justice Act (CJA) Task Force is conducting a review of the Multi-disciplinary Teams to assess for strengths and areas needing improvement. Recommendations will be provided by the CJA Task Force during this review.

WORKFORCE ABILITY TO PREVENT AND RESPOND TO CHILD SEXUAL ABUSE

A skilled and stable workforce is key to ensuring that children in the state's care are kept safe from sexual abuse and that their needs are met. As part of its investigation, the OIG identified 27 victims who were in state care when they were sexually abused. In each of these cases, system intervention had been unable to protect youth or had in fact made them more vulnerable to sexual abuse. The OIG also identified cases where sexual abuse investigations were not conducted in a timely or effective manner.

Based on these cases, the OIG examined barriers and challenges to the child welfare workforce appropriately preventing and responding to the sexual abuse of youth in the state's care.

Background Information on Workforce

A child welfare system's capacity to effectively protect children and care for families is directly impacted by the skill and ability of those who work on the frontline – both staff and supervisors.

For many years, child welfare systems in the United States have struggled to recruit and retain qualified staff. Common factors cited by available research indicate that challenges with child welfare workforce turnover and qualifications at both public and private agencies are impacted by low salaries, high caseloads, paperwork and documentation burdens, insufficient supervision, limited training opportunities, and a lack of relevant education experience (social work background). Subsequently, turnover and high caseloads have been shown to contribute to poor outcomes for children and families, leading to insufficient time to ensure child safety, work towards permanency, and ensure continuity of care.⁷⁰

Nebraska has not been immune to issues of turnover, vacancy, and high caseloads in the child welfare system. In 2012, Nebraska passed a law to require caseloads that comply with the Child Welfare League of America standards for case managers at both DHHS and its contractor Nebraska Families Collaborative. Since that time, compliance with adopted caseload requirements has not been achieved statewide, despite statutory requirements. On June 30, 2016, DHHS reported that statewide, 37 percent of workers had more than the statutorily set caseload limit.⁷¹

The OIG did not request the annual turnover rate of caseworkers, but interviews conducted with staff from each DHHS service area indicate it is a significant problem. As of February 2017, DHHS reported an 8.2 percent vacancy rate for caseworkers and Nebraska Families Collaborative, which provides case management in Douglas and Sarpy Counties, reported a 2.98 percent vacancy rate.⁷² High caseloads, high turnover, high workload, and vacancies together can contribute to the inability of staff to keep children in the state's care safe.

Findings

Caseload, workload, and turnover hindered DHHS efforts to prevent and respond to sexual abuse.

Caseload, workload, and turnover are all long standing problems for the child welfare system that have been shown to contribute to negative outcomes for children and families. Through its investigation, the OIG found that this is no different for preventing and responding to sexual abuse of children in

⁷⁰ US GAO, *Recruit and Retain Staff*, 3-5.

⁷¹ DHHS, *Caseload Report*.

⁷² DHHS, *Continuous Quality Improvement*.

Nebraska’s care. Through interviews and document reviews, the OIG discovered that workload, caseload, and turnover caused deficiencies in how sexual abuse cases were handled.

Outside agencies and system stakeholders saw high caseload and workload as a significant obstacle in investigations of child sexual abuse. A child advocacy center (CAC) told the OIG that issues with “time” and “a lack of staff” hinder effective investigations and limit coordination. The OIG also found evidence that staff workload and turnover is causing issues and errors in DHHS investigations.

DHHS has not completed initial assessments of all sexual abuse allegations in a timely manner. As of May 2017, 184 child sexual abuse reports accepted for DHHS assessment from 2013 to 2016 had not been completed (see Table II). By policy, initial assessments must be completed within 30 days.⁷³ Currently, there are investigations that have been pending for nearly four years.

| Year | DHHS Investigations | Law Enforcement Investigations |
|--------------|----------------------------|---------------------------------------|
| 2013 | 5 | 145 |
| 2014 | 41 | 351 |
| 2015 | 34 | 294 |
| 2016 | 104 | 560 |
| Total | 184 | 1,350 |

Turnover and high caseloads relate directly to investigations being incomplete and safety concerns going unaddressed in cases the OIG reviewed. In 2014, N.T., a resident of Group Home Z, was allegedly sexually assaulted by another youth. A report of the assault along with an allegation that staff had not gotten N.T. appropriate medical care was accepted for a DHHS out of home assessment. N.T. was interviewed at the local CAC and disclosed that he had been sexually abused. DHHS also conducted interviews with Public Health, indicating that there were concerns and issues at Group Home Z. However, the CFS Specialist working the case resigned before the investigation was complete. The case was added to a list of backlog cases and it was not until 2016, over two years later, that a new CFS Specialist was able to complete the investigation.

DHHS staff also failed to review reports and enter findings from child sexual abuse investigations that law enforcement has conducted alone. 1,350 of those reports from 2013 to 2016 period were missing findings (See Table II). Each service area is tasked with creating its own process to ensure findings from law enforcement investigations are entered and following up every three months to see if the investigation is still open or has concluded.⁷⁵ In many service areas, this task is given to IA workers. These reports do not count towards caseload calculations and are work on top of caseloads that often already exceed statutory requirements. Staff told the OIG that filling in these findings is a low priority given their many other duties and cases.

⁷³ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017 (adopted Feb. 2017)

⁷⁴ DHHS CFS Administrator, email message to OIG, May 19, 2017. The chart includes reports labeled as “Findings Not Entered” except for reports screened as Unable to Locate.

⁷⁵ Central Registry Entries, DHHS CFS Protection and Safety Procedure #31-2016 (adopted Sept. 22, 2016). Protection and Safety Procedure #35-2015 contained the same requirement.

Failing to follow up on law enforcement investigations in a timely manner can lead important information about sexual abuse victims and perpetrators to be missing from DHHS's system. The OIG found a number examples in the cases it reviewed where there were long delays entering information, in violation of DHHS policy requirements. In 2015, a report came in alleging 14-year-old female state ward, Q.U., was sexually abused by a 25-year-old man, S.E. Her foster mother knew of and encouraged the sexual contact. By 2016, S.E. had been criminally convicted. However, it was not until 2017, that DHHS staff entered the information into the Central Registry. The delay in entering this information meant that Q.U. would not have been included in DHHS's data collection on maltreatment in foster care, a required federal measure.

As the OIG conducted interviews with CFS Specialists, Supervisors, and Administrators and other system stakeholders, it became clear that caseload, workload, and turnover were not just a major obstacle to investigations of sexual abuse, but also effective ongoing case management.

One CAC told the OIG: "Cases involving the sexual abuse of children are highly complex and contain many issues outside of the sexual abuse to include past trauma experienced by both parent/caregiver and child. Workforce turnover makes it difficult to provide the consistency that these cases demand and training on the complex issues facing families affected by sexual abuse is ongoing."

A CFS Specialist explained the challenge this way: "The thing with caseloads so high [is] you just don't meet all of your kids' needs and you run yourself ragged by doing it. We are wearing out our most valuable employees." Staff told the OIG that even though staff try their best, high caseload and workload not only lead to employee burnout and turnover, but leave children in the state's care in danger, "If we are being honest, every time you have turnover and you have a higher caseload, something gets missed. [...] And it's not because you want to be less thorough, it's not because you don't want to be the best case manager you can be, it's that there's no time and there's more kids."

Staff indicated that in order to effectively prevent and address sexual abuse of children in the state's care they need to more time to establish relationships, gather information and understand individual and family dynamics, find appropriate placements, and get appropriate services. High workload and caseload, which both cause and are caused by turnover, inevitably means that the care and case management children receive is not what staff would have wished to provide if they had more time.

One example of ongoing cases where workload and turnover contributed to a failure to effectively prevent, identify, and respond to child sexual abuse, is that of brothers R.O. and K.O. The brothers entered state care in June 2014, at the ages of nine and 10. Both children had diagnosed developmental disabilities and mental illnesses, which impaired their ability to function. While in care, R.O. and K.O. were sexually abused by one of their foster parent's sons. K.O. also began to sexually act out and touch R.O. and the son of his foster mother, eventually resulting in the brothers' separation. From June 2014 to December 2016, R.O. and K.O. had seven different case managers.

Among some DHHS staff there exists discomfort with addressing the topic of child sexual abuse with children.

Child sexual abuse prevention initiatives suggest that talking to children about their bodies, sex, healthy boundaries, appropriate use of technology, and healthy relationships in a developmentally-appropriate way is important to both minimizing the risk that children will be sexually abused and increasing the

likelihood that children will report if sexual abuse occurs.⁷⁶ For most children, parents are responsible for having these conversations. However, children in the state’s care rely on the child welfare system to ensure that they receive the information they need to protect themselves and get help when something bad happens. Furthermore, children in out-of-home care are at heightened risk for child sexual abuse, making this information even more crucial.⁷⁷

However, in conducting interviews with supervisors and staff, the OIG learned that most case managers for DHHS and private providers do not discuss these topics with children in the child welfare system, in part because they feel they do not have the education or expertise to discuss these topics. However, interviews also revealed that many workers are deeply uncomfortable with the topic of child sexual abuse in general.

