OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

REPORT OF INVESTIGATION

Subject: Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney

Report Shared with Agency: June 17, 2026

Report Finalized: July 27, 2026

Jennifer A. Carter, Inspector General
Logan Chitty, Assistant Inspector General
Meghan Svik, Assistant Inspector General
Kelli Schadwinkel, Deputy Ombudsman for Institutions

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

TABLE OF CONTENTS

Abbreviations and Defined Terms

ACA	American Correctional Association
ART	Aggression Replacement Training
CAC	Child Advocacy Center
Central Registry	Nebraska Child Abuse and Neglect Central Registry
CFS	Division of Children and Family Services (within DHHS)
CIR	Critical Incident Report
CM	Case Manager
Compliance	Office of Juvenile Services Compliance Department
DHHS	Nebraska Department of Health and Human Services
Dickson	Dickson Behavioral Stabilization Unit
FIT	Facility Investigation Team
Hotline	Nebraska Child Abuse and Neglect Hotline
Juvenile Probation	Administrative Office of the Courts and Probation, Juvenile Probation Services Division
MRT	Moral Reconation Therapy
NSP	Nebraska State Patrol
OHA	Out of Home Assessment
OIG-CW	Office of Inspector General of Nebraska Child Welfare
OJS	Office of Juvenile Services
PREA	Prison Rape Elimination Act
UM	Unit Manager
YPS	Youth Program Specialist
YRTC	Youth Rehabilitation and Treatment Center
YSS	Youth Security Supervisor
YSSM	Youth Security Supervisor Manager

EXECUTIVE SUMMARY

The Office of Inspector General of Nebraska Child Welfare (OIG-CW) was notified of 44 different sexual-abuse-related allegations made by 37 separate youth against 19 different staff members at the Youth Rehabilitation and Treatment Center at Kearney (YRTC-Kearney) occurring between March 2025 and March 2026. The allegations ranged from more severe allegations of staff abuse of youth, including sexual abuse, assault, touching, or harassment, to less severe allegations of staff violations of appropriate and professional boundaries with youth. Within those 44 allegations were over 200 specific claims of a variety of improper conduct by staff. These allegations implicated violations of the Prison Rape Elimination Act (PREA), Nebraska state law, and Nebraska Department of Health and Human Services (DHHS) policies regarding appropriate and professional boundaries between staff and youth.

As of the date of this report, the status of the 44 allegations is:

- Four staff members have been criminally charged with sexual abuse of protected individuals, one of whom was also charged with additional felonies.
- Three other allegations have been substantiated by the Office of Juvenile Services' (OJS) Compliance Department (Compliance) at YRTC-Kearney.
- Nine allegations were unfounded or unsubstantiated by Compliance and the Nebraska State Patrol's (NSP) investigations into those allegations were also closed.
- The remainder of the allegations, which include the majority, have been unsubstantiated or unfounded by Compliance.

This investigation includes allegations of staff sexual abuse of youth from March 2025 through March 2026. However, the OIG-CW did not receive notice of any allegations until August 2025. The Office of Public Counsel, or Ombudsman's Office, which investigates complaints of any juvenile committed to the YRTCs, received some information about an incident in March 2025, but was not made aware that concerns included sexual abuse by a staff member. The Ombudsman's Office also received a complaint related to the August 2025 incident. It was not until late September and early October 2025 that the OIG-CW and Ombudsman's Office became aware of several other allegations. On October 17, 2025, the OIG-CW notified DHHS that it was opening an investigation into the sexual abuse allegations at YRTC-Kearney. Under the law, the OIG-CW and the Ombudsman's Office may coordinate on investigations in circumstances of overlapping jurisdiction and, as a result, the Deputy Ombudsman for Institutions participated in this investigation.

Summary of Critical Incidents

Four of the most serious allegations involving three separate youth (one youth alleged abuse by two different staff members) are summarized in detail in this report.[1]

The first incident and allegation occurred in March 2025 when three youth, including Youth A, were found with a cell phone at the facility. When YRTC-Kearney staff accessed the phone, they observed social media posts and photos of all three youth, as well as text messages that included plans to escape. It was quickly discovered, however, that the phone also contained sexually explicit content from two adult females—one who did not work at YRTC-Kearney, and one who was a current YRTC-Kearney Youth Program Specialist (YPS) staff member. In addition to photos, the phone contained four sexually explicit videos of that staff member—Staff 1—including ones of her masturbating dressed only in underwear or entirely naked. The phone also contained text messages between Youth A and Staff 1 that included terms of affection, discussion of the two living together in the future, and Staff 1 referring to Youth A as her "future hubby." Several months later, in September 2025, Youth A also disclosed that he and Staff 1 had engaged in sexual activities while at the facility. Compliance notified NSP of both the March incident and the September disclosure. During the internal compliance investigation, Staff 1 resigned. The incident and allegations related to the cell phone were substantiated by Compliance as a staff-to-youth boundary violation, rather than a PREA violation.

The second incident occurred in April 2025. Initially, this allegation came to the attention of YRTC leadership when another YPS staff member, Staff 2, reported that Youth B had touched her thigh. Youth B received a major rule violation and was placed in confinement. The next day, Youth B shared with YRTC staff a note between Staff 2 and himself, which included sexually graphic statements exchanged between the two. Video was then reviewed, which showed Staff 2 allowing Youth B to touch her buttocks and holding Youth B's hands on her hips while his pelvis touched her buttocks as they descended a stairwell in the living unit. Youth B later alleged that the two were in a relationship and that additional sexual contact had occurred between them. Compliance notified NSP. During the Compliance investigation, Staff 2 resigned. Compliance substantiated the incident as a staff-to-youth boundary violation, rather than a PREA violation.

A third allegation of staff sexual abuse was disclosed in October 2025 and also involved Youth B. The day after he was moved from YRTC-Kearney to another placement, Youth B alleged that

[1] To ensure confidentiality, all names and identifying information of the youth and staff members involved in this investigation have been changed.

he also had a sexual relationship with another YPS staff member, Staff 3, for the entire time he was at YRTC-Kearney. More specifically, he alleged that on his last night at YRTC-Kearney, Staff 3 had opened the door to his room to provide him with medications, and put her hand under his pants and provided manual stimulation of his penis. After the Nebraska Child Abuse and Neglect Hotline (Hotline) report related to this allegation was received by the YRTC, Staff 3 was placed on paid leave pending an investigation by Compliance and NSP. Compliance reviewed the evidence, but found that the allegation was unsubstantiated. Staff 3 later resigned.

The fourth incident was discovered in August 2025. In this case, a YRTC-Kearney staff member was told that a youth, Youth C, and a YPS staff member, Staff 4, were passing notes to each other. Video was immediately reviewed, and the note passing was confirmed. Staff 4 turned over the note and claimed Youth C was touching her thigh while they were passing the notes. She was suspended pending an investigation. Youth C was sent to confinement based on the allegation that he was touching the staff member's thigh. Later that day, Youth C was overheard by staff talking about kissing Staff 4. Additional video was reviewed and confirmed that Staff 4 and Youth C were kissing or groping each other on the landing of the stairwell of the living unit on three separate occasions over the course of two days. Staff 4 was terminated.

Each of the four staff members described above has been criminally charged in connection with conduct related to this investigation.

The remaining 40 allegations are discussed and analyzed through a composite summary later in this report. As noted, there were over 200 specific claims of a variety of behaviors by YRTC-Kearney staff. The result was a complicated web of allegations and facts. Allegations from one youth might involve multiple staff members. Youth also made allegations regarding abuse of other youth—not always just themselves—that they claimed to have witnessed or about which other youth told them. Often, the investigation into one allegation led to new revelations about different alleged incidents involving different youth or staff. These factors resulted in a remarkably high number of allegations within a short period, which were quite difficult to keep separate, and made it even more challenging to determine what had actually occurred.

The most common type of allegation, which arose approximately 50 times, involved allegations that staff made inappropriate statements to youth, including flirtatious comments and sexually suggestive or explicit conversation, shared intimate details of their personal lives, and expressed a desire to have sexual contact or relationships with the youth. The next most common allegation was that staff inappropriately touched youth, most commonly by touching a youth's legs and thighs, but it was also alleged that staff would press their buttocks or breasts

against youth in a way that might appear to be inadvertent, but the youth believed to have been deliberate. Many allegations also involved staff giving the youth their personal phone numbers. In at least 15 instances, youth were in possession of the personal phone numbers of staff. No conclusion was ever reached on how the youth obtained the phone numbers. Other specifics of the myriad of allegations are detailed within this report.

To provide background and context for these allegations and the OIG-CW's findings and recommendations, this report also includes: a summary of the legal framework for sexual abuse allegations of youth in a facility; background on the YRTCs' purpose, structure, staff roles, and internal compliance process; and an explanation of abuse and neglect investigations conducted by DHHS.

Findings

The OIG-CW made the following findings, summarized here and explained in more detail in this report,[2] as a result of this investigation:

1. **The culture at YRTC-Kearney normalized inappropriate staff behavior, which the facility failed to sufficiently address.**

Four former staff members have been criminally charged for sexual abuse of youth at YRTC-Kearney. Three other allegations were internally substantiated by Compliance to have occurred. Moreover, even though the majority of the sexual abuse allegations reviewed in this investigation have been determined to be unsubstantiated or unfounded, the number, breadth, and consistency of the allegations, along with the similarity to patterns of behavior seen in prior years, demonstrates a pervasive culture at YRTC-Kearney that normalized and insufficiently addressed behavior extending from boundary violations to inappropriate relationships and sexual abuse.

To be very clear, the OIG-CW does not find that all staff or administration at YRTC-Kearney engaged in or condoned this inappropriate staff conduct. On the contrary, it is clear that many staff members are committed to the safety, care, and rehabilitation of the youth. However, the patterns of behavior seen both in this investigation and in prior years, along with an inadequate response from the facility with regard to supervision, disciplinary action, and a failure to recognize and address broader systemic issues, have resulted in a problematic culture at YRTC-Kearney.

[2] The full explanation of the findings can be found at pgs. 54–75.

2. **Internal compliance investigations are necessary, but they are not sufficient to determine if abuse or neglect has occurred at the YRTCs.**

It is critical to recognize that much of the behavior alleged by the youth at YRTC-Kearney in the past year would and should be considered abuse. These youth are not only minors, but they are protected individuals under the law while at the YRTC and are committed to the care and custody of OJS and DHHS for rehabilitation and treatment. Many of these youth come to the YRTC with significant behavioral and mental health challenges, and often with trauma. It is the staff's role and duty, as is outlined in DHHS' policies, to maintain professional boundaries with the youth.

Compliance investigations and reviews are necessary to provide independent oversight of concerns reported within the facility, including sexual abuse, harassment, and assault allegations. However, the OIG-CW found that Compliance investigations and reviews are limited in two key ways. First, the focus of Compliance investigations is ensuring adherence to law and policy and the administration of the facility, and not on youth as potential victims of abuse. In its response to this report, DHHS notes that Compliance investigations are not intended to determine whether abuse and neglect occurred. By contrast, an Out of Home Assessment (OHA) is conducted by DHHS' Division of Children and Family Services (CFS) to determine if abuse and neglect has occurred at a facility. An OHA is a more complete and multi-faceted assessment, containing a more in-depth and complete picture of how the youth is doing in the facility. OHAs were previously conducted at the YRTCs until 2019. While there is significant overlap between behaviors that would amount to a policy violation and behaviors that would amount to abuse, there is an important distinction between a Compliance investigation to determine whether there have been violations of policy and an investigation to determine whether abuse has occurred. The former is oriented to the proper administration of the facility, while the latter is oriented towards the well-being of the youth.

Second, fact-finding is limited by Compliance's process and jurisdiction, making it harder to determine if an incident actually occurred. The OHAs are not subject to those same limitations in fact-finding.

3. **Without abuse and neglect investigations at the YRTCs, staff who abuse youth may not be placed on the Nebraska Child Abuse and Neglect Central Registry and can continue to work with youth elsewhere.**

The Nebraska Child Abuse and Neglect Central Registry (Central Registry) is maintained by DHHS and contains a record of all persons who have been found responsible for child abuse or

neglect. A person can be placed on the Central Registry by the courts, through, for example, a criminal conviction, or by DHHS, if DHHS determines, through an abuse and neglect investigation, that the abuse can be "agency substantiated" by a preponderance of the evidence. One of the primary implications of being placed on the Central Registry is on employment and volunteer opportunities. Any person appearing on the Central Registry may be denied employment or the opportunity to volunteer with youth. This process and the Central Registry serve as an essential safeguard to prevent perpetrators of abuse and neglect from having direct access to other youth and continuing their abusive conduct in any other setting.

Critically, Compliance at the YRTCs does not have the authority to place staff on the Central Registry even if an incident is substantiated. Currently, YRTC employees are only placed on the Central Registry for abuse of youth if there is a successful criminal conviction. CFS, however, does have the authority to place staff on the Central Registry when abuse and neglect is substantiated through an OHA. As a result, a critical safeguard for the safety of youth is lost when OHAs are not conducted at the YRTCs. DHHS should not apply a different standard to its own employees than it applies to every other person who allegedly abuses or neglects a child in their care.

4. **There were numerous issues and limitations with Compliance's reviews and investigations into the sexual abuse allegations at YRTC-Kearney.**

Compliance serves a vital oversight function at YRTC-Kearney by ensuring the facility adheres to internal and DHHS policies, state and federal laws, and established best practices. In many of the cases, however, the OIG-CW identified issues that were significant enough to prevent Compliance from determining whether specific sexual abuse allegations had occurred. The primary challenges apparent in Compliance's reviews and investigations fell into three broad categories: those arising from deficiencies in how facts were analyzed and how investigations were conducted; those arising from external resource limitations and a subsequent failure to pursue alternative means of gathering facts; and those arising from focusing too closely on individual incidents rather than identifying systemic and facility-wide issues.

5. **The OIG-CW was not notified of the initial incidents in March and April 2025 as a result of Compliance's determination that those incidents were not PREA violations, which placed them outside the required notifications under the law.**

OJS is required by law to report to the OIG-CW "as soon as reasonably possible" after an instance of an "internally substantiated" PREA violation. The two incidents from March and April 2025 for which the OIG-CW did not receive notice were both determined by Compliance

to be "boundary violations" rather than substantiated sexual abuse violations under PREA. When these behaviors are determined not to be PREA violations, even if substantiated, they fall outside of the reporting requirements under the law.

Recommendations

The OIG-CW makes the following recommendations as a result of this investigation, summarized here and explained in more detail in this report:[3]

1. **DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made.**

The staff behaviors and actions alleged and detailed in this investigation amount to abuse of the youth in DHHS' care and custody. These incidents should be investigated as such. In all other facilities licensed by DHHS, CFS conducts an abuse and neglect investigation through an OHA to determine if abuse occurred at the facility. Compliance investigations are not oriented to the abuse of the youth, and, in addition, fact-finding may be limited in the Compliance process. OHAs are not subject to those same limitations. Furthermore, Compliance does not have the authority to place a staff member's name on the Central Registry, but CFS, through an OHA, does. This ensures that staff who have abused youth cannot work with children elsewhere. DHHS should hold the staff at its own facilities to the same standards to which it holds staff at other juvenile facilities. DHHS successfully conducted OHAs at the YRTCs until 2019. It should conduct them again.

2. **DHHS and YRTC-Kearney should address the culture problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth**.

There are a number of specific conditions at YRTC-Kearney that created opportunities for the alleged staff misconduct to occur and that need to be addressed regardless of how many of the allegations in this investigation are ultimately substantiated. The OIG-CW recognizes that DHHS and YRTC-Kearney leadership have begun making some changes in response to the events described in this report and that some of the improvements are reportedly already underway. Those efforts are acknowledged and encouraged. The following areas, however, warrant deliberate and sustained attention going forward: (1) enhance supervision of YPS staff; (2) increase programming and structured activities for youth; (3) strengthen surveillance and

[3] The full explanation of the recommendations can be found at pgs. 77–87.

monitoring capabilities and practices; and (4) implement consistent processes for holding staff accountable for boundary concerns.

3. **DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report.**

The OIG-CW identified numerous concerns with how Compliance conducted its reviews and investigations into these sexual abuse allegations at YRTC-Kearney. The OIG-CW recognizes that Compliance's work improved in meaningful ways over the course of the period reviewed, and that the volume and highly complicated facts of allegations during this period presented genuine challenges. However, the OIG-CW identified some consistent issues that should be addressed. At a minimum, DHHS should conduct a thorough review of Compliance's investigative methods and standards, including how evidence is gathered, preserved, and evaluated; how the preponderance of the evidence standard is applied in practice; how allegations of verbal abuse are assessed in the absence of audio evidence; and how the distinction between unfounded and unsubstantiated determinations is made and applied consistently. That review should also examine Compliance's practices for identifying and addressing systemic or facility-wide concerns, including whether unsubstantiated allegations are analyzed collectively for recurring issues rather than treated solely as individual matters.

4. **The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth.**

The current statutory requirement that the YRTCs notify the OIG-CW of any “internally substantiated” PREA violations should be expanded to include any allegations of staff sexual abuse of youth, as well as boundary violations, whether or not the allegations are substantiated by Compliance. If such a requirement had been in place prior to this investigation, the OIG-CW would have been notified of some of the more serious allegations of sexual abuse of which it did not receive notice initially. In addition, such a requirement would allow for more consistent monitoring of how allegations of staff abuse are being handled by the facility and what the risk is to the youth at the facility. Ensuring that the OIG-CW is aware of the frequency of the allegations, proven or not, might also provide some indication of other challenges or concerns at the facility.

JURISDICTION

The OIG-CW provides oversight and accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, system monitoring and review, and recommendations for improvement.[4] This includes oversight of the YRTCs. The Ombudsman's Office is tasked with investigating the complaints of any juvenile committed to the custody of a YRTC.[5] The OIG-CW and the Ombudsman's Office may coordinate on investigations in circumstances of overlapping jurisdiction.[6] As a result, the Deputy Ombudsman for Institutions participated in this OIG-CW investigation.

The OIG-CW Act requires the OIG-CW to investigate any "[a]llegations or incidents of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules and regulations of: (i) The department by an employee of . . . the department."[7] The YRTCs in Nebraska are administered by DHHS, specifically the Office of Juvenile Services. OJS is required to notify the OIG-CW of any "internally substantiated violations" of the Prison Rape Elimination Act[8]—meaning an internal investigation at the YRTCs has determined that a staff member did sexually abuse or sexually harass a youth as prohibited under PREA.[9]

On August 5, 2025, the OIG-CW received a Critical Incident Report (CIR) from DHHS notifying the OIG-CW that Youth C "was seen on camera Friday August 1, 2025 . . . kissing [Staff 4]" in the Washington Living Unit at YRTC-Kearney. The Ombudsman's Office also received a complaint related to this incident on August 19, 2025.

At the time the OIG-CW received this CIR in early August, it was the only incident of sexual abuse of which the office was aware. The OIG-CW had not been notified of two earlier incidents—one from March 2025 and one from April 2025—and only learned of these incidents in late September.

On September 22, 2025, Youth A, a youth at YRTC-Kearney, made an allegation that he and YRTC-Kearney staff member Staff 1 had engaged in sexual activities in the upstairs closet of the Lincoln Living Unit. The Inspector General was notified of this allegation by phone and it was

[4] See Neb. Rev. Stat. §§ 50-1801–50-1821.
[5] Neb. Rev. Stat. § 50-2007(9)(a).
[6] Neb. Rev. Stat. § 50-1704(4).
[7] Neb. Rev. Stat. § 50-1806(1)(a)(i). See also Neb. Rev. Stat. § 50-1804(4) (defining "Department" as the Department of Health and Human Services).
[8] 34 U.S.C. § 30301 et seq.
[9] See Neb. Rev. Stat. § 50-1806(3)(a)(viii).

explained that documentation of the allegation would be sent to the OIG-CW as an update to a prior CIR from March 27, 2025. The March 27 CIR related to an incident involving three youth at YRTC-Kearney who were found to be in possession of a cell phone. As discussed in more detail in this report, YRTC staff quickly discovered the cell phone contained sexually explicit videos and photos of a staff member. The OIG-CW received the updated March 27 CIR on September 24.

The Deputy Ombudsman for Institutions had received a call in March 2025 from the OJS Administrator, who oversees all of the YRTCs, to alert her to the fact that a cell phone was found. The Deputy Ombudsman shared this information with the OIG-CW. At that time, however, the Deputy Ombudsman was not made aware of the sexually explicit material found on the cell phone.

On September 26, 2025, the OJS Administrator alerted the Inspector General to another allegation made in juvenile court 10 days prior regarding an inappropriate relationship between yet another youth, Youth B, and yet another staff member, Staff 2. A juvenile court hearing was held on October 1, 2025, in Youth B's case during which, according to the court order, multiple documents from the YRTC were offered as exhibits which verified that a relationship had taken place between Youth B and a staff member in April 2025. The OIG-CW was alerted to this development through the court order and the media.

On October 3, 2025, the OIG-CW sent a document request to DHHS related to all of these initial allegations. Between October 3 and October 16, 2025, the OIG-CW was notified by OJS of allegations involving four additional youth and one additional staff member.

On October 17, 2025, the OIG-CW sent a formal notice to DHHS that the OIG-CW would conduct a full investigation into the allegations of staff sexually abusing youth at YRTC-Kearney.

In total, the OIG-CW has received allegations from 37 youth involving 19 staff, spanning from March 2025 to March 2026. Beginning in late October 2025, the OIG-CW was notified of each additional allegation by phone from the OJS Administrator, which was followed by a CIR for each new allegation.

It is important to note that the OIG-CW's jurisdiction extends to the actions of DHHS with regard to its adherence to statutes, rules, regulations, and policies. The OIG-CW does not determine whether the allegations are true. Rather, the OIG-CW relies on the conclusions reached by law enforcement and DHHS to determine the veracity of the allegations.

SCOPE & PROCESS OF INVESTIGATION

The purpose of this investigation is to provide transparency regarding the allegations of sexual abuse, examine how those allegations were handled and investigated internally at the facility, examine whether and how the alleged actions by staff might have occurred at the facility, and offer recommendations for system improvement.

Specifically, the scope of this OIG-CW investigation includes:

- A review of allegations made by 37 youth at YRTC-Kearney related to sexual abuse of youth by staff;
- A review of the YRTC's process for responding to and investigating youth allegations of alleged staff abuse, including its internal compliance policies and procedures;
- A review of the various staff roles, supervision of staff within living units at YRTC-Kearney, and how boundary violations and inappropriate behavior are addressed;
- A review of the protocols and processes for supervision and reporting of problematic staff behavior; and
- A review of DHHS abuse and neglect investigation protocols.

This report focuses on allegations of staff sexual abuse of youth that occurred between March 2025 and March 2026. The OIG-CW's review of records for this investigation revealed similar allegations of staff behavior that occurred before 2025. While this information is relevant to the OIG-CW's analysis in this report, the OIG-CW has limited its findings and recommendations to the allegations starting in March 2025 that led to the investigation, though prior records are referenced where relevant to the analysis. Focusing on the more recent allegations allows the OIG-CW to analyze YRTC-Kearney's more recent policies, protocols, and the facility culture as it stands now to ensure that any of the OIG-CW's findings and recommendations are timely and relevant.

The OIG-CW has received additional notifications of sexual abuse allegations since March 2026. However, to ensure a timely conclusion to the investigation, the OIG-CW decided to limit the scope of this investigation to allegations received by March 2026 as the OIG-CW's fact gathering on the allegations received to that point was nearly complete. In addition, there was a noticeable decrease in the number of allegations since March. The OIG-CW has reviewed these later allegations, and any issues within them are covered by the findings and recommendations in this report.

All of the information in this report comes from documentation and information that the OIG-CW and Ombudsman's Office gathered and reviewed from the following sources:

1. Internal compliance investigations and reviews conducted by Compliance at YRTC-Kearney, including a review of video when available;
2. DHHS Hotline Intakes related to the youths' allegations;
3. Court documents;
4. Documents related to YRTC youth from the Administrative Office of the Courts and Probation, Juvenile Probation Services Division (Juvenile Probation);
5. Interviews of YRTC-Kearney personnel, Compliance personnel, and DHHS administration;
6. OJS policies, procedures, and training curriculum;
7. Compliance training curriculum;
8. The Prison Rape Elimination Act;
9. Relevant Nebraska statutes;
10. Documentation of prior investigations for PREA or boundary violations involving YRTC staff identified as alleged perpetrators; and
11. A review of forensic interviews of the youth conducted by the Child Advocacy Centers.[10]

The OIG-CW did not review any law enforcement records for this investigation. Most of the youths' allegations were referred to NSP and, under the law, the OIG-CW may request law enforcement records. However, since many of the NSP investigations remained open, and in the interest of maintaining the integrity of those investigations and any related prosecutions, law enforcement records were not reviewed.

In addition to the sources of information listed above, the OIG-CW visited YRTC-Kearney with the Deputy Ombudsman for Institutions in November 2025 and spoke with youth who had <u>not</u> made an allegation. Those youth reported that they felt safe at the facility at that time. The information gathered at that visit was not used in this investigative report.

The facts presented in this report are the facts as reported in the documents received from Compliance, in the interviews with YRTC-Kearney and DHHS personnel, and in court documents. As noted, the OIG-CW does not independently determine or verify the facts related to the allegations in this report. The OIG-CW's findings and recommendations are based on its independent review and analysis of those facts.

[10] While these forensic interviews were reviewed by OIG-CW staff, as allowed by law, that information remains confidential. As such, none of the information gathered from those interviews is included in this report.

INTRODUCTION

Given the complexity of the allegations and the issues in this investigation, it is necessary to provide some background on YRTC-Kearney itself, the applicable laws and policies regarding sexual abuse of youth at state facilities, and the internal compliance process at the YRTCs.

YRTC Organizational Structure and Roles

Under Nebraska law, the YRTCs operate to provide programming and services to rehabilitate and treat juveniles committed under the Nebraska Juvenile Code.[11] A juvenile is committed to a YRTC by a court order placing the youth into the care and custody of OJS, which is within DHHS and which has oversight and control over the YRTCs.[12] A juvenile committed to a YRTC under OJS is thus a state ward "committed to the care and custody of [DHHS] for the purpose of obtaining health care and treatment services."[13] Commitment to a YRTC is intended to be a placement of last resort, as Nebraska law requires that, before a juvenile can be committed, a court must find that all levels of probation supervision and options for community-based services have been exhausted and that placement at a YRTC is a matter of immediate and urgent necessity.[14] Each YRTC is subject to various requirements for the services and treatment that it must provide youth. These services are designed to address the youth's behavioral, mental health, educational, and other individual needs, with the goal of successfully reintegrating the youth into their home and community upon release.[15] Only individuals ages 14 to 18 can be committed to a YRTC.[16] In addition to the YRTC in Kearney,[17] which houses only male youth, there is also currently a YRTC in Hastings, which houses only female youth, and a YRTC in Lincoln, which houses both male and female youth.

The YRTC-Kearney campus includes four living units, where all youth reside, each staffed by several types of employees. Unit Managers (UM) oversee the living unit's operations, the youth, and the Youth Program Specialists (YPS) and Case Managers (CM) within the unit. Each youth is

---

[11] Neb. Rev. Stat. § 83-102(1). See also Neb. Dep't of Health & Hum. Serv., *Youth Rehabilitation and Treatment Center Facilities*, https://dhhs.ne.gov/pages/YRTC-Facilities.aspx (last visited June 6, 2025) (stating that the purpose of YRTC-Kearney, in particular, "is to help youth live better lives through effective services, giving youth the chance to become law-abiding, productive citizens").

[12] See Neb. Rev. Stat. § 43-403(2); Neb. Rev. Stat. § 43-404. See also Neb. Rev. Stat. § 43-286(1)(b), (c).

[13] Neb. Rev. Stat. § 43-408(1). See generally § 83-102.

[14] See § 43-286(1)(b)(iii); *In re Interest of Alan L.*, 294 Neb. 261, 882 N.W.2d 682 (2016); *In re Interest of Nedhal A.*, 289 Neb. 711, 856 N.W.2d 565 (2014).

[15] See, e.g., Neb. Rev. Stat. § 43-407; § 83-102.

[16] See Neb. Rev. Stat. § 43-245(12); Neb. Rev. Stat. § 43-251.01(4).

