Nebraska Citizen Review Panel for Child Protective Services Annual Report

Reporting Period:
April 1, 2022, through March 31, 2023

Nebraska Commission for the Protection of Children

Submitted April 1, 2023

Nebraska Commission for the Protection of Children Membership:

Mary Jo Pankoke, Co-Chair – President and CEO, Nebraska Children and Families Foundation
Gene Klein, Co-Chair – Executive Director, Project Harmony Child Advocacy Center
Alfred E. Corey III – Juvenile Court Judge, 9th District
Amy Hoffman - Nebraska Crime Commission
Ashley D. Brown – Social Services Director, KVC
B. Gail Steen - Steen Law Office, Attorney working with children
Bill Tangeman - Office of the Nebraska Attorney General
Bobbi Taylor – Youth Engagement Consultant
Cassie Wegelin – Nebraska State Patrol
Corrie Kielty - Nebraska CASA Association
Erin Konecky – Parent Representative
Ivy Svoboda - Executive Director, Nebraska Alliance of Child Advocacy Centers
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Jeanne Brandner - Deputy Administrator, Office of Probation Administration
Joshua Midgett - Integrated Life Choices
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Katie A. Reichert – Juvenile Case Attorney
Kitty Washburn – Supervisor, Winnebago Children and Family Services
Melody Hobson - Office of Early Childhood, Nebraska Department of Education
Hon. Michael Burns - Judge of the County Court, 10th District
Michael Jepsen – Sherman County Sheriff
Monika Gross - Director, Foster Care Review Office
Nicole Brundo - Douglas County Attorney's Office
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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 2022. During this period, the Citizen Review Panel conducted case reviews of 44 serious injuries and near fatalities due to child abuse or neglect that occurred between June 2020 and July 2021.

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:

1. The Citizen Review Panel recommends continued efforts to ensure law enforcement and medical reports are obtained by DHHS.
2. The Citizen Review Panel recommends continued efforts to strengthen coordination across disciplines on child abuse and neglect investigations.
3. The Citizen Review Panel continues to recommend that local Child Abuse and Neglect Investigation multidisciplinary teams conduct thorough reviews of all near fatality and serious injuries suspected to be caused by abuse or neglect.

Citizen Review Panel Overview

Established in 1993 by Executive Order 93-7, The Nebraska Commission for the Protection of Children (Commission) has since functioned as Nebraska's CJA State Task Force. The Nebraska CJA State Task Force is one of three Citizen Review Panels in the state. The Commission is supported and administered through a contract between the Nebraska Department of Health and Human Services, Division of Children and Family Services (DHHS) and the Nebraska Children and Families Foundation (Nebraska Children). Nebraska Children began subcontracting with the Nebraska Alliance of Child Advocacy Centers (Nebraska Alliance) to assist with some of those duties in 2019. Nebraska Alliance also began to assist with the Citizen Review Panel (CRP) in 2020. CRP functions as a subcommittee of the Commission.

The review of serious injury and near fatality cases due to child abuse has been the focused effort of CRP since 2017 under the Commission. It includes both Commission and non-Commission members from the larger community.

Preliminary identification of cases happens through the statewide Child Abuse and Neglect Hotline and additional screening is done 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.

2022-2023 Citizen Review Panel Activities

Reviews of serious injuries and near fatalities remained the focus of CRP this year. DHHS prepared case records and brought paper files to the review meetings for conducting of reviews. The paper files were used to fill out review forms by paper or electronic formats.

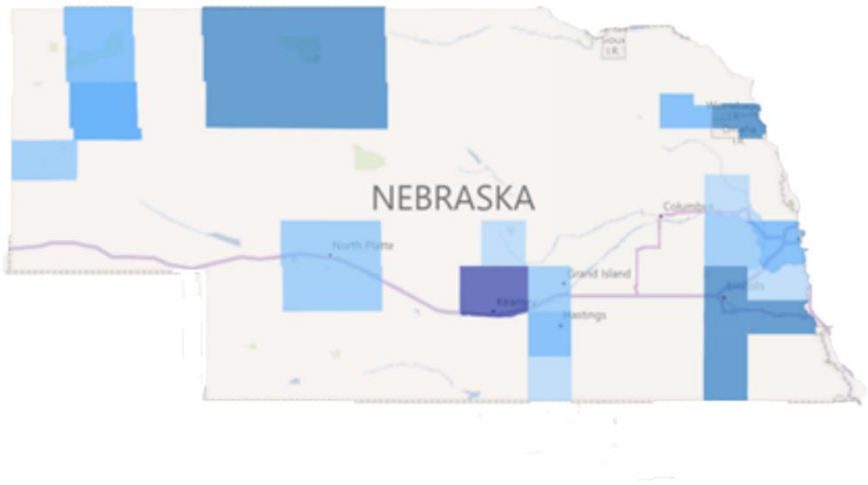
The CRP committee added an additional law enforcement professional to the review committee for additional representation from this discipline. Over the course of the year the CRP discussed issues found in the review process that were impacting the review process. This included a need for better coordination, more medical expertise, and missing records.

The CRP's activities were conducted in an in-person format where reviewers collaborated to review cases together. Each two-person review team submitted one form per case reviewed. A final virtual meeting took place in February 2023 to finalize recommendations based on reviews completed in 2022.

Serious Injury Review Results

The following section provides details on the 44 serious injuries and near fatalities that the CRP reviewed. The CRP Committee reviewed 44 cases, however at times questions were skipped if it was not applicable to a case; the data in this report is reflective of that. The children lived in 22 different locations across the state. 15 of 44 or 34% of all injuries reviewed occurred in Omaha in Douglas County. 6 of 44 or 14% of injuries reviewed occurred in Lincoln in Lancaster County. Two or more injuries occurred in Bellevue in Sarpy County; and in Plattsmouth in Cass County.

Figure 1. Location of Serious Injuries Reviewed.



County	Sum of Cases reported
Adams, County, NE	1
Box Butte, County, NE	1
Buffalo, County, NE	1
Cass, County, NE	3
Cherry, County, NE	1
Dawes, County, NE	1
Dodge, County, NE	1
Douglas, County, NE	15
Gage, County, NE	1
Hall, County, NE	1
Lancaster, County, NE	6
Lincoln, County, NE	1
Otoe, County, NE	1
Sarpy, County, NE	3
Saunders, County, NE	1
Scotts Bluff, County, NE	2
Sherman, County, NE	1
Thurston, County, NE	1
Wayne, County, NE	1
Webster, County, NE	1
Total	**44**

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: 32 of 44 or 73% of the children seriously injured were under the age of 2.
- Six additional children who were injured were between 2 and 4 years old. In total, 86% 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.