One CFS Specialist told the OIG, “[...] it’s probably not appropriate [to have a boundaries conversation] because that conversation could lead to this is what my Uncle Billy did...then you are like whoa, whoa, whoa you need to be seen at the CAC. So, you don’t really want to open any doors that you can’t close.” Another CFS Specialist said that caseworkers tried not to openly discuss these topics with children, because they “didn’t want to get accused of planting information.” Yet another case manager explained why they would not discuss these topics with youth: “It’s always good to defer to the professionals in that area. I could inadvertently re-traumatize that child.”

By policy, whenever a caseworker conducts a Safety Assessment, they must consider whether child sexual abuse is suspected and, if so, whether caregivers are taking appropriate action to protect children. Policy outlines a number of factors caseworkers must consider, including disclosures or inappropriate sexual behavior by a child, whether members of the household have prior sexual abuse allegations, or whether information exists about caregivers encouraging inappropriate sexual activities.⁷⁸ While DHHS policy suggests that staff should always be assessing for sexual abuse and asking appropriate questions to determine whether there is a risk, staff told the OIG that they do not do so, unless there is an allegation of sexual abuse.

Staff resoundingly said that preventative talks or education about sex, relationships, and healthy boundaries is left up to the discretion of therapists or other professionals, usually after an inappropriate action occurs. However, these professionals would not address boundaries and sexual abuse during regular therapy sessions unless it was a known issue or they were specifically asked to. It was also mentioned that CAC interviews begin with a discussion about good touch and bad touch. This, though, is not enough to help youth establish the skills to recognize these situations and to tell someone if sexual abuse does occur.

Furthermore, case managers interviewed by the OIG seemed to forget that *they* are system professionals, too. Case managers routinely have to deal with cases where child sexual abuse occurs. It is extremely difficult to effectively investigate or manage the case of a child when sexual abuse had occurred, if case managers are too uncomfortable to even discuss the topic.

Child welfare is a reactionary system. But once children are placed into that system because of abuse and neglect, it is important as their guardians to help establish their knowledge so any further abuse—sexual

⁷⁶ Darkness to Light, *5 Steps to Protecting Our Children*TM

⁷⁷ Sedlak, et al., *NIS-4*.

⁷⁸ Initial Assessment, DHHS CFS Protection and Safety Procedure #5-2017 (adopted Feb. 2017), 11.

abuse especially—may be prevented. Important opportunities to educate children and prevent child sexual abuse in the child welfare system are being missed.

Recommendations to DHHS

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

High caseload and workload hampers DHHS’s ability to prevent and respond to child sexual abuse. The OIG found investigations that went incomplete for years and delays in entering information from law enforcement findings due to high caseload, workload, and turnover. High caseloads prevent staff from spending the time they need with children to ensure their safety and supply appropriate services.

DHHS continues to be out of compliance with statutorily mandated caseload requirements, which set a threshold on the highest number of cases a worker should have at any time. As a first step for addressing high caseload and workload, DHHS must ensure they have enough filled positions in all areas of the state to comply with the law.

DHHS Response

DHHS accepts this recommendation.

10. Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.

DHHS policy currently requires that each Service Area develop a policy for retrieving and reviewing law enforcement reports and entering findings. When no information has been received from law enforcement about these cases, policy requires DHHS to contact law enforcement, according to the protocol in their service area, every three months and document if there is an active and ongoing investigation, or if an investigation has been discontinued or returned no evidence, mark the report unfounded.⁷⁹

The OIG found 1,350 law enforcement reports where no finding had been entered and cases where long delays in entering the results of law enforcement investigations occurred. The OIG recommends that DHHS review each Service Area’s protocol for gathering information and entering findings in these cases, make modifications as necessary to make the process timely and efficient, and monitor whether the policy is being followed.

DHHS Response

DHHS accepts this recommendation.

11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.

The OIG recommends that DHHS create a protocol that ensures that all state wards are given the information they need to protect themselves and report sexual abuse throughout their time in care in a developmentally-appropriate manner. This information should encompass information about the human body, appropriate boundaries, internet and social media safety, sex, and healthy relationships.

⁷⁹ Central Registry Entries, DHHS CFS Protection and Safety Procedure #31-2016 (adopted Sept. 22, 2016).

DHHS Response

DHHS accepts this recommendation.

12. Review and revise training on child sexual abuse for DHHS staff.

When interviewed, DHHS staff shared that they felt their training on child sexual abuse was very limited. Interviews and reviews of documentation revealed that some in the DHHS workforce have incorrect assumptions about child sexual abuse, are uncomfortable confronting it, and uncertain about how to speak with children about important topics that are key to children's safety, including appropriate and healthy boundaries and relationships.

Currently, some new worker and ongoing training touches on topics of child sexual abuse or that topics that relate to child sexual abuse (sex trafficking, e.g.). However, the training is not adequately preparing staff. The OIG recommends that DHHS review training on child sexual abuse to ensure that it better prepares staff to appropriately prevent, identify, and respond to sexual abuse of youth in the state's care, and make sure such training is available on an ongoing basis.

DHHS Response

DHHS accepts this recommendation.

CHILD SEXUAL ABUSE IN FOSTER, ADOPTIVE, AND GUARDIAN HOMES

Thirty-seven of 50 substantiated or court pending child sexual abuse cases identified by the OIG in its investigation occurred in foster, adoptive, and guardian homes. These were homes, approved by DHHS, which were supposed to be safe alternatives to the homes from which children had been removed. Twenty-two of the 37 child victims were sexually abused by a foster or adoptive parent or guardian. The remaining 15 child victims were sexually abused by siblings, both foster and biological, or other adults in the foster home.

Given the number of child sexual abuse cases that occurred in these homes, the OIG examined whether the process for approving and placing in these kinds of homes was sufficient to protect children from sexual abuse. The OIG also reviewed the degree to which foster and adoptive parents and guardians are equipped to prevent, identify, and respond to child sexual abuse.

Background on foster, adoptive, and guardian homes

When children cannot safely remain in their own homes, they are most often placed in foster homes where families approved by DHHS care for them on a temporary basis. The goal is to provide children with a safe family setting while issues are addressed through service provision and case management.

As of December 31, 2015, 48.7 percent of Nebraska state wards (1,586 children) in out-of-home care were living in kinship foster homes and 37.7 percent (1,228 children) were living in traditional foster or adoptive homes.⁸⁰

In order to accept placement of children, foster homes must be *licensed or approved* by DHHS. Requirements for foster home licensing and approval are primarily contained in DHHS rules and regulations.⁸¹ Most traditional foster homes in Nebraska are recruited, trained, and supported by child-placing agencies, private agencies with which DHHS contracts to recruit and support foster parents. As of June 15, 2017, there were 29 licensed child-placing agencies in Nebraska. These agencies also assist traditional foster families with the licensing process, completing home studies and other required forms, which DHHS Resource Development (RD) staff review to license homes.

Home *approval* is only allowed for kinship care foster homes – homes of either the child’s relatives or kin, those with whom a child had a significant relationship prior to their removal from their home. Approval does not include training requirements or compliance with non-safety related licensing requirements (e.g. – room size). However, background checks are still required, and safety issues identified in the home study process must be addressed in the same way they would be required and addressed for traditional licensed homes. Additional specifications for how home studies are completed and guidance on placing in kinship homes is provided in Protection and Safety Procedures.⁸² Unless a kinship care foster home gets a foster care license, if no child is placed in the home, they would not be considered an active foster placement.

⁸⁰ Tonkinson, *Kids Count*, 69.

⁸¹ 395 Neb. Admin. Code, ch. 3.

⁸² Placement of children in relative and kinship (formerly known as child specific) homes in emergency and non-emergency situations, DHHS CFS Protection and Safety Procedure #20-2017 (adopted June 5, 2017). Protection and Safety Procedure #18 -2013 was in effect prior and contained similar requirements.

There is a statutory preference to place children needing out-of-home care with relatives.⁸³ These federal and state policies have been enacted over time due to a general philosophical belief that children belong in their own families, when possible. Research also indicates that, on the whole, kinship care results in enhanced well-being for children, fewer behavioral problems and mental health diagnoses and, fewer placement changes.⁸⁴ Although differences exist in requirements for these homes nationally and in Nebraska, there is no research that suggests there are significant differences in child safety or the incidence of sexual abuse between kinship, relative, and traditional foster homes.