[17] YRTC-Kearney was founded in 1879, began receiving male and female youth in 1881, became a male-only youth facility in 1892 when a female-only YRTC opened in Geneva, and in 1997, moved from underneath the operation of the Nebraska Department of Correctional Services to DHHS. See Neb. Dep't of Health & Hum. Serv., supra note 11.

assigned a CM in their unit. CMs serve as the main point person for the youth, manage youth programming, and monitor and communicate updates on the youths' progress at the facility to the relevant parties. YPSs are the frontline staff with the most direct, daily contact with the youth. They are primarily responsible for implementing the youths' programming, ensuring the youth complete their required daily tasks, and escorting the youth throughout the campus. Youth Security Supervisors (YSS) and YSS Managers (YSSM) are responsible for the safety and security of the facility and all youth. YSSs are assigned to a living unit but cover the entire campus, checking in with their assigned unit throughout the day.

Applicable Legal and Policy Framework

The staff conduct alleged by the youth in this investigation implicates a broad and overlapping set of federal law, state law, and OJS and facility policies that together establish clear prohibitions on sexual abuse, sexual harassment, and a wide range of behavior that violates professional and appropriate boundaries between staff and youth in a setting such as a YRTC.

PREA, as is referenced above, is a federal law that applies to all federal, state, local, and private confinement facilities, including adult prisons and juvenile facilities like the YRTCs. PREA was enacted to eliminate and prevent the sexual assault, abuse, and harassment of individuals in such facilities. Through federal programs, grant funding, and PREA National Standards[18] established by the U.S. Department of Justice, PREA aims to develop a "zero tolerance" culture for sexual assault at the applicable facilities on the state and local level.[19] The PREA National Standards serve as the federal regulations mandating various policies, trainings, and audits of PREA practices at these facilities to ensure compliance with PREA, and set forth detailed definitions of prohibited staff conduct.[20]

This prohibited conduct under PREA includes sexual abuse, which is defined to include any form or degree of sexual penetration or genital contact—whether by hand, mouth, or other object, and whether direct or through clothing—as well as any other intentional touching of a youth's intimate body parts—including genitalia, anus, groin, breast, inner thigh, or buttocks—where the staff member has the intent to abuse, arouse, or gratify sexual desire.[21] PREA also prohibits

[18] National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA), Juvenile Facility Standards, 28 C.F.R. § 115 (2012).
[19] See Bureau of Justice Assistance, U.S. Department of Justice, Prison Rape Elimination Action (PREA): Overview, https://bja.ojp.gov/program/prea/overview (Aug. 21, 2025); 34 U.S.C. § 30302(1); 28 C.F.R. § 115.311.
[20] See generally 28 C.F.R. § 115. For more information about PREA and the PREA audit process, see National PREA Resource Center, https://www.prearesourcecenter.org/ (last visited June 6, 2025).
[21] See 28 C.F.R. § 115.6.

any attempt, threat, or request by a staff member to engage in such conduct.[22] Beyond physical contact, PREA prohibits staff from exposing their own genitalia, buttocks, or breasts to youth, and prohibits voyeurism, which is invading a youth's privacy for reasons unrelated to official duties, such as watching a youth using the restroom or performing bodily functions, requiring a youth to expose their intimate body parts, or taking images of a youth in a state of undress.[23] It is critical to note that, under PREA, these actions constitute sexual abuse *regardless of whether the youth consented*.[24] Similarly, Nebraska law states that an individual in the care and custody of DHHS, such as a youth at a YRTC, cannot legally consent to sexual penetration or sexual contact with a DHHS employee.[25] In addition, a person commits child abuse or neglect if they knowingly, intentionally, or negligently cause or permit a child to be placed in a situation that endangers his or her mental health or placed in a situation to be sexually abused, among other things.[26] Nebraska law separately criminalizes various degrees of sexual assault[27] and sexual assault of a child.[28] Other relevant offenses include sexual assault by use of an electronic communication device,[29] enticement by electronic communication device,[30] possessing or receiving child sexual abuse material,[31] and contributing to the delinquency of a child.[32]

PREA also prohibits sexual harassment, which encompasses a staff's repeated verbal comments or gestures of a sexual nature directed at youth, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.[33]

OJS policies and procedures that govern staff conduct at YRTCs generally mirror and, in some respects, expand upon PREA's prohibitions. OJS policies explicitly adopt PREA's requirement for zero tolerance of all forms of sexual abuse, harassment, and assault, as well as PREA's

---

[22] *Id.*
[23] See *id.*
[24] See *id.*
[25] See Neb. Rev. Stat. § 28-322.04 (providing that if a DHHS employee subjects a protected individual to sexual penetration or sexual contact, then that employee commits the criminal offense of sexual abuse of a protected individual, and it *is not a defense to the charge that the protected individual consented*). See also Neb. Rev. Stat. §§ 28-319, 28-319.01, 28-320, 28-320.01, 28-320.02, 28-1803 (proscribing additional sexual offenses under Nebraska law, including provisions addressing consent and age thresholds).
[26] See Neb. Rev. Stat. §§ 28-707(1), 28-710(2)(b).
[27] See, e.g., §§ 28-319 (sexual assault in the first degree), 28-320 (sexual assault in the second or third degree).
[28] See, e.g., §§ 28-319.01 (sexual assault of a child in the first degree), 28-320.01 (sexual assault of a child in the second or third degree).
[29] § 28-320.02.
[30] Neb. Rev. Stat. § 28-833.
[31] Neb. Rev. Stat. § 28-1803.
[32] Neb. Rev. Stat. § 28-709.
[33] See 28 C.F.R. § 115.6.

definitions for sexual abuse and sexual harassment. OJS policies define sexual contact to include not only direct or clothed touching of a youth's intimate parts, but also any written, electronic, or verbal communication of a sexual or romantic nature between staff and youth, and any demeaning or derogatory comments of a sexual nature directed at youth. OJS policies further require various procedures for reporting and responding to PREA violations and also state that every allegation of kissing, hugging, or sexual contact between staff and youth be reported to the Hotline.

Beyond these definitions of sexual contact, OJS policies on staff-youth relationships address a broader category of conduct that constitutes prohibited boundary violations between staff and youth, even where the conduct may fall short of sexual abuse or harassment. This includes prohibitions on staff sharing personal phone numbers or social media information with youth, purchasing items for youth with personal funds, using personal electronic devices in the presence of youth, being alone with youth in a room, discussing details of their personal and intimate or sexual lives with youth, passing written notes to youth, using nicknames when referring to youth, sharing feelings of sexual attraction with the youth, among other similar conduct. OJS policies separately define sexual harassment to include conduct such as inflammatory comments or jokes, pressure for sexual activity or demands for sexual favors, physical contact such as patting, punching, or brushing up against another's body, among other examples.

Taken together, these overlapping frameworks establish prohibitions on a wide spectrum of staff behavior. As will be discussed throughout this report, the staff conduct alleged by the youth at YRTC-Kearney during the period reviewed by the OIG-CW implicates virtually every category of conduct addressed by these frameworks.

OJS Compliance Process at the YRTCs

Compliance is responsible for investigating and reviewing allegations of sexual abuse at any of the YRTCs. These investigations are administrative, not criminal investigations. Soon after each allegation was made, facility staff first notified a Compliance staff member of the allegation. After Compliance was notified, it followed a relatively structured process of notifying numerous other parties of the allegation. These notifications typically included the Hotline, the YRTC-Kearney Facility Administrator, the OJS Administrator, the Compliance Administrator and Manager, NSP, and the legal parties to each youth's juvenile court case. In addition, other than the initial allegations in March and April 2025, the OIG-CW was promptly notified after each allegation as well.

The allegations were then investigated or reviewed by Compliance to determine if the alleged sexual abuse or boundary violation occurred, and if the YRTC and its staff complied with PREA, OJS and YRTC-Kearney policies, and Nebraska laws, rules, and regulations.

After each report was made to the Hotline, the Hotline either did not accept the allegation for investigation or screened the allegation as one that should be investigated by law enforcement. If NSP determined that the allegation warranted a criminal investigation, then Compliance did not conduct a full investigation into the incident while the criminal investigation was pending. Instead, Compliance only conducted a limited incident review, which was not as thorough in its fact-gathering.

When Compliance did conduct a full investigation, it always determined if each allegation—whether for sexual abuse or assault, touching, harassment, or boundary violations—was "substantiated," "unsubstantiated," or "unfounded." In the PREA context, a substantiated allegation is an allegation that was investigated and determined to have occurred.[34] An unsubstantiated allegation is an allegation that was investigated but the allegation produced insufficient evidence to make a final determination as to whether or not the event occurred.[35] An unfounded allegation is an allegation that was investigated and determined not to have occurred.[36] For every PREA allegation reviewed and investigated at the YRTCs by Compliance, the finding entered was based upon the legal standard of a preponderance of the evidence. This is a different standard than in a criminal investigation by NSP, which is focused on determining if criminal wrongdoing occurred based on the legal standard of proof beyond a reasonable doubt.

Immediately following this section are the detailed summaries of four allegations made by three separate youth against four separate staff. Three of these critical incidents were substantiated and resulted in criminal charges. The fourth incident was unsubstantiated by Compliance but has also resulted in criminal charges. Following the four detailed case summaries is a high-level summary of the remaining other sexual-abuse-related allegations included in this investigation, intended to provide a simplified picture of the number and specific types of allegations, as well as the various commonalities, trends, and issues between them.

[34] § 115.5.
[35] *Id*.
[36] *Id*.

SUMMARY OF CRITICAL INCIDENTS

&

BACKGROUND

Summary of Critical Incidents

A timeline of the following incidents can be found in Appendix A of this report. To ensure confidentiality, all names and identifying information of the youth and staff members involved in this investigation have been changed.

Youth A

The OIG-CW first learned there had been any critical incident involving Youth A on September 24, 2025, after the OIG-CW received a CIR disclosing that Youth A alleged on September 22 at a juvenile court hearing that he and YRTC-Kearney staff member Staff 1 had engaged in sexual activities in the upstairs closet of the Lincoln Living Unit. The OIG-CW was informed that this allegation would be sent to the OIG-CW as an update to a previous CIR, dated March 27, 2025, involving an incident that had occurred on March 26, where Youth A and two other youth were found at the facility with a cell phone. As is mentioned above, the OIG-CW had not been notified in March when the cell phone was found. The Deputy Ombudsman for Institutions had been notified by the OJS Administrator in March about the cell phone, but was only told of the concerns that the youth had the phone, which was considered contraband, and that discovered on the phone was a potential plan for an escape and inappropriate messages. The Deputy Ombudsman was not aware that the messages were with a staff member or that the phone contained sexually explicit content.

Similarly, the March 27 CIR regarding the cell phone incident only stated that it was discovered that the three youth were "making plans of a possible escape, inappropriate messages, and contact with a current staff" member. The name of the staff member involved in the cell phone incident was not known by the OIG-CW at that time, but it was later learned that it was also Staff 1.

March 2025 Cell Phone Incident

According to the information reviewed by the OIG-CW, the cell phone was discovered in the Lincoln Living Unit at YRTC-Kearney on March 26, 2025, after the facility's YSS department received a call from an outside source who disclosed that one of the facility's current youth, Youth D, had posted pictures on social media earlier that day, while at the facility. That call prompted a YSSM to review live camera footage of the Lincoln Living Unit, where he observed Youth D laying on the floor in one of the common areas, hiding underneath several coats and

blankets. Staff believed Youth D was attempting to hide from camera view and that he may have been using a vape or a phone.[37]

Numerous YSS staff members then entered the living unit and locked down the room where Youth D was observed on camera and suspected to have the phone. Staff searched the room and quickly found what appeared to be a new iPhone and an iPhone charger underneath a coat. The UM of the living unit then began questioning the youth present about the phone. Initially, none of the youth were forthcoming about who the phone belonged to, and how it came into their possession. Youth D then stated that the phone belonged to him, and that he had more information about it, but that he would not say anything else. Another youth being investigated, Youth E, also claimed the phone was his and that he knew the passcode, but he would not give staff the code. A third youth being investigated was Youth A, who was also unwilling to cooperate and answer questions about the phone, and later gave false information about which staff member was communicating with the youth on the phone.

Later that day, a CM was given information about where to find the passcode to open the phone. The UM and one of the CMs provided the phone to the YSS office, and the passcode gave them access into the phone. The UM, CM, and several YSS staff then began reviewing the phone's contents. When doing so, it became apparent to the staff that Youth A, Youth D, and Youth E were all sharing and using the phone in some capacity. Staff observed several recent social media posts, text messages, and pictures involving all three youth. Youth D and Youth A were observed in numerous pictures on the phone's camera roll that had been taken in the Lincoln Living Unit restroom. There were also plans to escape the facility in a few days found in text message exchanges on the phone. At some point, after two more CMs entered the YSS office and began looking through the phone, the YSS staff told all other staff that the phone was in the YSS staffs' control and that everyone else needed to exit the room so that the YSSs could secure the phone and look through it thoroughly. It was then discovered that the phone also contained a variety of sexually explicit content. After one of the YSSMs observed some of the explicit content, he notified Compliance and the YRTC-Kearney Facility Administrator at the time about the phone's content and the investigation into the incident. The YSS staff were instructed to keep the phone in their possession until Compliance could retrieve it and more thoroughly review its contents the following morning. That next day, March 27, the OJS

[37] Two days earlier, in a Compliance investigation into a separate incident involving allegations made by Youth D about a staff member's inappropriate conduct toward him, it was noted that a staff member observed Youth D and two other youth acting suspiciously underneath a blanket in the Lincoln Living Unit.

Administrator, Compliance Administrator, and Compliance Manager retrieved the phone and observed the sexual content.

The sexual content on the phone included nude pictures and videos of youth at the facility, and nude content of two different adult females. The sexual content was either sent over text message or within the phone's photo library. One of the adult females, who was exchanging text messages and sexual pictures with Youth E, did not work at YRTC-Kearney. The other sexually explicit content on the phone was from Staff 1, who was a frontline staff member at the facility. The YSSs cross-referenced all of the phone numbers discovered on the phone with the personal cell phone numbers listed in the YRTC staff directory, and one of the phone numbers matched that of Staff 1. In addition, before it was determined that Staff 1 was the staff member seen on the phone, YSS staff looked through the living unit's youth lockers and, in one of the lockers, discovered a note within a journal with three other staff members' personal phone numbers written on it. Why or how the youth came into possession of those staff phone numbers was not looked into.

According to Compliance documentation, in text messages exchanged between Staff 1 and the phone, Staff 1 and Youth A referred to each other as "mi amor," meaning "my love," and talked about being in love and living together in the future. There were numerous phone numbers and contacts saved on the phone, some of which had been frequently texted and called while the phone was at the facility. Facility staff stated that they believed the phone had been activated off-campus and brought into the facility at least a week earlier, on March 18 or 19, as that was when messages were first sent from and received on the phone. Staff 1 had been texted from the phone and responded to texts "dozens of times" within that timeframe. A couple of days after the phone was discovered, Youth D disclosed to the UM that Staff 1 was the one who had brought the phone into the unit and gave it to the youth.

On March 27, Compliance notified numerous parties of the cell phone incident and concluded its review of the incident. Compliance completed a Sexual Abuse Report form related to the incident, which is routinely done when there has been an allegation of sexual or physical abuse at an OJS facility, to comply with Nebraska law and federal PREA standards. In addition to basic information about the circumstances surrounding the incident, the form included a narrative of the incident details that Compliance reported to the Hotline. In pertinent part, the Compliance Manager wrote that he told the Hotline that a cell phone was found in the living unit where Youth A, Youth D, and Youth E reside, and on it, they "found explicit videos and pictures of an adult working at the facility sent to [Youth A]. Her name is [Staff 1]." The narrative goes on to state that Youth A seemed to have been using the phone the most and that Staff 1 singled out

Youth A in the content sent over the phone, which included "5 videos and one picture, explicit videos and pictures of her touching herself, and nude pictures."

In addition to the DHHS parties notified of the incident on March 26, the YRTC Mental Health Clinical Director, NSP, and Juvenile Probation were all notified of the incident on or about March 27. According to documentation from Juvenile Probation, however, the notice to Juvenile Probation did not include any reference to the sexually explicit nature of the contents on the phone. It only stated that a cell phone had been found in the youths' possession. In the following couple of weeks, youth progress updates from the facility to the juvenile court in each of the youth's juvenile court cases similarly only mentioned that the youth were found in possession of a cell phone that had plans for a possible escape, photos, and social media activity on it. There was no mention of the sexual content on the phone. According to Compliance, despite the sexually explicit content that was discovered on the phone sent from Staff 1 and another adult female to the youth, the OIG-CW was not formally notified of the incident as a CIR because Nebraska law only requires the YRTCs to notify the OIG-CW of internally substantiated violations of PREA.[38] Compliance did not believe the alleged conduct qualified as sexual abuse or harassment under PREA. Instead, the incident was passed along to NSP, and the OJS Administrator informally notified the Deputy Ombudsman for Institutions that a cell phone had been discovered at the facility, but no specifics about the sexual content found on the phone were shared at that time. The Deputy Ombudsman shared this information with the OIG-CW.

In an April 1, 2025, letter from the facility to Staff 1 notifying her of the allegations against her and advising her that disciplinary action may be taken against her in accordance with her employment contract, the UM of the Lincoln Living Unit provided a more detailed account of the content found on the cell phone. The phone contained four videos, each ranging from 11 to 18 seconds long, of Staff 1 sexually touching herself and masturbating in a bed, either dressed solely in underwear or entirely naked. These videos were dated March 21, 2025. The phone also contained pictures of Staff 1 sending a kissing face and sexually touching herself, and it showed that Staff 1 FaceTimed the cell phone 12 different times from March 19 to 21. Of the numerous text message conversations exchanged between Youth A and Staff 1, on March 25, the two told each other that they loved and missed each other, and Staff 1 referred to Youth A as her "future hubby." This letter from the facility to Staff 1 also outlined the many different

[38] See Neb. Rev. Stat. § 50-1806(3)(a)(viii).

provisions of her employment contract and of DHHS and OJS policies and procedures that Staff 1 may have violated.

In Compliance's review of the incident, it stated that a key strength identified in the incident was that the staff who discovered the cell phone "did well in reporting the incident." As for the "Opportunities/areas for improvement" section of the incident review, there were "None to report at this time." The incident was substantiated as an incident of staff-to-youth inappropriate boundaries, rather than sexual abuse or sexual harassment that would fall under PREA. Compliance found that the incident "does not indicate a need to change policy or practice to better prevent, detect, or respond to sexual abuse," and there were "no recommendations for additional modifications to any monitoring technology surrounding the Lincoln Living Unit." The review noted that Staff 1 had completed the required facility trainings before the incident. In concluding the incident review, Compliance stated that there were "No recommendations at this time" for an "Item/Issue needing Improvement" nor for a "Plan of Implementation/action." As is required by policy, Compliance shared its review and conclusions with the Facility Administrator.

Staff 1, through her union legal representative, resigned her position at YRTC-Kearney on April 2, 2025. In addition to this incident with the cell phone, Staff 1 had been formally disciplined previously, twice in 2024 for violations of facility policies unrelated to the type of conduct at issue in this investigation, and once in March 2025, just before the cell phone was discovered, for sharing one of her drinks with a youth and failing to maintain appropriate boundaries with the youth. Staff 1 was suspended and placed on disciplinary probation as a result of that most recent incident, and it was during that suspension, which began on March 23, that the cell phone was found at the facility. Staff 1 had also been given verbal counseling in February 2024 after it was reported that there were concerns about her boundaries with youth, including advice on how to appropriately respond to youth when they attempt to touch her and sit too close to her.

In addition to these past employment-related actions against Staff 1, she had also been named as a perpetrator in an allegation of sexual abuse against a youth as early as October 2023. In that incident, it was alleged that Staff 1 may have been engaging in sexual relations with Youth A and another youth. In particular, staff reportedly overheard a conversation where a youth stated that he was having sexual relations with Staff 1, and Youth A said that he was going to have sex with Staff 1 as well, and that he was going to pay her to do it. This allegation was closed as unfounded according to Compliance because, in large part, there was no video

evidence, no exact date of when the alleged conduct occurred, and Youth A and the other youth were not cooperative and their statements did not corroborate each other.

September 2025 Sexual Activities Allegation

Regarding the second allegation made by Youth A about Staff 1, on September 17, 2025, a CM completed a Sexual Misconduct First Responder Report after Youth A reported to her that day that former YRTC staff member Staff 1 had previously taken him upstairs in the Lincoln Living Unit to clean and that was how the upstairs closet got its name, the "boom boom room." A few days later, on September 22, during Compliance's investigation into the allegation, the meaning of the "boom boom room" was clarified when another staff member disclosed to Compliance that Youth A and several other youth had told her that Youth A and Staff 1 had entered this closet "alone on several occasions and that sexual activity between [them] had occurred there." Compliance notified all appropriate parties, including the OIG-CW, of the allegation.

In addition, one of the staff members interviewed by Compliance also stated that another staff member had told her that Youth A said he and Staff 1 were still in contact, despite Staff 1 not working at the facility since March. In particular, Youth A had stated that Staff 1 sent letters to him at the facility under a pseudonym, and also spoke on the phone with him for multiple hours at a time. Youth A stated that he knew the letters were from Staff 1 because they referred to him by a nickname she had given him while she was at the facility. Although Youth A later stated that he believed that the letters were still among his personal belongings at the facility, neither facility staff nor Compliance staff found any evidence of the letters. Compliance also listened to some of Youth A's recorded phone calls and did not hear any conversations with Staff 1.

Shortly after, in October and November 2025, numerous youth made many allegations about Staff 1 similar to the allegations made by Youth A, including allegations about sexual contact or relationships between Staff 1 and other youth, that Staff 1 inappropriately touched other youth, or allowed youth to touch her, and more. One of those allegations included a youth stating that he knew Staff 1 had been sending Youth A videos of her vagina and had offered to help Youth A escape the YRTC while she was still employed at the facility.

In November 2025, Youth A additionally disclosed that Staff 1 flirted with him and that they were emotionally attached to each other; that she brought him vapes, snacks, and a cell phone into the facility specifically so they could communicate when she was away for her suspension; that they would go to an area at the facility that was a blind spot, where cameras could not see, and would kiss and Staff 1 would touch his penis and perform oral sex; that Staff 1 touched his

penis underneath a table; that they would FaceTime call each other and she would be sexually touching herself on those calls; that she sent Youth A videos of her sexually touching herself and that she asked him to send her photos of his penis; and that he knew how to hide the cell phone at the facility because Staff 1 told him how, and that they would perform the sexual acts in the blind spot because Staff 1 knew where that blind spot was. Further, Youth A alleged that after the cell phone was discovered in March, he tried to tell staff about his relationship with Staff 1, but they responded by telling him that he was being manipulative and placed him in confinement at the Dickson Behavioral Stabilization Unit (Dickson). Compliance notified all appropriate parties of the November allegations. The OIG-CW received a CIR on November 19, 2025.

One month later, Compliance completed an internal incident review of both the September and November 2025 allegations. In the review, Compliance noted that no video footage related to either set of allegations was available because Staff 1 was last employed at the facility six months prior, thus placing any relevant footage outside of the security system's retention period. However, Compliance noted for the first time that it had reviewed video footage of Staff 1's movements during the three weeks preceding the discovery of the cell phone in March and did not observe her "entering any blind spots with youth for an extended period." Compliance documentation further stated that there were no cameras inside the closet where Youth A alleged that he and Staff 1 engaged in sexual activity, but there were cameras showing the entrance to the closet. Although Youth A did not specify when the alleged sexual activity occurred, Compliance reviewed footage from that same three-week period and noted that Staff 1 was never observed entering the closet with any youth.

Compliance identified an area needing improvement, which was that the CM to whom Youth A had initially reported the "boom boom room" allegation in September did not immediately notify Compliance of the allegation, as required by policy. Instead, the CM told another facility staff member, who, in turn, notified Compliance. Compliance concluded its review without determining whether the September or November allegations were substantiated, unsubstantiated, or unfounded, noting that it would continue to provide NSP with all information related to NSP's criminal investigation of the allegations.

Staff 1 has been criminally charged and arrested.

Youth B

First Allegation

A second substantiated incident occurred in April 2025 involving Youth B and Staff 2, who was also a YPS. The OIG-CW was not notified about this incident at the time it occurred. The OIG-CW learned about the incident in September 2025 when the OJS Administrator notified the OIG-CW that Youth B's attorney had disclosed in juvenile court that Youth B had a relationship with a YRTC staff member.

After that disclosure, the court ordered that all records related to these allegations be turned over to the legal parties. The OIG-CW requested those same documents, in addition to others. The YRTC-Kearney records revealed that on April 18, 2025, Staff 2 reported to a YSS that Youth B groped her thigh in the Lincoln Living Unit. Staff 2 reported that she verbally redirected Youth B, by saying, "Do not lay a hand on me." She then reported the incident and completed a First Responder Form. In response, Youth B received a major rule violation and was moved to Dickson. The incident was reported to Compliance.

However, on April 19, 2025, Youth B provided a note to a YSS that had been passed between Youth B and Staff 2 and contained inappropriate conversations. The notes are written in both blue and green ink with different handwriting patterns. Youth B identified the blue writing as belonging to Staff 2 and the green writing as his own. The conversation within the notes is sexually graphic, including detailed descriptions of various sexual acts they might engage in with each other. This was also reported to Compliance. Staff 2 was suspended, though it is unclear from documentation if this occurred on April 19 or 20, 2025.

Youth B, however, remained in Dickson. A YPS reported that Youth B asked if he knew why Youth B was in Dickson. The YPS reportedly told Youth B that he did not know, as that information was confidential. Youth B then disclosed that he was in a mutual relationship with Staff 2 and that they wrote love notes to each other. The YPS notified Compliance of this disclosure by email on April 19, 2025.

The next day, a YSS sent an email to Compliance stating that he talked to Youth B, who also asked the YSS why he was still in Dickson. The YSS told Youth B that information would be presented to Youth B eventually. Youth B was reportedly angry and asked the YSS, "Is this because of [Staff 2]? cuz it was reciprocated!" Youth B was told he would be in Dickson until further notice.

On April 20, 2025, after being advised by a YPS that Staff 2 and Youth B had gone upstairs in the living unit alone on April 12, 2025, to retrieve something for Youth B, a YSS reviewed video from

that date and discovered evidence of physical contact between Staff 2 and Youth B. The YSS immediately reported this to Compliance. Youth B was interviewed by Compliance that same day, and he disclosed that he was in a mutual relationship with Staff 2 and that she had allowed Youth B to touch her inappropriately.

The video review completed by Compliance on April 20, 2025, showed the following interactions between Youth B and Staff 2:

- On April 10, 2025, Youth B touched the buttocks of Staff 2 while upstairs in the stairwell. The two are also seen passing a notebook back and forth while playing chess in the game room.
- On April 12, 2025, Youth B is seen touching his foot to Staff 2's foot in the game room. Youth B places his hand high on the inner thigh between the legs of Staff 2 and slides it down towards her knee, to which she smiles and shakes her head. A few minutes later, the two are seen alone upstairs in the dormitory and Youth B puts his arms around her waist. She holds his hand before turning around, at which time he tries to lift up her shirt and she stops him. They are then seen going down the stairs with his pelvis touching her buttocks. She continues to walk forward while holding Youth B's hands on her hips.
- On April 18, 2025, Youth B grabs Staff 2's leg on the outer thigh above the knee and pulls her leg closer to him. This is when Staff 2 got up to report the touching.

The relationship between Youth B and Staff 2 was reported to the Hotline on April 20, 2025. NSP and Juvenile Probation were not notified directly at that time.

Staff 2 emailed the UM of the Lincoln Living Unit on April 20, 2025, to resign from her position at the YRTC.

On April 21, 2025, Staff 2 emailed Compliance and reported that she was manipulated by a youth and that she did not consent to him touching her. She stated that she "told him to stop many times, but he didn't," she "felt scared and trapped," and that due to past trauma, she did not respond the way that she wished she would have. She did state that there were notes written to her by a youth and that she responded to them because she felt that she had no choice.

A YPS who was interviewed by Compliance on April 21, 2025, stated that Staff 2 and Youth B spent a lot of time together playing cards and chess. He stated that he overheard Youth B

recently mention something about Staff 2 taking him upstairs and recalled that they went up on April 12 to get a water bottle. The YPS reported not seeing any red flags from Staff 2.

On April 22, 2025, another YPS emailed Compliance about a conversation that she had with Youth B. According to that YPS, Youth B disclosed that he and Staff 2 had been passing notes and that there had been more than just touching between them. Youth B suggested that they had not been caught so he did not believe Staff 2 should be in trouble. Youth B further stated he had given Staff 2 consent, but then also stated he knew there was no consent in a YRTC setting. Youth B stated that if he were to see Staff 2 "on the outs" he would be happy to "go there" with her again. He said he had love for Staff 2 and that he got involved with her because he is a "horny boy." Youth B also stated he did not regret anything but wanted to apologize to Staff 2 because he believed that she blamed him because they were caught on camera.