- 25 of 44 or 57% of children seriously injured were white, although white children make up 77% of Nebraska's child population according to 2021 5-year census data.
- While Black children were only 6% of the child population, however accounted for 9 of 44 or 20% of those injured. American Indian children make up 1% of the child population but 6 of 44 or 14% of those seriously injured.
- 23 of 44 cases or 52% of the children had a diagnosed condition prior to their injury. Of those with a diagnosed condition:
  - Nine responses, or 53%, had medical diagnoses
  - Six responses, or 35% had developmental disabilities
  - Three responses or 18% had mental health diagnoses
  - Five responses, or 29% had other conditions.

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 accounted for 23 of 44 cases or 52%, and abusive head injuries accounted for 5 of 44 or 11%. These were most frequently recorded as the primary injury to children in the cases reviewed. Physical abuse was determined to be the cause of the injury most frequently – in 20 of 44 or 45% of cases. 11 of 44 or 25% of cases were determined to have an accidental cause. Neglect was the cause of injury in 10 of 44, or 23% of cases.
- Secondary injuries noted included fractures, bruising, abusive head injuries, other physical trauma, burn(s), and other skin findings.
- 29 of 44 or 66% of serious injuries occurred in the child's household. An additional 7 of 44 or 16% of serious injuries occurred in other households. Four injuries or 9% occurred in an unknown location. Only one or 2% of serious injuries occurred in a childcare setting.
- 27 of 44 responses or 61% of the injuries were caused by the parent/guardian, or caregiver of the child.
- In 8 of 44 responses, or 18%, the party responsible for the abuse or neglect was an "other" adult household member, or "other" individual.
- In 9 of 44 cases or 20%, 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, law enforcement and medical providers were frequently 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 included in 40 of 44 cases or 91% of investigations compared to 2021's report of medical providers being included in 74% of investigations.
- Child advocacy centers were only used in 6 of 44 cases or 14% of investigations.

- Criminal charges related to the injury were filed in only 8 of 44, or 18% of cases.
- Only 15 of 44 cases or 34% resulted in an ongoing child welfare case – 12 with court involvement and 3 through voluntary or non-court services.
- Issues with investigation found by reviewers included insufficient documentation (24%), better coordination needed (16%), additional medical expertise needed (16%), identification of further interviews that could have been done (11%), and information that needed further verification in the cases (16%).

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.

- 30 of 44, or 68% had no child welfare involvement at the time of their injury.
- 8 of 44 cases or 18% had contact with the child welfare system at the time of injury in the past 12 months, involvement with Alternative Response in the past 12 months, and/or a screened-out report to the Hotline.
- 2 of 44 responses or 5% had open non-Court cases.
- In 36 of 44 cases or 82%, at least one risk factor was noted. Of the 36 cases with risk factors, the following reasons were present:
    - In 21 of 36 responses or 58% of cases an "other" reason was specified. The "other" risk factors noted included prior criminal disposition or activity of a parent, foster care system involvement of the parents when they were a child, external family stressors, stressful family dynamics, or prior DHHS involvement.
    - In 16 of 36 cases or 44% a family history related to abuse and neglect.
    - In 16 of 36 cases or 44% a caregiver with diagnosed severe persistent mental illness and/or substance use disorder.
    - In 10 of 36 cases or 28% there were prior incidents of domestic violence.
    - In 10 of 36 cases or 28% the caregiver was under the age of 25.
- 38 of 44 cases or 86% had at least one protective factor. 22 of 38 responses or 58% noted Concrete supports as a protective factor; this was the most frequently reported category.

Of the 36 cases with risk factors, the following child welfare involvement was present:

- In 9 of 36 cases or 25%, the children were part of cases involved with DHHS in which there were calls involving the child to the child abuse and neglect hotline in the prior 12 months.
- In 4 of 36 cases or 11%, 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

Last year in 2021 55% of cases flagged for CRP review were ultimately determined by investigating parties to be accidental or the ultimate cause was not able to be determined. This year in 2022, that percentage decreased to 26% of CRP cases.

Recommendations

Based on the reviews it conducted in 2022, the CRP makes the following recommendations to improve the child welfare response in Nebraska:

Continue efforts 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. It should be noted that DHHS made a change in practice in how medical records are requested from hospitals which has resulted in a timelier receipt of medical records, especially from hospitals in rural areas of. The state. This change was made in the last quarter of 2022 so it is anticipated that the CRP will see more medical records in DHHS files in future reviews.

Continue efforts to strengthen coordination across disciples on child abuse and neglect investigations.

The CRP requests an update on efforts to work with local MDT's to identify ways to improve information sharing and coordination on child abuse and neglect investigations.

The CRP continues to recommend that local Child Abuse and Neglect Investigation multidisciplinary teams conduct thorough reviews of all near fatality and serious injuries suspected to be caused by abuse or neglect.

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. DHHS' response to this recommendation contained in the CRP's 2021 report was that DHHS staff is participating in a national organization, the national Partnership for Child Safety, supported by Casey Family Programs. What is the status of this collaboration and what changes have resulted in how local MDT's function and their role in reviewing near fatality and serious injury cases?

