Nebraska Citizen Review Panel for Child Protective Services Annual Report – 2021

Nebraska Commission for the Protection of Children

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Nebraska Commission for the Protection of Children Membership:

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Hon. Lynelle Homolka – Judge of the County Court, 5th District
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Amanda Hoffman - Nebraska Crime Commission
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The report that follows serves as the State of Nebraska's Citizen Review Panel for Child Protective Services Annual Report covering activities of the work completed starting in April 2021. During this period, the Citizen Review Panel conducted case reviews of 38 serious injuries and near fatalities due to child abuse or neglect that occurred between October 2019 and September 2020.

This report was prepared on behalf of the Citizen Review Panel subcommittee Governor's Commission for the Protection of Children (Commission), which serves as one of Nebraska's three Citizen Review Panels.

Based on its reviews, the Citizen Review Panel offer the following five recommendations to improve Nebraska's child welfare system:

- Improve internal policy and process to ensure law enforcement and medical reports are obtained by DHHS.
- Develop strategies to strengthen coordination across disciplines on child abuse and neglect investigations.
- Conduct thorough reviews of all near fatality and serious injuries suspected to be caused by abuse or neglect at local Child Abuse and Neglect Investigation multidisciplinary teams.
- Form a workgroup on improving response to failure to thrive/malnutrition across disciplines.
- Provide training on failure to thrive/malnutrition.

Citizen Review Panel Overview

The Nebraska Commission for the Protection of Children (Commission) was established in 1993 by Executive Order 93-7. Since that time, it has functioned as Nebraska's CJA State Task Force and one of three Citizen Review Panels in the state. The Nebraska Department of Health and Human Services, Division of Children and Family Services (DHHS) contracts with the Nebraska Children and Families Foundation (Nebraska Children) to support and administer the Commission. Nebraska Children began subcontracting with the Nebraska Alliance of Child Advocacy Centers (Nebraska Alliance) to assist with some of those duties in 2019. In 2020, the Nebraska Alliance also began to assist with the Citizen Review Panel (CRP) that functions as a subcommittee of the Commission.

Since 2017, the CRP under the Commission has focused its efforts on the review of serious injury and near fatality cases due to child abuse. It includes both Commission and non-Commission members from the larger community.

The cases are preliminarily identified through the statewide Child Abuse and Neglect Hotline and then additionally screened by staff with the Nebraska Department of Health and Human Services (DHHS) to see if they meet the criteria for review. DHHS then prepares case files for CRP review.

2021-2022 Citizen Review Panel Activities

This year, the CRP continued its focus on review of serious injuries and near fatalities. The reviews were conducted using paper files of case records prepared by DHHS. Reviewers used the information to fill out a review form that was available in both paper and electronic format.

To increase its effectiveness this year, the CRP added and onboarded four additional members and revised its review form. The full review form used can be found in the appendix. Throughout the year,

the CRP reviewed results of the reviews and discussed issues that were impacting the review process – from missing records to areas on the review form that needed further clarification. In November, a reviewer reliability exercise was conducted to identify improvements to training and the review form tool for 2022.

The CRP's activities and meetings continued to be impacted by the COVID-19 pandemic this year. The CRP conducted socially distanced reviews with virtual follow-up meetings in April and August 2021 – reviewing 36 cases. In person case reviews and meetings were able to occur in November and December 2021, where reviewers collaborated to review an additional two cases together. A final virtual meeting took place in February 2022 to finalize recommendations based on reviews completed in 2021 and annual report structure.

Serious Injury Review Results

The following section provides details on the 38 serious injuries and near fatalities that the CRP reviewed. The children lived in 14 different locations across the state. 16 or 42% of all injuries reviewed occurred in Omaha in Douglas County. Multiple injuries reviewed also occurred in Lincoln, Bellevue, and Kearney.