Youth B was also interviewed by Compliance on April 22, 2025, and Youth B disclosed that he had touched Staff 2's vagina and she had touched his penis on the way upstairs and in the dorm multiple times.

On April 23, 2025, Compliance attempted to interview Staff 2. She did not answer the phone. She later emailed stating she would need to do any interview over the phone or in writing via email due to traveling for a family emergency. No interview was ever conducted by Compliance.

In its internal investigation, Compliance noted that there was "evidence of mutual participation in a relationship" between Staff 2 and Youth B, including evidence from a 30-day review of video in which Youth B and Staff 2 are seen smiling at each other and separating themselves from others. The incident was substantiated for a staff-to-youth boundary violation, not a PREA violation. The incident review found that there should be more frequent living unit rounds and supervisory check-ins, particularly with staff still in an initial probationary period, as Staff 2 was, and noted that if staff had more support this might have been prevented.

On September 16, 2025, Youth B had a juvenile court hearing to review his YRTC commitment, and it was at this hearing that Youth B's attorney reported Youth B had disclosed a relationship with a staff member. During that hearing, it was stated that Juvenile Probation, the court, the attorneys, and law enforcement were not notified of the inappropriate interactions between Staff 2 and Youth B in April 2025.

As noted, this incident was also not reported to the OIG-CW when it occurred. The OIG-CW has never received a CIR for this incident, as it was classified by YRTC as a boundary violation rather than a PREA violation. The initial incident reported by Staff 2 of Youth B touching her leg was

determined to be a boundary violation committed by the youth. When the note and other incidents were discovered through video review, it was determined that there was no sexual touching of Youth B by Staff 2, and Compliance determined that the incidents of her allowing Youth B to touch her were not covered by PREA.

On October 1, 2025, Youth B had an evidentiary hearing and was moved by the court to a juvenile detention center after exhibits provided by the YRTC, as detailed above, illustrated inappropriate behavior from Staff 2. The court also noted a concern for the lack of disclosure of these events to anyone outside of the YRTC.

Staff 2 has been criminally charged and arrested.

A review of the employment records of Staff 2 and the court exhibits entered at Youth B's evidentiary hearing revealed an investigation from March 24, 2025, regarding Staff 2 and Youth D. Youth D alleged that Staff 2 was constantly seeking his attention by sitting too close to him and asking him to play cards. He stated she would get mad if he declined. He also stated that she asked him to be in a relationship, to which he responded that it would have to wait until he was out of the facility. He shared that she let another youth touch her thigh and that she would get close to Youth B to make Youth D jealous. There were also allegations of inappropriate conversations about sexual positions and her promises to bring a vape into the facility for good behavior. When Youth B was interviewed on March 24, 2025, as part of this investigation, he denied that Staff 2 was ever inappropriate with youth. Staff 2 was interviewed that same day and she detailed an incident in which some youth, including Youth D, were under a blanket, and she thought they had a vape. She reported this, and she asserted that this led to threats against her by the youth. All threatening behavior was logged in the living unit logbook by Staff 2 at the time. According to Compliance documentation, a review of video did not reveal any inappropriate behavior between Youth D and Staff 2, and that Staff 2 was not present on campus the weekend these incidents were alleged to have occurred. The investigation was unsubstantiated and it was recommended that Youth D receive a rule violation for making a false allegation.

Second Allegation

On October 2, 2025, the day after he was moved from YRTC-Kearney to another placement, Youth B disclosed that he had also had a sexual relationship with Staff 3 while at YRTC-Kearney. According to the Hotline report, Youth B disclosed that on his last night at YRTC-Kearney, Staff 3 went to Youth B's room in Dickson to give him his medications. While in his room, Staff 3 put her hand under Youth B's pants and provided manual stimulation of his penis. Youth B reported

that he had a sexual relationship with Staff 3 the entire time that he was at YRTC, which began in August 2024, and that she had sexual relationships with multiple youth. Youth B stated they did not have sexual intercourse, but the report states that there was digital penetration. Youth B also reported that Staff 3 gave him her personal phone number and her Facebook profile name.

Hotline staff informed the OJS Administrator of these allegations, and Staff 3 was suspended immediately.

Compliance began a review into these allegations in October 2025, which was completed in April 2026. Youth B was not interviewed for this review as he had been moved by the court to juvenile detention. Staff 3 was also not interviewed, as she was on suspension, failed to attend interview appointments, and then communicated through her attorney that she would not be participating. The only potential witness in Dickson at the time of the allegations was another YPS. He was interviewed by Compliance in October and described Youth B as immature and disruptive, often being placed in Dickson due to altercations or refusing staff directives. He stated that Youth B would make inappropriate comments only to female staff, and would do so to all female staff, not singling anyone out. He recalled that Youth B was quiet and withdrawn the night of October 1, 2025, which he attributed to Youth B knowing he was leaving the next day. The YPS described Staff 3 as enjoyable to work with and having normal behavior, not engaging in drama like some other female staff. He confirmed that she held youth accountable. The YPS also described the relationship between Staff 3 and Youth B as professional. He did state that Staff 3 often avoided Youth B, which he attributed to the way Youth B treated female staff.

NSP was notified of the allegation by Compliance on October 6, 2025. The OIG-CW was notified of this second allegation involving Youth B on October 10, 2025.

Multiple video reviews were conducted by Compliance, with footage from July 17, 2025, to October 2, 2025, reviewed in its entirety, including all cameras in Dickson. Among all the footage, one incident involving Youth B was identified, occurring on October 1, as he had alleged.

Video review from Dickson shows that on October 1, the YPS who had been interviewed and was the only potential witness, walked into the hallway where Youth B's room was on the left side. He completed a visual check of Youth B and talked with him briefly. A minute later, Staff 3 also entered the hallway and walked to Youth B's door with two cups in her left hand, which were presumed to contain his medication. She opened the door to Youth B's room and looked

down the hallway towards the other YPS. Staff 3 then took a step into Youth B's room and leaned against the door frame. In the next 30 seconds, Staff 3 looked toward the other YPS at the end of the hallway four separate times. She then moved her left hand from the door frame and into the room, out of camera view. Her left arm can be seen going back and forth, in and out of the camera frame, for a total of nine seconds. She then backed away from the door frame and closed the door.

Compliance also reviewed Youth B's phone calls from June to September 2025. In the calls with his mother, Youth B alluded to sexual contact with female staff. Youth B's mother encouraged him not to discuss these things on recorded calls, to work his program, and get home. This occurred in multiple calls in August and September 2025.

In its investigation, Compliance found Youth B's allegation to be unsubstantiated due to a lack of evidence. Specifically, the lack of camera footage other than the hallway footage was cited, as well as the inability to interview Staff 3 and Youth B. The investigation recommended that the facility evaluate the feasibility of expanding camera coverage in areas where youth and staff frequently interact, while maintaining required privacy protections. It also recommended the facility assess whether current video retention timelines adequately support investigative needs, particularly for incidents reported weeks or months after they allegedly occur. The Compliance incident review additionally recommended that the facility should consider revising policies and procedures to require all critical training, including PREA, to be completed at least once every 12 months.

Staff 3 remained on suspension for several months, with pay. However, once she was criminally charged and arrested, Staff 3's suspension became unpaid, and she resigned through her attorney.

Youth C

The OIG-CW was notified of the third substantiated incident shortly after it happened in August 2025. The Deputy Ombudsman for Institutions also received a complaint regarding these incidents on August 19, 2025.

On August 2, 2025, a YPS was notified by a youth that Youth C and Staff 4 were passing notes to each other earlier that day in the game room of the Washington Living Unit. The YPS reported this to a YSS staff member. Camera footage was reviewed that day and confirmed that this occurred. Staff 4 was brought into the administration building at YRTC-Kearney, and she turned the notes over to the YSS when asked about them. They included the following statements: "If I win, you send me $500," "If I win, you bring me edibles for my birthday," and "If I win, you

bring me exclusive pictures." Staff 4 reported to the YSS that Youth C was rubbing her leg during this interaction.

At the conclusion of that meeting on August 2, 2025, Staff 4 was sent home. Compliance and the UM of the Washington Living Unit were notified immediately. Youth C was sent to Dickson due to Staff 4 reporting that he was rubbing her leg while sitting at the table.

That same day, Youth C was in Dickson talking to other youth. A YPS overheard Youth C talking about kissing Staff 4 on the stairs and that it had been going on for two to three weeks. The YPS reported this to a YSS. Another YSS reviewed additional footage from August 2, and found video of Staff 4 and Youth C on the landing at the top of the stairs, kissing. More footage was found when a review of video from August 1 was completed, which shows Youth C and Staff 4 on the landing at the top of the stairs. Youth C grabs the buttocks of Staff 4, and she smiles and points to the camera. Later that same day, the two are seen on camera again at the top of the stairs, kissing. In the days leading up to these incidents, video shows Youth C and Staff 4 sitting near one another, separated from other youth and staff. Compliance was contacted a second time and documentation notes that the Hotline and NSP were notified on August 2.

On August 3, YRTC-Kearney mental health staff checked in with Youth C per the request of Compliance. He stated that he did not have any concerns.

Staff 4 was sent a letter dated August 4, informing her that her employment was terminated effective immediately.

On August 5, the OIG-CW was notified of the situation through a CIR.

Youth C's mother, his Juvenile Probation Officer, and his attorney were also all notified of these incidents. Youth C's mother informed the UM and the Juvenile Probation Officer that Youth C asked her to look up and message Staff 4 on Facebook. Screenshots of the messages were received by Compliance. The screenshots of the messages begin on August 3, after Staff 4 was suspended. Youth C's mother begins by thanking Staff 4 for helping her son and explains some of his trauma. When Youth C's mother asks when Staff 4 will be back so that Youth C might talk to her, Staff 4 explained that she was suspended, but that nothing happened. Staff 4 does mention the notes between her and Youth C. On August 4, Staff 4 messaged Youth C's mother to tell her that she had been fired.

Since NSP was conducting a criminal investigation, Compliance conducted a review, rather than an investigation, which was completed on August 20. The incident review recommended no additional training, as all staff on shift were up to date on annual PREA training. It notes that

supervisors could have conducted spot checks. No internal compliance interviews of the youth were completed due to the ongoing criminal investigation.

Staff 4 has been criminally charged and arrested.

Summary of Additional Allegations

As mentioned above, between March 2025 and March 2026, there were 44 different allegations, ranging from more severe allegations such as sexual abuse, assault, touching, or harassment of youth by YRTC-Kearney staff, as well as inappropriate relationships between staff and youth, to less severe allegations of staff violating appropriate and professional boundaries with youth. Within those 44 were over 200 specific claims of a variety of sexual-abuse-related behaviors and actions by staff. However, given the large quantity of allegations within a short timeframe and the considerable amount of factual overlap between the allegations, it is nearly impossible to state with exact certainty how many allegations of specific behaviors and actions were made against staff in total. As will be discussed more below, it is essential to clarify that these were only *allegations* made by the youth. This is not the total number of allegations that were substantiated. Thus far, the actual number of substantiated improper staff conduct is significantly smaller than what was alleged.

Four allegations involving staff sexual abuse of three youth have resulted in criminal charges against four staff members. Three other allegations classified by Compliance as staff violations of professional or appropriate boundaries with youth were substantiated by Compliance but have not resulted in criminal charges. Allegations from nine other youth were unsubstantiated or unfounded by Compliance and were also closed after an investigation by NSP without criminal charges filed. Many other allegations that were unsubstantiated or unfounded by Compliance were still referred to NSP. Although NSP received the reports, it did not undertake an in-depth investigation, not because it determined that the alleged boundary violation or inappropriate staff conduct had not occurred, but because the allegation itself did not rise to the level of criminal conduct.

The result of all of this was a complicated web of allegations and facts. Allegations from one youth might involve multiple staff members. Youth also made allegations regarding abuse of other youth—not always just themselves—that they claimed to have witnessed or about which other youth told them. Often, the investigation into one allegation led to new revelations about different alleged incidents involving different youth or staff. While most of the allegations were made against the same core group of staff, ultimately, allegations were made against 19 different staff members. These factors resulted in a remarkably high number of allegations within a short period, creating difficulties for the facility, Compliance, NSP, and the OIG-CW to keep the allegations separate. It was often even more challenging to determine what had actually occurred.

Most Common Types of Allegations

Youth named 19 different YRTC-Kearney staff members as alleged perpetrators**.** The OIG-CW's review of all of the cases determined that the most common type of allegation involved inappropriate statements that staff members allegedly said to the youth. For 18 of the 19 alleged perpetrators, and in approximately 50 combined instances, this included allegations that staff members flirted with the youth, engaged in sexually suggestive or explicit conversations with youth and other staff—including comments on genitalia and sexual activity and preferences—shared intimate details of their personal lives, discussed the desire to have sexual contact or relationships with youth, talked in a way that made the youth feel uncomfortable, and more of that nature.

In addition, youth alleged that 13 different staff members, in approximately 30 combined instances, inappropriately touched youth, most commonly on the youths' legs and thighs, as well as their hair, hands, and by pressing their buttocks or breasts against the youth in a way that the youth believed was intentional but could have appeared to others as inadvertent.

At least seven different staff members were allegedly engaged in sexual contact with youth or had ongoing relationships with youth while they were at the facility. This alleged sexual contact included kissing, touching of private areas and genitalia over and underneath clothing, masturbating, oral sex, and sexual penetration. Included in these seven allegations are the critical incidents summarized in detail above. The other allegations of sexual contact or ongoing relationships were either unfounded, unsubstantiated, or part of the ongoing criminal investigations.

The next most common type of allegation involved staff giving youth, or youth being found in possession of, the personal cell phone numbers of staff. In approximately 15 total instances involving nine different staff members, youth either alleged that they had the personal cell phone numbers of a staff member, but it could not be proven, or, more commonly, youth were found in possession of the staff phone numbers, and they alleged that they received the numbers directly from the staff. The phone numbers were often found written down on pieces of paper and notebooks within the youths' personal possessions at the facility. Several youth were also able to recite the personal cell phone numbers of staff from memory. Despite numerous youth alleging that these staff were volunteering their phone numbers to the youth, Compliance rarely determined whether staff distributed their cell phone numbers to the youth, how the youth might otherwise be obtaining the staff's phone numbers, or whether and how the youth were sharing the phone numbers with each other once the first youth came into possession of the numbers.

Some of the other most prevalent types of allegations made by the youth against the staff included:

- Youth and staff discussing plans to be in a relationship, have sexual relations, live together, or meet up with each other after the youth's discharge from the YRTC.
- Staff wanting attention from and expressing a desire to be in a relationship with youth.
- Staff sitting too close to youth at tables when playing games.
- Staff allowing youth to inappropriately touch them, such as in the buttocks.
- Staff watching youth in the nude while the youth shower, change clothing, and use the restroom.
- Staff bringing in contraband and prohibited personal items to the youth, such as food, drinks, and vapes.
- Staff passing notes with the youth and writing letters to the youth that contained flirtatious and sexually suggestive or explicit topics.
- Staff complimenting youth on their physical appearance and making comments on which youth they found attractive.
- Staff asking youth to touch them or commit sexual acts with them.
- Staff bending over in front of youth or adjusting their clothing in a sexually suggestive manner to present their buttocks or breasts to the youth.
- Staff letting youth use their cell phone at the facility, showing youth sexual content on a cell phone, and asking youth for their social media information.

Several youth made general allegations about a highly-sexualized culture at the facility and staff not doing enough to stop youth from masturbating, showing their genitalia, and making sexual remarks to other youth. Several youth similarly made comments about feeling uncomfortable or unsafe at the facility because of all of these types of behaviors alleged.

Other Allegation Data Points and Commonalities

All of these allegations were made by 37 different youth and one YRTC-Kearney staff member. In total, 19 different youth alleged that they alone had personally been subjected to a YRTC-Kearney staff member's sexual abuse or assault, harassment, or violation of professional boundaries. Another 18 allegations involved youth alleging that not only had they been victims of such conduct, but that they knew of at least one other youth who had been a victim as well. Another six allegations involved youth who were not alleging that they had been abused, but rather that they knew about other youth victims or who were alleging general allegations about a staff's conduct without naming or specifying a youth victim.

Of the 19 different alleged staff perpetrators, 17 were YPSs, and the remaining two staff held other roles at the facility. All but one of the alleged perpetrators were female staff members.

Approximately two-thirds of all allegations that the OIG-CW is aware of and reviewed in this investigation involved the same six staff members, including Staff 1, Staff 2, Staff 3, and Staff 4, who each had four or more sets of allegations against them. Allegations made against Staff 4 alone made up approximately 25% of all allegations. The remaining 13 of the 19 staff members accused had just three or fewer sets of allegations made against each of them, accounting for approximately 25% of the total number of allegations. Approximately less than 10% of the total allegations were made against unnamed or unknown staff members.

The alleged staff PREA violations and improper activity reportedly occurred in various locations within the facility. The bulk of the disclosures occurred after some of the initial allegations were made public. Of the 44 different sets of allegations made against staff, 10 were made between March and September 2025, 24 were made in October 2025 (after the initial allegations were publicized), five were made in November 2025, and five were made between January and March 2026.

Allegations came out of each of the four living units on the campus—Bryant, Creighton, Lincoln, and Washington—as well as in Dickson and the medical exam room, hallways, classrooms, gymnasium, weight room, and other areas.

Approximately one-third of the allegations against staff were either made by youth living in the Washington Living Unit or the alleged activity occurred in that living unit. During the investigations into some of those allegations, all of the youth in the living unit were interviewed and the majority of the youth made additional allegations about themselves or other youth as well, even if unrelated to the initial allegations and staff perpetrators that triggered the investigation. These new allegations typically led to subsequent investigations and interviews. In contrast, the other three living units and Dickson each produced approximately similar numbers of youth allegations to each other, with each individually accounting for fewer than in Washington. Some of the alleged improper physical contact between staff and youth reportedly occurred in several security camera “blind spots” in the facility, such as in certain areas of the gymnasium, weight room, stairwells, living unit foyers and common rooms, as well in restrooms and closets. Whether all of these areas actually lacked adequate camera coverage was not established by the record reviewed in this investigation. Many allegations did not specify the location of where the activity occurred, most often when the allegation involved inappropriate statements that staff made rather than inappropriate physical contact.

Other Substantiated Allegations

Once again, it is important to note that very few of the allegations have been substantiated. Of the four allegations summarized in detail earlier in this report, three were substantiated by Compliance and one was unsubstantiated. All four of those cases have resulted in criminal charges. There were only three other Compliance investigations or reviews into an allegation that resulted in a substantiated finding. In all three of those cases, however, Compliance only substantiated staff for violations of professional boundaries with youth.

One of the incidents that was substantiated occurred in May 2025. A youth alleged that a different youth had told him that a staff member looked at youth naked in their rooms in Dickson, engaged in inappropriate conversations with a youth and asked him to touch her private parts through the slot in the door to his room, and gave the youth "a drink of something that made him horny" and watched him masturbate in the room. The Compliance investigation concluded that none of that conduct could be proven due to a lack of any witnesses to corroborate what was allegedly said and occurred in the youth's room. Although camera footage showed the staff stopping at the youth's door, conversing with him and giving him items, no security camera view showed the inside of the youth's room. The staff was substantiated for violating boundaries after admitting to giving the youth a stress ball and sticky note with essential oils rubbed on it, which she claimed she gave to the youth to help him with his mental health struggles. Compliance made no recommendations or suggestions as a result of that incident.

Another substantiated case occurred in September 2025. There, a youth alleged that two staff made flirty and sexually inappropriate comments to him; that one of the staff suggestively bent over in front him, spread her legs to him, and showed him her "hickies"; and that the other staff sat close to him and poked his leg with a pen in a classroom. According to Compliance, there was a lack of corroborating statements and security camera footage to support all allegations of what was said and occurred except for the staff poking the youth in the leg with a pen, which was observed on video. The poke drew blood on the youth's leg and the staff was then seen wiping the youth's leg with a tissue and hand sanitizer. Compliance made no recommendations or identified any needs for improvement as a result of that incident, but noted that facility administration will take any action it deems necessary.

The final substantiated case involved the sole male YRTC-Kearney staff member to be named as a perpetrator in any allegation. There, in October 2025, a youth was getting a drink at a water fountain when the staff allegedly hit the youth in his genitals with an ice pack. The youth claimed the staff laughed after doing so and tried to bribe him with a snack if he agreed not to

say anything. The staff was observed on video hitting the youth as alleged, and he also was found to have said inappropriate and derogatory remarks about this youth and other youth in the past. Several other staff members were present for the incident and did not immediately report what happened. The staff present were suspended pending an investigation, and after substantiating the case for violations of the staff code of conduct and ethics and youth professional boundaries, the staff who hit the youth in the genitals was ultimately terminated. Compliance recommended that all staff be retrained in PREA to mitigate any further incidents from not being reported.

Other than these cases, all other allegations made by youth that were investigated by Compliance and that are included in this report were unsubstantiated, unfounded, or remain pending if a criminal investigation is ongoing.

Unfounded and Unsubstantiated Allegations

Once again, many allegations were determined by Compliance to be unsubstantiated or unfounded. Approximately 15 allegations against staff were unsubstantiated, approximately 15 allegations were unfounded, numerous cases that involved distinct types of allegations included a combination of unsubstantiated and unfounded determinations, and approximately four cases are currently pending in some form or another.

An unfounded allegation is an allegation that was investigated and determined not to have occurred. In its documentation, Compliance identified several different reasons why a specific allegation may have been unfounded. For example, after making an allegation, a couple of youth recanted and later stated that they had not actually been perpetrated against, and other youth would not identify who the alleged perpetrator was or would not provide details as to when and how they had been abused. For several of the unfounded allegations, youth alleged that a certain staff member perpetrated against them on a particular date or within a particular timeframe, or at a specific location at the facility. However, Compliance stated it was able to eliminate the possibility of any abuse occurring as alleged because that staff member was documented to be elsewhere at that time, or, when reviewing security camera video footage, the staff or youth could be observed on camera and no such abuse occurred. In addition, in some of these unfounded cases, there was a lack of corroboration or contrary evidence when numerous other staff and youth who were present for an alleged statement that was made or physical conduct that occurred stated that the alleged incident did not occur.

An unsubstantiated allegation is one that was investigated but the allegation produced insufficient evidence to make a final determination as to whether or not the event occurred. It

is thus important to note that any allegation with an unsubstantiated finding does not necessarily mean the alleged violation did not occur. Instead, this finding simply means that Compliance determined there was insufficient evidence to determine whether the allegation did or did not occur. One of the more common explanations Compliance gave for an unsubstantiated determination in these cases was that youth making an allegation or who were witness to an allegation changed their stories over time and provided new information about the alleged abuse each time that they were spoken to. Often, after reviewing camera footage, interviewing numerous persons, and collecting written statements and other documentation, Compliance determined that, although some factors may have indicated that the allegation did occur, there was not enough evidence to meet the preponderance of the evidence standard. Other times, allegations overlapped with each other and youth frequently gave inconsistent, and even contradictory accounts of how, where, and when they had been abused. As such, Compliance found many youth accounts not to be credible. Compliance and YRTC-Kearney staff also believed on several occasions that some youth made false allegations against staff as a form of retaliation for the staff issuing rule violations against the youth.

In addition, after some of the earlier allegations were found to be substantiated against Staff 1 and Staff 4, and certain details regarding those incidents were made public and widely talked about at the facility, there was an influx of substantially similar or identical allegations made by many youth against those same staff members. Approximately 70% of all allegations against staff occurred in October or early November 2025, shortly after some details of the substantiated allegations against staff became public in early October. Numerous investigations noted that Compliance and YRTC-Kearney staff believed the youth had made a false or "copycat" allegations in hopes of getting an emergency juvenile court hearing and transferring out of the YRTC. In fact, in several of the investigations, youth were overheard by staff, other youth, or on the telephone essentially saying they would be making an allegation to achieve just that. Regardless, as will be discussed more later on in this report, the fact that many similar allegations were made, and that many were made within a short amount of time, does not necessarily mean they were copycat allegations. In some cases, the similarity of the allegations could also be indicative of a pattern of behavior by staff.

For the allegations that included some element of a staff member allegedly saying something inappropriate to a youth, Compliance usually indicated it had no way of proving what may have been said. The security camera system at the facility does not record audio, and, as such, if there were no other staff or youth present for the alleged statement, it could not be corroborated by Compliance. Further, Compliance frequently noted that it was limited in its

investigations insofar as it could not interview any youth or staff if they were no longer at the facility. Numerous youth made allegations after they left the facility, and many of the alleged staff perpetrators were suspended, fired, or resigned either before or after the allegations. Based on the OIG-CW's review, there were at least 10 youth who made an allegation against a staff member or who were named as a witness to an allegation but who were not spoken to by Compliance. Compliance did not interview these alleged youth victims and witnesses because the youth were no longer at the facility, for example, because they had been discharged or temporarily moved to a different facility. Similarly, in at least 12 allegations made by just as many youth, the alleged staff perpetrator was not interviewed and questioned about the alleged sexual abuse because they were not at the facility when Compliance was investigating, either because they had resigned or been suspended or terminated.

Compliance also could not review any security camera footage if the allegation's date extended beyond the facility system's retention period, which generally lasted up to 90 days. Often in the investigative reports, Compliance noted that some of the camera footage from the timeframe when the alleged sexual abuse occurred was partially outside of the retention period and thus unavailable for review. In those instances, Compliance attempted to talk to youth and staff who were present or who may have had knowledge about the circumstances surrounding the allegations. But if there was no other evidence that a boundary violation, inappropriate contact, or sexual assault occurred, the youth's allegation was most likely deemed unsubstantiated, even if there could have been camera footage of the alleged incident at an earlier time.

Compliance Recommendations and Identified Areas Needing Improvement

When conducting a review or investigation into a PREA allegation, Compliance has the opportunity to make recommendations to change facility policies or procedures and to identify any areas that need improvement, regardless of whether the allegation is substantiated. In all of the Compliance reviews and investigations that the OIG-CW received, Compliance made recommendations or identified areas for improvement in approximately one-third of the cases. Over half of the reviews and investigations had no recommendations or identified areas that needed improvement. Other cases noted that while Compliance had no formal recommendations or suggestions, it would continue to monitor the situation for retaliation between the staff and youth, that facility administration may take appropriate action, that staff should continue to document everything and monitor the behaviors of the youth who made the allegation to deter false reporting, or that no recommendations were being made because the allegation was an isolated incident not the result of improper staff supervision or was simply the result of one youth's behavioral issues.

Some of the recommendations and areas needing improvement that were identified by Compliance included:

- Staff should challenge youth demonstrating inappropriate behavior and support frontline staff in reporting and documenting such behaviors. Issue rule violations to youth for false reporting, and remind the youth of the importance of truthful reporting and the dangers of making false allegations as a form of retaliation.
- For a staff member to seek guidance from a more experienced female staff to learn how to become more comfortable in dealing with difficult situations with youth and challenging poor behavior from youth of the opposite sex.
- More frequent rounds in the living units and supervisor check-ins should be done to prevent inappropriate relationships between staff and youth from forming and more living unit searches should be done to find notes passed between staff and youth.
- Supervisors should conduct more spot checks to discover the inappropriate behaviors between staff and youth.
- Staff should be re-trained by Compliance on PREA reporting obligations.
- OJS policy should be revised to require Human Resources to establish or communicate a clear requirement or to explicitly state that staff are expected to remain available to report to the facility and be interviewed by Compliance even when the staff is on suspension.
- A facility procedure or plan should be implemented to notify the mental health department when Compliance and facility leadership are notified after any allegation is made to ensure mental health staff is aware and able to assist the youth victim and initiate appropriate PREA protocols.
- Acknowledging that an area needing improvement was that Compliance was unable to interview several of the alleged perpetrators due to them no longer being at the facility.
- Stronger onboarding and policy acknowledgement processes are needed and a supervisory plan is needed for holding staff accountable to complete their review and acknowledgment of facility policies and procedures.
    - When investigating numerous allegations against three separate staff members, it was discovered that none of the staff had reviewed or acknowledged the facility policies or procedures from the time of hire through their resignation or suspension following the allegations made against them.
- Stricter monitoring protocols for youth phone calls are needed, including post-call reviews to ensure policies were followed.
- Explore options to extend the length of time camera footage is retained and determine if it is cost-effective to do so.

- Consider adding more cameras inside of the medical area at the facility, excluding the examination room within medical, or consider relocating the single camera currently in medical to a position that can provide better surveillance.
- The facility should review the recent patterns of behavior and several investigations involving a certain staff member and determine the proper course of action moving forward.