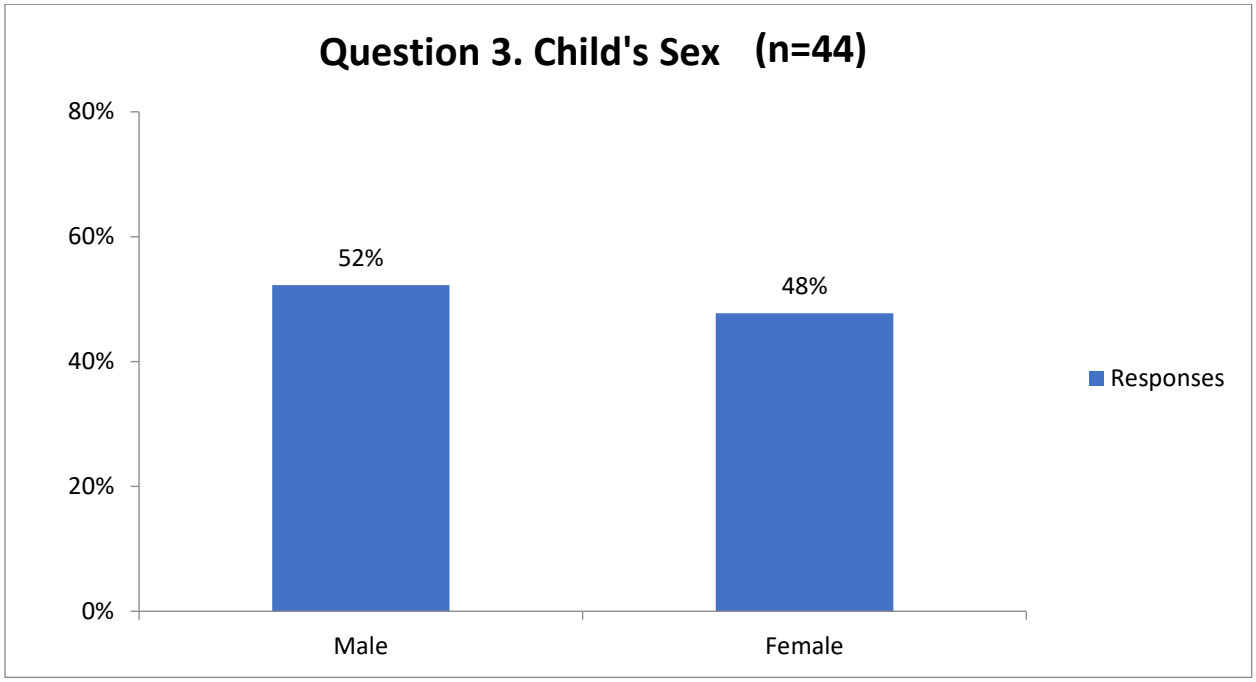
Request for Updates

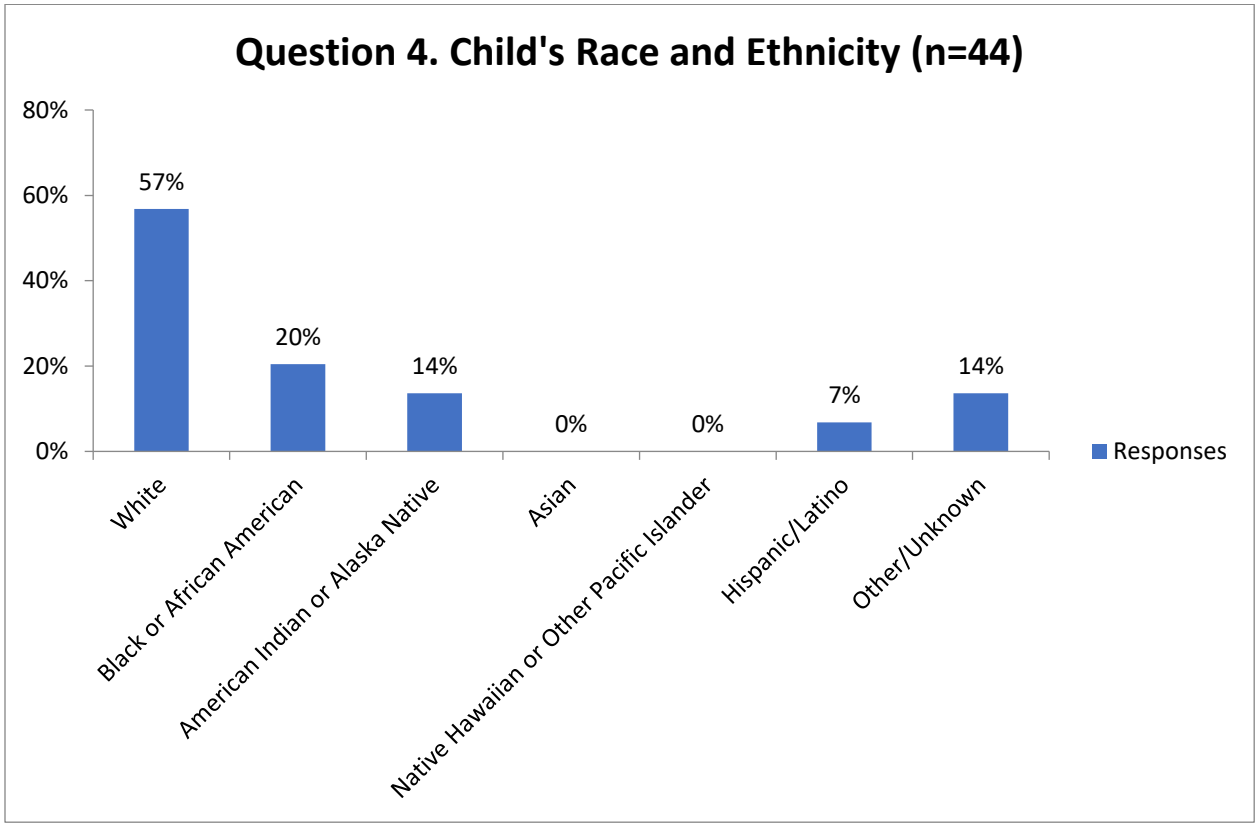
In addition to the follow up on the recommendations contained in our 2021 report, the CRP requests an update on the following recommendations contained in reports from prior years.

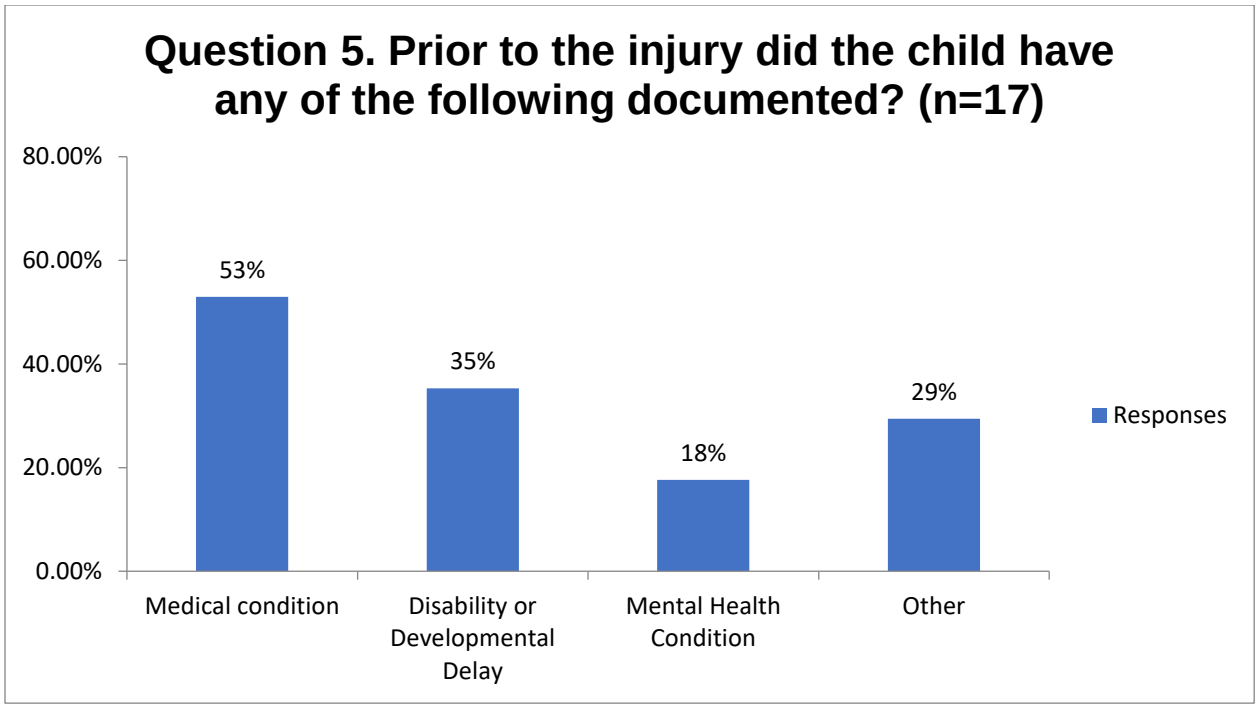
- In the 2019-2020 report, the CRP recommended that the Hotline increase collateral calls in certain situations. DHHS indicated there was a new level of internal review of reports from medical providers or law enforcement. What is this process, and what are the outcomes of these reviews? DHHS also indicated there would be a formal review of all SDM tools in 2020. What was the outcome of this review? Were changes made to the tools? If so, what were they? Will collateral calls be made more frequently?