The role of DHHS RD staff in vetting, supporting, approving, and licensing foster placements has evolved over the past several years. As of May 2017, these “resource development” functions are divided among Foster Care Resource Development (FCRD), Contract Management Resource Development (CMRD), and a Service Array Administrator. FCRD works with child-placing agencies or directly with families to recruit, train, and support foster homes. CMRD oversees child-placing agencies and monitors compliance with statutory requirements and contracts. The Service Array Administrator is charged with working with staff to develop resources and services for children and families across the state.

When state wards leave the child welfare system, they are most often reunified with their parents. When a child cannot be reunified, a permanent family is sought for them through adoption or guardianship in homes that DHHS and the courts approve. In 2015, 24.8 percent of exits from the child welfare system resulted in adoption, and 7.8 percent resulted in guardianship.⁸⁵ The process for being approved to adopt or have guardianship of a child is specified in Nebraska law.⁸⁶ Both types of permanency require placement of the child for six months before adoption or guardianship is finalized. However, the process for adoption is more intensive and requires a new home study, while guardianship does not. Guardianship also does not require that the parental rights of the birth parents be terminated.⁸⁷ Often, guardianship is used by relatives and kin who are approved, but not licensed to provide foster care.

Findings

Completion of home studies alone is not adequate to ensure that placements are safe and suitable for children.

Nebraska law requires that before issuing a foster care license or giving final approval to relative or kinship placement, DHHS, “cause such investigation to be made as it deems necessary to determine if the character of the applicant, [or] any member of the applicant's household [...] are such as to ensure the proper care and treatment of children.”⁸⁸ DHHS fulfills these requirements through the home study process. The law also requires that when a child placed in the child welfare system is to be adopted by their placement, DHHS or a licensed child-placing agency must conduct a post-placement adoptive home study that includes, “facts relating to the petitioner or petitioners as may be relevant to the propriety of such adoption.”⁸⁹

Currently, DHHS has established a home study format and guidebook laid out in a Protection and Safety Procedure. DHHS and child-placing agency staff, as well as private contractors who conduct home

⁸³ Neb. Rev. Stat. § 43-533

⁸⁴ Winkour, et al., “Kinship care.”

⁸⁵ Tonkinson, *Kids Count*, 71.

⁸⁶ Neb. Rev. Stat. §§ 43-107, 43-1312.01

⁸⁷ Neb. Rev. Stat. § 43-1312.01

⁸⁸ Neb. Rev. Stat. § 71-1903.

⁸⁹ Neb. Rev. Stat. § 43-107.

studies, must collect information on specific fields including: family background and composition; physical and behavioral health of applicants; motivation to foster or adopt, ability to meet a child's needs, and parenting philosophy; education, employment, and finances; and a physical description of the home.⁹⁰

Based on the information collected, the author of the home study must then, "provide his/her analysis of all the information gathered to draw conclusions that identify the family's strengths, needs and recommendations." DHHS offers no guidance on how gathered information should be interpreted. Under the relevant policies and regulations, the evaluation and recommendation relies entirely on the judgment of the author of the home study.⁹¹

The home study and recommendation is then reviewed by RD staff to make and confirm a licensing or approval decision. Currently, there is no clear policy or procedure which guides this review; it relies on the experience and motivation of the foster care RD worker to read, analyze, and identify any missing information. RD would be able to check for basic compliance with policy and may have access to additional information about the family through their records. However, there is no easy way for RD to verify whether the information in the home study is complete or appropriately analyzed.

Even when home studies are completed according to the standardized format and properly reviewed, there is no evidence that the information gathered in a home study is sufficient to identify a risk of child sexual abuse or other risk to the child's safety. Even at its best, the home study process relies heavily on the subjective impressions and experience of the staff conducting and reviewing the studies. Considering that the home study process is not evidence-based and has not been independently validated, DHHS appears to over-rely on the findings of home studies alone.

Nationally, only limited research has been conducted on the effectiveness and accuracy of home studies. In its review, the OIG found only one model that has any research behind its effectiveness – the Structured Analysis Family Evaluation (SAFE) home study, which as of 2007 was in use in 10 states.⁹² Unlike Nebraska's current home study guidebook, the SAFE home study is a structured decision-making model that uses uniform questionnaires and scoring guides. It is not considered an evidence-based practice and has not been compared to other models in terms of home safety and suitability. However, available research suggests that it has made home studies more consistent across evaluators and assisted inexperienced staff in gathering important psychosocial information.⁹³

In reviewing the cases of child sexual abuse in foster, adoptive, and guardian homes, the OIG discovered instances where home studies did not follow policy requirements or had not gathered sufficient information. L.N. (boy, age 4) and P.N. (girl, age 6) were placed with their great-grandparents. The home study was conducted by a child-placing agency. The home study identified the grandson, S.N. (age 19), as another member of the household, but the worker did not complete the required background check on him.⁹⁴ The evaluation and recommendation sections do not mention S.N. at all. Two months later, it was discovered that S.N. had been sexually abusing L.N. and P.N. It is unknown whether background checks and additional assessment and evaluation related to S.N. would have revealed a risk of harm to L.N. and

⁹⁰ Completion of a Home Study for Licensed, Relative, Kinship, Adoptive, Parental, and ICPC Foster Homes and Standardized Format, DHHS CFS Protection and Safety Procedure #9-2015 (adopted March 30, 2015).

⁹¹ Completion of a Home Study, DHHS CFS Protection and Safety Procedure #9-2015.

⁹² Crea, et al., "Home Study Methods".

⁹³ "Research and SAFE," SAFE Home Study, Consortium for Children, accessed August 2017, <http://www.safehomestudy.org/Research/Research.aspx>.

⁹⁴ 395 Neb. Admin. Code, ch. 3. § 220.01A (4) (b).

P.N., but the placement should not have been approved without complying with minimum regulatory requirements. RD staff did not catch this omission.

DHHS staff in the field further told the OIG that while a home study may have been conducted and the home had gone through the RD process to license the foster home, additional red flags that were missed are identified and sometimes led them to believe that the home is not safe or suitable. In the case of some licensed foster homes, caseworkers will decline to place children, when they have the time to dig into the case, because of “an icky feeling.”

In interviews, DHHS staff told the OIG that understaffing and the Department’s push for “operating efficiencies” was hampering the ability of RD staff to properly review home studies. An administrator in DHHS told the OIG that, “There are all these priority projects we’re working on, and trying to have efficiencies. And, we haven’t been able to hire some staff positions for resource development and the Director and others are looking at maybe we wouldn’t review 100 percent of home studies.” In addition to considering conducting less review of the home studies, DHHS is apparently considering making the home studies themselves less thorough because, according to one DHHS administrator, “Some child-placing agencies and staff said that it is a lengthier process than what it needs to be.”

A wide variety of agencies and individuals conduct foster and adoptive home studies in Nebraska. In addition to limitations with the home study itself, DHHS’s current structure of reviewing of home studies is limited. There is no way to currently ensure that information is appropriately gathered and analyzed in home studies, or confirm placements are safe and suitable for children.

A shortage of appropriate placements creates pressure to place children in inappropriate or unsuitable homes.

During 2015, there were 4,703 licensed foster home beds in Nebraska and 3,555 approved beds in relative or kinship homes. This greatly exceeds the 5,667 children who were in out of home care at some point during 2015.⁹⁵ Although numbers suggest that there are adequate foster care beds, the OIG discovered a shortage of appropriate placements for youth in foster care.

By law, there is a preference to place children needing out-of-home care with relatives.⁹⁶ Children in relative and kinship care now make up the majority of those placed in foster care. Staff interviewed by the OIG shared that it can be difficult to find a relative or kinship home that is willing to take and can adequately meet the needs of children. Caseworkers mostly expressed support for encouraging relative placements, but told the OIG that, “Sometimes we push those relative placements where it is not in the kids’ best interests,” to meet policy obligations. Furthermore, staff also said that they looked for relative and kinship homes in some instances when other placement options fell through: “We are putting kids at risk sometimes because we have so much pressure to do [relative/kinship placements], because we have no foster homes, we have nothing.”

While staff interviewed repeatedly expressed concerns about the pressure to place with relatives or kin who might not be suitable, it should be noted that in the cases of child sexual abuse identified by the OIG, there were not significant differences in numbers of children sexually abused in relative or kinship homes compared to traditional foster homes. While the process for approving and placing children in these homes differs, the OIG found similar concerns with safety, suitability, and appropriateness in both types

⁹⁵ Tonkinson. *Kids Count*, 65, 69.