Status of Youth, Staff, and Facility Leadership

Eight youth were moved out of the facility by court order when the juvenile court was informed of the allegations. A few youth were moved to YRTC-Lincoln to continue their rehabilitation. Many of the youth remained on the YRTC-Kearney campus after the allegations were determined to be unfounded or unsubstantiated and the majority of those youth have since earned their release from the facility. A few youth remain at YRTC-Kearney at the time of this report.

All but one of the staff members against whom Compliance substantiated allegations are no longer employed at the facility. Three staff members were terminated from the facility following the allegations. One of those staff members was terminated for an unrelated personnel matter, while the other two were terminated after Compliance substantiated the allegations against them. Three other staff members against whom Compliance substantiated allegations voluntarily resigned from their employment at the facility, either shortly after the allegations were made or after criminal charges were filed. The staff member who remained at the facility was substantiated for a boundary violation unrelated to sexual abuse.

At least three additional staff members who were the subject of numerous allegations that were all ultimately determined to be unsubstantiated or unfounded voluntarily resigned from their employment as well.

The Facility Administrator who oversaw YRTC-Kearney during the period included in this investigation is no longer at the facility, and the facility has been operating under new leadership since March 2026. Similarly, DHHS recently announced that the OJS Administrator who oversaw all YRTCs during the period included in this investigation is no longer in that position, and the Facility Administrator at YRTC-Hastings has been named as the interim Youth Facilities Senior Administrator.

COMPLIANCE INVESTIGATION PROCESS

Compliance's purpose, as stated by DHHS, is to ensure best practices are observed in accordance with both federal and state laws and regulations. Compliance's role is to help ensure that the requirements and standards for the Joint Commission, Public Health Licensure, American Correctional Association (ACA), and PREA are met. Compliance for the YRTCs does not report to facility management, though Compliance's offices are on the YRTC campuses. Compliance is meant to provide independent oversight of concerns reported within the facility, including sexual abuse, harassment, and assault allegations. It completes administrative reviews or investigations into alleged incidents to ensure adherence to state and federal laws and regulations, accreditation standards, licensure requirements, and internal policies. Compliance does not investigate violations of criminal law. Recommendations are then made to the facility, though the facility does not have an obligation to implement recommended changes.

Compliance for the YRTCs includes the Compliance Administrator, who supervises a Compliance Manager. The Compliance Manager then supervises five Compliance Specialists, who conduct internal compliance reviews and investigations. OJS policy states that each juvenile facility shall employ a compliance specialist to coordinate the facility's efforts to comply with the federal and state-determined standards. YRTC-Kearney has two Compliance Specialists on campus.

The Compliance Administrator and Compliance Manager are tasked with providing oversight of all accreditations and licensure requirements, including PREA. The Compliance Manager reviews and approves the incident reviews and investigations completed by the Compliance Specialists. The OIG-CW learned through interviews that the Compliance Manager meets with the Compliance Specialists once a week to discuss current workload, the work ahead, and to look at any audit preparation needed. The Compliance Manager also oversees the investigative process and tracks grievances. The Compliance Manager and Compliance Administrator reportedly debrief at the end of each day on any compliance-related issues.

YRTC Staff Reporting of Suspected Abuse

DHHS OJS Standard Operating Procedure (SOP) requires that staff immediately report any suspicion or knowledge of sexual abuse, harassment, or assault (among other behaviors) by filling out the First Responder Form. [39] This form is turned over to a YSS, who then informs the Compliance Manager. Staff are also required to take immediate action to protect the juvenile if they know the juvenile is at substantial risk of imminent sexual abuse.

[39] See DHHS OJS SOP #1251-PREA Prevention, Detection, Reporting, Staff Responses, Investigations.

Juvenile Reporting of Suspected Abuse

DHHS OJS SOPs state that OJS and all YRTCs "mandate zero tolerance toward all forms of sexual abuse, sexual harassment, or sexual assault from other juveniles, staff, contractors, or volunteers."[40] It also states that those who report and cooperate with investigations have the right to be free from retaliation.

Upon arrival at any YRTC facility, the juveniles are provided information explaining the zero-tolerance policy regarding sexual assault, abuse, and harassment, which includes prevention, self-protection, reporting, and treatment. The juveniles will also receive, within 10 days of admission, orientation and education regarding their rights to be free from sexual abuse and sexual harassment, and retaliation for reporting.

Juveniles may report to any facility staff verbally or in writing, may call the Hotline, may file an emergency grievance, or may call the Ombudsman's Office. There is no time limit on when an emergency grievance must be filed when it is in relation to sexual abuse. The staff member who is the subject of the complaint will not be allowed to review the grievance. If it is determined that a juvenile filed a grievance in bad faith, the treatment team will determine the appropriate consequence. In interviews with YRTC-Kearney personnel, it was clear that youth are always allowed to fill out grievance forms when they would like to report something, and that youth often go to trusted staff members when they would like to report.

Incident Review and Investigation Process

Compliance is required to complete an administrative investigation or review for all allegations of sexual abuse. In the event NSP is conducting a criminal investigation into the allegations, Compliance is only required to complete an incident review. Compliance will complete its investigation once the law enforcement investigation is completed. If no criminal investigation is to be completed by NSP, then an incident review, as well as an administrative investigation, is to be completed by Compliance. The distinction between a Compliance investigation and a review is largely that an investigation will include interviews by Compliance staff and will result in a finding as to whether the incident occurred, whereas a review will not include interviews or an ultimate determination on whether the incident occurred.

Compliance investigations are to include: collection of physical, electronic, and documentary evidence; physical interviews with all alleged victims, suspects, and witnesses; collection of written statements and audio recordings, or both, with signed acknowledgements from all

[40] *Id*.

individuals interviewed; and a review of all prior investigative history or any other reports or complaints. OJS policy states that only investigators who have received specialized training in sexual abuse investigations involving juvenile victims pursuant to PREA National Standards will conduct the investigation. This training covers techniques for interviewing juvenile sexual abuse victims, proper use of *Miranda* and *Garrity* advisements, sexual abuse evidence collection, and criteria and evidence required to substantiate a case for administrative action or prosecution referral. Investigatory reports are prepared by the Compliance Specialists and reviewed and approved by the Compliance Manager. Importantly, an investigation includes a result or finding, which, as discussed, can be a finding that the allegation was substantiated, unsubstantiated, or unfounded. They may also include recommended actions. The standard of evidence for an internal investigation is preponderance of the evidence.

According to other OJS procedures, incident reviews are to be completed within 30 days of the conclusion of an investigation, whether the investigation is done by Compliance or NSP.[41] The following is considered in the incident review: whether a change in policies or procedures is needed, what motivated the incident, physical barriers in the facility, adequacy of staffing levels, and the need for monitoring technology changes. Incident reviews do not result in a finding or conclusion as to whether the incident occurred. However, recommendations are made to the YRTC Facility Administrator, and the facility shall implement them or document its reasons for not doing so.

Reporting of Sexual Abuse Allegations

Any allegations of kissing, hugging, or sexual contact between a staff member and youth shall be reported to the Hotline.[42] The YRTC Hotline Reporting Form is used for all calls to the Hotline and sent to Compliance. It should be noted that any time that an intake regarding the YRTCs is accepted at the Hotline as "Law Enforcement Only," that intake is also sent to law enforcement by the Hotline. However, Compliance is also currently reporting all sexual abuse allegations of youth by staff to NSP, as required by its policy. Legal party notifications are to be made to the youth's parent or guardian, assigned juvenile probation officer, Children and Family Services Specialist, assigned attorney, committing county attorney, and the committing judge on file for any youth identified as a potential victim. Legal parties are to be notified within five business days of allegations.

[41] DHHS OJS SOP #1252-PREA Treatment, Follow-up and Reports of Abuse, Neglect, Sexual Harassment & Sexual Abuse / Assault.
[42] DHHS OJS SOP #3359-Legal Notifications for Incidents and Allegations.

OJS policy dictates that youth who allege or experience sexual abuse are required to receive certain supports and information. Youth alleging sexual abuse shall be offered forensic medical examinations at an outside facility, such as through a Sexual Assault Nurse Examiner exam at a hospital or at a CAC. These are facilitated only when cases are being investigated by NSP. Forensic interviews are also only conducted at the request of NSP. Youth alleging sexual abuse are also to be referred to mental health staff and be provided with outside victim advocates for emotional support services related to sexual abuse, which should be provided through the CAC. In addition, youth are to be informed as to whether their allegation has been determined to be substantiated or not, the staff member's employment status, and the status of legal charges against the staff member.

STAFF ROLES, SUPERVISION, AND TRAINING

Staff Roles and Supervision

The roles of different staff within YRTC-Kearney were explained to the OIG-CW through interviews with various staff.

Each unit consists of a Unit Manager, who oversees the staff within that unit, including Youth Program Specialists and Case Managers. The UM position is supervised by the Facility Administrator.

The Youth Security Supervisor role is focused on the safety and security of the facility and the youth. The YSSs carry mechanical restraints and respond to crises with youth. The YSSs are assigned to a particular unit, and check in with the units throughout the day and evening, essentially making rounds, but are also covering the whole campus as needed. There are two YSSs on campus overnight, while there are four to five on campus during the day. YSSs are the point of contact for the YPSs when they are in need of assistance. YSSs do not directly monitor the YPSs, but are considered supervisors and can discipline or coach them, keeping them accountable. There are two YSSMs within the facility, who are also supervised by the Facility Administrator, and who oversee the YSS team.

YPSs are the frontline staff who are with the youth the majority of the time. YPS staff are present at the facility 24 hours a day, operating on three different shifts. They are in charge of implementing programming and ensuring that the youth complete their required tasks. The YPSs play a part in the youths' treatment, helping them develop and implement skills, like getting along with others and staying out of conflict. The YPSs can write-up the youth for minor violations. Other YPS responsibilities include moving the youth throughout campus during the day, escorting them to school, recreation, and meals, and distributing medications to the youth. Importantly, YPSs are also responsible for coming up with things for the youth to do in their downtime within the unit, with the goal of tying those activities back to the skills they are to be developing. YPSs are to be within a 1:8 staff-to-youth ratio when the youth are awake and a 1:16 ratio while the youth are asleep, with no other types of staff counted within the ratio. Every shift has a debrief log where the YPSs log activity, violations, issues, or any other pertinent information from the shift. There are no lead workers among the YPS staff. When they are alone in the unit with the youth, they are to come together as a group for any decisions that need to be made.

Each youth is directly assigned a CM. There are two CMs per living unit. CMs are the lead staff member for the youth to go to when they need something, such as to speak with a member of

their team, like their juvenile probation officer or attorney, or for concerns they have. CMs also monitor each youth's progress. The CMs check in on the youth during school, attend family team meetings, escort the youth to meetings, ensure the youth get to therapy, attend court hearings, and complete progress letters to the court. CMs typically work 10:00 a.m. to 6:00 p.m., and the last two hours of their shift are spent completing Moral Reconation Therapy (MRT) and Aggression Replacement Training (ART) groups with the youth on certain days. CMs are also the point of contact for families, Juvenile Probation, attorneys, and the courts. CMs can direct YPSs to complete tasks, inform them about youth needs, or redirect the YPSs' behavior.

There are weekly team meetings within each living unit, attended by the UM, YSSs, YPSs, and CMs. During these meetings, staff discuss youth progress, needs, and any concerns. These meetings assist the YPSs in knowing what skills each youth is working on so that they can assist the youth in practicing those skills.

As noted, there are some basic lines of authority and supervision between the different roles at YRTC-Kearney. However, the OIG-CW interviews also revealed that YRTC-Kearney tends to operate on a community policing mentality. If any staff member sees something that needs to be addressed with any other staff member, they can address it—including by calling out behavior. The majority of the time, YPS staff are the staff members with the youth, particularly in the early morning and evenings. While UMs, CMs, and YSSs come in and out of the units, their presence is not as consistent. Among the staff interviewed by the OIG-CW, there was a consensus that staff feel as if they can report concerning behavior by other staff, staff have trusted supervisors they feel they can speak to, and staff feel they would be aware if another staff member was violating boundaries with a youth. It was stated that the reminders to report concerns and monitor their own boundaries with youth have increased since the allegations in this report came to light.

YRTC Staff Training

YRTC staff are required to complete 120 hours of training in their first year of employment. Staff training is extensive and includes training on PREA, boundaries, employee manipulation, interpersonal relations, adolescent development, and 29 other areas.

Full-time staff are also required to complete 40 hours of training per year after their first year of employment in 13 topic areas, including PREA, juvenile rights and regulations, and trauma-informed care.

The OIG-CW has been able to review the training materials pertaining to OJS Policies, the YRTC-Kearney Youth Manual, PREA, Professional Boundaries, and Interpersonal Relations Training.

The content of this training appears to be appropriate and covers the areas of concern in this report.

Compliance Training

Compliance Specialists are required to complete all of the facility-based trainings that all YRTC staff go through upon hire, and all of the annual refresher trainings. They also complete "Specialized Training: Investigating Sexual Abuse in Confinement Settings" through the National PREA Resources Center. [43] This training consists of nine modules on PREA, legal issues and liability, culture, trauma and victim response, medical and mental health care, first response and evidence collection, adult and juvenile interviewing techniques, report writing, and prosecutorial collaboration. This specialized training has detailed information on trauma, youth response to trauma, and being trauma-informed when speaking with youth, and delves into why youth may behave in certain ways based on what they have been exposed to and their response to possible sexual abuse in the facility.

Staff may also attend a one-day virtual PREA specialized investigations training through The Moss Group[44] annually, if that training is available. Additionally, Compliance Specialists complete training on the Reid Technique of Investigative Interviewing and Advanced Interrogation Techniques.[45] This training lists topics such as preparation, room environment, factors affecting behavior, behavior symptom analysis, behavior analysis interviews, and the actual interrogation, which has nine steps. This training does not appear to have any variation for use with adults as opposed to youth.

The Compliance staff will also attend various trainings by The Moss Group, PREA Resource Center, the ACA, or through The Justice Clearing House as needed.

[43] *Specialized Training: Investigating Sexual Abuse in Confinement Settings*, National PREA Resource Center (May 5. 2023), https://www.prearesourcecenter.org/resource/specialized-training-investigating-sexual-abuse-confinement-settings.
[44] *One-Day Virtual PREA Specialized Investigations Training*, The Moss Group, https://www.mossgroup.us (last visited June 6, 2025).
[45] *The Reid Technique of Investigative Interviewing and Advanced Interrogation Techniques*, John E. Reid and Associates, Inc., https://reid.com/programs/program-descriptions/the-reid-technique-of-investigative-interviewing-and-advanced-interrogation-techniques (last visited June 6, 2025).

Children and Family Services' Out-of-Home Assessment Process

When a call reporting concerns for child abuse and neglect comes into the Hotline, a screening tool is utilized to determine if such a report should be accepted for investigation. Those reports can pertain to individual families or facilities that care for children, such as daycare centers and group homes. If a report is accepted for investigation, CFS then assesses the family or facility regarding the safety of the child or youth and the risk of child abuse or neglect. The OHA tool is used to assess whether abuse and neglect has occurred within facilities. This OHA tool is used currently within facilities licensed by DHHS, including child care facilities and in-home licensed daycares, group homes, shelters, and treatment facilities. Until 2019, CFS staff completed OHAs at the YRTCs when the Hotline received an intake that was accepted for investigation regarding alleged abuse or neglect, including sexual abuse of a youth at the YRTCs. The CFS staff assigned entered the facility and completed a full investigation with the youth classified as the victim. Specific to sexual abuse allegations, the focus of an OHA was on whether an identified staff member perpetrated abuse or neglect on the victim through sexual contact or harassment. The focus of the OHA was not on how the facility is run, the policies of the facility, or compliance with any federal or state regulations. The focus of these investigations was specifically whether the victim was abused or neglected.

The access to information and the process for fact-gathering are different for OHAs compared to Compliance investigations. For example, CFS staff are able to coordinate with law enforcement on the investigation if needed, and are able to ensure that youth are interviewed at a CAC when appropriate. CFS has access to the information from the CAC interviews to use in their determination of whether abuse or neglect occurred. CFS staff are also able to interview youth even if the youth making the allegation is no longer placed at the YRTC, and can interview collateral contacts such as family members, attorneys, and juvenile probation officers. CFS staff are trained by the CACs in Nebraska to interview children in a specific, trauma-informed, and appropriate manner for their age and development.

At the conclusion of the CFS investigation through an OHA, a finding or determination is made as to whether there is a preponderance of evidence to show that the youth was a victim of child abuse or neglect. If CFS finds that abuse and neglect occurred, the staff member perpetrating the abuse is placed on the Central Registry. Once on that registry, they are likely to be unable to obtain employment working with children elsewhere. CFS can also recommend changes for the facility regardless of whether abuse or neglect is substantiated.

OHA abuse and neglect investigations at the YRTCs ended in 2019. DHHS reported through interviews with the OIG-CW that having CFS conduct OHAs was determined to be a conflict of interest. The YRTCs are organizationally placed under OJS, and OJS is an office within the Division of Children and Family Services. This makes the CFS Director responsible for both the CFS child abuse and neglect functions, as well as the operation of the YRTCs. DHHS' position is that an OHA resulted in CFS investigating CFS.

DHHS has created the Facility Investigation Team (or FIT) Reviews. The FIT reviews are done by personnel within DHHS' legal department. According to interviews with DHHS, the FIT evaluates the Compliance investigations to provide a legal review of the facility's adherence to policies and procedures and whether those policies and procedures are sufficient. The FIT review results in a legal opinion provided to the facility, which can contain recommendations that the facility must follow. It was confirmed in these interviews that Compliance investigations do not assess whether abuse and neglect occurred, except to the extent that a violation of facility policy might amount to abuse and neglect if an OHA were conducted. Neither the Compliance investigation nor the FIT review can place an employee on the Central Registry if their conduct is substantiated.

FINDINGS

FINDINGS

Based on the OIG-CW's review and analysis of the information and documentation gathered in this investigation related to the sexual abuse allegations at YRTC-Kearney, the OIG-CW makes the following findings.

1. The culture at YRTC-Kearney normalized inappropriate staff behavior, which the facility failed to sufficiently address.

The allegations in this investigation have resulted in four former staff members being criminally charged. Three other allegations were substantiated by Compliance. Moreover, the number, breadth, and consistency of the other allegations, the similarity to patterns of behavior seen in prior years, and the inadequate response from the facility with regard to supervision, disciplinary action, and a failure to recognize and address broader systemic issues, demonstrates a pervasive culture at YRTC-Kearney that normalized and insufficiently addressed behavior extending from boundary violations to inappropriate relationships and sexual abuse.

The OIG-CW does not find that all staff or administration at YRTC-Kearney engaged in or condoned this inappropriate staff conduct. On the contrary, it is clear that many staff members were committed to the safety, care, and rehabilitation of the youth.

But the concerns about the culture and management at YRTC-Kearney persist. The totality of the evidence paints a clear and concerning picture. The fact that many of the allegations were unsubstantiated, some were unfounded, and still others assumed to be "copycat" allegations does not undermine this conclusion. As noted, there were over 200 specific claims arising from 44 separate allegations, made by 37 unique youth against 19 different staff members, across all four living units and multiple other locations at the facility, over the course of approximately one year. Three of the most severe sexual abuse allegations and examples of improper staff conduct in this investigation were substantiated and occurred between March and August 2025, *before* any details of the allegations were made public. And even though most of the allegations were made after these few initial allegations became public, that does not necessarily mean, for reasons provided below, that all of those later allegations were untrue. These factors, the nature and extraordinary consistency of the allegations, and the facility's response to those allegations, warrants serious attention regardless of how many allegations were ultimately unsubstantiated, unfounded, or potentially fabricated.

As discussed above, many allegations were unsubstantiated, not because the evidence disproved them, but because the evidence was limited, witnesses were unavailable, or the

investigation was not thorough enough. The appropriate facility response to a large number of unsubstantiated allegations would not be to treat the alleged conduct as if it did not happen, but to ask what those allegations collectively suggest about the culture or environment at the facility, and use the opportunity to make improvements, including to the investigative process.

Fundamental questions did not appear to have been asked often enough. Even if many or all of the unsubstantiated allegations were untrue, Compliance did not appear to ask why there were so many youth making those false allegations. The facility did not assess if there were certain factors, such as the dynamics between youth and staff and the culture or management within the living units, that contributed to the frequency and consistency of the allegations. An underlying assumption seemed to be that some youth made allegations to retaliate against staff or to be discharged from the facility. The facility did not appear to determine if there were any issues with the youth going on beneath the surface of these allegations. But it is also worth considering the possibility that public disclosure of the earlier allegations may not have prompted fabrication, but may have created conditions in which some youth who had previously experienced or witnessed inappropriate staff conduct felt, for the first time, that they could come forward. The facility's apparent failure to consider that possibility demonstrates broader institutional deficiencies in how allegations were assessed and responded to. These deficiencies include a failure to view youth as potential victims and a failure to prioritize creating an environment in which the alleged conduct was less likely to occur and more likely to be detected or stopped.

The concerns about the culture identified in this investigation were reinforced by the similarity of those incidents to ones dating as far back as 2022. The OIG-CW reviewed previous allegations made by youth and disciplinary actions taken against the same staff members alleged as perpetrators in this investigation. It was apparent that the same exact types of alleged staff conduct and patterns were present then as are present now. These recurring allegations were not only present in cases involving staff who have been criminally charged in 2025 and 2026, but also cases involving staff who have since resigned, or some who remain employed at the facility. In total, of the 19 different staff members named as alleged perpetrators in this investigation, at least 11 of them were previously written-up, verbally counseled, placed on disciplinary probation, or were previously named by youth in sexual abuse or boundary-related allegations. Previous allegations made by multiple different youth, across different living units, describe the same types of unprofessional, inappropriate, and sexual conduct by numerous different staff members, some of which were substantiated. Several staff

who were the subjects of substantiated findings in this investigation had previously been the subjects of similar allegations in the past that were closed as unfounded or unsubstantiated.

For example, Staff 3 was the subject of several previous allegations that involved behavior strikingly similar to the behavior for which she was criminally charged. In 2022, a youth was investigated for inappropriately touching Staff 3, but the youth claimed that she touched him first and tried to initiate a relationship with him. The youth's allegation was unfounded and Compliance's documentation of the incident stated that the youth was "a victimizer blaming the victim of their actions." In 2024, a third youth alleged that Staff 3 had sexual contact with him through the slot opening of the door to his room at Dickson, an allegation that was unfounded because video review of a three-week period showed no such sexual activity, and the youth was noted as having "an extensive pattern of making accusations." That same youth twice alleged in 2025 that Staff 3 touched his penis in the same manner through his door. For at least one of those occasions, the youth stated that Staff 3 touched his penis when she put her hand through the door and pretended to hand him a tissue. Two other youth alleged in 2025 that Staff 3 watched them masturbate at the door to their room in Dickson, allegations that were unfounded or unsubstantiated. Two additional youth alleged in 2025 that Staff 3 was making flirtatious and sexually inappropriate comments towards them.

As mentioned earlier in this report, in 2023, it was alleged that one youth was having sexual relations with Staff 1, and that a different youth, who was the same youth allegedly having sexual relations with Staff 1 in 2025, stated that he wanted to start having sex with Staff 1 too. This 2023 allegation was unfounded for lack of corroborating evidence. Staff 1 was given a verbal counseling in 2024 for allowing youth to touch her and sit too close to her, and she was encouraged to remove herself and ask for help in those situations. Numerous different youth, and at least one staff member, stated throughout 2025 that Staff 1 was engaging in sexual and romantic relationships, spending a lot of time with one youth in particular, flirting, and engaging in sexual conversations and inappropriate touching. She was also placed on disciplinary probation in early 2025 for sharing food and drinks with youth and was told to review facility policies and maintain appropriate boundaries with youth. Staff 1 has been criminally charged for conduct related to this investigation.

Staff 4, who was also criminally charged for conduct related to this investigation, after she was observed kissing and touching a youth, including underneath a table while they sat next to each other, was written-up and counseled just two weeks before that incident for boundary issues with a different youth where she was sitting close to the youth on his bed. She was reminded at

that time to keep a reasonable distance from youth and that when she sits at a table with youth, she should keep her hands visible to the cameras.

The allegation by a youth against Staff 2, the fourth staff member who has been criminally charged, claimed that between April and October 2025, he and Staff 2 were in a relationship, that they had sexual contact on multiple occasions, including touching each other in the stairwell and at a table sitting next to each other, and passing sexually explicit notes. A different youth made similar allegations in March 2025. In that earlier allegation, the youth alleged that Staff 2 discussed her favorite sexual positions and being in a relationship with him outside of the YRTC, that she wanted attention from him, sat close to him at a table, and let other youth rub her thigh. Those allegations were unfounded, and the youth who reported them received a rule violation for making a false allegation.

Another staff member who was named by two different youth in two allegations, one in late 2025 and the other in 2026, allegedly allowed youth to use her personal cell phone, gave her phone number to youth, shared personal and intimate sexual details about her life with youth, sexually pressed her breasts into youth when assisting them, and discussed having relationships with them. All of this alleged activity was unsubstantiated or unfounded by Compliance. In late 2024 and early 2025, however, this same staff was twice substantiated for violations of professional boundaries, then counseled and placed on disciplinary probation, for using her personal phone for personal reasons in front of the youth, allowing youth to look at her personal phone while she was using it, and purchasing meals for a youth during a trip outside the facility.

There was other evidence of certain staff members needing and receiving additional training and requiring multiple instances of verbal counseling related to appropriate boundaries and professionalism with youth. Two staff members receiving the additional training were collectively the subject of over 20 youth allegations regarding a wide variety of sexual and inappropriate conduct in late 2025 that were all unfounded or unsubstantiated by Compliance. Before their re-training, a youth also alleged that one of those staff members was making flirtatious and sexually suggestive comments towards him. Likewise, two other staff members named in approximately 12 youth allegations between July and November 2025 were verbally counseled by facility management at least four times earlier that year to maintain appropriate boundaries with youth, not share drinks or print song lyrics for youth, stop showing favoritism toward youth, and to be a better role model and stop using profane or degrading language. Compliance documentation specifically noted that numerous different individuals raised concerns about one of those staff members having ongoing boundary issues with youth.

This pattern and indications of longstanding institutional and supervisory deficiencies at YRTC-Kearney extends further still. After reviewing the OHA investigations conducted by CFS at YRTC-Kearney between 2016 and 2019, it is clear that the same types of alleged staff conduct have persisted for at least a decade. In those OHAs, CFS investigated allegations that staff members talked to youth in sexual innuendo, passed notes and were flirtatious with youth, brought contraband into the facility for youth, engaged in ongoing relationships with youth, touched a youth's penis, that there was a particular room or closet where sexual activity may have occurred, and, in one case, a staff member sexually abused a youth, leading to that staff member's arrest. Those investigations resulted in CFS recommendations aimed at addressing the cultural conditions that had allowed such conduct to occur, even in cases that were not substantiated.

As described earlier, some of those exact behaviors were the subject of the allegations in this investigation. But, in a significant number of cases in this investigation, those allegations were closed without substantiation, often because there was no audio recording to confirm what was said. Whether or not any individual verbal allegation was provable, the frequency with which the many different youth reported this type of conduct suggests that sexually inappropriate verbal conduct by staff was not an isolated occurrence, and that the facility's response when it was reported or observed was insufficient to deter it.

Further, in interviews conducted as part of this investigation, the OIG-CW spoke with both facility frontline staff, facility management, as well as Compliance staff. With remarkable consistency, most interviewed characterized the staff members who engaged in the alleged conduct as merely isolated bad actors—"a few bad apples"—whose conduct was not indicative of any broader cultural, systemic, or operational problem at the facility. The staff's conduct, according to this view, could not have been anticipated or prevented and did not reflect any deficiency in the facility's policies, practices, staffing structure, or institutional environment. This attitude was evident in the facility and Compliance's failure to consistently identify issues or recommendations for improvement when reviewing allegations.