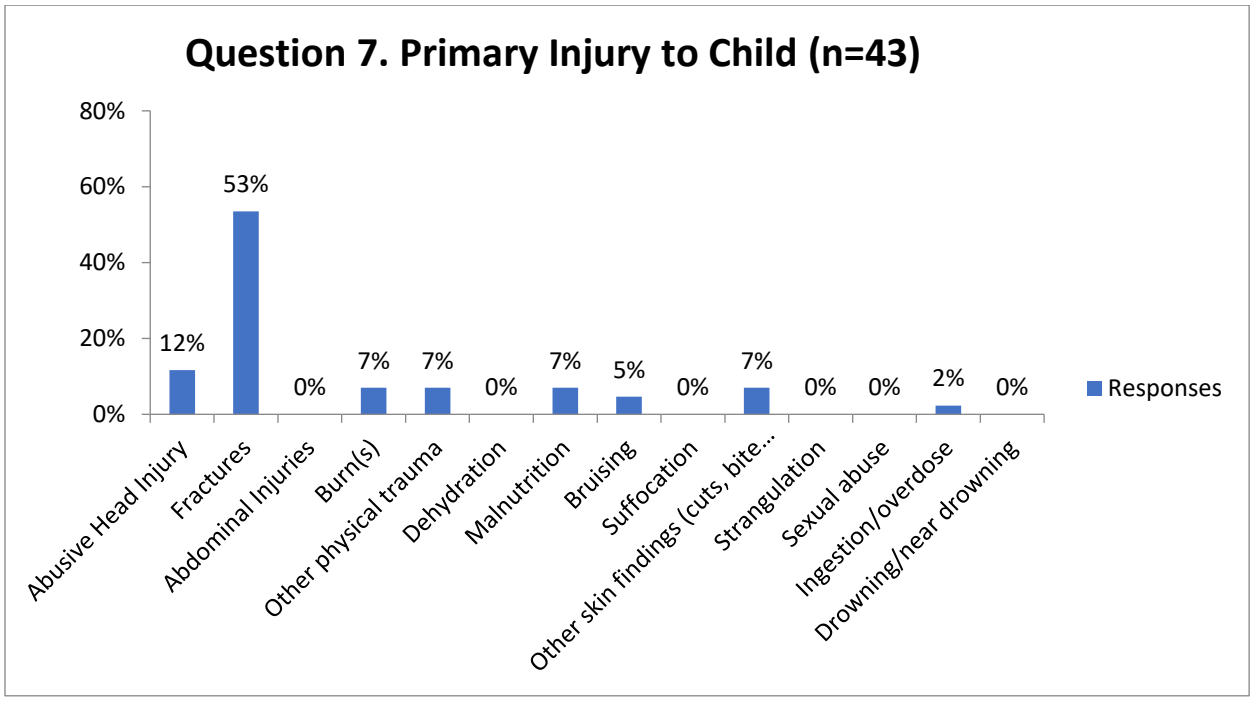
- The CRP was concerned about the frequency of meth use in the cases involving injury to a child, and recommended that more information be provided to the public about the potential impact of meth use on child safety. The Department indicated that these efforts were put aside due to the Covid situation. What is the status of this effort today? Have any Public Service Announcements been drafted, or other educational/informational material developed?