Child Characteristics

The reviews gathered basic demographic information about the children who were injured in addition to asking about any diagnosed conditions and additional vulnerabilities. Of the children injured:

- 50% (19 of 38) of the children seriously injured were under the age of 2 years old. Five additional children who were injured were between 2 and 4 years old. In total, 63% of children injured were under the age of 5.
- Racial disparities were prevalent. Black and American Indian children were disproportionately represented in the injuries relative to their percentage of the population.
    - Only 45% of children seriously injured (17 of 38) were white, although white children make up 68% of Nebraska's child population.
    - While Black children were only 6% of the child population, they were 24% of those injured.
    - American Indian children make up 1% of the child population, but 10% of those seriously injured.
- 15 of the children had a diagnosed condition prior to their injury. Seven had medical diagnoses, 8 had developmental disabilities, and four had mental health diagnoses.
- Male children made up 53% of the children who were injured (20 of 38).

Injury Characteristics

The reviews gathered information on the cause of injury, where the injury occurred, and the party determined responsible for the injury. The reviews revealed:

- Fractures (12), burns (6), and abusive head injuries (6) were most frequently recorded as the primary injury to children in the case reviewed.

- Physical abuse was determined to be the cause of the injury most frequently – in 37% or 13 of 39 cases. Neglect was the cause of injury in 14% of cases and medical neglect in 5% of the cases.
- Secondary injuries noted included bruising, malnutrition, other skin findings, physical trauma, and sexual abuse.
- 55% of cases flagged for CRP review were ultimately determined by investigating parties to be accidental, due to lack of supervision, or the ultimate cause was not able to be determined. This was identified as an area for further study by the CRP and is discussed more later in the report.
- 73% of serious injuries (27 of 38) occurred in the child's household. Five additional injuries occurred in other households. Only one serious injury occurred in a child care setting.
- Over 80% of the injuries were caused by or in the presence of the child's caregiver at the time (29 of 39), most often their parent or guardian.
- In 4 cases, the party responsible for the abuse or neglect was not able to be determined.

Investigation of and Response to Serious Injury

The reviews gathered information on how the injury was investigated as well as what services were provided to the family to ensure continued safety. This year's reviews showed:

- In most cases DHHS and law enforcement were frequently both involved in investigations. Reviewers noted concerns about a lack of documentation and coordination between these agencies during the response to the injury.
- Medical providers were **not included** in over 26% of investigations (10 of 38), and child advocacy centers were only used in 5 investigations.
- Criminal charges related to the injury were filed in only 14 cases (36%).
- Only 47% of serious injuries (17 of 36) resulted in an ongoing child welfare case - 9 with court involvement and 8 through voluntary or non-court services.
- Reviewers generally felt that agencies fulfilled their responsibilities during and after the investigation of the serious injury. However, missing documentation and records were a recurring concern and limited the extent of the review. A lack of coordination between agencies was noted repeatedly.

Household Characteristics and Child Welfare System Involvement

The reviews gathered information on the child's family and household circumstances and the child and family's involvement with the child welfare system before and after the injury for those cases where a parent or caregiver was found to be responsible for the abuse or neglect.

- 56% of the children (18 of 38) had no prior child welfare involvement at the time of their injury. 7 children had open DHHS cases or investigations when the injury occurred (18%). Many other children had contact with the child welfare system in the past 12 months and/or a screened-out report to the Hotline.
- In 25 cases, at least one risk factor was noted. Most often, a family history related to abuse and neglect (12 cases) or prior incidents of domestic violence (11 cases) were the factors noted.
- 23 cases had at least one protective factor. Concrete supports was most frequently noted (15 cases).

- 7 of the children involved with the child welfare system during or prior to their injury scored as high or very high risk for future abuse on the DHHS structured decision making (SDM) tool.