The OIG-CW does not dispute that any individual staff members who perpetrated on a youth were bad actors and made choices and engaged in misconduct that they must be personally responsible for. The OIG-CW also acknowledges that some degree of staff and youth misconduct is difficult to prevent and unrealistic to eliminate in any institutional setting, regardless of the safeguards put into place. But the consistency with which different types of staff characterized the perpetrators' conduct as just a few bad actors, and the absence of a commitment—especially in the earlier allegations—to examine whether the facility's

environment, culture, policies, or practices contributed to or failed to prevent the alleged conduct is a significant concern and both reflects and reinforces the culture problem that this finding describes. Effective efforts to prevent staff sexual abuse, harassment, and violations of professional and appropriate boundaries should identify how the bad actors were able to engage in the conduct, why the conduct was not detected sooner, whether the facility's culture made it easier for the conduct to occur or more difficult for youth and staff to report it, and what changes to facility policies or practices are necessary to reduce the likelihood of similar conduct in the future. In several instances, youth were also characterized by staff and in Compliance documentation as manipulative, as initiators of inappropriate contact, and as having fabricated allegations for some ulterior motive. The OIG-CW acknowledges that some youth may have behaved in those ways and that managing the behavioral dynamics of the YRTC population presents real and ongoing challenges for staff. The OIG-CW also observed evidence suggesting that some staff members and youth appeared to have developed what they may have genuinely perceived as romantic relationships with each other, as well as a dynamic where many of the staff members alleged as perpetrators were young, female, and relatively new employees. This dynamic and type of staff, serving an adolescent male population with histories of trauma and some with hypersexualized behavior, contributes to some of these challenges.

But these challenges and characterizing the youth in this way, even where accurate, does not diminish the facility, and ultimately the state's, responsibility. The youth at YRTC-Kearney are in the care and custody of the state. DHHS, OJS, and YRTC-Kearney are obligated to protect them from sexual abuse and other forms of child abuse and improper treatment. That obligation should not depend on whether youth behave appropriately or initiate the improper conduct. Despite their past criminal history or conduct while at the facility, the YRTC-Kearney population are still youth, and any sexual or other type of abuse perpetrated on them makes them a victim. If anything, a population that frequently engages in sexualized behavior or that attempts to initiate relationships with staff makes the need for a robust, consistent institutional culture of professional boundaries and staff conduct more urgent, not less. Newer and younger staff may be less prepared and comfortable to recognize and put a stop to inappropriate and boundary-testing youth behavior. The facility should account for these circumstances through robust onboarding and training, vigorous supervision and mentorship from more senior employees, and a facility leadership and culture that consistently enforces appropriate boundaries and provides all staff with tools to maintain those boundaries.

OJS policies on staff and youth relationships explicitly address many of the specific behaviors alleged in this investigation, including sharing of personal phone numbers, purchasing items for

youth, passing notes, engaging in inappropriate conversations about intimate or sexual activities, and being alone with youth. The breadth of conduct covered by that policy, and the breadth of substantially similar conduct alleged across this investigation, suggests that the policy has not functioned as an effective cultural standard at YRTC-Kearney in the sense that these boundary violations were either not recognized as serious or were not treated as such in day-to-day practice. When more minor staff and youth boundary issues are not consistently addressed, the distinction between acceptable and unacceptable conduct can become blurred, increasing the risk that more serious misconduct may occur or go unreported.

The appropriate response to a hypersexualized environment, even one created in part by the youth, is not to tolerate inappropriate conduct or for staff to respond to it in the lighthearted or joking manner that appeared to be present too often in this investigation. Instead, the appropriate response is to address that conduct directly through clearly communicated expectations, boundaries, and programming that helps youth develop healthy ways of managing these issues, as well as through consistent staff responses that do not normalize inappropriate conduct, and through a facility culture that treats professional boundaries as non-negotiable. Based on the evidence reviewed in this investigation, the consistent institutional enforcement of professional staff and youth boundaries did not appear to exist at YRTC-Kearney in practice, even if it was described in policy, and it will not develop without intentional and consistent effort from facility staff and leadership.

2. Internal compliance investigations are necessary, but they are not sufficient to determine if abuse and neglect has occurred at the YRTCs.

It is critical to recognize that much of the behavior alleged by the youth at YRTC-Kearney in the last year would and should be considered abuse. That is true even if the youth initiated the contact or relationship with the staff member. These youth are not only minors, but they are protected individuals under the law while at the YRTC and are committed to the "care and custody" of OJS and DHHS for the purpose of rehabilitation and treatment.[46] These youth come to the YRTC with significant behavioral and mental health challenges, and often with significant trauma. It is the staff's role and duty, as is outlined in DHHS' policies, to maintain professional boundaries with the youth.

The stated purpose of Compliance at the YRTCs is to provide independent oversight of concerns reported within the facility, including sexual abuse, harassment, and assault allegations.

[46] See Neb. Rev. Stat. § 43-408.

Compliance reviews and investigations are meant to ensure the facility adheres to state and federal law and regulations and internal policy. The Compliance process is important and necessary to the proper functioning of the YRTCs. However, the OIG-CW found that Compliance investigations and reviews are limited in two key ways. First, the focus of Compliance investigations is on adherence to law and policy and the administration of the facility, and not on youth as potential victims of abuse. Indeed, as DHHS noted in its response to this report, Compliance investigations "are not intended to determine whether abuse and neglect occurred." (See Appendix C.) Second, fact-finding is limited by Compliance's process and jurisdiction, making it harder to determine if an incident actually occurred.

As noted above, until 2019, CFS conducted abuse and neglect investigations within the YRTCs through OHAs. Currently, CFS conducts OHAs in all juvenile facilities except YRTCs and juvenile detention centers. During OIG-CW interviews in this investigation, it was stated that the Compliance investigations are sufficient to address abuse because the facility policies are there to prevent abuse and neglect. Certainly, there is significant overlap between behaviors that would amount to policy violations and behaviors that are abusive. But there is an important distinction between an investigation to determine whether there have been policy violations and an investigation to determine whether abuse has occurred. The former is oriented to the proper administration of the facility, while the latter is oriented towards the well-being of the child. Compliance is not empowered under the law to make a finding of abuse and neglect. An OHA determines what happened to the child, how any abuse has impacted the child, and what needs to be done going forward to protect other children.

This difference in orientation was borne out in the response to the youths' allegations in a number of cases. For example, in three of the cases detailed earlier in the report, the youth were immediately placed in confinement in Dickson for a behavior violation upon making the allegation. While the youth's behavior may have amounted to a rule violation—possessing a cell phone and touching staff—the punitive approach did not appear to end even when other evidence was uncovered to indicate that the staff had engaged in sexual contact or inappropriate behavior.

The differences in process between an abuse and neglect investigation and the Compliance reviews and investigations is important. To begin, the OHA is a more complete and multi-faceted assessment. OHAs contain a more in-depth and complete picture of how the youth is doing in the facility. Previously completed OHAs explored the youths' history, diagnoses, progress in the program, and disabilities or limitations, asking these questions of multiple people filling varying roles with the youth, including talking with the youths' parent or guardian.

OHAs explored the facility functioning and protocols from the perspective of staff in different roles, as well as the youth. This allowed CFS to identify any inconsistencies between what is required of staff and what is being done in practice. OHAs described the staff involved, their employment history at the facility, and their attitude regarding the facility and the allegations. OHAs also examined the response of the facility to any safety concerns and all evidence reviewed.

In Compliance investigations, by contrast, information about the youth was focused on the details of the youth's allegations and the veracity of the youth's statements. In the investigations reviewed, inquiries about the youth's behavior were more often focused on whether the youth might have been at fault and whether the youth may have been intimidating the staff through their behavior. The power dynamic between youth and staff is not mentioned or explored in the internal compliance documents. It is not emphasized in any Compliance reviews that these youth are minors and that those alleged to have violated PREA or boundaries are adults tasked with caring for the youth. In addition, while the staff members' training history was reviewed, there was not often any examination of previous concerns with that employee. It would seem that in order to determine if there is a pattern of behavior, previous related concerns within a staff member's employment would be key. The focus on the facility and how it functions alone leaves out the well-being of the youth and discounts the seriousness of this behavior by staff.

Further, the OHA process is not subject to some of the limitations found in the Compliance process, allowing for more robust fact-finding. For example, in Compliance reviews and investigations, when the youth are no longer residing on the YRTC campus, they are not interviewed by Compliance. If the youth has been discharged or—as was the case in many of these investigations, the youth was temporarily moved to juvenile detention by the court—those youth are not interviewed at all in regard to the allegations. As a result, a direct account from the potential victim may not be gathered. By contrast, CFS staff completing an OHA would have the ability to interview youth regardless of their placement or the status of their commitment to the YRTC. In addition, CFS has the ability to refer youth to be interviewed at the CAC, where a forensic interview by a highly trained professional can be completed, which is the standard when interviewing youth in potential sexual abuse cases. Several of the youth in this investigation had forensic interviews at a CAC. But the request for an interview was made by law enforcement. The YRTCs cannot request a CAC interview for youth. It is essential that the youth's voice is included in any investigation into instances of sexual abuse and Compliance lacks the ability to interview youth who are no longer actively on the YRTC campus. Youth often

make allegations of sexual abuse when they are no longer in a place where the alleged perpetrator has access to them, further highlighting this concern.

Similarly, if the staff members involved or present at the time of the allegation are on leave, including vacation or medical leave, or no longer work at the facility, they are also not interviewed. There were a few instances where staff that were on investigative suspension were called and asked to come back in to be interviewed, but it was rare that these interview attempts were successful. The only procedural barrier that CFS staff would have in speaking with YRTC staff members would be a request by law enforcement that CFS hold off on interviews or if a YRTC staff member refused to cooperate.

CFS also does not face the same limitations as Compliance when working with law enforcement. When law enforcement is involved, Compliance only completes an incident review, rather than a full investigation. As stated previously, these reviews are focused on policy and internal facility procedures, they do not have a finding with regard to the alleged behavior. If there is no law enforcement involvement, Compliance will complete an investigation that will result in a finding related to the allegations. More importantly, information gathered by law enforcement from CAC forensic interviews of youth, or interviews of staff by NSP, for example, are not shared with Compliance. This creates a gap in the information Compliance may need to determine if a staff member is safe to continue working with youth. CFS staff, however, work very closely with law enforcement, are often informed as to what alleged perpetrators expressed in interviews with law enforcement, and are allowed to view CAC interviews of youth, ensuring that all of the relevant information available is included in the determination that is made in their abuse and neglect investigation.

Both Compliance and OHAs can make recommendations for changes at the facility. From a review of Compliance investigations, however, it appears that recommendations were not regularly made, particularly if the allegations were unfounded or even unsubstantiated, even though an unsubstantiated allegation, by definition, might have occurred. Previous OHAs, on the other hand, often included recommendations for improvement within the facility, even when the finding was unfounded. Some of these previous recommendations included refresher training, evaluating supervision of staff, evaluating how management handles staff complaints regarding other staff, calling the Hotline immediately after an allegation, monitoring youth phone calls at random, increasing the number of staff in Dickson, and requiring staff to wear body cameras and never be alone with youth. In addition, previous OHAs included recommendations for personnel action even when the allegation could not be substantiated,

including recommendations that a specific staff member no longer work with youth and that a staff member should be terminated.

The allegations in this investigation amount to abuse and should be investigated as such. OHAs and Compliance investigations and reviews are both necessary to serve the best interests of the youth.

3. Without abuse and neglect investigations at the YRTCs, staff who abuse youth may not be placed on the Nebraska Child Abuse and Neglect Central Registry and can continue to work with youth elsewhere.

Outside of the YRTC setting, when CFS completes an investigation into a report of child abuse or neglect and determines by a preponderance of the evidence that the abuse or neglect occurred, the subject of that report is placed on the Central Registry.[47] The Central Registry is maintained by DHHS and contains a record of all persons who DHHS or the courts have found to be responsible for child abuse or neglect.[48] A person can be placed on the Central Registry if a report of child abuse or neglect is classified in one of three ways: (1) court substantiated, which applies when a court has entered a judgment of guilty against the subject of the report in a criminal case or when a juvenile court has adjudicated jurisdiction over the child in a juvenile case which relates to the reported abuse or neglect; (2) court pending, which applies when a criminal case or juvenile petition related to the reported abuse or neglect has been filed and remains pending before a court; or (3) agency substantiated, which applies when DHHS determines by a preponderance of the evidence that the subject of the report did abuse or neglect the child.[49]

One of the primary implications of being placed on the Central Registry is on employment and volunteer opportunities. Any person appearing on the Central Registry may be denied employment or the opportunity to volunteer with the youth. This process and the Central Registry serve as an essential safeguard to protect youth and prevent perpetrators of abuse and

[47] See Neb. Rev. Stat. § 28-720(1)(c). See also Neb. Rev. Stat. §§ 28-712.01, 28-713 (governing CFS investigations into child abuse or neglect).
[48] See Neb. Rev. Stat. § 28-718(1). For more information about the Central Registry, see Neb. Dep't of Health & Hum. Serv., *Abuse and Neglect Central Registry and Expungements*, https://dhhs.ne.gov/pages/abuse-and-neglect-central-registry.aspx (last visited June 9, 2026).
[49] See § 28-720(1). See also §§ 28-713.01(1)(b) (CFS must notify the subject of the reported abuse or neglect of the determination of the case and whether they will be entered into the Central Registry as a result); §§ 28-713.01(2), (3) (notification must include, among other things, the nature of the report made against the subject, which of the classifications the report falls under, and, if the person is placed on the Central Registry, various provisions regarding their rights and an explanation of the implications of being placed on the Central Registry).

neglect from having direct access to other youth and continuing their abusive conduct in any other setting.

Critically, Compliance at the YRTCs does not have the authority to place staff on the Central Registry, even if an incident is substantiated. CFS, through its abuse and neglect investigations, does. The practical consequence of DHHS' decision to discontinue completing OHAs at the YRTCs is that DHHS now has no mechanism to agency substantiate an allegation of child abuse or neglect against a YRTC staff member and place them on the Central Registry, thereby significantly undermining the safeguard found in the Central Registry. Therefore, the only remaining means of placing an accused YRTC staff perpetrator on the Central Registry for allegedly sexually or physically abusing or neglecting a youth in their care is if the staff is criminally charged and a court substantiates the allegation by finding them guilty. Absent that criminal conviction, the staff member would not be prohibited by law from leaving their employment at the YRTC and proceeding to work at any school, daycare, church, hospital or other medical setting, juvenile detention facility, or any other agency, facility, or organization that serves youth.

Relying only on criminal convictions, however, is imprudent for several reasons. First, the standard of proof required to prove guilt for a criminal conviction—proof beyond a reasonable doubt—is substantially higher than the preponderance of the evidence standard of proof that applies in a CFS abuse and neglect investigation. This fundamental difference between the two standards of proof matters. There is a broad range of YRTC staff conduct that could be proved as child abuse or neglect under the lesser preponderance of the evidence standard, but which would not necessarily arise to the level of criminal charges being filed, or could not be proved beyond a reasonable doubt. As established above, a CFS investigation could substantiate non-criminal levels of abuse and place a staff member on the Central Registry based on that finding. Compliance cannot. The significant limitations of the Compliance investigative process may prevent Compliance from being able to substantiate those non-criminal abuse allegations or investigate them thoroughly. By relying on criminal convictions, all YRTC staff members whose improper conduct would be considered child abuse or neglect in any other setting, but not necessarily criminal abuse, are not placed on the Central Registry and therefore do not face the same accountability without a CFS investigation and finding.

Out of the 44 sexual abuse allegations against 19 different YRTC-Kearney staff members included in this report, which contained over 200 claims of a variety of specific behaviors within them, only four staff members have been criminally charged.

Allegations against at least five other staff members may have warranted substantiation as well, but for the limitations on fact-gathering in Compliance's investigations. Each of those staff members resigned or were terminated from YRTC-Kearney following the allegations against them, some of whom were repeatedly the subjects of many different youth allegations. In almost all of those instances, the allegations were either unsubstantiated, unfounded, or were not thoroughly investigated because the staff member or youth involved had already left the facility and they could not be interviewed by Compliance, or because relevant security camera footage had not been retained and was no longer available for review. Compliance's investigations in those cases often concluded without a definitive determination of what occurred. Without a CFS investigation or criminal conviction, these staff also will not appear on the Central Registry.

Second, a criminal charge only results in placement on the Central Registry if the staff member is found guilty and convicted. Even though the four staff members mentioned above have been criminally charged for sexually abusing youth, if they were to be found not guilty for any reason, they would not appear on the Central Registry, and they would not be legally prevented from working with youth again. There are inherently and necessarily more procedural safeguards and a broader range of legal protections afforded to a defendant in a criminal proceeding than in a juvenile proceeding, including more restrictive evidentiary rules and the right to a jury trial. These factors could complicate a successful prosecution or prevent certain charges from being filed altogether. Further, a staff member criminally charged with a child abuse or neglect-related offense could potentially, for a variety of reasons, be offered a plea deal and ultimately plead to a different, lesser criminal offense that may not clearly or automatically place them on the Central Registry. Moreover, unlike CFS, NSP is only focused on whether criminal conduct occurred, not whether it would be in the youths' best interests for a certain staff member to continue working at the YRTC.

DHHS should not apply a different standard to its own employees than it applies to every other person who allegedly abuses or neglects a child in their care. In every other setting outside of the YRTCs, with the exception of detention centers, CFS has the authority and obligation to investigate an allegation of child abuse or neglect and, if the allegation is supported by the evidence, will place that person on the Central Registry to prevent that person from further working with youth. YRTC staff should not be exempt from this same process merely because they work at a DHHS-operated facility.

4. There were numerous issues and limitations with Compliance's reviews and investigations into the sexual abuse allegations at YRTC-Kearney.

The OIG-CW observed numerous significant issues with how Compliance's reviews and investigations were conducted and with Compliance's processes and practices. Compliance serves a vital function of providing oversight to facilities like YRTC-Kearney and ensuring it adheres to internal and DHHS policies, state and federal laws, and established best practices. In some of the cases reviewed by the OIG-CW, Compliance effectively investigated an incident, identified issues at the facility, and recommended action to improve those issues. In many of the cases, however, the OIG-CW identified issues with Compliance's investigations that were significant enough to prevent Compliance from determining whether specific sexual abuse allegations had occurred or not, and resulted in widespread problems at the facility being missed or uncorrected. The thoroughness and quality of Compliance's work seemed to improve in meaningful ways over the course of all of the cases that the OIG-CW examined for this investigation—with the more recent reviews and investigations generally identifying more issues at the facility and recommending corrective action to improve upon those issues. However, the issues described below were not isolated to any one case and reflect a concerning pattern in the way that DHHS currently addresses sexual abuse allegations at the YRTCs.

The primary challenges apparent in Compliance's reviews and investigations fell into three broad categories: those arising from deficiencies in how facts were analyzed and how investigations were conducted, those arising from external resource limitations and a subsequent failure to pursue alternative means of gathering facts, and those arising from focusing too closely on individual incidents rather than identifying systemic and facility-wide issues.

Deficient Investigation Analysis and Methods

In many of the reviews and investigations, Compliance was not evenhanded in its evaluation of the allegations. Instead of weighing all available evidence objectively, Compliance consistently gave disproportionate weight to facts suggesting that an alleged incident did *not* occur, while giving comparatively little, or no, weight to facts that equally, or even more strongly, suggested that it did. This pattern was apparent when Compliance appeared to minimize or discredit some allegations by overly relying on a youth's prior behaviors or history of past inappropriate conduct or false allegations, without further examination. For example, many of the allegations shared a remarkable degree of consistency in their substance and nature, with multiple youth, across different living units, over an extended period of time, making similar accounts about

similar types of conduct by the same or different staff members. Compliance did not appear to treat that consistency as a factor warranting sufficient scrutiny or as an indication that certain staff may have been demonstrating the same type of inappropriate behavior to numerous youth, or that the facility management may have been complicit in permitting an environment where certain types of inappropriate behavior was tolerated. Instead of approaching that consistency with careful consideration, Compliance seemed to overlook, disregard, or attribute it to youth they believed falsified or repeated the same types of allegations as each other with an ulterior motive in mind.

At the same time, Compliance did not appear to consistently examine the prior disciplinary history of the staff members named as alleged perpetrators in these cases or consider whether a staff members' prior counseling by supervisors about inappropriate conduct and boundaries with youth, prior write-ups and formal discipline, or earlier allegations made by different youth against that same staff member reflected a pattern of conduct relevant to the current allegation. In some instances, that prior history involved the same or similar inappropriate staff conduct as alleged in a current case. Those prior incidents, however, were rarely mentioned and did not appear to adequately inform Compliance's analysis of whether the current allegation had merit or warranted additional inquiry. A prior allegation against a staff member should not determine the outcome of a subsequent one, and each allegation must be evaluated on its own merits. But when a staff member has been the subject of multiple prior allegations that are similar or identical in nature to the current one, or has a documented pattern of discipline or counseling for related conduct, that history is relevant context that should shape how the investigation is approached and, at a minimum, prompt heightened scrutiny where more questions and additional investigative steps are taken before concluding that insufficient evidence exists. While a staff member's history should not lower the evidentiary threshold to substantiate an allegation, it should raise the threshold for what constitutes a thorough investigation.

Compliance also appeared to apply an inconsistent evidentiary standard when evaluating whether corroborating facts supported an allegation. On one hand, when youth made an allegation against a staff member without a corroborating witness, Compliance frequently concluded that the allegation could not be substantiated because no other youth or staff could confirm what occurred. When multiple youth alleged similar or identical conduct by the same staff member, however, Compliance tended to treat that consistency not as meaningful corroboration, but as an indication that the youth were coordinating false allegations or repeating allegations that they had heard from other sources. There was some evidence of

youth making false or repeat allegations, but that was only in a handful of cases. The effect of this double standard was that a single youth allegation was treated as insufficient because it was uncorroborated, but the allegations of multiple youth were insufficient because they were too similar. This rendered most allegations incapable of substantiation, regardless of the volume or nature of supporting evidence. Similarly, in several investigations, Compliance cited a youth's failure to disclose alleged abuse on recorded phone calls with family or friends as a factor undermining the youth's credibility, without accounting for the many reasons that a victim of abuse may choose not to discuss the abuse on a monitored call.

Exacerbating these issues, Compliance's reviews and investigations in practice frequently appeared to require a degree of certainty that exceeded the applicable evidentiary standard. OJS policies and procedures adhere to the PREA National Standards for evidentiary standards in administrative investigations, which state that the "agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated."[50] The Nebraska Supreme Court has stated that a preponderance of the evidence is the equivalent of the greater weight of the evidence, requiring proof which leads the fact finder to find that the existence of the contested facts is *more probable than not*, or, in other words, is *more likely true than not true*.[51] Compliance, however, frequently appeared to require either direct evidence—such as an eyewitness account or audio or video recording of the alleged conduct—or, even when such direct evidence existed, required that such evidence conclusively and fully capture the alleged conduct to substantiate an allegation.

The preponderance of the evidence standard permits Compliance to give appropriate weight to all available evidence, including circumstantial evidence, common sense inferences, numerous consistent youth accounts, youth and staff behaviors and history, video and other evidence partially showing certain conduct, and the overall circumstances surrounding an allegation to determine that it was more probable or likely than not that the staff abused the youth. Compliance often disregarded such evidence and effectively required definitive proof to substantiate an allegation, which is inconsistent with this standard. For example, the incident involving Youth B and Staff 3, in which Youth B alleged that Staff 3 sexually abused him while he was within his room at Dickson and she stood in the doorway, was unsubstantiated by Compliance for lack of video footage within Youth B's room fully showing what Staff 3 was

[50] National Standards to Prevent, Detect, and Respond to Prison Rape Under the Prison Rape Elimination Act (PREA), Juvenile Facility Standards, 28 C.F.R. § 115.372 (2012).
[51] See, e.g., *State v. Bixby*, 315 Neb. 549, 997 N.W.2d 787 (2023) (emphasis added).

doing to him, despite video footage of the hallway partially showing Staff 3 engaging in the alleged conduct. Even the surrounding circumstances noted within Compliance's documentation suggested that some degree of abuse had occurred. Again, Compliance unsubstantiated this allegation under its preponderance of the evidence standard, but Staff 3 was criminally charged under a heightened evidentiary standard for this same conduct.

A related challenge was that in numerous Compliance reviews and investigations, it appeared to the OIG-CW that Compliance may have inaccurately characterized an allegation as "unfounded" when it was perhaps more appropriately "unsubstantiated." As explained previously, for Compliance and PREA purposes, an unsubstantiated allegation is one that was investigated but produced insufficient evidence to make a final determination either way, while an unfounded allegation is one that was investigated and determined not to have occurred. Compliance classified a few allegations as unfounded because either the youth later recanted and said that the allegation did not occur, or the allegation could be disproved by numerous witnesses. For most of the other allegations classified as unfounded, however, Compliance's documentation identified, but disregarded, multiple reasons why it could not rule out the possibility that the alleged abuse occurred, or did not sufficiently explain how it was able to affirmatively conclude that the alleged conduct had not occurred. The most common examples of this included Compliance noting that alleged staff perpetrators or alleged youth victims or witnesses were no longer at the facility and could not be interviewed about the allegation, that video footage could not be reviewed because it was outside of the retention period, and that no audio recording existed. In several cases, Compliance noted that other youth or staff stated they had witnessed, overheard, or had information supporting the allegation being investigated—yet still classified those allegations as unfounded rather than leaving the determination open as unsubstantiated.

In a number of instances, the explanations provided for an unfounded determination were indistinguishable from explanations provided for unsubstantiated findings in other cases, with the same noted evidentiary limitations, uncertainty, and inability to conclude whether the staff perpetrated on the youth or not. This inconsistency raises questions about the reliability of Compliance's findings as to how many allegations were appropriately unfounded.

The OIG-CW also identified a related and particularly concerning pattern in which consequential facts and information relevant to an allegation uncovered in the course of a Compliance review or investigation were occasionally briefly noted in Compliance's documentation but then not mentioned again and apparently not followed up on before Compliance concluded its review. These most commonly included statements by youth or staff about inappropriate physical

contact between staff and youth that they allegedly witnessed, inappropriate conversations between staff and youth that they allegedly overheard, or written down staff phone numbers found in youths' possession.

In other instances, the investigation process was insufficient to adequately evaluate each allegation independently and on its merits. There were a number of examples where Compliance grouped multiple different allegations together and, after concluding that insufficient evidence existed to substantiate one allegation, extended that conclusion to related allegations without independently evaluating each one on its own merits. Other times, it appeared to the OIG-CW that Compliance did not thoroughly review each allegation to determine its validity, and some of the details of allegations may have been forgotten or ignored in light of other allegations considered a higher priority. The OIG-CW acknowledges, however, that many of the reviews and investigations involved complicated facts where many different youth made similar, overlapping allegations about staff, and some youth then recanted or provided new, inconsistent, or contradictory information at a later date. Some of this may be attributable to how youth were often interviewed by Compliance more than once, several days or weeks apart.

An additional related problem was that some of the reviews and investigations appeared to conclude before all available investigative steps had been taken, and without attempting to understand how the alleged conduct could have occurred or gone undetected. Instead of attempting to get to the root of an issue and sufficiently exploring the possibilities for why an allegation was being made, whether it was possible the allegations had some validity, and ways the facility could make improvements regardless of whether the alleged abuse had occurred, Compliance often settled with determining an allegation was unsubstantiated or unfounded without comprehensively looking at the whole scope of allegations in relation to one another. In several of those instances, the failure was not attributable to an incomplete investigative follow-through, it was simply the result of reviews concluding so prematurely that certain steps were foreclosed from happening. The fact that some Compliance reviews were completed the same day or the following day after an allegation was made illustrates this problem. Although Compliance staff could not be expected to pursue every lead and they needed to be judicious with their time, resources, and what they decided to examine and document, many of the facts that were only noted but not followed up on went to the core of the allegation being reviewed.

Failure to Pursue Alternatives to External Investigative Limitations

Still another challenge was that Compliance too often treated the absence of audio or video evidence as the primary reason to conclude an allegation was unsubstantiated or unfounded.

The absence of tangible evidence did not prompt Compliance to conduct a deeper investigation and pursue other available facts and investigative avenues. A recurring example of this issue involved allegations of inappropriate or sexual statements and conversations between staff and youth, which were the most common types of allegations in this investigation. Compliance tended to unfound or unsubstantiate these allegations primarily because there was no audio capturing what was said, or there did not happen to be another staff or youth immediately near that might have overheard the comments. The lack of audio recording capabilities in the facility's security camera system is a current limitation at the facility outside of Compliance's control. Still, Compliance too often seemed to inadequately explore all available evidence that might support or undermine the youth's allegation, such as corroborating accounts from other staff or youth or determining if the staff was known to make inappropriate statements on other occasions.

Similarly, in most of the allegations involving staff members' personal phone numbers being found in the youths' possession, another of the most common types of allegations, Compliance suggested that because it could not be determined which youth originally obtained the numbers, and how they obtained them, it was most likely that some of the youth discovered the numbers on their own and shared them with each other. It was never explained how the youth would have obtained the numbers themselves. Nor did Compliance ask why the youth would risk having the phone numbers and for what purpose. Yet, Compliance did not entertain the possibility that at least some of the staff members may have been providing their phone numbers to some of the youth. By minimizing the presence of the written phone numbers in the youths' possession, and the fact that several youth knew some of the staff phone numbers by memory, Compliance did not sufficiently investigate or explain how it was possible that so many staff numbers came to be known nor attempt to identify any flaws at the facility that needed addressing to prevent staff phone numbers from being shared by youth in the future.