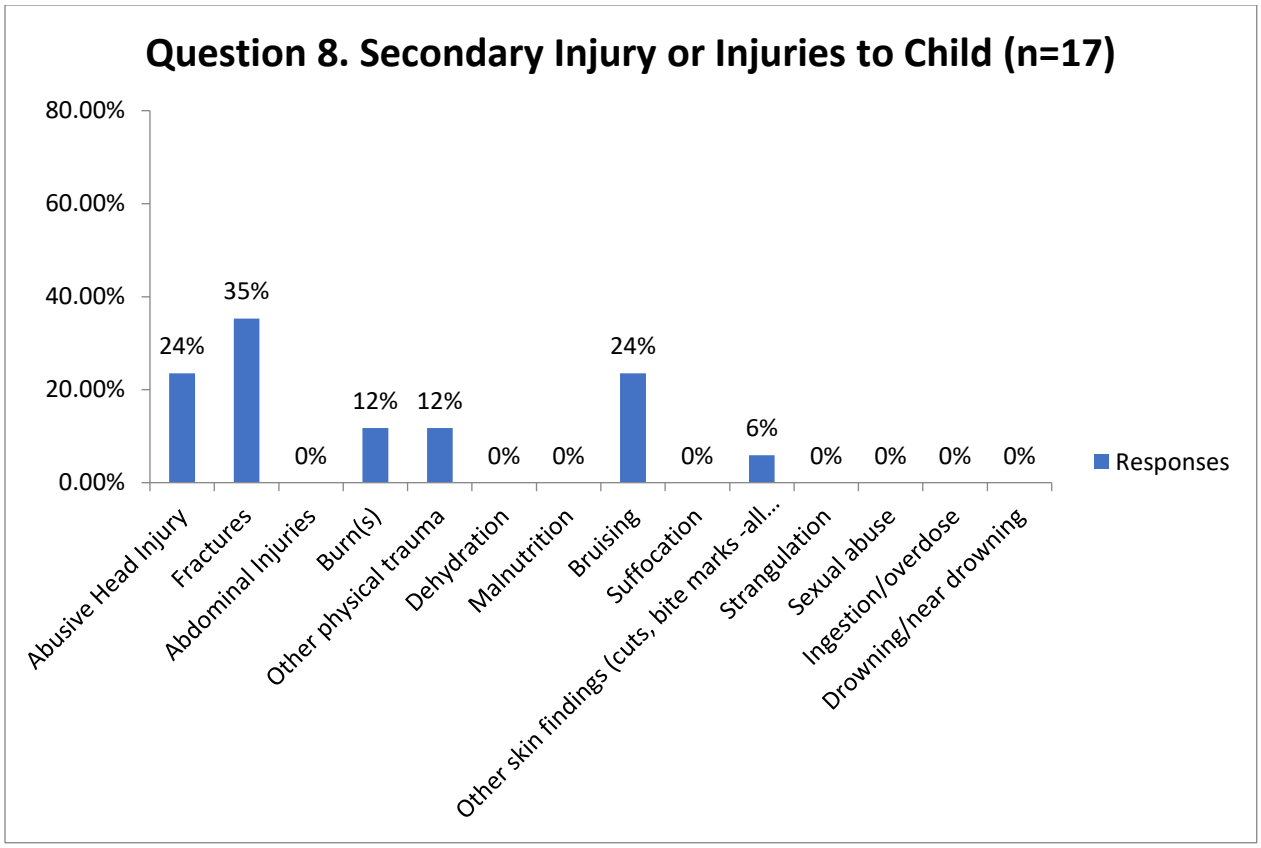
Appendix A. Full Data from Case Reviews

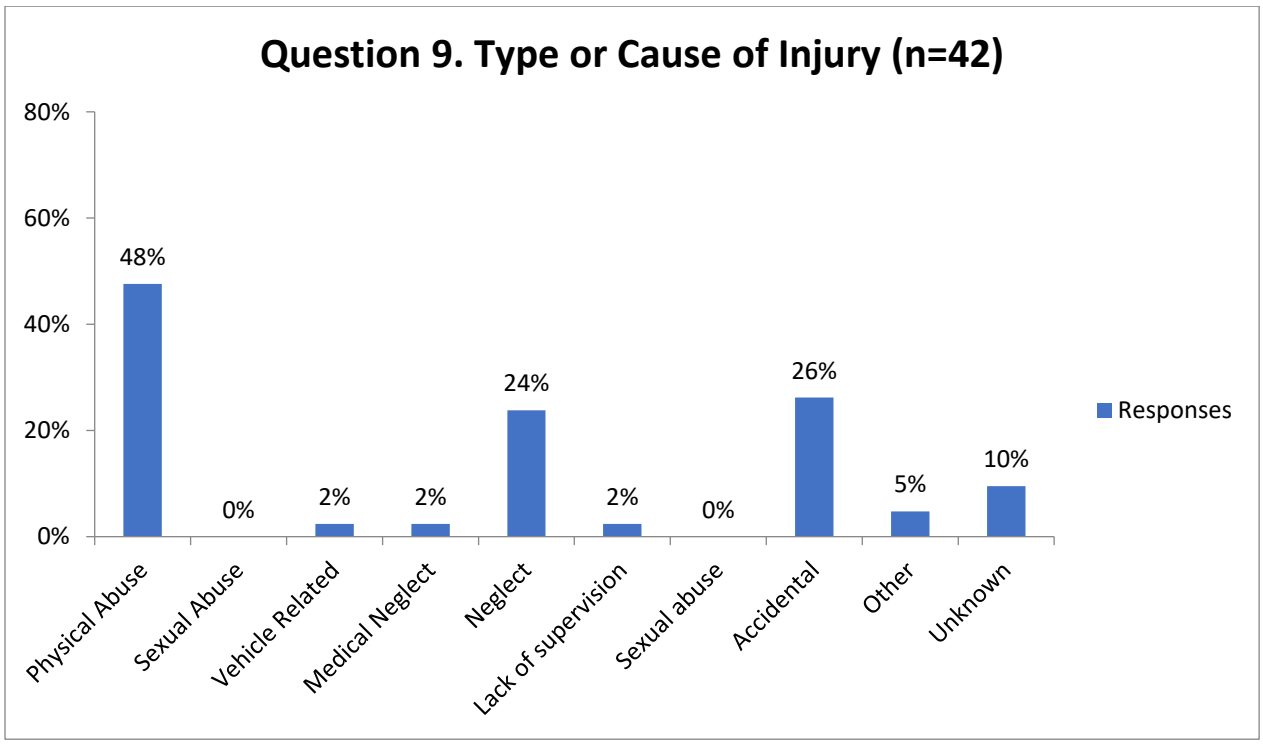


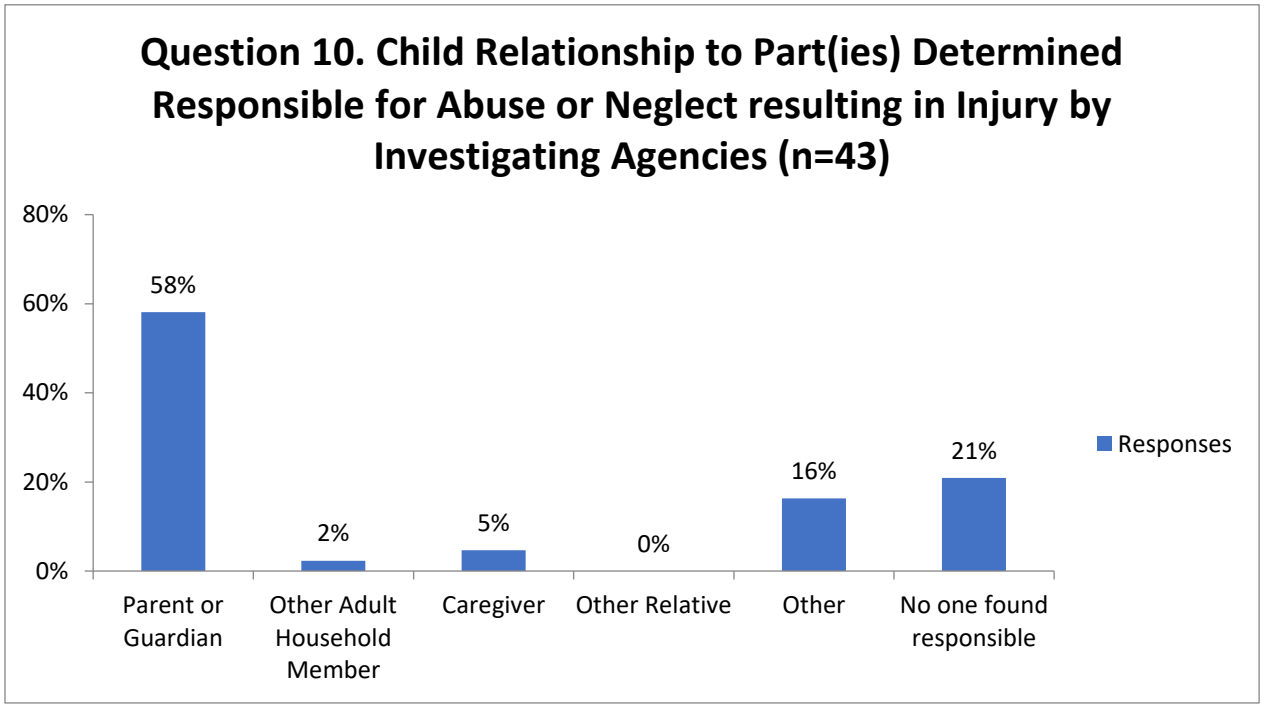


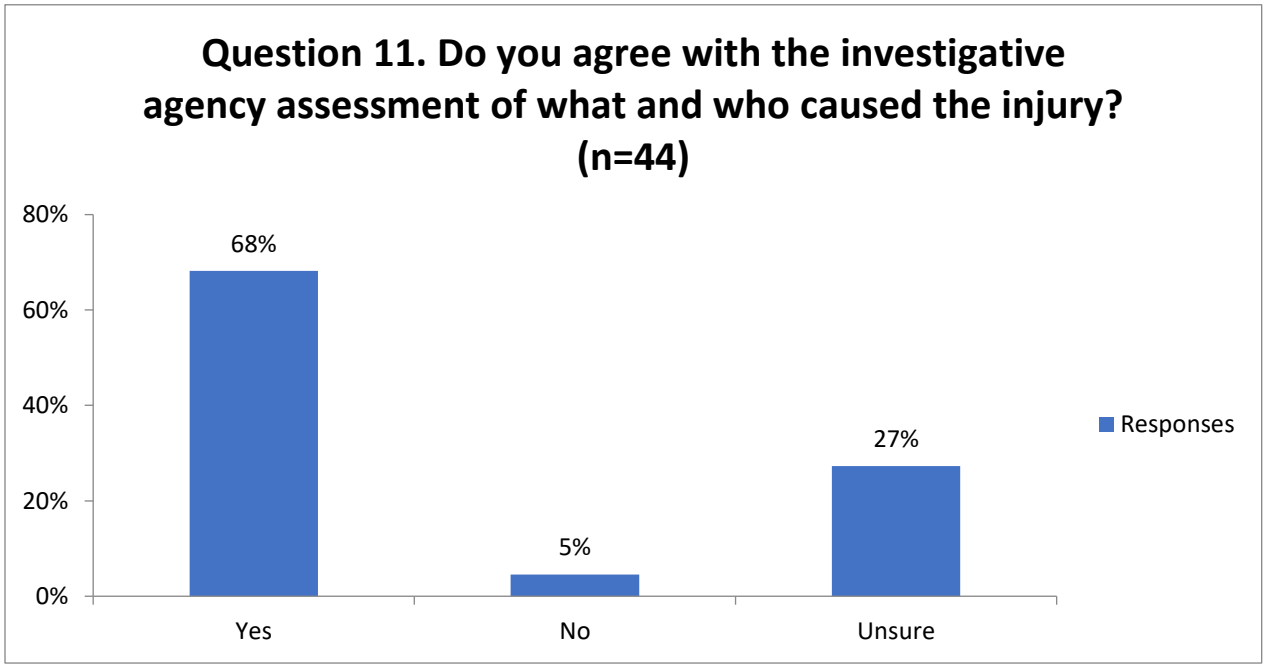

Question 5. Prior to the injury did the child have any of the following documented? (n=17)
80.00%
60.00%
40.00%
20.00%
0.00%
53%
35%
18%
29%
Medical condition