⁹⁶ Neb. Rev. Stat. § 43-533

of homes. Research on maltreatment of youth in out-of-home care by placement type is limited, but does not suggest that kinship placements are categorically more or less safe than non-relative foster care.⁹⁷

Many of the licensed foster home beds in Nebraska have no children placed in them. Staff shared in interviews that this is either due to licensed foster parents not wanting to accept certain children who need care, who tend to be older and/or have challenging issues and behaviors, like having been a victim of sexual abuse, or because, although the home is licensed, staff do not feel comfortable placing children there.

If staff have the time to critically think about placing in marginal homes and do not do so, then that is a successful check on the system. But the OIG found times the caseworker is trying to find any available placement, without having the time to analyze whether that placement is suitable and appropriate for that particular child or children, because they have no other choice at the time placement is needed.

Staff told the OIG in multiple interviews that efforts to specifically recruit more homes that are willing to take teenagers and vulnerable youth are underway. However, staff also said that there has been little progress recruiting these homes. That often leaves staff with few options on where youth can reside, and creates a pressure to license, approve, and place children in inappropriate or unsuitable homes – those that may meet the bare minimum standards for placement, but have concerning issues. Caseworkers in some service areas reported that there is confusion about RD’s role in recruiting, vetting, and supporting homes. If RD does not have available homes identified or cannot locate homes in a timely manner, it greatly limits the caseworker in recommending appropriate placement.

The OIG found a number of instances where the urgent need to find a placement led to children being placed in homes that were not appropriate or safe. In the instances reviewed by the OIG, children suffered sexual abuse in these marginal homes.

The approval and use of the foster home of A.S. and M.S. highlights how the pressure to locate foster placements can overwhelm the judgment of DHHS staff and put children at risk of sexual abuse. The risks of placing foster children with A.S. and M.S. were known throughout the home study and licensing process. RD workers were concerned about the ability of the home to care for foster children. RD staff repeatedly identified reasons to deny a license to the A.S. and M.S. or limit the number of children they could serve. However, they repeatedly backed down under the pressure to find foster placements (see Case Example).

Even after A.S. was accused of sexually abusing Y.N., a female teenage foster child placed at his home, there was an attempt to place another female teenage foster child in that home while the license was on hold. A staff member told the OIG this was, “due to desperation for placement.” While this placement did not end up occurring, DHHS emails show it was debated internally. It shows the degree to which circumstances place staff under pressure to overlook serious safety concerns and red flags when placement options are limited.

⁹⁷ Font, “Are Children Safer with Kin.”

Case Example: Foster Home of A.S. and M.S.

The following timeline highlights how key information and concerns about A.S. and M.S. were overlooked in the licensing and placement process. Ultimately, dismissing these concerns led to the sexual abuse of Y.N.

Begin: A.S. and M.S. signed consent forms to conduct background checks to be considered for a foster care license.

Later the same month: M.S.'s daughter, G.R., then 15 years old, reported that her stepfather, A.S., had sex with her in the past. This was reported to the Hotline. G.R. had entered the juvenile justice system after repeatedly running away from home several months earlier and was placed in a group home at the time. The allegation was never investigated or noted in the home study.

7 months later: The assigned RD staff reviews the home study and placement information and does not support A.S. and M.S. becoming licensed foster parents.

One week later: The RD staff reported that there wasn't anything specific to prevent the home from becoming licensed, but was concerned about approving them when their child was in state care. The RD staff said that there was "more to the story than what is being portrayed" with G.R.

One month later: A.S. and M.S. were licensed as a foster home for two youth, rather than the four that had been requested. The home study stated that they, "need assistance with learning how to intervene with youth who demonstrate oppositional and defiant behaviors" and "should not accept placement of youth who exhibit severe behavioral or mental health issues."

10 days later: Two brothers, ages 7 and 9, were placed in the home. An intake was received reporting that the boys had been inappropriately touching each other's genitals. The 9-year-old was moved to another placement within 2 months of being placed there.

7 months later: Y.N. (age 13) and her sister D.N. (age 9) were placed in the home, even though it was not approved for three children. The foster placing agency proposed the possibility of amending their license to three beds, but RD found that the proposed sleeping arrangements were not acceptable and told the foster placing agency to, "rethink this placement option for the girls." Then sleeping arrangements were rearranged and the foster home license was amended to allow placement of three children.

2 months later: The foster care license for the home was placed on hold, after allegations that A.S. is sexually abusing Y.N. are reported to the Hotline. Y.N. and D.N. are removed from the home.

3 months later: An RD supervisor from Southeast Service Area (SESA) emailed Eastern Service Area RD staff because A.S. was under consideration for a relative placement of a 15-year-old girl, and they wanted the hold lifted. Southeast Service Area staff continued to push for the placement until Eastern Service Area staff brought the matter to the attention of the SESA Administrator, and the 15-year-old girl was placed elsewhere.

The OIG found additional examples of placements in homes where concerns were overlooked. Z.C., a teenage girl, was placed in the foster home of G.T. and R.T. At the time of her placement, there had been two unfounded allegations that R.T., the foster father, had been fondling teenage foster daughters. Although this should have prompted concern about placing another teenage girl in the home, Z.C. was placed there anyway. R.T. then sexually abused Z.C.

F.C., a 16-year old boy, was sexually abused by a foster brother, D.V., staying in the same home. Although D.V. had entered care for sexually abusing his own brothers, he was nonetheless placed in a foster home with three other teen boys. Placements for teenage boys with troubling behaviors can be difficult to find. However, consideration should still be given on whether the placement is appropriate and safe for all the youth in a foster home.

Foster and adoptive parents and guardians are often ill-prepared to protect children and report sexual abuse.

To obtain a foster care license, a licensee is required to complete 21 hours of training prior to licensure and 12 hours annually to renew the license. The Department may waive the licensing required training for relatives seeking approval to become foster parents. For most prospective foster parents, the training is contained in a curriculum called Trauma Informed Partnering for Safety and Permanence - Model Approach to Partnerships in Parenting (TIPS-MAPP) and Deciding Together (DT). For relative and kinship placements, training is not required. However, the Nebraska Foster and Adoptive Parent Association (NFAPA) has prepared a voluntary training curriculum called The Kinship Connection.

Both programs discuss the additional needs of children that have been sexually abused prior to placement. Both training curricula contain guidance for foster parents on what to do when foster children make false sexual abuse allegations against them. The trainings suggest that foster children make allegations to “gain attention” or “get people in trouble.” This information is contrary to research that indicates false sexual abuse allegations are rare.⁹⁸

The training contains little to no information on the dynamics of child sexual abuse, appropriate boundaries, the elevated risk of sexual abuse for youth in foster care, reporting sexual abuse, how to identify and respond to worrisome behavior that may indicate sexual abuse has occurred, and other important topics related to preventing sexual abuse of children in care. Training that focuses on how to prevent, recognize, and react to child sexual abuse, such as Darkness to Light’s Stewards of Children program, already exists and is occasionally offered in Nebraska as a voluntary training through the CACs.

In 14 of 37 child sexual abuse cases that the OIG reviewed in foster and adoptive homes, caregivers dismissed sexual abuse allegations that children made as false or failed to report them to the authorities, a violation of Nebraska law. Z.C., a teenage girl, told her foster mother that her foster father had fondled her. The foster mother never reported these allegations, and it was only after an investigation was started based on a separate report, that the foster mother admitted Z.C. told her about this in the past, but she did not report because Z.C. was “a liar.” B.R., adoptive mother to N.R., R.R., and J.R., similarly dismissed sexual abuse reports from her daughters for the same reason. D.D. adopted three children, X.D., E.D., and W.D., from the foster care system. For years, D.D. ignored concerning sexual behaviors and when W.D. disclosed that her brother had raped her, D.D. did not report the allegation. J.L. and H.L. adopted N.L. and F.L. F.L. had told J.L. that H.L. was sexually abusing her when it first began—at least 2 years before

⁹⁸ Everson and Boat, “False allegations of sexual abuse by children and adolescents.”

the abuse was reported. J.L. ignored the disclosure and is now facing child abuse charges. In all the cases where sexual abuse allegations were not reported, foster and adoptive parents and guardians, left children vulnerable to ongoing sexual abuse.

Thirteen adoptions and guardianships disrupted after sexual abuse was reported because non-offending caregivers did not believe disclosures or take appropriate action to protect them. After reports that 14-year-old S.K. was sexually abused by her uncle were investigated, her grandmother, who had adopted her, refused to care for her any longer, because she considered S.K. to be “a liar” and “a slut.” C.P., who was a guardian to her niece, 12-year-old D.S., and a licensed foster parent, ended her guardianship of D.S. and her brother, after D.S. disclosed that C.P.’s husband (and D.S.’s uncle and guardian), G.P. had been fondling her.

In all, many of the foster and adoptive parents, and guardians in cases of child sexual abuse reviewed by the OIG were inadequately prepared to prevent, identify and report, and respond to child sexual abuse appropriately. A training curriculum that more appropriately and thoroughly discussed these topics may have better equipped parents and guardians to prevent and adequately respond to any sexual abuse in their home.