The OIG-CW also observed that when Compliance encountered external limitations on its authority, other avenues for gathering or corroborating evidence were not explored. For example, when a staff member or youth who was the subject of or witness to an allegation left the facility—whether because they departed after the allegation was made but before Compliance completed its review, or because the allegation was not made until after they had already left—Compliance frequently declined to thoroughly pursue the allegations related to those persons or dismissed them without a sufficient investigation. On at least one occasion, Compliance noted that it could not interview several youth who were either the victim or a witness to alleged staff abuse because the investigation did not begin until several weeks after

the allegation was made, and the youth had been discharged from the facility. Although Compliance may have lacked the authority to interview those persons after they left the facility and may not have had sufficient staff or resources to explore every allegation fully, their departure did not diminish the need to understand what may have occurred, nor diminish the value of examining whether systemic failures contributed to the circumstances that gave rise to the allegation. This concern is compounded by the fact that in many of these instances, the alleged staff members who left the facility and were not interviewed about an allegation were the same staff members who had been previously named in numerous youth allegations, or were staff against whom allegations were later substantiated and led to criminal charges against them.

Failure to Identify Systemic and Facility-Wide Issues

Another of the more significant issues identified by the OIG-CW in Compliance's reviews and investigations was that they tended to focus almost exclusively on whether an individual incident of sexual abuse had occurred, and gave little to no attention to whether the allegations, individually or collectively, reflected broader, systemic, or facility-wide issues. This narrow, incident-focused approach resulted in Compliance's reviews rarely asking, let alone answering, the broader questions that the volume, nature, and consistency of the allegations warranted, such as why certain conduct was being alleged, how alleged conduct may have occurred or gone undetected, and which facility conditions, practices, or cultural issues may have enabled or failed to prevent the alleged conduct from happening.

This problem was particularly evident in cases where Compliance unfounded or unsubstantiated an allegation. In those cases, Compliance typically concluded its review without examining whether the circumstances surrounding the allegation revealed anything about how the facility was being operated that warranted closer examination, regardless of whether the specific allegation was ultimately substantiated. This posture was especially significant because Compliance made no recommendations and identified no areas for improvement in over half of all reviews and investigations.

The problem was also present in half of the cases where an allegation against a staff member was substantiated, as Compliance still made no recommendations nor identified any areas that needed improvement. This was true in the cases where a staff member brought in contraband for a youth; where a staff inappropriately touched a youth on his thigh; and, most concerning of all, where a staff member brought in a cell phone for youth at the facility and three youth used the phone at the facility, undetected, for at least a week, to take pictures, use social media, send text messages, make phone calls and FaceTime calls, and receive sexually explicit videos

and photos from the staff member. In another instance, when a newer staff member was identified as struggling in her role, Compliance's recommendation was essentially that the staff member should seek out support and guidance from other, more senior staff members on her own, without any structured plan for follow-up, supervision, or accountability.

As noted earlier in this report, Compliance began making more recommendations and identified more areas for improvement in its reviews and investigations as time went on. But collectively, throughout the period of all allegations reviewed by the OIG-CW in this investigation, systemic or facility-wide recommendations or issues were rarely made or identified. In addition, in most cases where recommendations were made, the recommendations were either only to address a singular issue amidst many issues present in the case, or were to address a relatively minor issue, whereas the more consequential and concerning issues were left unaddressed. These outcomes illustrate a concerning trend of Compliance generally not utilizing its reviews and investigations as an opportunity to identify the areas that the facility could improve and to implement meaningful changes to avoid similar types of incidents and allegations in the future.

5. The OIG-CW was not notified of the initial incidents in March and April 2025 as a result of Compliance's determination that those incidents were not PREA violations, which placed them outside the required notifications under the law.

OJS is required by law to report to the OIG-CW "as soon as reasonably possible" after an instance of an "internally substantiated" PREA violation.[52] The March 2025 incident involving Staff 1 and Youth A and the April 2025 incident involving Staff 2 and Youth B were both determined by Compliance to be "boundary violations" and thus determined not to be PREA violations, thereby falling outside the notice requirement in the law. As a result, the OIG-CW did not receive a CIR from OJS regarding these incidents when they occurred.

It is important to note that there is a separate obligation in the law which requires DHHS to notify the OIG-CW of any allegations of sexual abuse by a state ward.[53] However, given the significant number of sexual abuse allegations related to all state wards, DHHS provides those allegations to the OIG-CW through a monthly list, which does not provide any specifics regarding the allegation. In fact, most of the names of the youth who made allegations in this investigation appeared on that monthly list. Due to the limited nature of the monthly report, however, the OIG-CW received no information regarding whether the abuse happened at the

[52] Neb. Rev. Stat. § 50-1806(3)(a)(viii).
[53] Neb. Rev. Stat. § 50-1806(2)(b).

YRTC, whether a staff member was the alleged perpetrator, or any details of how the youth had been abused. Therefore, the additional requirement for direct notification from OJS is critical. The CIRs the OIG-CW receives from OJS contain the specifics regarding the allegation that the monthly list from DHHS does not.

Given how critical the OJS notification is, the current notification requirement itself may be too narrow by limiting notice to those allegations that were substantiated rather than including all allegations of staff abuse of youth. Under the current law, the OIG-CW would not have been made aware of the numerous unsubstantiated findings related to many of the allegations in this investigation had OJS not chosen to be more transparent than the law required and notify the OIG-CW of those allegations.

RECOMMENDATIONS

RECOMMENDATIONS

1. DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made.

The behaviors alleged and detailed in this investigation amount to abuse of the youth in DHHS' care and custody. These incidents should be investigated as such. With the exception of juvenile detention centers, in all other juvenile facilities, including ones licensed by DHHS, abuse is investigated through an OHA, with the focus on the well-being of the youth. As stated, Compliance reviews are necessary. But the difference in the orientation and purpose of a Compliance investigation and an OHA is critical. Compliance is necessarily focused on the facility's functioning and adherence to the law, policy, and procedure. As DHHS states in its response to this report, Compliance investigations do not determine if abuse and neglect occurred. An OHA is focused on the youth, whether they experienced abuse, their overall well-being, and the risk to other youth at the facility. Both types of investigations are necessary and DHHS should once again conduct OHAs at the YRTCs.

While the facility policies are in place, in part, to prevent abuse and neglect within the facility, that does not change the fact that a Compliance review does not assess for abuse. OHAs, however, assess all types of abuse, including sexual, verbal, physical, and emotional abuse within the facility. A facility-wide issue with any type of abuse may be more easily detected through the use of the OHA, completed by CFS staff trained in abuse and neglect investigations. The OIG-CW's review of past OHAs done at the YRTCs demonstrated their effectiveness. Not only was the focus on the youth's well-being—a striking contrast to the Compliance investigations reviewed in this investigation—but as detailed, the OHAs are not subject to the same external process limitations, allowing for more thorough fact-finding. OHAs can also provide recommendations to the facility, whether or not abuse of an individual is substantiated.

The other equally critical reason to conduct an OHA is that Compliance does not have the ability to place a staff member's name on the Central Registry for any reason. CFS, through an OHA, does. In fact, interviews confirmed that when CFS conducted OHAs before 2020, YRTC employees would be placed on the Central Registry when an OHA substantiated an allegation of abuse at the facility. Currently, the only instance in which a YRTC staff member is placed on the Central Registry is if they are convicted of a crime in relation to the alleged abuse within the facility. However, abuse and neglect often occurs in a manner that does not rise to the level of a criminal citation. For all the reasons previously stated, DHHS should not rely only on criminal

convictions to ensure that staff who perpetrate abuse are barred from working with children and youth in the future. DHHS has the ability to protect other children from the actions of those perpetrating such acts by placing them on the Central Registry. DHHS should hold its own YRTC staff to the same standards to which it holds the employees of the other facilities it licenses.

According to OIG-CW interviews, DHHS stopped conducting OHAs because DHHS believes that (1) CFS staff completing such assessments creates a conflict of interest and that (2) CFS does not have jurisdiction to conduct an abuse and neglect investigation at the YRTCs.

To the first point, DHHS argues that OJS is housed within the Division of Children and Families Services at DHHS, and therefore, the staff that would conduct the OHAs and the staff at the YRTCs are ultimately led by a common division director, thereby creating a conflict of interest. However, the current compliance process, by that reasoning, is no less fraught with a conflict of interest. Currently, the YRTCs, which are OJS facilities, are investigated by those also employed by OJS. Both Compliance and YRTC staff are overseen by the OJS Administrator. It is true and beneficial that, for purposes of independence, Compliance does not report to the Facility Administrator. But their offices are on the same campus, and they interact frequently. Compliance becomes familiar with the facility staff within these confines. CFS staff, by contrast, are in different offices, perhaps within the same city or town, and are doing completely different work. Further, OJS operates separately from the CFS Division. The OJS Administrator is, by law, appointed by the Chief Executive Officer of DHHS, not the CFS Division Director.[54] OJS' administrative duties are also largely directed by statute, are distinct from CFS, and indicate OJS' unique posture within DHHS by, for example, requiring OJS to have separate budgeting processes and developing and reporting budget information separate from DHHS.[55] The conflict-of-interest argument is tenuous.

Even if the conflict-of-interest concern had merit the core issue that abuse and neglect investigations should occur at the YRTCs remains. The current combination of Compliance reviews, FIT evaluations, and law enforcement referrals does not accomplish that. In its response to this report, DHHS focused on the importance of having a neutral third party conduct any investigation that would result in placing a staff member on the Central Registry. DHHS notes, for example, that there is no conflict with Adult Protective Services conducting abuse and neglect assessments at adult DHHS facilities because the adult facilities are administered by a different division within DHHS. This can serve as a model for conducting

[54] See Neb. Rev. Stat. § 43-404.
[55] See Neb. Rev. Stat. § 43-405.

abuse and neglect investigations at the YRTCs. DHHS and the Legislature can explore legislative changes to move OJS into another division or its own division, ensuring that OHAs at the YRTCs would be conducted by a different division within DHHS.

DHHS' second argument is that CFS does not have jurisdiction to conduct an abuse and neglect investigation at the YRTCs. It is true that there is no express language in Nebraska law permitting CFS to conduct OHAs at the YRTCs. Nor is there language prohibiting it. CFS conducts OHAs in juvenile facilities that DHHS licenses, so it would stand to reason that a facility that DHHS operates should be held to the same standard. Any concern about CFS' jurisdiction to conduct OHAs at the YRTCs could be resolved with a statutory change that specifically adds YRTCs as a facility subject to abuse and neglect investigations.

Requiring CFS staff to complete independent, child and trauma-focused reviews of abuse and neglect allegations provides not only a different lens through which to view the concerns, but it also allows for perpetrators of abuse and neglect to be placed on the Central Registry.

DHHS successfully conducted OHAs at the YRTCs until 2019. It should conduct them again.

2. DHHS and YRTC-Kearney should address the culture problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth.

There are a number of specific structural and operational conditions at YRTC-Kearney that created opportunities for the alleged staff misconduct to occur and that need to be addressed regardless of how many of the allegations in this investigation are ultimately proven.

The OIG-CW recognizes that DHHS and YRTC-Kearney leadership have begun implementing some changes in response to the events described in this report and that some of the improvements are reportedly already underway. On June 10, 2026, the OIG-CW received a letter from the Compliance Administrator detailing 37 different actions taken or changes made at the YRTCs during the previous year in response to the sexual abuse incidents and allegations included in this investigation.[56]

These actions and changes generally relate to areas such as notification procedures for youth allegations; changes to internal facility and Compliance policies and practices; safety and security measures concerning the supervision and surveillance of staff and youth; and increased training and reminders for staff and youth on PREA and related topics. More specifically, the

[56] The letter is attached to this report in Appendix B.

letter states, for example, that weekly team meetings at the facility now include discussions with staff on appropriate boundaries with youth; that the facility has increased reminders and directives regarding sight and sound observation of all youth and the expectation of reporting; that only clear backpacks are permitted for staff entering the facility; that staff lockers are checked more frequently to ensure cell phones are not brought into the facility and that staff and youth lockers are checked for contraband; and that DHHS Human Resources has reinstated professional and employment reference checks for new hires.

These efforts are acknowledged and encouraged. The following areas, however, warrant deliberate and sustained attention going forward nonetheless.

Enhance Supervision of YPS Staff

YPSs are the frontline staff who spend more time with the youth than any other type of staff at the facility. That extended and direct contact with youth, while essential to the YPS role for building rapport and helping the youth achieve positive change, also creates more opportunities for boundary issues and inappropriate relationships to develop. All but two of the sexual abuse and boundary violation allegations in this investigation were made against YPSs, and the OIG-CW's review of how the YPSs are supervised revealed significant gaps that made those issues more likely to occur, and less likely to be detected.

YPSs are often the only staff regularly present in the living units for extended periods, often for several hours in the morning or evening, without a staff member with clear supervisory authority consistently present during that time. YSSs are supposed to periodically check in with the living units throughout the day and loosely monitor the YPSs and youth for any safety and security issues. They are not, however, consistently present in any given unit, at any given time. The presence of the previous Facility Administrator, UMs, and CMs in each living unit is even more limited and unpredictable, based on their various responsibilities. There are no lead workers among YPS staff, and when YPSs are alone in a unit, they are expected to function collectively without any individual designated as ultimately responsible. The facility operates on a community policing mentality in which staff are expected to hold each other accountable, address inappropriate staff and youth conduct, and report concerns when they arise. While peer accountability does have some value, it is not a substitute for regular or structured supervision. Fellow staff members hardly ever reported each other in the cases reviewed by the OIG-CW in this investigation, and there were numerous incidents of inappropriate staff conduct that were more than likely observed or known by other staff members, but not reported. The OIG-CW recommends that DHHS and YRTC-Kearney evaluate whether the creation of a YPS lead or supervisor role with clear authority over the other frontline staff would be appropriate to

provide the structured oversight that is currently lacking when YSSs, CMs, and UMs are not present, or at least require more consistent presence from those other types of staff members in the living units.

Relatedly, the OIG-CW further recommends that OJS review its policy regarding staff being alone with youth. The policy states that staff shall not be alone in a room with a youth, but contains an exception that allows for that one-on-one time when "necessary," with the requirement that other staff be informed when that occurs. The OIG-CW observed numerous instances in the allegations reviewed in this investigation where a YPS staff member spent extended alone time with a youth when it did not appear necessary—most often the common room of the living units, playing games or having private conversations—or when transporting a youth to another area of the facility alone through stairwells and various areas of the living unit, without any other youth or staff present. Staff interviewed by the OIG-CW reported that it was not uncommon for this alone time to regularly occur. This type of alone time allows for more opportunities for inappropriate relationships to potentially develop or improper conversations or physical contact to occur, without anyone else to notice or hold that misconduct accountable, as well as to be a witness to corroborate or refute any allegation. Although current facility staffing levels and required staff-to-youth ratios render it impossible for more than one staff to be with each youth at all times, it appeared to the OIG-CW that the exception of alone time with youth too often became the rule in practice, and there were circumstances when it was not truly necessary. Staff members should more consistently decline to transport a youth alone, for example, until another staff member is available to accompany them.

Increase Programming and Structured Activities for Youth

A notable number of the allegations reviewed in this investigation involved conduct that allegedly occurred during unstructured time in living unit common areas, including game rooms and similar spaces where youth had significant amounts of loosely supervised free time, particularly between the end of school day and bedtime. In addition, almost all of each weekend is devoid of any programming or structured activity. Staff interviewed by the OIG-CW stated that YPSs are responsible for filling much of that unstructured time on their own without clear programming guidance or structured support, and youth often have downtime for several hours each day and do not know how to appropriately fill that time. That arrangement places significant additional responsibility on the YPS staff during some of the hours most commonly associated with the alleged misconduct in this investigation and creates additional opportunities for the kinds of informal staff-youth interactions in which boundary issues may often arise.

This appears to be largely attributable to the facility's current activity and programming options for the youth, or lack thereof. The current primary programming options—MRT and ART—may be appropriate and effective components of treating and rehabilitating the youth, but they alone do not appear sufficient to fill the current large amount of unstructured time youth experience each day. Some facility staff interviewed by the OIG-CW communicated that it was the facility's approach that programming should be more than just an hour or so a day of structured MRT and ART. Rather, it should be a 24/7, wholistic process where all staff are reinforcing the skills learned in those structured programs, helping youth develop skills to deal with their emotions and behaviors in individual conversations and group settings, and more. While that broader, more informal type of programming can also be appropriate and essential to achieving positive change in the youth in theory, it does not appear to be happening as often, or as effectively, in practice as it should, and may not be a sufficient substitute to additional structured programs and activities.

The OIG-CW recommends that DHHS conduct a comprehensive review of both the structured activities—including things like recreational activities, group time outside, participating in projects at the facility, leaving the facility to go out into the community—as well as the therapeutic programming currently offered to the youth at YRTC-Kearney, to reduce the amount of unstructured time that youth currently have. YPSs should be provided with additional programming and activity guidance and support. Given the incidents and allegations in this report, a programming option that should be explored or implemented is one that specifically helps youth understand and manage sexual feelings and behaviors in healthy and appropriate ways. Although the facility has a designated staff member for recreational activities, that staff member could be more involved in integrating structured activities beyond the brief recreation and gym time each day. YRTC-Kearney should also prioritize filling a staff position primarily dedicated to programming. That role existed previously but was absorbed into the previous Facility Administrator's responsibilities.

In addition to filling the abundance of unstructured downtime for the purpose of reducing the likelihood of opportunities for youth and staff to engage in inappropriate conduct, evaluating if more programming and activities can be offered would also potentially result in more productive rehabilitation and treatment for the youth, which is the ultimate goal of their commitment to the facility.

Strengthen Surveillance and Monitoring Capabilities and Practices

YRTC-Kearney's current video surveillance system has several significant limitations that affected both the prevention of inappropriate conduct and Compliance's ability to investigate

it. These limitations include no audio recording capability, an approximately 90-day footage retention period, a lack of consistent daily review of footage—both live video monitoring and reviewing at least a sampling of video after each day—and several blind spots without adequate camera coverage.

Staff who know that their conduct is being actively and consistently monitored are less likely to engage in inappropriate conduct. A surveillance system that is not monitored daily, that has known blind spots, and that does not capture audio provides significantly weaker deterrence than one that does, allowing for more opportunities for misconduct to occur. In Compliance's documentation of the reviews and investigations involving dozens of allegations of inappropriate, unprofessional, and sexual comments that staff made to youth, it was frequently noted that it could not be determined what had been said due to a lack of audio recordings and no other means to verify the allegation if no other witness heard what was said. Further, throughout Compliance documentation, it was also frequently noted that any video camera footage that would have captured an area where an incident allegedly took place, including incidents of sexual abuse and sexual contact between staff and youth, could not be reviewed because that footage was outside of the retention period—a problem most often due to an allegation being made months after the incident allegedly occurred, and occasionally because the investigation into the incident was not conducted in a timely manner.

With that said, had there been consistent daily review of camera footage, either live monitoring or a review of at least a sampling of video after each day, the issue of video camera footage falling outside of the retention period would have been much less prevalent, as staff would be much more likely to observe any alleged misconduct as it was happening. Despite live video camera recording capabilities currently at the facility, and Compliance staff members, YSS staff members, and the Facility Administrator having access to that live footage and purportedly having that footage always displayed and occasionally watched by someone, there was not a single incident included in this investigation that was discovered in real-time by Compliance or facility staff. In the four incidents summarized in detail earlier in this report, and several others that could be substantiated, it was not discovered, for example, that youth were using a phone within the living unit, that staff and youth were kissing and touching each other inappropriately, and more, until an allegation was made and then the facility decided to review the footage, and observe some of that conduct happening in the moment or shortly after the fact. Some of that activity was occurring for several days and even weeks, and perhaps longer, before it was discovered.

With regard to the existence of camera footage blind spots, numerous youth stated that they believed there were such blind spots where they or other youth and staff could engage in inappropriate conduct undetected. Several alleged incidents occurred in alleged blind spots, and one youth stated that at least one staff member directed him to go to a certain area at the facility to engage in inappropriate activity with her because it would be undetected due to a lack of cameras. Although not all of the alleged blind spots may have existed, there were at least some areas in the facility that lacked adequate camera coverage. Some of that gap is for good reason, such as in restrooms and individual youth rooms at Dickson to maintain the privacy rights of the youth, but the existence of other blind spots in areas where youth and staff regularly interact warrants review.

Another significant surveillance gap identified by the OIG-CW in the course of this investigation is the lack of consistent monitoring of youth telephone calls at the facility. The phone calls that youth are permitted to make with approved contacts outside the facility are, like the video camera footage, not reviewed by the facility or Compliance in the moment nor randomly or semi-regularly spot-checked after the fact for any safety or security concerns or for any concerns that the youth may have about staff. Instead, facility and Compliance staff will only go back and review the recorded phone call conversations if they have a concern about a youth, or if they are investigating an allegation involving that youth. In the documentation of numerous Compliance reviews and investigations, however, various youth were recorded telling family and friends material information about some of the sexual abuse allegations, including abuse that they had allegedly suffered, sexual misconduct that they believed other staff and youth were involved in, statements about wanting to have sexual relations with certain staff who were flirtatious, and some statements suggesting that the youth did or would make an allegation so that they could be moved to a different facility. Other documented recordings of phone calls included conversations about youth planning to assault other youth at the facility in response to crimes or conflict originating from outside of the facility. And in one instance, the entirety of a phone call involving a youth who was named as a victim in an allegation against a staff was in Spanish but was not translated to English and the staff therefore noted that they could not know what was said.

The OIG-CW thus recommends that DHHS: (1) assess the feasibility of expanding audio recording capability; (2) evaluate whether extending the video footage retention period beyond 90 days is viable; (3) implement a policy requiring daily review of surveillance footage or random spot-checking of daily footage; (4) conduct a comprehensive review of video camera coverage to identify and address blind spots; and (5) assess if enhanced telephone monitoring

practices, including more daily or live monitoring or at least semi-regular monitoring, are feasible to ensure safety and security concerns or information related to staff sexual abuse of youth do not go undetected. Some of these areas were also recommended by Compliance in some of the later reviews and investigations, and, as mentioned above, DHHS has stated that it has begun doing or are actively considering these steps.

The OIG-CW recognizes that some of these measures may require significant investment in upgraded equipment, infrastructure, or staffing, and the feasibility of the costs and operations required to support these changes is a legitimate consideration. How these issues can be addressed in the most effective and efficient manner is better suited for DHHS and the YRTC to determine, but these measures may also warrant consideration from the Legislature to help address.

It is worth noting that improved surveillance capabilities and monitoring practices would not only strengthen the facility's ability to detect inappropriate conduct and protect youth from abuse—it would also strengthen the facility's ability to quickly disprove allegations that are false, protecting staff from unfounded accusations and spare the facility, Compliance, and law enforcement the time, resources, and disruption of undertaking lengthy investigations into incidents that clear video or audio evidence could resolve almost immediately. The investment in an enhanced surveillance infrastructure could better protect youth, staff, and allow for more efficient investigations into allegations.

Implement Consistent Processes for Holding Staff Accountable for Boundary Concerns

The OIG-CW's review of YRTC-Kearney's staff training curriculum on professional boundaries, appropriate staff-youth relationships, and PREA requirements did not identify significant deficiencies in its content. In fact, the required training upon hiring a new staff member, and the required training that each staff member must complete annually, appears generally appropriate and covers the relevant areas of concern. Training alone, therefore, is not currently functioning as an effective prevention tool.

Looking beyond training, when staff were identified as having boundary concerns with youth—whether through a substantiated allegation, prior disciplinary action, or a concern raised by a staff or youth in the course of a Compliance investigation—the follow-up response from the facility was often insufficient. Staff identified as having boundary issues were occasionally directed to either seek guidance from more senior staff on their own, not given structured retraining, not required to be provided increased supervision, or not given formal monitoring plans to ensure the boundary violations and inappropriate conduct with youth ceased. Several

staff members who were ultimately the subjects of substantiated findings in this investigation had previously been the subjects of boundary-related concerns or disciplinary actions that did not result in meaningful corrective follow-through.

OJS should therefore develop and routinely implement a more structured protocol for when staff are identified as having boundary concerns with youth, including more defined steps for retraining, supervision, and follow-up monitoring, and ensure that prior concerns about the staff are documented and factored into any future assessment of their conduct.

3. DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report.

The OIG-CW identified numerous significant concerns with how Compliance conducted its reviews and investigations into these sexual abuse allegations at YRTC-Kearney. Those concerns spanned the full scope of Compliance's work—from how individual allegations were evaluated and what evidentiary standards were applied, to whether investigations were completed thoroughly, and to whether reviews were used as an opportunity to identify systemic issues and make meaningful recommendations for improvement. While the OIG-CW recognizes that Compliance's work improved in meaningful ways over the course of the period reviewed, and that the volume and highly complicated facts of allegations during this period presented genuine challenges, the issues identified were not isolated to any one case and reflect practices that need to be examined and addressed institutionally.

At a minimum, DHHS should conduct a thorough review of Compliance's investigative methods and standards, including how evidence is gathered, preserved, and evaluated; how the preponderance of the evidence standard is applied in practice; how verbal allegations are assessed in the absence of audio evidence; and how the distinction between unfounded and unsubstantiated determinations is made and applied consistently. That review should also examine Compliance's practices for identifying and addressing systemic or facility-wide concerns—including whether unsubstantiated allegations are analyzed collectively for recurring issues rather than treated solely as individual matters—and whether corrective recommendations are consistently developed and followed up on when concerns are identified, regardless of whether a specific allegation is substantiated. DHHS should also evaluate Compliance's investigative processes and timelines, including how investigations are prioritized, how cases involving staff or youth who leave the facility are handled, and what steps are taken when potentially significant facts are identified in the course of a review but not yet fully examined.

4. The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth.

The current statutory requirement that OJS notify the OIG-CW of any "internally substantiated" PREA violation should be expanded to include any allegations of staff sexual abuse of youth, as well as boundary violations, whether or not the allegations are substantiated by Compliance.

As noted, there are limitations in the Compliance process that can make it harder for PREA violations to be internally substantiated. In this investigation, there was an allegation that was not substantiated by Compliance and, therefore, not required to be sent to the OIG-CW, and yet resulted in criminal charges. There were allegations that were substantiated for boundary violations, rather than PREA violations, and therefore, OJS was also not required to notify the OIG-CW. Those allegations also resulted in criminal charges.

The OIG-CW recommends that the law be amended to require OJS to notify the OIG-CW of any allegations of staff sexual abuse of youth, as well as boundary violations. If such a requirement had been in place, the OIG-CW would have been notified of some of the more serious allegations of sexual abuse of which it did not receive notice initially. While notifying the OIG-CW of all allegations of staff on youth sexual abuse is likely to mean that the OIG-CW will be notified of allegations that are proven to be unfounded or unsubstantiated, such a requirement would allow for more consistent monitoring of how such allegations of staff abuse are being handled by the facility and what the risk is to the youth at the facility. In addition, ensuring that the OIG-CW is aware of the frequency of the allegations, proven or unproven, might provide some indication of other challenges or concerns at the facility.