Disability or Developmental Delay
Mental Health Condition
Other
Responses

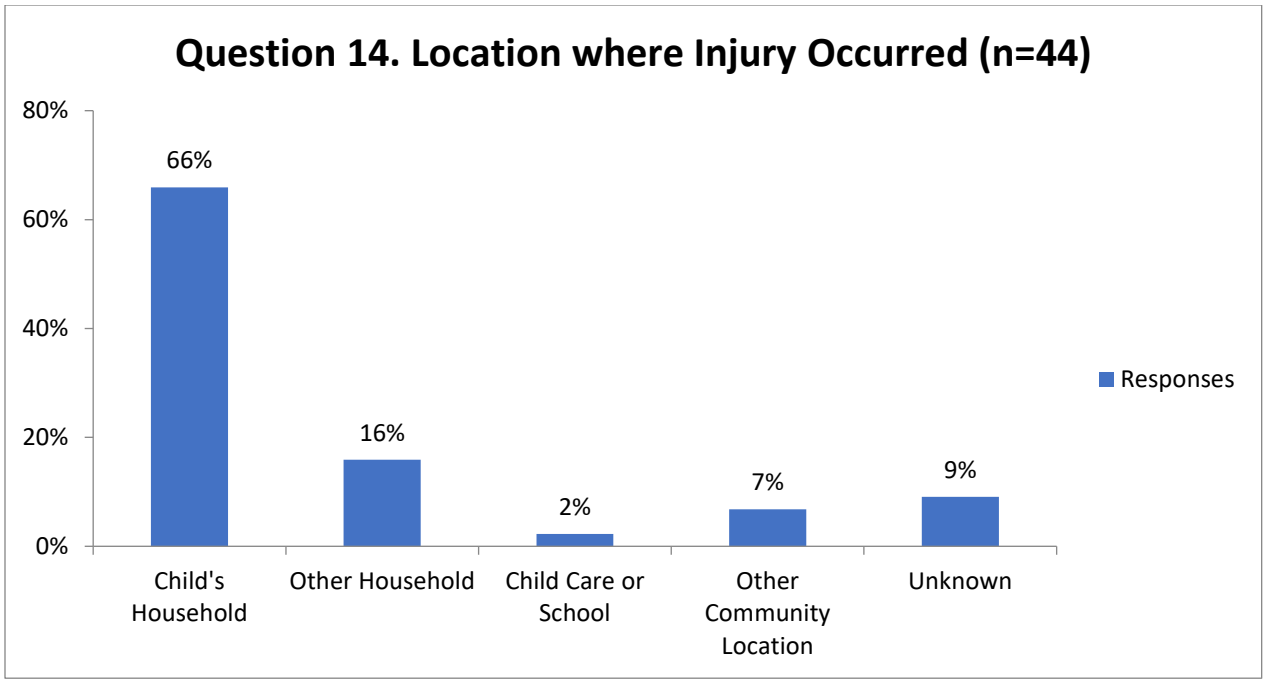

Question 7. Primary Injury to Child (n=43)
80%
60%
40%
20%
0%
12%
53%
0%
7%
7%
0%
7%
5%
0%
7%
0%
0%
2%
0%
Abusive Head Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts, bite...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
Responses