Accidental Injury Review

Due to the high number of injuries determined to be accidental by investigating agencies, the CRP conducted an analysis to see how the injuries reviewed in April and August 2021 differed between those marked accidental and those determined as resulting in abuse and neglect. The analysis yielded the following results:

Higher percentages of accidental injuries:

- Involved children aged 5-12
- Involved male children
- Involved white, Hispanic, and American Indian children
- Had medical providers involved in Investigation
- Resulted in non-court/voluntary cases and community referrals
- Touched the child welfare system in 12 months prior to the injury

Lower percentages of accidental injuries:

- Involved children under 2
- Involved Black children
- Resulted in criminal charges or juvenile petitions

Going forward, the CRP identified additional changes to its review form to better capture reviewer agreement or disagreement with how the injury was categorized by investigating agencies.

Recommendations

Based on the reviews it conducted in 2021, the CRP makes the following recommendations to improve the child welfare response in Nebraska:

Improve internal policy and process to ensure law enforcement and medical reports are obtained by DHHS.

Having complete and accurate information is essential to fully understanding cases and conducting accurate reviews. The CRP found key reports and information from law enforcement agencies and medical professionals responding to near fatalities was frequently missing from DHHS files. The CRP recommends that DHHS make changes to internal policy and process to ensure these files are available to both staff and reviewers.

Develop strategies to strengthen coordination across disciplines on child abuse and neglect investigations.

In addition to written records, the CRP found that communication and coordination with key disciplines, especially law enforcement and medical professionals was lacking in the cases reviewed. The CRP

recommends that DHHS develop strategies with other disciplines to strengthen its investigations of child abuse and neglect and improve coordination.

Conduct thorough reviews of all near fatality and serious injuries suspected to be caused by abuse or neglect at local Child Abuse and Neglect Investigation multidisciplinary teams.

Nebraska law requires multidisciplinary teams in each county set protocols and processes for how investigations will be carried out across disciplines. These teams must also conduct case review. The CRP found that in the cases it reviewed local team coordination or case review was not consistently or effectively occurring. Local teams should review these cases consistently.

Form workgroup on improving response to failure to thrive/malnutrition across disciplines.

From the CRP reviews, there seems to be a lack of knowledge and consistent best practice on how to approach failure to thrive/malnutrition cases across disciplines to ensure child safety and effective support for families. The CRP recommends that DHHS establish a multidisciplinary group to come up with guidance to address not only how DHHS should respond, but also provide best practices and recommendations to law enforcement, medical professionals, and other key groups.

Provide training on failure to thrive/malnutrition.

Based on the CRP's reviews, there is a need for training across disciplines on failure to thrive for both DHHS staff at multiple levels, including the Hotline and front-line staff and supervisors, as well as their multidisciplinary partners.

Appendix. Case Review Tool 2021- 2022

1. Separate attachment

2021 - 2022 Serious Injury Review - Citizen Review Panel

Thank you for volunteering your time for the serious injury and near fatality citizen review panel.

The following case review survey asks you to gather information and fill out the following sections:

- **Child Demographic Information**
- **Information About Injury**
- **Investigation of the Injury**
- **Household and Caregiver Characteristics**
- **Child Welfare Involvement at Time of Injury**
- **Child Welfare History**
- **Final Comments and Information**