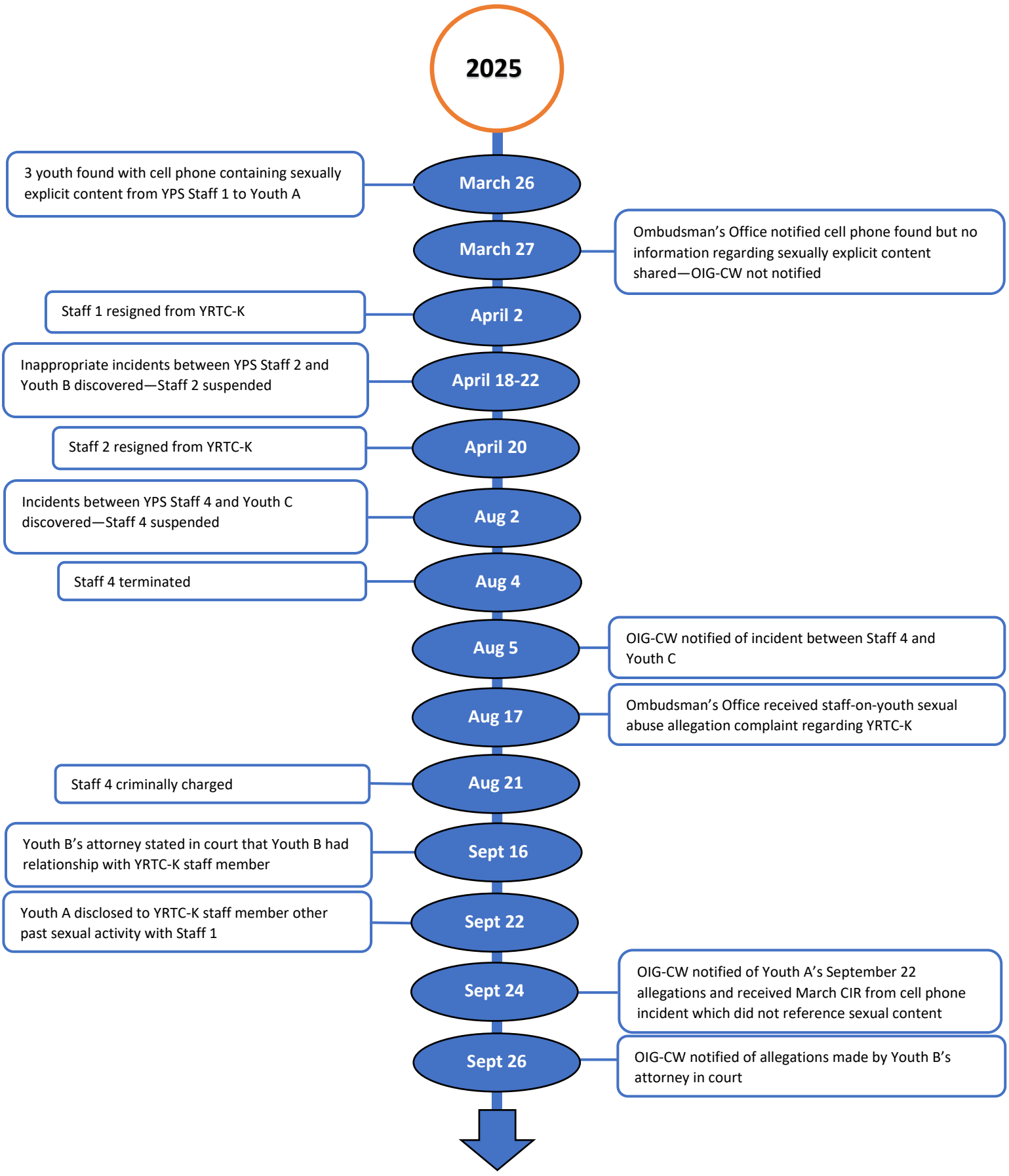
CONCLUSION

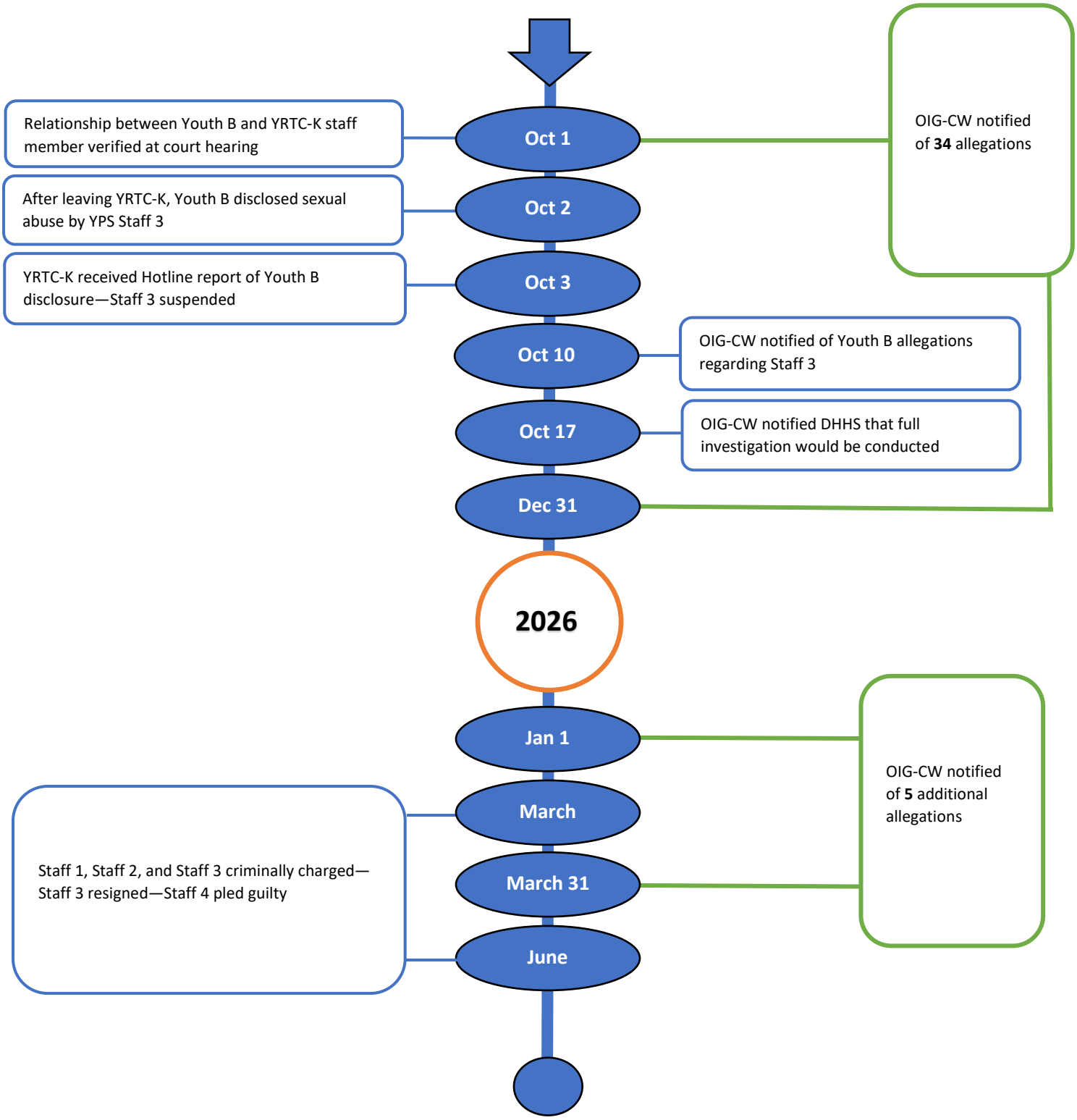
The OIG-CW would like to acknowledge and express appreciation to DHHS and, in particular, the OJS Administrator and the Compliance Administrator, for their cooperation and responsiveness to the OIG-CW's requests for information.

The OIG-CW will continue to monitor any developments in the investigations that remain open related to this investigation, as well as any additional allegations that may arise.

APPENDICES

Appendix A:
Timeline of Incidents & Notifications


2025
March 26
3 youth found with cell phone containing sexually explicit content from YPS Staff 1 to Youth A
March 27
Ombudsman's Office notified cell phone found but no information regarding sexually explicit content shared—OIG-CW not notified
April 2
Staff 1 resigned from YRTC-K
April 18-22
Inappropriate incidents between YPS Staff 2 and Youth B discovered—Staff 2 suspended
April 20
Staff 2 resigned from YRTC-K
Aug 2
Incidents between YPS Staff 4 and Youth C discovered—Staff 4 suspended
Aug 4
Staff 4 terminated
Aug 5
OIG-CW notified of incident between Staff 4 and Youth C
Aug 17
Ombudsman's Office received staff-on-youth sexual abuse allegation complaint regarding YRTC-K
Aug 21
Staff 4 criminally charged
Sept 16
Youth B's attorney stated in court that Youth B had relationship with YRTC-K staff member
Sept 22
Youth A disclosed to YRTC-K staff member other past sexual activity with Staff 1
Sept 24
OIG-CW notified of Youth A's September 22 allegations and received March CIR from cell phone incident which did not reference sexual content
Sept 26
OIG-CW notified of allegations made by Youth B's attorney in court


Relationship between Youth B and YRTC-K staff member verified at court hearing
Oct 1
OIG-CW notified of **34** allegations
After leaving YRTC-K, Youth B disclosed sexual abuse by YPS Staff 3
Oct 2
YRTC-K received Hotline report of Youth B disclosure—Staff 3 suspended
Oct 3
Oct 10
OIG-CW notified of Youth B allegations regarding Staff 3
Oct 17
OIG-CW notified DHHS that full investigation would be conducted
Dec 31
2026
Jan 1
OIG-CW notified of **5** additional allegations
March
Staff 1, Staff 2, and Staff 3 criminally charged—Staff 3 resigned—Staff 4 pled guilty
March 31
June

Appendix B:
Letter from the Department of Health and Human Services

NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

5/14/2026

To: Jennifer Carter
Inspector General of Nebraska Child Welfare
Office of the Inspector General

From: Shaylee Fortner
Office of Juvenile Services Compliance Administrator
Nebraska Department of Health and Human Services, Child and Family Services

RE: YRTC Operational Changes – Incident & Allegation Response

Ms. Carter,

This letter is to provide you with information on the actions taken in response to the incidents and allegations made over the last year. Our goal is to be fully transparent and ensure you are aware of the operational enhancements we have implemented to strengthen the overall safety and well-being of those in our care. The facilities are committed to continuous evaluation, operational improvement, and prioritizing youth safety.

The actions taken or changes made over the last year at the Youth Rehabilitation and Treatment Centers (YRTCs) include:

1. Priority critical incident reports are being provided to the Nebraska Department of Health and Human Services (NDHHS) Chief Executive Officer (CEO), NDHHS Chief Legal Officer (CLO), Probation, the Office of Inspector General (OIG), and Parents/legal guardians.
2. Standard Operating Procedure on Legal Notifications for Incidents and Allegations was created and implemented.
3. Expedited legal notification letters are provided to the Courts for incidents and allegations.
4. The Monthly Progress Letters regarding the youth that are provided to the Courts were enhanced.
5. Unannounced rounds by facility administration and supervisory staff have been doubled.
6. Weekly treatment team meetings now include appropriate boundary discussions and reminders with Youth Program Specialists (YPS), case management staff, mental health staff, and the Unit Managers.
7. Office of Juvenile Services (OJS) Compliance department has doubled video monitoring reviews of the YRTC-Kearney campus.
8. The facilities are now using an acknowledgement form verifying receipt and understanding of incident reporting, boundaries, and Prison Rape Elimination Act (PREA) policies from all YRTC-Kearney staff. This includes a section where allegations will be

reported to the Nebraska State Patrol (NSP) for investigation and prosecution. The form will be signed by the employee, the direct supervisor, and the Facility Administrator.

9. Nursing Staff continue to have another nurse or another facility/YPS Staff member present while the youth are being examined.
10. Licensed mental health staff use a room with a video capability to conduct their individual mental health therapy session and/or family therapy sessions.
11. NDHHS Human Resources reinstated professional/employment reference checks for new hires.
12. Updated the Garrity Warning form and procedures for compelled interviews during administrative investigations.
13. All staff interviews for OJS Compliance investigations involving allegations against staff are now voice-recorded.
14. The interview panel team for YRTC now includes at least one hiring manager in the interviewing process.
15. Implemented the use of only clear backpacks for all staff entering the facility or grounds.
16. Increased checks of staff lockers by security supervisors to account for personal phones.
17. Implementation of the use of a metal detector wand on parents and other visitors for visitation with the youth.
18. Monthly compliance checks of youth unit phones for connection to the Ombudsman line and the Abuse and Neglect hotline.
19. Increased checks of staff and youth lockers on the units for contraband in the living units.
20. Replaced the Ombudsman's contact information with enlarged posters for easier legibility.
21. Facility-wide reminders and directives for constant sight and sound observation of all youth and the importance and expectation of reporting.
22. Revamped facility staff PREA training by adding site-specific content, updated videos, real examples of past violations, and the consequences.
23. Auditing of PREA training facilitated by the OJS Compliance Specialist by OJS Compliance Supervisors.
24. Compliance interviews now require the OJS Compliance Supervisor's presence for any interview where staff invoke their right to union representation.
25. Living Unit Managers have been providing additional reminders and directives to staff during team meetings regarding cell phones at the facility and appropriate boundaries with youth.
26. The age-appropriate PREA video that youth receive upon intake is now played in every living unit at least once a month for the youth.
27. Youth phone monitoring will be conducted by administrative staff. However, all youth can make private, non-recorded phone calls to the Child and Family Services (CFS) Child Abuse and Neglect Hotline and the Ombudsman's office without staff assistance or monitoring.
28. If a Children and Family Services Specialist (CFSS) or a probation officer request to meet privately with a youth, this visit will be honored. If there are safety concerns for a private visit, the facility administrator will be contacted.

29. Camera vulnerability (blind spots) assessment and staffing analysis (with costs) for two-person integrity and escorts submitted to the CEO on October 28, 2025.
30. Three separate all-staff meetings were held on November 4, 2025, to address the importance of mandatory reporting, professional boundaries, and sight and sound supervision of all youth.
31. OJS Compliance supervisors held a meeting with NSP to inform on the newly implemented changes and standard operating procedures within the facilities, and to discuss enhanced collaboration strategies during active criminal cases.
    a. OJS Compliance is actively working to create a SharePoint site for cross collaboration with NSP to employ more effective information sharing, similar to what is currently used for the OIG and Ombudsman.
32. NDHHS Facility Leadership partnered with the Nebraska Department of Correctional Services (NDCS) to explore investigative training opportunities for administrative investigators.
    a. OJS Compliance supervisors completed investigative training facilitated by NDCS in February 2026.
33. The OJS Compliance Administrator is actively exploring a continuing education opportunity for a national compliance certification.
34. The facilities are actively working to implement an additional confidential phone line on the unit phones for youth to contact probation without the assistance of facility staff and free of charge.
35. Efforts to offer further information and education on the YRTC are continuously being pursued for external stakeholders.
    a. MARCH 2026: NDHHS Leadership and OJS Compliance Administrator met with Probation Administrator Gene Cotter and Deputy Probation Administrator Kari Rumbaugh to discuss the following:
        i. PREA standards and procedures within the YRTCs
        ii. Available options for youth to report allegations and measures in place to monitor for retaliation
        iii. OJS Compliance team responsibilities and hierarchy
        iv. Internal administrative PREA investigative processes and burden of proof
        v. Legal and external notification process, along with legal notification letters
        vi. Critical Incident Reports on sexual abuse allegations
        vii. Procedures when collaborating with the NSP, facilitation of forensic interviews with FAN/CAC, and reporting to the NDHHS CFS Hotline.
    b. APRIL 2026: OJS Compliance supervisors provided a webinar for the Foster Care Review Office that presented information on the internal OJS Compliance department, the investigative process, fundamentals of PREA, and OJS partnerships with the CFS hotline, NSP, and FAN/CAC when responding to allegations of sexual abuse and assault within the YRTCs
    c. MAY 2026: The YRTCs and OJS Compliance Supervisors are scheduled to facilitate a two-day Judicial Branch Educational webinar.

i. Day 1:Will cover the programming, treatment, and educational services provided to the youth.
ii. Day 2: Will cover the internal OJS Compliance department, the investigative process, the fundamentals of PREA, OJS partnerships with the CFS hotline, NSP, and FAN/CAC when responding to allegations of sexual abuse and assault within the YRTCs.

36. The YRTC-Kearney facility is participating in an internal NDHHS Central Office audit schedule to last from May 13, 2026, through June 2, 2026. This audit will encompass a comprehensive review of the facility's onboarding and ongoing training processes to evaluate the design, execution, and effectiveness in supporting operational objectives.
    a. The focus points of the audit will include onboarding workflow and execution; training content, delivery, and accessibility; ongoing training and competency maintenance, operational efficiency; and risk management and compliance within the training.
37. The YRTC-Kearney facility is also participating in an external performance-based standard accreditation audit through the American Correctional Association (ACA) from June 3, 2026, through June 5, 2026.
    a. Three external auditors will tour the facility, review policies and procedures, as well as 369 standards to ensure the physical conditions of the facility, daily operations, documentation, and procedures comply with the national ACA standards.
    b. A total of 331 non-mandatory standards and 38 mandatory standards will be reviewed during this audit. To achieve ACA accreditation, the facility must score at least 80% on all non-mandatory standards and 100% compliance on all mandatory standards.

The purpose of these actions, trainings, and updates to policies or procedures is to ensure greater safety for youth and staff at the Nebraska YRTCs. We appreciate your attention to this update and your continued partnership as we work to strengthen our practices. We will continue to communicate openly regarding our progress and any other significant changes made.

Respectfully submitted,

Shaylee Fortner
OJS Compliance Administrator
NDHHS, CFS

Appendix C:
Department of Health and Human Services Response to the OIG Report of Investigation

NEBRASKA
Good Life. Great Mission.

DHHS Response to the OIG Report of Investigation

Note: The original DHHS Response was sent to the OIG on July 9, 2026. After a conversation between CFS Director Bish and Office of Inspector General Carter July 23rd, 2026 a revised version for public consumption was submitted on July 23rd, 2026. The edited version only omits a specific reference to a youth to ensure we are not releasing any identifiable information that would otherwise be confidential.

On June 17, 2026, DHHS received a copy of the Office of Inspector General of Child Welfare's Report of Investigation regarding "Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney" ("OIG Report"). Pursuant to Neb. Rev. Stat. § 50-1815, DHHS is authorized to respond in writing and may accept, reject or request modification of the recommendations. This letter serves as the agency's response to the OIG Report.

The Office of Inspector General of Child Welfare ("OIG-CW") was created by the Office of Inspector General of Nebraska Child Welfare Act.[1] The OIG-CW assists in improving and provides inquiry into the child welfare system.[2] The OIG-CW was not intended to interfere with investigative responsibilities of any state agency.[3] The Deputy Ombudsman of Institutions ("Ombudsman") was created within the Office of Public Counsel.[4] The Ombudsman investigates, among other things, administrative acts by DHHS's facilities, including the Youth Rehabilitation and Treatment Centers ("YRTC").[5]

The YRTCs are operated by the Office of Juvenile Services ("OJS").[6] OJS is housed in DHHS's Division of Children and Family Services ("CFS").[7] The OJS Administrator is responsible for the administration of the YRTC facilities[8] and supervises the facility administrators for each of the YRTC facilities. The OJS Administrator reports to the CFS Director.[9]

Recommendation 1:
"DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made."

Response:
DHHS respectfully rejects this recommendation. The OIG-CW concludes OJS Compliance investigations are insufficient to investigate child abuse and neglect. Due to the inherent conflict of interest present when CFS investigates its own facilities, DHHS has determined the best course of

[1] Neb. Rev. Stat. § 50-1801 et seq
[2] Neb. Rev. Stat. § 50-1803
[3] Neb. Rev. Stat. § 50-1803(2)
[4] Neb. Rev. Stat. § 50-2006
[5] Neb. Rev. Stat. § 50-2007
[6] Neb. Rev. Stat. § 43-404
[7] Neb. Rev. Stat. § 81-3116(2)
[8] Neb. Rev. Stat. § 43-404
[9] Neb. Rev. Stat. § 81-3116(2)

action is a combination of investigation by law enforcement, the OJS Compliance Team, and the FIT team.

It is important to understand the difference in each agency and entity's role and authority, as they all serve a different and unique purpose.

The OJS Compliance Team investigates incidents and concerns at all three YRTCs and Whitehall, and assesses compliance with the facility's policies and procedures, the Prison Rape Elimination Act ("PREA"),[10] the American Correctional Association ("ACA"), and Handle with Care.[11] The OIG-CW states that one of the objectives of the OJS Compliance Team is to investigate violations of state and federal law.[12] This is a mischaracterization of the Compliance Team's role. The OJS Compliance Team does not investigate violations of law that amount to criminal activity, and these investigations are not intended to determine whether abuse and neglect occurred. Instead, the Compliance Team conducts administrative internal investigations to ensure adherence to state and federal laws, accreditation standards, licensure requirements, and internal policies and procedures.

The OIG-CW suggests the OJS Compliance Team investigations fail to evaluate the safety of the youth.[13] DHHS disagrees. The objective of OJS policies, including those aimed at enforcing PREA, is to protect youth committed to the YRTC. The Compliance Team is constantly evaluating the safety of youth by ensuring adherence to YRTC policies and procedures designed to, among other things, prevent child abuse and neglect. In fact, many policy violations identified by the Compliance Team do not meet the statutory threshold of abuse or neglect but are shared with facility administration to provide an opportunity to address concerns before any abuse and neglect occurs. The OIG Report fails to recognize the important part these investigations play in ensuring the safety of youth.

Under the Child Protection and Family Safety Act,[14] it is DHHS's responsibility to screen reports made to the Nebraska Child Abuse and Neglect Hotline ("Hotline") for further action.[15] This can include accepting the report for Traditional Response, Alternative Response, or requiring no further action.[16] When a report is classified as Traditional Response, CFS assesses safety and risk, the need for services, and whether the case shall be entered on the Central Registry.[17] All Hotline reports, except Alternative Response reports, are automatically forwarded to law enforcement for review and investigation.[18]

The responsibility to investigate whether child abuse and neglect occurred at the YRTC is designated to law enforcement. The OIG Report alleges no child abuse and neglect investigations occurred within the facility. This is not true. OJS referred all incidents referenced in the OIG Report to the Nebraska State Patrol ("NSP") for investigation.

In 2021, DHHS established the Facility Investigation Team ("FIT") as part of DHHS's legal services team. FIT is comprised of attorneys in the Office of Ethics & Compliance, the Chief Legal Officer, Agency Legal Counsel, and Agency Compliance Officer. The FIT team investigates DHHS staff's compliance with existing policies and procedures for any call to the Abuse and Neglect Hotline involving an employee at the 24-hour facilities operated by DHHS. The FIT team is a separate entity

[10] 34 U.S.C. § 30301 et seq.
[11] Handle with Care refers to a model of behavioral intervention utilized by OJS.
[12] OIG Report, p. 61
[13] OIG Report, p. 62-64
[14] Neb. Rev. Stat. § 28-710 et seq.
[15] Neb. Rev. Stat. § 28-712(1)
[16] Id.
[17] Neb. Rev. Stat. § 28-713
[18] Neb. Rev. Stat. § 28-713(5)

from both CFS and OJS, and the FIT team reports are confidential attorney client privileged documents. The FIT team investigation allows individuals outside of OJS, to evaluate whether the OJS Compliance Team and OJS Administration responded appropriately to the report. This assists in mitigating risk against the agency, which, in turn, mitigates the risk of abuse and neglect occurring in DHHS's facilities. DHHS believes one of the greatest risks to the agency is a finding that the agency abused or neglected a child in its care.

The OIG Report places significant emphasis on DHHS's Out of Home Assessments ("OHA"). OHAs are conducted by CFS when DHHS receives a report of child abuse and neglect occurring at a location other than the victim's home, such as a foster home or daycare.[19] Requiring CFS to investigate its own facility employees creates the potential for the appearance of impropriety. CFS investigating its employees of its own facilities is significantly different than CFS investigating individuals employed in a private capacity, such as a daycare. In the case of a YRTC employee, CFS is the employer, facility operator, and the investigator. YRTC employees have due process and employee rights which are outlined in the Rules and Regulations and labor contract governing the employee. When CFS enters its own employee on the Central Registry, doing so negatively impacts the individual's employment. The OIG-CW has essentially requested CFS to act as the judge, jury, and executioner, which creates the appearance of impropriety. It is very difficult for the employer in this situation to dispel any accusation of self-interest. Utilizing a neutral third-party to conduct abuse and neglect investigations avoids even the appearance of a conflict.

Requiring CFS to investigate allegations of abuse or neglect by CFS employees in a CFS operated facility would result in CFS being placed in the position to make a finding of abuse or neglect against CFS. DHHS would argue this is a per se conflict which can only be mitigated through the use of a neutral third party. Currently, CFS relies on NSP as the neutral party to determine whether child abuse and neglect occurred at the YRTC.

This can also be differentiated from when DHHS receives reports of abuse and neglect involving a CFS child welfare case manager in their personal capacity. First and foremost, the alleged abuse and neglect occurred outside the employee's scope of employment. In these situations, DHHS immediately suspends or reassigns the employee and designates a case manager from a different service area to investigate, which mitigates the risk of bias. This would not result in DHHS making a finding of abuse and neglect against one of its own employees working in the scope of their employment.

This also differs from Adult Protective Services ("APS") investigations at DHHS's adult facilities. The adult facilities are managed by the Division of Behavioral Health or the Division of Developmental Disabilities. APS is administered by CFS. Thus, investigations at adult facilities are conducted by a separate division of the agency which mitigates the risk of any appearance of impropriety.

Further, the OIG-CW raises concerns with the OJS Compliance Team's inability to enter alleged perpetrators on the Central Registry. DHHS agrees it is important to enter perpetrators of child abuse or neglect on the Central Registry. DHHS, however, disagrees with the assertion that no abuse and neglect investigations occur at the YRTC and disagrees that DHHS must be the entity to conduct abuse and neglect investigations at the YRTCs.

The Child Protection and Family Safety Act provides two pathways for a child abuse and neglect perpetrator to be entered into the Central Registry.[20] A perpetrator can be listed on the Central Registry as "court substantiated" or "agency substantiated."[21] A perpetrator is listed as court substantiated when "a court of competent jurisdiction has entered a judgment of guilty against the

[19] DHHS-CFS Protection and Safety SOP for Out-of-Home Assessments, #821
[20] Neb. Rev. Stat. § 28-720
[21] Neb. Rev. Stat. § 28-720

subject of the report of child abuse or neglect upon a criminal complaint, indictment, or information or there has been an adjudication of jurisdiction of a juvenile court over the child under subdivision (3)(a) of section 43-247 which relates or pertains to the report of child abuse or neglect…"[22]

A perpetrator is entered as "agency substantiated" following DHHS's determination that the perpetrator has committed child abuse and neglect by a preponderance of evidence and based on an investigation under Neb. Rev. Stat. § 28-713.[23]

A perpetrator may also be identified as "court pending" when "a criminal complaint, indictment, or information or a juvenile petition under subdivision (3)(a) of section 43-247, which relates or pertains to the subject of the report of abuse or neglect, has been filed and is pending in a court of competent jurisdiction…"[24] A case classified as "court pending" does not result in the perpetrator's entry on the Central Registry until after the final judgment in the related criminal case or the adjudication in the related juvenile case.

Throughout the OIG Report, concerns are raised about CFS itself not conducting the abuse and neglect investigations at the YRTC. However, utilizing NSP to investigate potential criminal activity is specifically authorized by statute. The Child Protection and Family Safety Act provides both DHHS and law enforcement investigatory authority and authorizes DHHS to seek assistance from law enforcement in conducting child abuse and neglect investigations.[25]

CFS routinely collaborates with law enforcement when conducting child abuse and neglect investigations.[26] During these joint investigations, it is not uncommon for law enforcement to request that CFS delay its investigation to allow the law enforcement agency time to complete interviews or other vital pieces of the criminal investigation. This often prevents CFS from conducting its own investigation and gathering the information necessary for a Central Registry finding of agency substantiated.

The OIG Report suggests the four former YRTC employees would've been on the Central Registry if DHHS had conducted an abuse and neglect investigation. However, it must be noted that, as of the date DHHS received the OIG Report, none of those employees could be entered on the Central Registry because the criminal charges were still pending and the cases had to be listed as court pending.

In 2026, the Child Protection and Family Safety Act was amended to provide alleged perpetrators 14 days' notice prior to their entry on the Central Registry.[27] Effective July 18, 2026, the alleged perpetrator is entitled to a hearing prior to entry to determine whether the Central Registry entry is consistent with Nebraska law.[28] Any final judgment in a related criminal case issued on or after July 18, 2026 would also entitle the perpetrator to the 14 day notice period as required by the amended statutes, thereby further delaying the Central Registry entry.

Contrary to the OIG Report's assertion no abuse and neglect investigations occurred, DHHS referred all incidents included in the OIG Report to NSP for investigation. It should be noted that in 2023, the OIG-CW annual report discussed PREA violations at the facility. The OIG-CW pointed out that the one allegation involving a staff member was investigated by NSP. At that time, the OIG-CW reported no concerns with NSP conducting the investigation instead of CFS.[29]

---

[22] Neb. Rev. Stat. § 28-720(1)(a)
[23] Neb. Rev. Stat. § 28-720(1)(b)
[24] Neb. Rev. Stat. § 28-720(1)(c)
[25] Neb. Rev. Stat. § 28-713
[26] DHHS-CFS Protection and Safety SOP for Initial Assessments, #895
[27] LB668 (Laws, 2026)
[28] Neb. Rev. Stat. § 28-713.01(2); § 28-720(6)
[29] OIG-CW 2023 Annual Report

DHHS understands the concerns raised by the OIG-CW and is exploring processes to make a Central Registry determination earlier in the process. Processes being explored would utilize a neutral third party investigator to prevent CFS from being the sole entity to determine whether abuse and neglect occurred. DHHS is currently evaluating the best way to ensure the child abuse and neglect investigation is completed by a third party.