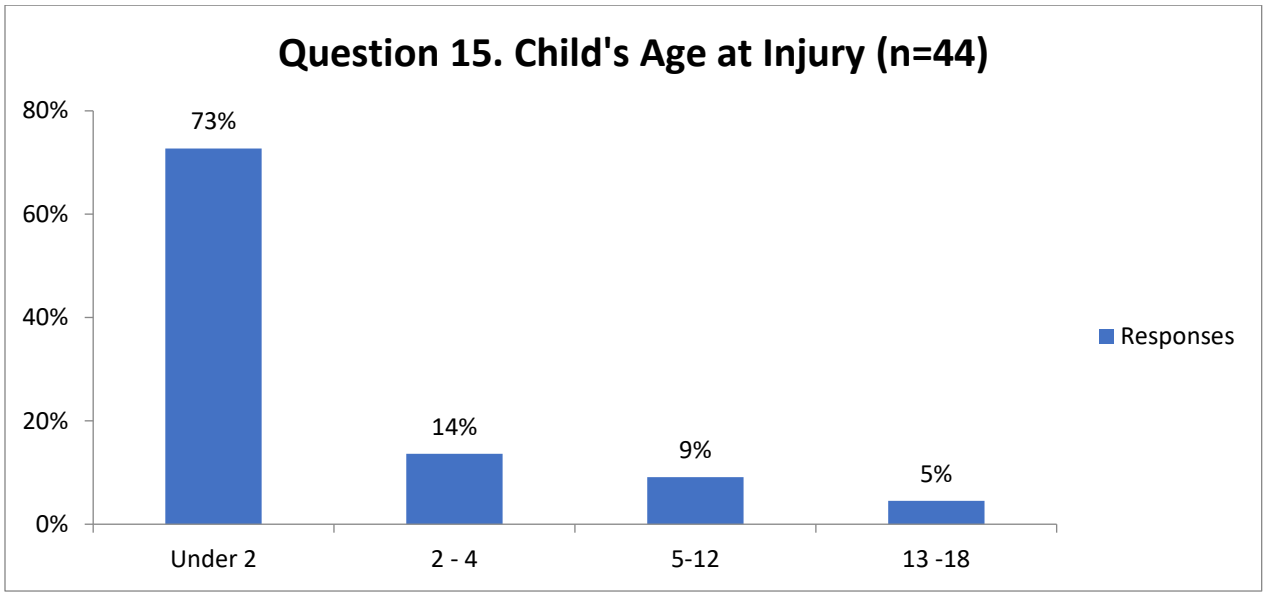

Question 8. Secondary Injury or Injuries to Child (n=17)
80.00%
60.00%
40.00%
20.00%
0.00%
24%
35%
0%
12%
12%
0%
0%
24%
0%
6%
0%
0%
0%
0%
Abusive Head Injury
Fractures
Abdominal Injuries
Burn(s)
Other physical trauma
Dehydration
Malnutrition
Bruising
Suffocation
Other skin findings (cuts, bite marks -all...
Strangulation
Sexual abuse
Ingestion/overdose
Drowning/near drowning
Responses

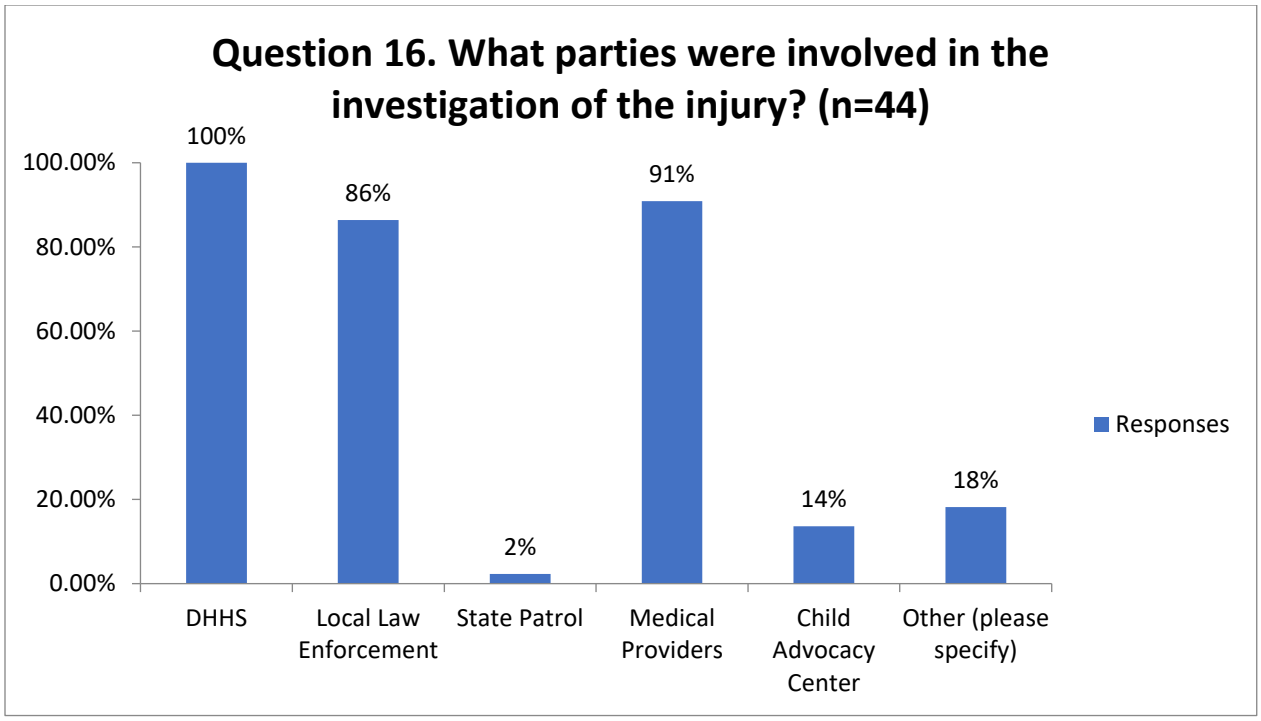

Question 9. Type or Cause of Injury (n=42)
80%
60%
40%
20%
0%
48%
0%
2%
2%
24%
2%
0%
26%
5%
10%
Physical Abuse
Sexual Abuse
Vehicle Related
Medical Neglect
Neglect
Lack of supervision
Sexual abuse
Accidental
Other
Unknown
Responses