Recommendations to DHHS

13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements to ensure safety and suitability.

The OIG found that home study accuracy, quality, and oversight are insufficient to ensure that placements are safe and suitable for children. Currently there are no standard procedures for review of home studies, although there is increasing emphasis being placed on streamlining the process to limit the time DHHS staff spend on this function.

The OIG recommends that DHHS develop quality assurance procedures to ensure that home studies are complete and accurate. Furthermore, the OIG recommends that the approval (kinship and relative) and licensing processes be clearly documented on the DHHS case management system so that staff have easy access to any concerns or limitations about homes’ appropriateness and suitability for the children they must place.

DHHS Response

DHHS accepts this recommendation.

14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.

If licensed foster homes are not prepared to meet children’s needs or have significant issues that may lead to children in their care being abused or neglected, they should not be licensed by DHHS. The OIG recommends that DHHS enhance its foster care licensing processes to ensure that foster homes that are not appropriate to care for children in the child welfare system do not obtain or keep their license.

DHHS Response

DHHS accepts this recommendation.

DHHS will explore strengthening the process for “approved or relative or kinship” homes. DHHS has defined licensing standards that can be used to close a licensed home. There is a due process component in place when action is taken to close a license.

15. Include a component on child sexual abuse prevention in foster and adoptive parent training.

The OIG recommends that DHHS ensure that accurate information on child sexual abuse, including prevention strategies and appropriate reporting, in the training it requires for foster and adoptive parents. This should include ensuring appropriate information on child sexual abuse is offered in kinship foster training as well. While appropriate training cannot prevent all cases of child sexual abuse in foster and adoptive homes, enhancing and correcting the content available will improve the ability of foster and adoptive parents to protect children and appropriately respond to any incidents that may occur.

DHHS Response

DHHS rejects this recommendation. Sexual abuse and all other types of abuse are currently presented in foster and adoptive parent training. DHHS will explore ways to better educate youth at the time of placement in out-of-home care.

Child Welfare System Action Items

6. Improve foster home recruiting to ensure homes are prepared to meet the needs of children.

Many licensed foster homes in Nebraska are either unwilling or ill-prepared to serve children in the child welfare system, including those who have a history of sexual abuse as victims, perpetrators, or both. While DHHS has already created a federally-approved foster home recruitment plan, Nebraska communities, private foster care agencies, DHHS, and Probation must work together to recruit homes that are prepared and qualified to meet the significant needs that many children in care have and are able to be protective and nurturing. The OIG believes that collecting and maintaining quality data on the specific needs of children seeking placements and the particular strengths of potential homes across systems would help match children with foster parents best suited for them and help drive successful recruiting efforts.⁹⁹

DHHS Response

DHHS accepts this recommendation.

⁹⁹ The Annie E. Casey Foundation, *A Movement to Transform Foster Parenting*.

CHILD SEXUAL ABUSE IN RESIDENTIAL FACILITIES

A significant number of Nebraska youth in out-of-home care, especially those in the juvenile justice system, live in residential facilities that care for large numbers of children. The use of these facilities is often referred to as congregate care and includes a wide range of placements – from detention centers to group homes.

During its investigation, the OIG became aware of three substantiated cases of child sexual abuse in residential facilities between 2013 and 2016. Two sexual abuse cases occurred at privately-run group homes licensed by the DHHS Division of Public Health, Children’s Services Licensing (Public Health). One case occurred at a residential facility administered by DHHS. The OIG also received nine critical incidents related to sexual abuse at residential facilities, either run or licensed by DHHS, where the allegations were never substantiated.

Because of these cases, the OIG examined DHHS’s role in preventing and responding to youth sexual abuse at residential facilities, specifically at the residential facility administered by DHHS and privately-run facilities licensed by Public Health. The OIG gathered information to determine whether current statutes, rules and regulations, and policies and procedures were being appropriately followed and whether they were adequate in preventing and responding to sexual abuse at residential facilities.

Background on Residential Facilities

The majority of residential facilities in Nebraska are privately-run. These residential facilities (e.g. group homes and shelters) are required to be licensed by the DHHS Division of Public Health as Residential Child-Caring Agencies. The licensing process and standards for these facilities are governed by the *Children’s Residential Facilities and Placing Licensure Act (Neb. Rev. Stat. §§ 71-1924 to 71-1951)* and Public Health rules and regulations.

As of June 2017, there were 30 licensed residential child-caring agencies in Nebraska. Youth are usually placed at these facilities through the juvenile justice system, although some youth have child welfare involvement as well. Some facilities also take youth who are privately placed by their families. In addition to Public Health standards, residential child-caring agencies must meet requirements set by contracts and agreements with Probation and CFS who place youth in the facilities.

Research indicates that youth placed in group care facilities are particularly vulnerable to sexual abuse.¹⁰⁰ In the United States, facilities that serve youth in the juvenile justice system have long documented issues with youth being sexually abused. National research by the Bureau of Justice Statistics (BJS) estimated that in 2012, 9.5 percent of youth in juvenile facilities experienced sexual victimization while confined.¹⁰¹ Cases of sexual abuse by other youth and male youth being sexually abused by female staff members in encounters where, the “youth appeared to be willing,” are particularly common.¹⁰²

Due in part to research on the problem of sexual abuse in juvenile justice facilities, federal and state governments have taken action to address this problem. In 2003, the federal government passed the Prison Rape Elimination Act (PREA), intended to create basic standards to address sexual violence and

¹⁰⁰ Euser, et al, “The Prevalence of Child Sexual Abuse.”

¹⁰¹ Beck et al., *Sexual Victimization in Juvenile Facilities*.

¹⁰² Beck and Rantala, *Sexual Victimization Reported by Juvenile Correctional Authorities*.

victimization in confinement. In June 2012, the Department of Justice released the final PREA regulations and standards facilities must follow, including specific standards for juvenile facilities.

According to the PREA standards, juvenile facilities include any that are, “primarily used for the confinement of juveniles pursuant to the juvenile justice system or criminal justice system.” These facilities include detention centers, correctional facilities, and group homes and other residential facilities where youth in the juvenile justice system are placed, both those that are run by the state and those with which the state contracts.¹⁰³ While state participation is voluntary in PREA, Nebraska has chosen to participate. As of March 2016, Nebraska informed the Justice Department that its facilities were fully compliant with PREA.¹⁰⁴ While Nebraska’s DHHS-administered residential facilities have adopted PREA standards, most other licensed residential facilities have not. While compliance with these standards is voluntary, facilities that do not implement PREA may be subject to litigation, since the standards represent “generally accepted professional standards,” for preventing sexual abuse.¹⁰⁵

Findings

Public Health does not have the capacity to adequately investigate and respond to cases of sexual abuse at residential facilities.

Adopted in 2013, *The Children's Residential Facilities and Placing Licensure Act*¹⁰⁶ authorizes Public Health to establish and enforce “basic standards” for residential facilities through the licensing process, “to protect the public health and the health, safety, and welfare of children who reside in or who are placed in settings other than the home of their parent or legal guardian.”¹⁰⁷ The *Act* allows for Public Health to inspect facilities, grant licenses, determine compliance with licensing standards, investigate complaints related to violations of the *Act* and rules and regulations, take emergency action to protect the safety and welfare of children, and take disciplinary action, up to revoking a license, for specific violations.

The regulations currently in effect for residential child-caring agencies have no specific requirements related to sexual abuse.¹⁰⁸ However, the *Act* specifically lists, “sexual abuse, sexual assault, or sexual misconduct,” as grounds for denying, refusing to renew, or taking disciplinary action against a license.¹⁰⁹ Public Health staff confirmed in interviews with the OIG that sexual abuse complaints or allegations are “in our purview,” to investigate and take action based on what is found. Currently, **one** Child Care Inspection Specialist is assigned to license, conduct yearly inspections, and investigate complaints relating to all 30 residential child-caring agencies, in addition to child-placing agencies. The work of the Inspection Specialist is overseen by the Program Manager for Children’s Services Licensing.

Nebraska statutes clearly authorize Public Health to investigate and respond to sexual abuse allegations and give it broad options for disciplinary and emergency action to protect children. However, the OIG

¹⁰³Center for Children’s Law and Policy, *Understanding the Impact of the PREA Standards*.

¹⁰⁴ “FY 2016 List of Re-Certification and Re-Assurance Submissions for Audit Year 2,” U.S. Department of Justice, updated Feb. 9, 2017, <https://www.bja.gov/Programs/16PREA-AssurancesCertifications.pdf>.

¹⁰⁵ Center for Children’s Law and Policy, *Understanding the Impact of the PREA Standards*.