2021 - 2022 Serious Injury Review - Citizen Review Panel

Reviewer and Child Demographic Information

1. Reviewer's Name:

2. Child Information

DHHS ID Number

Date of Birth

City/Town of Residence

County of Residence

3. Child's Sex

- ○ Male
- ○ Female

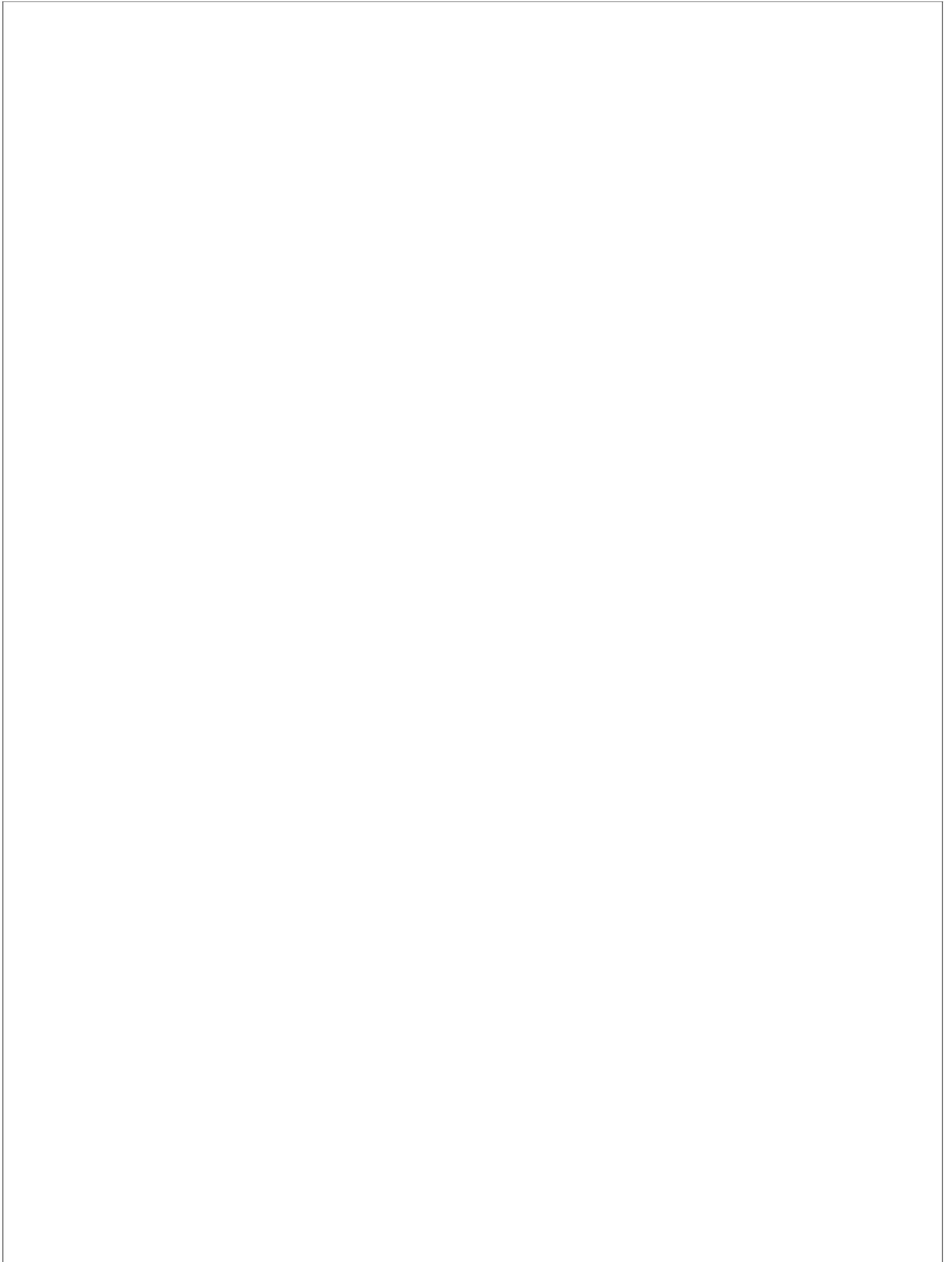
4. Child's Race and Ethnicity

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Hispanic/Latino
- ☐ Other/Unknown

5. Prior to the injury did the child have any of the following documented?

- ☐ Medical condition
- ☐ Disability or Developmental Delay
- ☐ Mental Health Condition
- ☐ Other

Provide any relevant details.