DHHS is willing to pursue a process, in collaboration with NSP, whereby CFS could rely on a preliminary finding from NSP Investigator to enter a perpetrator into the Central Registry. However, such an entry would necessarily have to occur prior to the filing of a criminal complaint. Once a complaint is filed, the agency can only identify the case as court pending until the case is resolved.

Recommendation 2:

"DHHS and YRTC-Kearney should address the cultural problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth."

Response:

DHHS agrees that structural improvements could be made to the facility. DHHS respectfully requests the OIG-CW modify this recommendation.

DHHS has already implemented various operational and structural improvements. There are additional accountability measures and corrective actions underway. The OIG Report contains Appendix B, a letter sent to the OIG-CW from OJS.[30] This document includes a total of 37 operational and structural changes to the YRTCs in response to the incidents referenced in the OIG Report. DHHS would like to correct numbers 1 and 11 in that letter. Paragraph number 1 should include the Director of CFS as an individual notified of priority critical incidents. Paragraph number 11 should be modified to say, "DHHS has consistently conducted comprehensive background checks, employment verification, and PREA reference checks for staff. Beginning December 1, 2025, DHHS implemented additional reference checks for all direct care staff in our facilities."

The OIG Report correctly notes the OIG-CW must rely on the conclusions reached by OJS and law enforcement.[31] The OIG-CW cannot substitute its own conclusions or interfere with The OJS Compliance Team's investigations.[32] The OIG-CW cannot rely on the number of allegations to conclude that the culture at YRTC-Kearney condones inappropriate staff behavior. Further, the OIG Report itself establishes that the culture at the YRTC was not one that condoned maltreatment of youth. "The OIG-CW does not find that all staff or administration at YRTC-Kearney engaged in or condoned this inappropriate staff conduct. On the contrary, it is clear that many staff members are committed to the safety, care, and rehabilitation of the youth."[33]

The OIG Report alleges that, instead of focusing on the youth as victims, OJS used a more punitive approach, such as confinement, citing the phone incident.[34] It is important to note the YRTC is a behavior modification program. Part of that programming includes holding youth accountable for their behaviors and teaching them that they have agency over their own lives. While discipline should be sympathetic to the idea that some of the youths were victims, DHHS cannot forego discipline. This only reinforces the behavioral issues that led the youth to the YRTC.

[30] OIG Report, app. B
[31] OIG Report, p. 10
[32] Neb. Rev. Stat. § 50-1803(2)
[33] OIG Report, p. 4-5
[34] OIG Report, p. 61

The OIG-CW asserts that the cultural concerns at the YRTC have been present for ten years.[35] This statement is contradicted by multiple OIG-CW reports and other agencies' reports. The OIG-CW issues a report regarding the child welfare and juvenile justice systems annually.[36] Not once in the last ten years has the OIG-CW reported concerns regarding a culture of inappropriate staff behaviors or sexual abuse at YRTC-Kearney in any of its annual reports.

The 2025 Annual Report of the OIG-CW indicated youth at the YRTCs consistently told the OIG-CW they had positive relationships with the staff, trusted the staff, and felt like the staff were invested in their success.[37] In 2024, the OIG-CW pointed to gang affiliations and violent behavior by youth as the biggest concerns facing YRTC-Kearney, and made no mention of inappropriate behavior by staff.[38] In 2023, the OIG-CW discussed reports of PREA violations, noting that the office received only one report involving a staff member, which was investigated by NSP. There was no reference to a concern regarding the facility culture.[39] The 2022 report noted concerns regarding a staffing shortage, but no concerns regarding staff behavior at YRTC-Kearney.[40] In 2021, the OIG-CW again mentioned staffing shortages, but no concerns of staff behavior at YRTC-Kearney.[41] The 2020 report discussed the incident at YRTC-Geneva, which has since been closed, but contained no references to a culture at YRTC-Kearney.[42] In 2019, the OIG-CW praised OJS for achieving compliance with PREA.[43] The 2018 report briefly mentioned an increase in critical incident reports, but attributed this to increases in escapes and assaults.[44] In 2017, the OIG-CW noted OJS's implementation and completion of all recommendations made by the OIG-CW and specifically noted that OJS "had taken additional steps to successfully stabilize and improve the centers in the past 12 months."[45]

In 2016, the OIG-CW completed an investigation into deteriorating physical facility conditions at YRTC-Kearney. There was no indication of a culture concern noted in that report. The 2017 Annual Report briefly touches on the 2016 investigation into the physical conditions of the facility, but does not identify any concerns regarding sexual abuse or other inappropriate behavior by staff.[46]

The Ombudsman only reported concerns regarding systemic issues in 2025, and those concerns were specifically related to the incidents referenced in this OIG Report. In 2022, the Ombudsman specifically reported there were no systemic issues at YRTC-Kearney noted in complaints made to the Ombudsman.[47]

Further, OJS has passed its last four PREA audits, which are conducted by an external federal entity to assess the facility's compliance with the federal PREA standards to prevent, detect, and respond to sexual abuse and harassment.

In addition, multiple external entities enter the YRTCs every day. In addition to a re-entry probation officer located on each YRTC campus, each youth has a private monthly visit with his or her home probation officer. Youth are appointed an attorney, and occasionally a guardian ad litem, in the juvenile court case who attend family team meetings and are permitted private visits with

[35] OIG Report, p. 58
[36] Neb. Rev. Stat. § 43-4331 (Cumm. Supp. 2024); transferred to Neb. Rev. Stat. § 50-1818
[37] OIG-CW 2025 Annual Report, p. 42
[38] OIG-CW 2024 Annual Report, p. 37-40
[39] OIG-CW 2023 Annual Report, p. 16
[40] OIG-CW 2022 Annual Report, p. 10
[41] OIG-CW 2021 Annual Report, p. 12
[42] OIG-CW 2020 Annual Report, p. 2-6
[43] OIG-CW 2019 Annual Report, p. 17
[44] OIG-CW 2018 Annual Report, p. 4
[45] OIG-CW 2017 Annual Report, p. 3
[46] 2016 OIG-CW Annual Report, p. 13
[47] Ombudsman's 2022 Annual State Institution Report, p. 28

the youth. Cases may be reviewed by the Foster Care Review Office. For dually adjudicated youth, the CFS child welfare case manager also visits the youth on campus monthly. Prior to 2025, none of these entities raised any concern about a "culture of normalized inappropriate staff behavior."

DHHS disagrees that the YRTC culture normalizes inappropriate staff behavior. In fact, in September 2025, DHHS requested the Ombudsman and OIG-CW come to YRTC-Kearney and interview youth privately to determine whether youth felt safe and to assess the general well-being of the youth. On November 6, 2025, the Deputy Ombudsman of Institutions and OIG-CW conducted a safety welfare check which included interviewing 13 youth chosen at random by the Ombudsman and OIG-CW from a list of youth who had not made an allegation against YRTC staff. [48] According to the Ombudsman and OIG-CW all the youth interviewed indicated they felt safe at the facility.[49] Interestingly, the OIG-CW notes this information was not used in the OIG Report.[50]

It is unreasonable for the OIG to assert that a culture that normalizes inappropriate staff behavior exists and that the facility failed to address said systemic culture problem, when they themselves failed to identify any such problem over the last ten years.

Recommendation 2.1:
"Enhance supervision of YPS staff."

Response:

DHHS respectfully requests the OIG-CW modify this recommendation. The OIG Report incorrectly states that Unit Managers oversee all staff, including Youth Security Supervisors, Youth Security Supervisor Managers, Youth Program Specialists, and Case Managers.[51] While Unit Managers are responsible for the overall operations of each living unit, they only supervise the Youth Program Specialists and the Case Managers located in that living unit.

DHHS is exploring opportunities to increase staffing and additional ways to enhance supervision.

Recommendation 2.2:
"Increasing programming and structured activities for youth."

Response:

DHHS respectfully requests the OIG-CW modify this recommendation. The OIG Report identifies concerns with a perceived lack of programming and structured activity during the weekend.[52] General programming is incorporated into almost all daily activities, along with scheduled large muscle recreation, and leisure activities. Youth attend school, therapy, and specific programming on weekdays. Visitation is scheduled from 8:00 a.m. to 4:00 p.m. on both Saturday and Sunday. It is important programming and treatment time does not conflict with visitation time. In addition, youth must be provided downtime to practice the skills they learn in therapy and groups. DHHS will conduct a comprehensive review of the current activities and programming to determine whether any modifications to the unstructured time should be made.

Recommendation 2.3:
"Strengthen surveillance and monitoring capabilities and practices."

[48] OIG Report, p. 12
[49] OIG Report, p. 12
[50] OIG Report, p. 12
[51] OIG Report, p. 13-14
[52] OIG Report, p. 81

DHHS accepts this recommendation. DHHS has implemented additional security measures, to include requiring staff to carry clear backpacks, periodic staff locker checks, and increased video reviews by The OJS Compliance Team.

DHHS continues to explore ways to enhance the YRTC facilities. Current facilities are aging and lack many of the benefits available in a more modern building. Modernizing the facilities would assist with security. Facility upgrades or relocation require either legislative change, legislative appropriation, or both.

Recommendation 2.4:
"Implement consistent processes for holding staff accountable for boundary concerns."

Response:

DHHS respectfully requests the OIG-CW modify this recommendation. Staff members are currently held accountable for their actions involving boundaries. OJS maintains a host of SOPs employees are required to follow. A violation of a policy or SOP may result in discipline, up to and including termination. When CFS identified policy violations for boundary or any inappropriate employee conduct it took corrective or disciplinary action in accordance with contractual or regulatory requirements. It's important to note CFS, as the employer, must comply with state personnel rules and regulations and applicable labor contracts. DHHS will continue to ensure processes for holding staff accountable are consistently followed.

Recommendation 3:
"DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report."

Response:

DHHS accepts this recommendation but asserts that any deficiencies which may have been present have since been rectified. OJS has changed its investigative processes based on reviews of the incidents in the OIG Report. DHHS is committed to ensuring the adequacy of practices and procedures, and, as such, the OJS Compliance Team has implemented additional training and procedures regarding the investigative process.

The OIG Report identifies several limitations of the OJS Compliance Team, including the limited ability to interview involved youth and staff and the evidence utilized during the investigation.[53] However, as previously stated, the OJS Compliance Team is not conducting a criminal investigation and any investigation to determine whether child abuse and neglect occurred should be conducted by a neutral third-party. The YRTC utilizes NSP as that neutral third-party.

The OIG-CW raises the concern that the OJS Compliance Team did not properly consider the number of consistent reports from youth as evidence during compliance reviews.[54] The OJS Compliance Team, however, reviews each incident individually to determine whether policies and procedures were properly followed. This is consistent with the OIG-CW's statement "[a] prior allegation against a staff member should not determine the outcome of a subsequent one, and each allegation must be evaluated on its own merits."[55] The OIG Report characterizes the allegations investigated by the Compliance Team as several youth making similar reports about one employee and one youth. This is inaccurate. Most reports were allegations made by a youth regarding that

[53] OIG Report, p. 67-74
[54] OIG Report, p. 54
[55] OIG Report, p. 68

youth's own interaction with an employee, not another youth. The OJS Compliance Team investigated each allegation and made a finding based on the evidence available to the team at the time of the investigation.

The OIG Report points to several cases which the OIG-CW argues should have been substantiated as a PREA violation. As previously stated, the OIG-CW cannot make these determinations.[56]

The OIG Report often conflates policy violations, PREA violations, and determinations of child abuse or neglect. Not all policy violations, even those involving boundaries, will necessarily give rise to a PREA violation nor a determination of abuse or neglect. A policy violation is an employment standard. Generally, employment standards are determined based on a preponderance of evidence. YRTC has policies to prevent inappropriate employee interactions with youth in the facilities and to provide guidance as to appropriate interaction. Policies create a broad standard for employee conduct. PREA standards are established by federal law and are specific to sexual abuse, sexual harassment, and voyeurism which are defined very narrowly.[57] By their broad nature, policy violations may not even implicate PREA. It can be assumed, in an appropriately operated facility, there will be more policy violations than PREA violations.

A finding of abuse or neglect is an even narrower standard than PREA. Not every PREA violation will give rise to a finding of abuse or neglect. Thus, it can be assumed, in an appropriately operated facility, there will be more PREA violations than findings of abuse or neglect.

DHHS takes every allegation of abuse or neglect seriously and values youth voice.

Recommendation 4:

"The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth."

Response:

At this time, DHHS is not taking a position as to whether the law should be changed.

DHHS respectfully disagrees with the OIG-CW's contention that DHHS failed to notify the OIG-CW of the March 2025 phone incident, as it is a deliberate mischaracterization. DHHS did not fail to notify the OIG-CW or Ombudsman of the March 2025 phone incident. The OJS Administrator notified the Deputy Ombudsman for Institutions on March 28, 2025. Until June 4, 2025, the Office of Inspector General was part of the Ombudsman's Office, both of whom reported to the Office of Public Counsel[58]. In March 2025, notifying the Ombudsman was notifying the OIG-CW. It wasn't until June 2025 when the OIG-CW was separate from the Ombudsman and the Office of Public Counsel.[59]

[56] Neb. Rev. Stat. § 50-1803(2)
[57] 28 CFR § 115.6
[58] LB298 (Laws, 2025)
[59] Neb. Rev. Stat. § 50-2006; Neb. Rev. Stat. § 50-1805

Appendix D:
OIG-CW Reply to DHHS Response to the OIG Report of Investigation

JENNIFER A. CARTER
Inspector General

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

July 27, 2026

Mr. Steve Corsi
Chief Executive Officer

Dr. Alyssa Bish
Director, Children and Family Services

Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Dear CEO Corsi and Dr. Bish,

Thank you for your July 9, 2026, memorandum detailing DHHS' Response to the Office of Inspector General of Nebraska Child Welfare's (OIG-CW) Report of Investigation, "Allegations of Sexual Abuse of Youth by Staff at the Youth Rehabilitation and Treatment Center at Kearney." We appreciate DHHS' responses and clarifications and the shared concern for ensuring the safety of the youth at the YRTCs.

As required by the OIG-CW Act, we have considered DHHS' requests for modifications to the OIG-CW's Recommendations. As explained in this letter, we have not modified the Recommendations as requested. However, we have made edits to the report to clarify or add to certain points based on DHHS' response. Those changes are detailed below.

DHHS Response to Recommendation 1 – *DHHS should resume conducting abuse and neglect investigations at the YRTCs and any statutory changes that are deemed necessary to effectuate this should be made.*

DHHS rejected this recommendation for two main reasons: (1) abuse and neglect investigations are unnecessary because Nebraska State Patrol (NSP) does a criminal investigation of abuse and neglect and the Office of Juvenile Services Compliance Team's (also referred to as "OJS Compliance Team" or "Compliance") internal investigations, along with the Facility Investigation Team's (FIT) review of the Compliance team, serves to ensure the safety of youth;

and (2) a conflict of interest prohibits DHHS from conducting abuse and neglect investigations at the YRTCs.

As to the first point, we agree criminal investigations by NSP are critical. But NSP abuse and neglect investigations do not capture all allegations of abuse and neglect because NSP investigations necessarily focus on *criminal* abuse. DHHS notes that it referred each allegation to NSP. But not every referral will result in an investigation by NSP if the referral does not allege criminal activity. Abuse and neglect that does not meet the higher legal standard of criminal abuse is not addressed by a criminal investigation. Therefore, a criminal investigation by NSP will only capture a subset of behaviors that may be considered abuse and neglect.

OJS Compliance Team investigations are also very important and serve a different purpose than a criminal investigation. DHHS suggests that the OIG-CW report states or implies that Compliance conducts a criminal investigation. This is not correct. However, in an effort to ensure that point is clear, language has been added to the report to explicitly state that Compliance investigations are not criminal. (See pages 16, 44.)

Further, DHHS states that the OIG-CW mischaracterized the role of the OJS Compliance Team by stating that Compliance's role is to investigate violations of state and federal law. Yet, within that same paragraph, DHHS states that the role of Compliance is to "ensure adherence to state and federal law." Ensuring adherence to state and federal law would necessitate ensuring that there are no violations of state and federal law. Given that there is no substantive difference in this language, the OIG-CW has edited the report to reflect DHHS' preferred terminology that the OJS Compliance Team "ensures adherence to state and federal law." (See pages 5, 44, 61.)

The OIG-CW acknowledges that Compliance investigations can uncover safety concerns. However, as DHHS' response repeatedly notes, Compliance investigations "are not intended to determine whether abuse and neglect occurred." The FIT reviews are also not abuse and neglect investigations. DHHS has described them as a compliance review for the Compliance process and are meant to evaluate the legal risk to DHHS and "assist in mitigating the risk against the agency" of a finding that abuse or neglect occurred in a DHHS facility. These are important measures. But neither serves the purpose of assessing for abuse and neglect at the YRTCs. As a result, a gap remains: a non-criminal assessment for abuse and neglect does not occur at the YRTCs.

Regarding DHHS' assertion that there is a conflict of interest if Children and Family Services (CFS) conducts abuse and neglect investigations at the YRTCs, for the reasons stated in the OIG-CW report, and CFS' history of conducting Out of Home Assessments (OHAs) in the past, the OIG-CW believes this conflict, if it exists, is not prohibitive and can be addressed. Indeed, in its response, DHHS offers one solution: a neutral third party could be used to conduct abuse and neglect investigations at DHHS facilities. For the reasons stated in the report and above, relying solely on NSP as that third party does not address all potential abuse and neglect. However, DHHS notes that Adult Protective Services within CFS *does* conduct investigations at other DHHS facilities because those facilities, while part of DHHS, are administered by other DHHS divisions. We appreciate DHHS' perspective on this. To that end, the OIG-CW has revised its recommendation to note that other solutions might be explored that would allow CFS to assess

abuse and neglect at facilities with a greater level of independence, thereby resolving DHHS' concerns about a conflict. For example, DHHS could explore legislative changes necessary to move OJS into another DHHS division or its own division. This would mirror the structure with Adult Protective Services. (See pages 78-79.)

We appreciate that DHHS agrees that it is important to ensure that YRTC staff who have committed abuse are placed on the Central Registry. However, DHHS expresses a concern that there will be an appearance of impropriety and DHHS will become the "judge, jury, and executioner" if required to investigate and substantiate abuse by its own employees and place them on the Central Registry. The OIG-CW does not accept this premise. But, even if this is a concern, as DHHS notes, the law was changed this year to allow anyone being placed on the Central Registry to appeal the Department's decision prior to their names appearing on the Registry. With regard to the determination to place someone on the Central Registry, then, the ultimate decision is made by a third party—either a hearing officer or a court.

The OIG-CW also appreciates DHHS' intent to make a Central Registry determination earlier in the process. But to be clear, the OIG-CW's concern is not about the timing of the process. Rather, the concern is that there is no method for placing a YRTC employee on the Central Registry through the agency substantiating the abuse rather than having to rely solely on a successful criminal prosecution. This was the main point of the OIG-CW's recommendation. Allegations of abuse and neglect should be assessed at the YRTCs as they are at other juvenile and licensed facilities. Failing to do so allows YRTC employees to escape accountability for the same conduct that employees in other DHHS facilities or private juvenile facilities rightly face. Under the current process, if a YRTC employee and an employee at a juvenile facility perpetrate the same abuse, the YRTC employee is only held accountable—and only placed on the Central Registry—if the conduct amounts to a crime, while the employee at the private facility could be substantiated for abuse and placed on the Central Registry by the DHHS through an OHA. DHHS should hold its own employees to the same standards to which it holds employees at the juvenile facilities it licenses.

The OIG-CW will finalize Recommendation 1 and the related Finding with the edits identified above.

DHHS Response to Recommendation 2 – *DHHS and YRTC-Kearney should address the culture problem at the facility, including implementing operational and structural improvements to prevent staff sexual abuse and violations of professional boundaries with youth.*

DHHS has also requested a modification to this recommendation. We appreciate that DHHS agrees that structural improvements could be made to the facility. We are not clear on what specific modification is requested, but understand that DHHS believes it was inappropriate for the OIG-CW to find that there is a problematic culture at YRTC-Kearney based on two main reasons: (1) that the OIG-CW could not rely on the number of allegations to make that finding and (2) that the OIG-CW had not previously found a culture problem in its annual reports from the last 10 years and, therefore, cannot find one now despite new evidence. The OIG-CW has decided not to modify this recommendation, but has made some minor edits to the report to ensure clarity around the finding, recommendation, and reasoning for each.

The OIG-CW did not base its finding and recommendation regarding the culture at YRTC-Kearney simply on the number of allegations. As is stated repeatedly in the report, four former staff members are being criminally charged, three other allegations regarding three additional staff were substantiated internally by Compliance, and approximately 15 other allegations were unsubstantiated—meaning they might have occurred, but the evidence was inconclusive or could not be gathered. The behaviors that resulted in criminal prosecution and internal substantiation alone establish a documented pattern of inappropriate behavior that supports the conclusion of a culture problem at the facility. In addition, the number, breadth, and consistency of all the other allegations also support this finding.

DHHS' assertion that the OIG-CW cannot make a new finding based on new evidence if such a finding had not been made before, even though the evidence did not previously exist or was not made known to the OIG-CW, is illogical. The OIG-CW receives notifications of critical incidents on an ongoing basis, as required by law. This investigative report is based on information the OIG-CW began receiving in August 2025. It is appropriate, and the OIG-CW's duty under the law, to investigate these new incidents and determine its findings and recommendations based on that new information. None of the incidents within the scope of the OIG-CW's report had occurred or been reported to the OIG-CW from 2016 to 2025, and so could not have been included in those annual reports.

Similarly, the Ombudsman's office would have only mentioned systemic concerns regarding the high number of sexual abuse allegations in its 2025 report because, again, that is when the Ombudsman's Office was made aware of the allegations.

DHHS also suggests that the OIG-CW cannot claim the culture problem has existed for 10 years. That is a mischaracterization of the OIG-CW's finding. The finding is that a culture problem exists and that there is evidence in personnel files and previous OHAs of the same patterns of behavior extending back 10 years. In an effort to ensure clarity, we have edited language on page 58 to ensure it is not interpreted as implying a finding that the culture problem identified by the OIG-CW in this report has existed for 10 years.

Finally, DHHS also suggests that the OIG-CW cannot find a problematic culture at YRTC-Kearney because the OIG-CW and Ombudsman visited YRTC-Kearney in November 2025 and spoke with 13 youth who, overall, said they felt safe at the facility. The OIG-CW and Ombudsman's visit to the YRTC does not undermine the OIG-CW's finding. To clarify, the OIG-CW and Ombudsman's Office do not conduct safety and welfare checks. However, we are obligated as part of our monitoring duties to observe the facility and speak to youth, particularly when systemic concerns arise. At the time of that visit, the OIG-CW had already been notified of at least 34 allegations by nearly as many youth, and the OIG-CW received notifications of several additional allegations after that visit. The OIG-CW's findings are based on an in-depth analysis of those allegations and the resulting Compliance investigations. The conversations with those 13 youth do not negate the significant evidence of the 44 total allegations. Moreover, safety and culture are distinct concerns. The fact that most of the 13 youth felt they could be made safe at the facility at that time does not speak to whether a culture existed that might allow for inappropriate behavior by staff.

Response to Recommendations 2.1-2.3
With regard to the OIG-CW's recommendation that the supervision of YPS staff be enhanced, we appreciate that DHHS is exploring opportunities to increase staffing and additional ways to enhance supervision. The OIG-CW also appreciates the clarification on the supervision of the Youth Security Supervisors and has edited the report to reflect that. (See pages 13-14, 48.)

Similarly, we appreciate that DHHS will conduct a comprehensive review of current activities and programming, specifically regarding unstructured time, and that DHHS has accepted the recommendation to strengthen surveillance and monitoring capabilities and practices.

Response to Recommendation 2.4
DHHS requests a modification to this recommendation. We are not clear on what specific modification is being requested, but we understand that DHHS asserts action is taken whenever a boundary violation is found and that action must be in accordance with personnel rules and regulations and labor contracts. To clarify, the OIG-CW's finding is that the response to boundary violations has been insufficient to address or prevent inappropriate behavior, as is evidenced by the behavior and allegations in this investigation. The OIG-CW understands that DHHS must address those behaviors within the constraints of the labor contract. The recommendation is broad enough to encompass an examination of whether changes should be made to those contracts and personnel policies if they are inhibiting OJS' response to boundary violations. Given our lack of clarity on the requested modification, none has been made, although the OIG-CW appreciates DHHS' commitment to ensuring staff are held accountable.

DHHS Response to Recommendation 3 – *DHHS should evaluate and improve Compliance's investigative and review practices to address the deficiencies identified in this report.*

The OIG-CW appreciates that DHHS has accepted this recommendation.

DHHS makes several points in response to this recommendation that require clarification. First, as noted above, the OIG-CW report does not claim that Compliance investigations are criminal investigations. The findings and recommendations related to Compliance investigations are based on the OJS Compliance Team's process and a review of its internal investigative reports.

Second, in response to the report's concern that the OJS Compliance Team did not consider consistent reports from youth as evidence, DHHS states that each incident is reviewed individually. That is the OIG-CW's understanding as well, as explained in the report. The concern raised was that viewing each incident in isolation prohibited Compliance from giving weight to corroborating statements across allegations and prevented Compliance from recognizing patterns of behavior.

Third, DHHS suggests that the OIG-CW argues that Compliance's determinations in certain investigations should be changed. This is not correct. The OIG-CW's analysis is focused on Compliance's process and instances in which Compliance's documentation and conclusions did not align with the standard of review. To ensure clarity on this point, edits have been made on pages 54-55, 69, 70, 74.

Fourth, DHHS believes that the OIG-CW report conflates policy violations, PREA violations, and determinations of abuse and neglect. We disagree. The OIG-CW is acutely aware that these, along with criminal investigations, are distinct and that while they can overlap—for example, some policies are meant to prevent abuse and a violation of those policies might amount to abuse—the overlap is not complete. Indeed, understanding this is critical to the OIG-CW's recommendation that abuse and neglect investigations are necessary at the YRTCs.

DHHS Response to Recommendation 4 – *The law should be changed to ensure that the OIG-CW is notified of all allegations of staff abuse of youth.*

DHHS' response to this recommendation was surprising. The law is very clear—DHHS and OJS are required to notify the OIG-CW, not the Ombudsman's Office, of deaths and serious injuries, sexual abuse allegations, and a host of information from the YRTCs, including internally substantiated PREA violations. *See* Neb. Rev. Stat. § 50-1806 (2), (3). These requirements are found in the Office of Inspector General of Nebraska Child Welfare Act, *not* the act related to the Office of Public Counsel. The OIG-CW has always been a separate office within the legislative division in which it is housed.

DHHS has always understood and operated with this understanding of the law. The OIG-CW cannot recall a single time in the 14-year history of the office when the OIG-CW received any required notification through the Ombudsman's Office. In fact, DHHS created two separate SharePoint sites—one for the OIG-CW and one for the Ombudsman—to share confidential information with those offices. These sites were created when the OIG-CW was still an office within the Division of Public Counsel and were mutually exclusive—neither office could access the Partner's site belonging to the other.

For these reasons, the information YRTC leadership shared with the Ombudsman's Office about the March 2025 incident did not serve as notice to the OIG-CW. Moreover, the information shared with the Ombudsman did not include any mention of the sexually explicit material. The OIG-CW did not receive notice of the March 2025 incident through a Critical Incident Report posted on the Partners Site, as is the agreement and long-standing practice, until a new, related allegation arose in September 2025. However, since that March 2025 incident was determined not to be a PREA violation, the law did not require notice to the OIG-CW. The point of this recommendation is to make clear to the Legislature that certain behavior by staff towards youth is not currently required to be shared with the OIG-CW, and legislative changes would be necessary to change that. Edits to the finding have been made to clarify this further. (See pages 74-75.)

Finally, we have updated the report on page 43 to reflect the most recent changes in OJS leadership.

Again, we appreciate DHHS' response and the opportunity to clarify the report. We also want to express our appreciation again to the team at YRTC-Kearney for being responsive to our requests for information.

With the changes identified above, the report is final. We plan to release the report publicly tomorrow, July 28, 2026. It will, of course, also be included in the annual report this fall as required by law.

As always, we welcome any questions and would be happy to speak.

Sincerely,

Jennifer A. Carter