¹⁰⁶ Neb. Rev. Stat. §§ 71-1924 to 71-1951.

¹⁰⁷ Neb. Rev. Stat. § 71-1925.

¹⁰⁸ 474 Neb. Admin. Code, ch. 6 § 008.

¹⁰⁹ Neb. Rev. Stat. § 71-1940.

found that Public Health was not able to conduct appropriate investigations and take action, due to a lack of capacity.

At the time the OIG was conducting its investigation, Public Health staff confirmed that they had issued no reports on sexual abuse at residential facilities from 2013 to 2016. Neither of the two substantiated cases of sexual abuse by staff members that the OIG identified at licensed residential facilities – B.L. at Group Home Z and R.Z. at Group Home Q – resulted in any reports or action being taken by Public Health. Additionally, there were not any reports or records available to the OIG on unsubstantiated incidents the OIG identified either through its investigation or critical incident reporting.

Public Health also confirmed that they had not taken any disciplinary actions or formally required corrective action when sexual abuse occurred. In some cases, the investigations were still open even though the incident occurred more than a year prior. In other cases, reports were never issued, although investigations were closed. There were also cases where Public Health may have never opened an investigation. Public Health staff told the OIG that if an incident involves sexual abuse between youth, then they will only open an investigation if there is an indication that facilities or staff were negligent.

For residential facilities, sexual abuse of youth in their care had no consequences. The staff who had sexually abused youth were criminally charged, but the shortcomings at facilities that created the conditions where sexual abuse occurred were not identified or remedied. This, coupled with CFS not completing Out of Home Assessments in a timely and well-coordinated way and lacking the authority to follow-through with recommendations made for residential facility improvement (discussed earlier in this report), meant that DHHS oversight of residential facilities was lacking.

In the case of Group Home Z, there were multiple incidents involving sexual abuse, “conduct or practices detrimental to the health, safety, welfare of any individual residing in [...] the residential child-caring agency,” and repeated failure by staff to “file a report of suspected abuse or neglect.”¹¹⁰ However, the OIG found no record of action taken by Public Health on some of the most concerning cases from 2013 to 2016, despite clear violations of the *Act* or rules and regulations (see Group Home Z Incidents).

When Public Health provided documents to the OIG, they had not yet finished their investigation and report on B.L.’s sexual abuse, which was reported to DHHS nearly two years prior. They indicated that many of the incidents following B.L.’s abuse had been rolled into that investigation, but that it was ongoing. If Public Health had acted sooner to complete investigations and require corrective action, it is possible the incidents at Group Home Z may have been prevented.¹¹¹

Public Health staff acknowledged to the OIG that there were shortcomings in how they responded to sexual abuse allegations, “I guess I just acknowledge that [...] these processes didn’t go like they should. I just feel the need to say that. I’m hoping that this just kicks us in gear to develop the things that we need to do to [...] ensure that these kids are kept in environments that are safe.”

According to Public Health staff, the failure of residential facility licensing to take action was caused by, “a bit of a perfect storm.” Both the past Program Manager for Children’s Services and the Inspection Specialist assigned to residential facilities left DHHS in 2014. When these staff left, Public Health had no written internal policies or procedures governing complaints and investigations. While policies are currently being developed by new management, when new staff started they had nothing to use as a basis

¹¹⁰ Neb. Rev. Stat. § 71-1940.

¹¹¹ Note: Subsequently, in the Spring of 2017, Group Home Z decided to close its residential program before any report or disciplinary action was issued by Public Health.

for investigative and disciplinary decisions and timeframes. Furthermore, before September 2016, there was no system of tracking complaints and investigations at residential facilities. As new staff took over, there was no historical information on incidents that had occurred or action taken by Public Health readily available.

Group Home Z Incidents

Month 1 – Multiple incidents of youth being inadequately supervised at Group Home Z are reported. Youth were fighting with each other, running away from the group home, and climbing on the roof of the building.

Month 4 – N.T. (resident) is reportedly sexually assaulted with a golf club by another resident. Although N.T. detailed the abuse during a CAC interview, the incident is never substantiated. The OHA was finalized two years later. Reports are also made that Group Z staff did not get N.T. appropriate medical care and that staff are incorrectly distributing psychotropic medications.

Month 10 – An inappropriate relationship between a staff member, and a resident, is reported. The staff member is fired, but no action is taken by Public Health.

Month 17 – A sexual relationship between B.L., a resident, and M.O., a staff member, is reported. Although Group Home Z staff knew about these reports four months earlier, they did not report allegations to the authorities. After giving birth to B.L.'s child, M.O. was eventually charged and sentenced to 10 to 16 years in prison. L.S., another youth, discloses sexual abuse by M.O. during a CAC interview. The incident was never substantiated.

Month 23 - An inappropriate relationship between a staff member, T.A., and a resident, D.G., is reported. D.G. does not disclose anything inappropriate when interviewed by law enforcement and the investigation is closed.

Month 24 – Public Health conducts an investigation and substantiates that Group Home Z is violating food safety regulations. Group Home Z must adopt a policy on donated food.

Month 36 - Multiple youth at Group Home Z overdose on medication. Reports allege that there were delays in staff seeking medical treatment.

Around Month 39 – Group Home Z voluntarily closes its residential facility with no report issued by Public Health.

Staff also indicated that Public Health had a history, especially under the previous Program Manager, of accepting action by or discussions with facilities in lieu of conducting full investigations of incidents, issuing formal reports on violations and taking disciplinary action. The staff person recalled in one case the Program Manager was satisfied with a staff person who had acted inappropriately being fired and said, "They've done what they need to do - ok." The current Inspection Specialist told the OIG she will often request documents from facilities and issue informal suggestions, rather than issuing a formal report. Incidents and issues have tended to be investigated superficially and individually, rather than analyzed for deeper concerns.

A lack of thorough investigations and reports on facilities when troubling incidents occur makes it difficult to identify when concerns are systemic or take action when facilities cannot or refuse to make improvements. One Probation administrator interviewed on their perception of sexual abuse at facilities told the OIG, “It’s difficult for me to know is this culture, is this pervasive, or is this just a one –off. [...] When you go out to facilities...it’s hard to truly judge unless you’re in it. It’s really hard. Because they’ll give you a tour, and they’ll show you their policy and protocol and training schedules and they’ll let you talk to a kid or two. [...] But you don’t know what is really going on at second shift, at 8pm, unless you show up [...] unless you live it. [...] We don’t always get a good idea of what is really happening.” While Probation has devoted two administrative staff to monitoring concerns and coordinating with facilities they use, they shared they rely on Public Health to identify whether incidents are isolated or indicative of a larger problem where action must be taken.

Finally, Public Health staff did acknowledge that there were some challenges with having one person assigned to license the entire state. Investigations cannot always be started quickly due to the distance between facilities. Despite these challenges, Public Health did not feel that their staffing prevented them from taking appropriate action when facilities violate regulations. However, other agencies that work with them and rely on them to ensure facilities are safe for youth, did.

One CFS staff person tasked with overseeing DHHS contracts said, “My impression is that they are very short-staffed. [...] I think it would be difficult for them to maintain a good handle on that type of issue [sexual abuse at residential facilities]. I think it’s impossible for them. I think they have one person that’s assigned to license the entire state, those type of facilities. So, I think they’re sorely understaffed.”

An administrator with Probation charged with helping to oversee placement at residential facilities told the OIG, “From my perspective, they have a lot of facilities to address and very minimal staff to do that.”

Ultimately, Public Health did not take appropriate action to investigate sexual abuse and protect youth in residential facilities. This can be attributed to a lack of capacity in staffing and a lack of internal policies and protocols on how investigations are conducted and discipline imposed.

A DHHS-administered residential facility responded appropriately to sexual abuse of a youth by a staff member.

The OIG reviewed whether a DHHS-administered residential facility was taking adequate steps to prevent and respond to sexual abuse as part of its investigation. Using the sexual abuse of C.O. by his therapist as a case study, the OIG examined the residential facility’s implementation of PREA, whether it was followed and whether it was effective in addressing the issue of sexual abuse.

Broadly, PREA Juvenile Facility Standards address standards for creating a zero-tolerance culture towards sexual abuse and harassment, prevention planning, training, screening youth, responding to sexual abuse and harassment and employee misconduct, appropriate reporting of sexual abuse internally and externally, conducting investigations and incident reviews, and collecting and reviewing data.¹¹² Since the Department of Justice released the final standards for juvenile facilities in 2012, Nebraska’s juvenile facilities have been in the process of implementing PREA. This residential facility passed an independent audit certifying that it was meeting PREA standards. Despite meeting standards, staff told the OIG that there are still obstacles to complying with PREA staffing ratios, which must be in effect by October 2017.

¹¹² Juvenile Facility Standards, 28 C.F.R. § 115.