2021 - 2022 Serious Injury Review - Citizen Review Panel

Information about Injury

6. Date of Injury

Date / Time

Date

MM/DD/YYYY

7. City/Town and County where Injury Occurred

8. Primary Injury to Child: Please select the most serious injury requiring treatment.

- Abusive Head Injury
- Fractures
- Abdominal Injuries
- Burn(s)
- Other physical trauma
- Dehydration
- Malnutrition
- Bruising
- Suffocation
- Other skin findings (cuts, bite marks -all skin findings other than burns and bruising)
- Strangulation
- Sexual abuse
- Ingestion/overdose
- Drowning/near drowning

9. Secondary Injury or Injuries to Child Noted

- [ ] Abusive Head Injury
- [ ] Fractures
- [ ] Abdominal Injuries
- [ ] Burn(s)
- [ ] Other physical trauma
- [ ] Dehydration
- [ ] Malnutrition
- [ ] Bruising
- [ ] Suffocation
- [ ] Other skin findings (cuts, bite marks -all skin findings other than burns and bruising)
- [ ] Strangulation
- [ ] Sexual abuse
- [ ] Ingestion/overdose
- [ ] Drowning/near drowning

10. Please select the cause(s) of injury

- [ ] Physical Abuse
- [ ] Sexual Abuse
- [ ] Vehicle Related
- [ ] Medical Neglect
- [ ] Neglect
- [ ] Lack of supervision
- [ ] Sexual abuse
- [ ] Accidental
- [ ] Other
- [ ] Unknown

11. Child's Age at Injury

- ○ Under 2
- ○ 2 - 4
- ○ 5-12
- ○ 13 -18

12. Location where Injury Occurred

- ◯ Child's Household
- ◯ Other Household
- ◯ Child Care or School
- ◯ Other Community Location
- ◯ Unknown

Please use this space to provide any clarification or additional information.

13. Provide a brief narrative of the injury

Investigation of Serious Injury

14. What parties were involved in the investigation of the injury?

- [ ] DHHS
- [ ] Local Law Enforcement
- [ ] State Patrol
- [ ] Medical Providers
- [ ] Child Advocacy Center
- [ ] Other (please specify)

15. What was the outcome of the investigation?

- [ ] Criminal Charges Filed
- [ ] Juvenile Petition Filed/Court-Involved Child Welfare Case Opened
- [ ] Non-Court Child Welfare Case Opened
- [ ] Child welfare case open prior to injury continued
- [ ] Community Services and Supports Offered
- [ ] None of the above
- [ ] Other (please specify)

16. Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury

- [ ] Parent or Guardian
- [ ] Other Adult Household Member
- [ ] Caregiver
- [ ] Other
- [ ] Unknown

Please use this space to provide any clarification or additional information.

17. Did the use of controlled substances, alcohol, or prescription medication contribute to the injury?

- ◯ Yes
- ◯ No

18. Please respond to the following questions about the agencies participating in the investigation of the injury

	No, Definitely Not	No, Mostly Not	Unsure	Yes, Mostly	Yes, Definitely
In your judgment, were law enforcement responsibilities fulfilled?	◯	◯	◯	◯	◯
In your judgment, were DHHS's investigative responsibilities fulfilled?	◯	◯	◯	◯	◯
In your judgment, did DHHS offer appropriate services and intervention after the investigation of the injury?	◯	◯	◯	◯	◯
In your judgment, were other agencies' responsibilities fulfilled?	◯	◯	◯	◯	◯

Comments

19. Do you have recommendations to improve the investigation and system response to the injury?

- ◯ Yes
- ◯ No

Please provide your suggestions

Household and Caregiver Characteristics

20. What was the child's involvement with the child welfare/protection system at the time of the injury? (mark all that apply)

- [ ] DHHS Ward
- [ ] Open Non-Court Case
- [ ] Open Investigation/Initial Assessment
- [ ] Open Alternative Response Case
- [ ] Closed ongoing case in the past 12 months
- [ ] Closed Investigation/Initial Assessment in past 12 months
- [ ] Closed Alternative Response in the past 12 months
- [ ] Reports to Hotline not accepted/screened out in past 12 months
- [ ] None
- [ ] Other (please specify)