Implementing PREA standards is not a guarantee that sexual abuse and harassment will not occur. In 2016, video footage of a female therapist having sexual contact with a youth, C.O., on six different occasions within one month, was discovered.

The sexual abuse was discovered by happenstance. Video of the therapist's office was being reviewed because there were concerns that she had been giving youth access to her cell phone. Because older video footage was not stored by the residential facility, and C.O. never agreed to be interviewed about the sexual abuse, it is unclear when the sexual abuse first began. A DHHS investigation discovered that the therapist had other inappropriate relationships with boys living at the residential facility, although there was no evidence that they had reached the point of sexual abuse.

In reviewing the incident, the OIG identified a number of factors that may have created the conditions for the sexual abuse of C.O. to occur.

Prior to his sexual abuse being discovered, C.O.'s assaultive and self-injurious behaviors had been escalating. C.O. was placed in a secure care unit and spent long periods of time in isolation. His behavior was a constant challenge for staff. Staff interviewed for the report indicated that because of these challenges and other concerns at the facility, some concerns about the therapist's relationship with C.O. were overlooked. The therapist was holding individual therapy sessions with C.O. that lasted for as long as three hours in her office or C.O.'s room. When one staff member went to administration with concerns about the therapist spending too much time with C.O., the report was not followed up on. One staff person described the situation: "He [C.O.] was an absolute train wreck. And we were running a fine balance there between her spending too much time with him because of his needs, and yet, being responsive to his needs at the same time." An administrator at the residential facility indicated that because of C.O.'s behaviors, they were trying to "prioritize" time with mental health.

In retrospect, staff told the OIG that oversight of the mental health care and therapy provided to C.O. had been lacking and supervision of the therapist, who was only provisionally licensed at the time, insufficient.

While PREA implementation at the residential facility did not prevent the sexual abuse from occurring, it did provide the framework for staff to respond appropriately when the sexual abuse was discovered. The Program Manager who discovered the sexual abuse on video, immediately notified the Facility Administrator, and reported the abuse to law enforcement and the Hotline, so that appropriate outside investigations could take place. The therapist was immediately suspended, protecting other youth at the residential facility, while the investigation occurred. Furthermore, staff attempted to provide mental health services and follow up to C.O., even though he had been moved when the abuse was discovered. All of these steps are covered in PREA standards and policies the residential facility has adopted.

Staff interviewed told the OIG that there was some frustration that they had to wait for other investigations to conclude before being able to review the incident themselves, as required by PREA. However, once the review was undertaken, the residential facility took action to better prevent and respond to sexual abuse and harassment. Thirty-five new video cameras were installed in current "dead zones," and footage will be saved for three months instead of just one. A program of random video review has also been developed and instituted. Therapists' offices have all been consolidated on one hallway and will all have cameras, all therapists are now trained as PREA investigators, and changes to how therapists are supervised have been made. Staff also shared that changes have been made to communication during shift change and more attempts are being made to address any concerns or issues proactively.

PREA implementation provided the structure for appropriate reporting and identifying and instituting changes in the aftermath of C.O.'s abuse, and leadership at the residential facility was key to their proper reaction to the sexual abuse incident. The responsiveness of this DHHS-administered residential facility contrasts greatly with the approach taken by Group Home Z to the discovery of sexual abuse.

Standards on sexual abuse for residential child-caring agencies are inadequate.

The OIG reviewed standards of care for residential child-caring agencies to determine what requirements related to preventing and responding to sexual abuse exist, whether they are being followed, and whether they are adequate.

Standards of care at residential child-caring agencies are currently governed by three separate entities. Public Health establishes rules and regulations which facilities must comply with in order to be licensed and operate. CFS and Probation, who place children at these facilities, then have additional and separate contract requirements. All three agencies conduct their own reviews and inspections to determine compliance with the standards they set.

Residential facility staff told the OIG that the three different sets of standards and three different entities reviewing compliance is confusing and burdensome. Sometimes the different agencies come out to review the same documents or incidents, but on different days. Additionally, after reviews, or when facilities ask questions, they can get conflicting advice or guidance where standards do not match. One staff member told the OIG, "You can have licensure telling you one thing and your contract people telling you another thing."

When it comes to standards for preventing, reporting, or responding to sexual abuse incidents at facilities, however, all three sets of standards fail to adequately address the issue. All three require background checks for staff, and Public Health rules and regulations also have staffing ratios and a broad requirement that staff have, "sufficient ability and education to perform their assigned duties."¹¹³ Public Health can also take action against facilities for sexual abuse incidents under the *Act*. However, beyond these basic requirements, *no* standards related to sexual abuse exist.

Of the residential facilities licensed by Public Health and used by Probation, according to Probation administrators only one is working to comply with PREA's Juvenile Facility Standards. This is despite the fact that many of these residential facilities would meet PREA's definition of a juvenile facility, "a facility primarily used for the confinement of juveniles pursuant to the juvenile justice system."¹¹⁴ The PREA Juvenile Facility Standards are increasingly considered standard requirements for facilities housing juvenile justice youth to ensure safety from sexual abuse and victimization.¹¹⁵

The OIG conducted a thorough review of Group Home Z's policies and ability to effectively prevent, identify, report, and respond to sexual abuse. The OIG found that Group Home Z's adopted internal policies and practices related to sexual abuse were inadequate.

Before the female staff member's sexual abuse of B.L. was discovered, Group Home Z did not have comprehensive training for staff on boundaries and sexual abuse. The Chief Operating Officer also shared with the OIG that Group Home Z's policies on reporting incidents of sexual abuse did not meet

¹¹³ 474 Neb. Admin. Cod, ch. 6 § 008.02A

¹¹⁴ Juvenile Facility Standards, 28 C.F.R. § 115.

¹¹⁵ Center for Children's Law and Policy, *Understanding the Impact of the PREA Standards*.

requirements for mandatory reporting in state law. Instead of reporting sexual abuse allegations to authorities, Group Home Z was conducting internal investigations.

While some corrections had been made at Group Home Z, other areas were still lacking when the OIG conducted its review in the spring of 2017. The group home, which has since made the decision to close, had not addressed key areas for preventing and responding to sexual abuse, including: adopting detailed policies establishing “zero tolerance” for sexual abuse and harassment; providing information and training for youth; establishing clear mechanisms for youth reporting sexual abuse; and, instituting staff supervision requirements.

Despite sexual abuse incidents and allegations at residential facilities, none of the standards require that facilities have policies or take appropriate steps to prevent, report, and respond to sexual abuse. While some facilities may have taken initiative to adopt policies and training on this topic, or even become PREA compliant, others have not. The lack of standards related to sexual abuse at certain facilities exposes youth to the risk of sexual abuse and victimization.

Recommendations to DHHS

16. Ensure adequate staffing for residential-child caring agency licensing operations.

The OIG recommends that DHHS carefully assess what staffing levels are necessary so that investigations and inspections of residential-child caring agencies across the state can be completed in a timely manner and appropriate action can be taken when facilities are not keeping youth safe.

Inadequate staff capacity at Public Health has led no investigations being completed from 2013 through 2016 related to sexual abuse at residential facilities. This exposed youth to dangerous conditions and meant that facilities were not held accountable when youth were sexually abused. These facilities care for youth with complicated needs and significant risk factors 24-hours a day. There must be staffing adequate to investigate issues quickly all across the state and coordinate with the other entities involved with these facilities, Probation and CFS.

DHHS Response

DHHS rejects this recommendation.

DHHS has met the requirements to inspect, license, and investigate the 29 licensed child caring agencies in Nebraska with existing staff.

Disciplinary action may be taken when allegations are substantiated. In the instance of [Group Home Z], the matter was investigated in coordination with Children & Family Services and law enforcement; however, the facility decided to close prior to the investigative report being finalized and prior to any disciplinary action being taken. The additional staff training that is planned and the development of policies to address timeliness of investigations and preparation of final reports will result in improvement in this area.

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.

The OIG recommends that DHHS adopt internal policies to make more consistent and timely decisions on when investigations are opened, how they are conducted, and what action should be taken at their conclusion. DHHS should also ensure policies address record-keeping and tracking all complaint reports,

even those that were not investigated. Effectively tracking all cases and complaints can help to identify systemic issues at facilities and guide staff on where investigations and actions are most needed.

There are existing regulations that provide a broad framework for processing complaints alleging child abuse and neglect.¹¹⁶ When the OIG conducted its investigation, Public Health did not have internal policies governing investigations, although staff did share that they were developing drafts. Public Health also indicated that it had started a rudimentary tracking spreadsheet less than a year prior. Adopting clear policy on how decisions are made will help ensure the process is fair for facilities and sufficient to ensure child safety and well-being.