21. What risk factors were present?

- [ ] Family living in poverty, lack of basic needs
- [ ] Caregiver with diagnosed severe persistent mental illness and/or substance use disorder
- [ ] Prior incidents of family or domestic violence
- [ ] Family history of abuse/neglect or trauma
- [ ] Caregiver under age 25
- [ ] Other (please specify)

22. What protective factors were present?

- [ ] Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma
- [ ] Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support
- [ ] Knowledge of parenting and child development: Understands child development and parenting strategies that support physical, cognitive, language, social, and emotional development
- [ ] Concrete support in times of need: Has access to support and/or services (e.g., healthy food; a safe environment; specialized medical, mental health, social, educational, and legal services, as needed) that address a family's needs and help minimize stress caused by challenges
- [ ] Social-emotional competence of children: Encourages family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships
- [ ] Other (please specify)

Child Welfare Involvement at the Time of the Injury

23. Please respond to the following questions

	Yes	No	Unsure
Was there an active safety plan in place?	○	○	○
Was the family classified as high or very high risk?	○	○	○
Was the child welfare case meeting the family needs and child safety?	○	○	○

Comments:

24. Please respond to the following questions

	No, Definitely Not	No, Mostly Not	Unsure	Yes, Mostly	Yes, Definitely
In your judgment, was the child welfare case addressing the child's safety?	◯	◯	◯	◯	◯
In your judgment, was the child welfare case addressing the family needs?	◯	◯	◯	◯	◯
In your judgment, could something have been done to make the injury less likely?	◯	◯	◯	◯	◯

Comments

25. Please provide a brief description of the child and family's involvement at time of injury.

26. Do you have recommendations to improve the child welfare system response in this case?

- ◯ Yes
- ◯ No

Please provide your suggestions

Child Welfare History

27. How many child abuse reports were made in the following categories?

Reports accepted alleging abuse/neglect of the child in the twelve months before the injury?

Reports accepted alleging abuse/neglect by the perpetrator in the twelve months before the injury?

Reports screened out alleging abuse/neglect of the child in the twelve months before the injury?

Reports screened out alleging abuse/neglect by the perpetrator in the twelve months before the injury?

28. Please respond to the following questions

	Yes	No	Unsure
Did child welfare history relate to issues similar to those that caused the serious injury?			
Was the family classified as high or very high risk in the 12 months before the injury?			

Comments:

29. Please respond to the following questions about the case as a whole

	No, Definitely Not	No, Mostly Not	Unsure	Yes, Mostly	Yes, Definitely
In your judgment, were prior hotline reports screened appropriately?	◯	◯	◯	◯	◯
In your judgment, did DHHS fulfill its responsibilities to the child and family in prior cases?	◯	◯	◯	◯	◯
In your judgment, could something have been done to make the injury less likely?	◯	◯	◯	◯	◯

Comments

30. Do you have recommendations to improve the child welfare system response in this case?

◯ Yes

◯ No

Please provide your suggestions

2021 - 2022 Serious Injury Review - Citizen Review Panel

Final Comments and Recommendations

31. Please respond to the following questions about the child welfare history

	No, Definitely Not	No, Not Really	Unsure	Yes, Mostly	Yes, Definitely
In your judgment, did Nebraska fulfill its responsibilities to this child before and after the injury?	◯	◯	◯	◯	◯
In your judgment, did the case reveal any concerns about how our child protection system is working?	◯	◯	◯	◯	◯
In your judgment, could something be done to make similar injuries less likely in the future?	◯	◯	◯	◯	◯
In your judgment, were there strengths in the system response that should be used more broadly?	◯	◯	◯	◯	◯

Comments

32. Please provide any additional comments, recommendations, or suggestions based on your review of this case.