DHHS Response

DHHS recommends modification of this recommendation to reflect the following: “Clarify current, and as necessary, adopt new internal policy and timelines on tracking, opening, investigating, and taking action on possible violations of statutes, rules and regulations at residential child-caring agencies.”

18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.

The OIG recommends that DHHS require compliance with Juvenile Facility Standards for residential-child caring agencies, to help protect youth at these facilities from sexual abuse.

PREA juvenile facility standards were carefully developed by the Department of Justice to create a basic standard to ensure youth placed in facilities were protected from sexual abuse and harassment.

The OIG believes that requiring facilities to comply with the PREA juvenile facility standards will help establish a culture of zero-tolerance for sexual abuse, help safeguard youth from sexual abuse, and promote swift corrective action whenever sexual-type incidents do occur.

DHHS Response

DHHS requests modification of this recommendation to reflect the following: “Review the Department of Justice, Prison Rape Elimination Act (PREA) standards to determine which standards are relevant to child-caring agencies.”

PREA standards are intended for juvenile facilities that are primarily used for the confinement of juveniles pursuant to the juvenile justice system or criminal justice system. While child-caring agencies are not subject to PREA standards, DHHS will review these standards to determine if there are PREA standards that would be appropriate for child-caring agencies and develop an associated action plan.

¹¹⁶ 474 NAC 6-005.22.

Child Welfare System Action Item

7. Move licensing of residential child-caring and child-placing agencies from the Division of Public Health to the Division of Children and Family Services.

Currently, statute specifies that licensing residential child-caring and child-placing agencies is a function of the Division of Public Health. However, it is one of the only programs that deals with child welfare and juvenile justice-involved youth in the entire division. Public Health has less child welfare expertise and knowledge among management and staff than CFS. Furthermore, licensing and CFS tend to duplicate each other's work when investigating complaints.

The OIG recommends moving licensing of residential facilities and child-placing agencies to CFS to ensure that this important function gets the attention it deserves and inefficiencies and duplication are eliminated.

DHHS Response

DHHS rejects this recommendation.

Moving this function to the Division of Children and Family Services does not remedy the issues identified. Other steps as far as ongoing training, partnership and collaboration etc., will help address the issue.

APPENDIX A. RECOMMENDATIONS AND ACTION ITEMS

Recommendations to the Department of Health and Human Services

1. 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.
2. 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.
3. 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.
4. Enhance training on sexual abuse, especially the dynamics of youth abusing other youth, for Hotline staff.
5. Ensure all allegations meeting the DHHS definition of child sexual abuse are investigated by DHHS or law enforcement.
6. Create a process to fulfill DHHS's statutory obligation to assess for risk of harm and provide necessary and appropriate services for reports of child sexual abuse cases referred for law enforcement investigation alone.
7. Provide additional guidelines on meeting the preponderance of the evidence burden of proof for agency substantiation in child sexual abuse cases.
8. Adhere to policy on out of home assessments and enhance quality assurance.
9. Meet the statutorily required caseload standard for initial assessment and ongoing case management.
10. Review, modify, and enforce process for gathering information and making findings in law enforcement only cases.
11. Adopt specific protocols on providing children developmentally-appropriate education to prevent sexual abuse and exploitation.
12. Review and revise training on child sexual abuse for DHHS staff.
13. Improve and formalize quality assurance procedures for all foster, adoptive, and guardianship placements.
14. Strengthen foster care licensing to remove inappropriate and unsuitable homes.
15. Include a component on child sexual abuse prevention in foster and adoptive parent training.
16. Ensure adequate staffing for residential-child caring agency licensing operations.
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.
18. Require compliance with Department of Justice standards on sexual abuse prevention and response in regulations governing residential child-caring agencies.

Action Items for the Child Welfare System

1. Foster a culture of zero-tolerance for child sexual abuse in the child welfare system.
2. Examine strategies to improve child abuse reporting.
3. Ensure law enforcement follows their statutory duty to share child abuse reports with DHHS.
4. Clarify the *Child Protection and Family Safety Act*.
5. Improve multi-disciplinary coordination in child sexual abuse investigations and ensure all allegations are investigated.
6. Improve foster home recruiting to ensure homes are prepared to meet the needs of children.
7. Move licensing of residential child-caring and child-placing agencies from the Division of Public Health to the Division of Children and Family Services.

APPENDIX B. OIG INVESTIGATIVE PROCESS

The Office of the Inspector General of Nebraska Child Welfare (OIG) provides independent investigation and performance review of Nebraska's child welfare and juvenile justice system. *The Office of Inspector General of Nebraska Child Welfare Act*¹¹⁷ sets out duties for the OIG, with the primary aim of improving agency operations through identification of errors, systemic issues, and needed changes to policy and practice.¹¹⁸

The OIG focused this investigation on whether the Nebraska Department of Health and Human Services (DHHS) was taking adequate steps to prevent and respond to the sexual abuse of children in the state's care, including state wards, those placed in licensed residential facilities or adopted from the child welfare system. The investigation included a review of the role and actions of the child welfare operations of the Division of Children and Family Services (CFS) and the Division of Public Health's Children's Services Licensure Unit (Public Health).

Over the course of the investigation, the OIG gathered information from the following sources:

1. Critical incident reports related to sexual abuse sent to the OIG between July 2013 and October 2016 (provided by Administrative Office of Probation and DHHS);
2. Court substantiated, agency substantiated, and court pending sexual abuse reports to the Hotline, between July 2013 and October 2016 (provided by DHHS);
3. Police records on specific sexual abuse cases identified by the OIG (provided by local police departments);
4. Records, including home studies, on foster and adoptive homes where cases of sexual abuse occurred (provided by DHHS);
5. Records from DHHS private contractors (provided by private contractors);
6. Licensing records on Group Home Z from 2013 to 2016 (provided by DHHS)
7. Other Public Health information on sexual abuse complaints they reviewed at licensed residential facilities from 2013 to 2016 (provided by DHHS);
8. Group Home Z records related to sexual abuse of B.L. and possible other victims (provided by Group Home Z);
9. Residential facility records for a DHHS-administered facility (provided by DHHS);
10. N-FOCUS and JUSTICE¹¹⁹ records on identified youth victims of sexual abuse, perpetrators of sexual abuse, and licensed homes and facilities where sexual abuse occurred (accessed by OIG);
11. Site visits to the Child Abuse and Neglect Hotline (Hotline) in Omaha, Group Home Z, and a DHHS-administered facility;
12. 54 interviews with administrators, supervisors and frontline staff at DHHS from every Service Area, NFC, and other agencies with knowledge of specific sexual abuse cases or

¹¹⁷ *Neb. Rev. Stat.* § 43-4318 (1) (a).

¹¹⁸ *Neb. Rev. Stat.* § 43-4302.

¹¹⁹ N-FOCUS (Nebraska Family Online Client User System) is the electronic case management system used by the Nebraska Department of Health and Human Services. JUSTICE is the trial court case management system used by Nebraska's judicial branch.

responsibility for implementing and overseeing policy and practice related to the OIG's investigation;

13. Information from child advocacy centers from across the state;
14. New Children and Family Services Specialist training materials (provided by the University of Nebraska's Center for Children, Families, and the Law);
15. Foster Parent training curricula, including materials utilized by private child-placing agencies (provided by DHHS);
16. A literature review on child sexual abuse conducted by OIG staff; and
17. Data on prevalence of sexual abuse in Nebraska and the United States.

The investigation was focused on identifying systemic shortcomings in how cases of child sexual abuse in state care are handled and providing recommendations to alleviate them.

As part of the process, the OIG identified current or former system-involved youth who were victims of child sexual abuse. To be included in this group, cases had to be reported to the Hotline between July 2013 and October 2016 and involve state wards, youth placed in licensed facilities, or youth adopted or placed in a guardianship from the child welfare system. The allegations in the reports also needed to be subject to a pending court case or substantiated by a court or DHHS.

For the purpose of this investigation, the OIG used the definition of child sexual abuse used by DHHS at the Hotline, which includes, "any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, child, vulnerable adult, or other person."¹²⁰

Along with identified child sexual abuse victims, the OIG reviewed critical incident reports the office had received to begin determining key issues for further investigation.

The OIG's investigation cannot be considered a comprehensive examination of all issues related to sexual abuse of youth in state care. Some relevant topics were not addressed relating to child sexual abuse. For example, since there were no substantiated DHHS cases involving sex trafficking of youth identified within the scope of the investigation, this issue was not examined by the OIG.

Throughout the investigation, staff of DHHS and its contractors were responsive to OIG requests for documents, information, and interviews. Their cooperation and the information they provided to the office were extremely valuable in the completion of the report and recommendations.

¹²⁰ NE DHHS. "Intake Screening: Policy and Procedures Manual." March 2012. p. 19.

APPENDIX C. REFERENCES

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