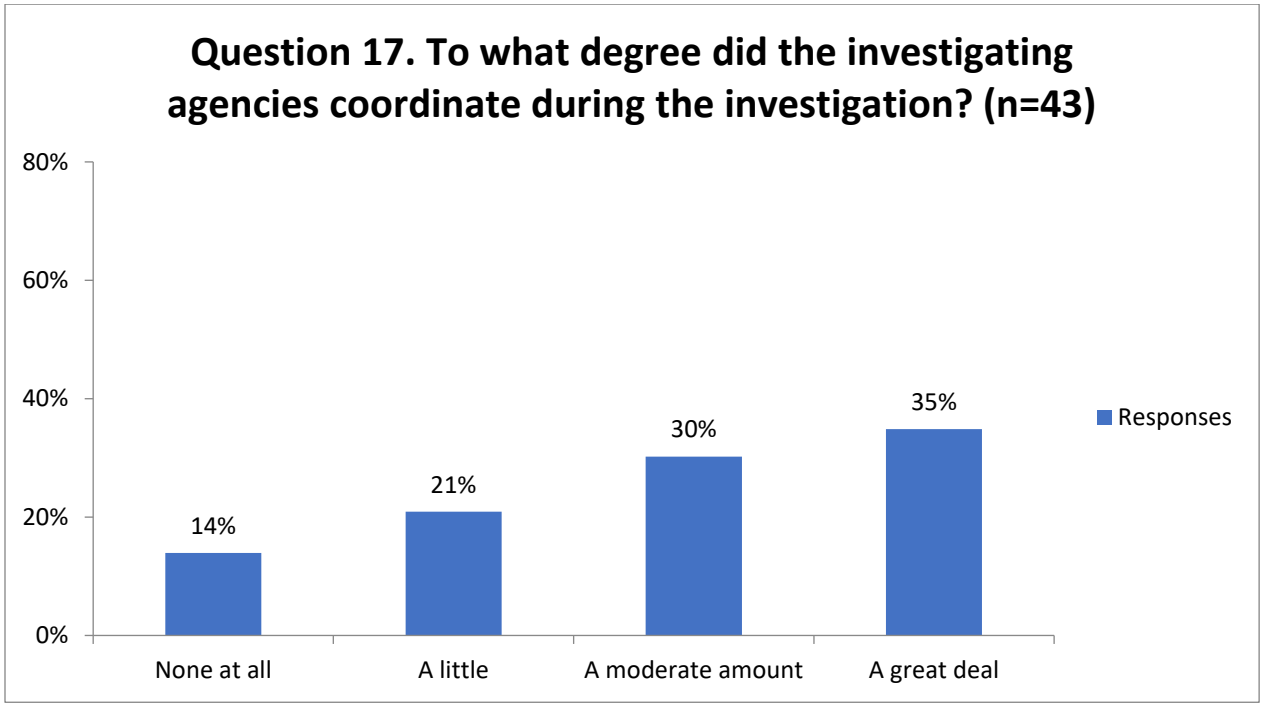

Question 10. Child Relationship to Part(ies) Determined Responsible for Abuse or Neglect resulting in Injury by Investigating Agencies (n=43)
80%
60%
40%
20%
0%
58%
2%
5%
0%
16%
21%
Parent or Guardian
Other Adult Household Member
Caregiver
Other Relative
Other
No one found responsible
Responses

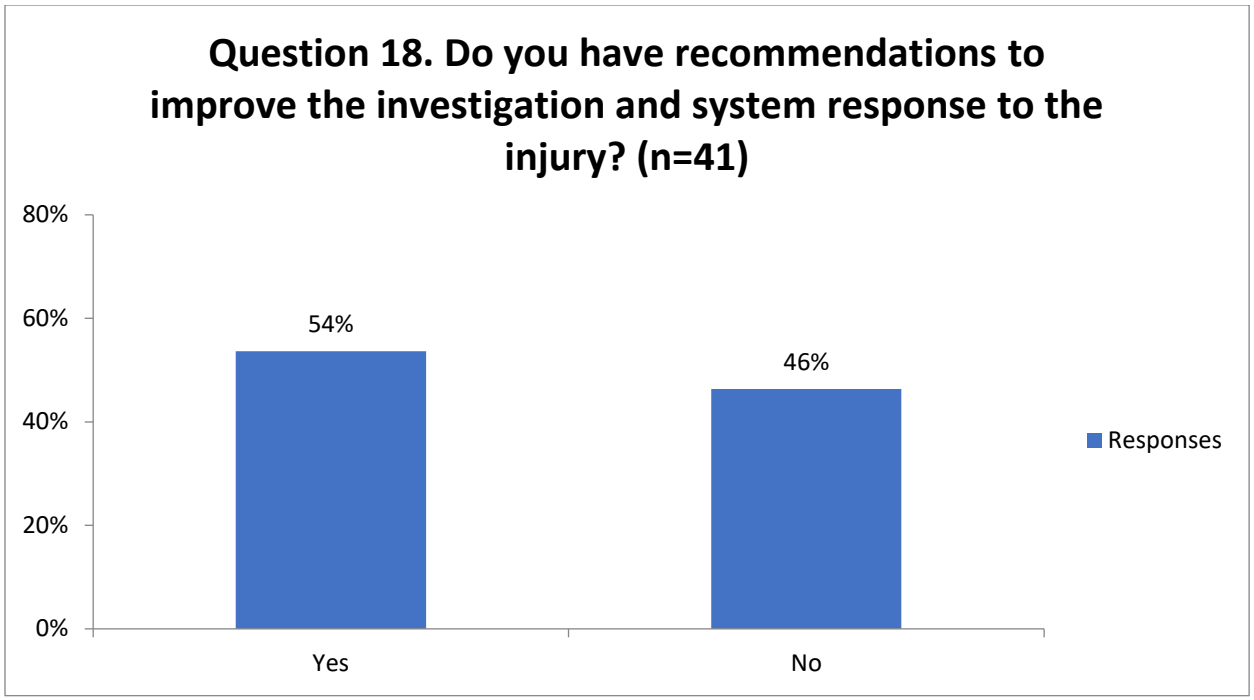

Question 11. Do you agree with the investigative agency assessment of what and who caused the injury? (n=44)
80%
60%
40%
20%
0%
68%
5%
27%
Yes
No
Unsure
Responses

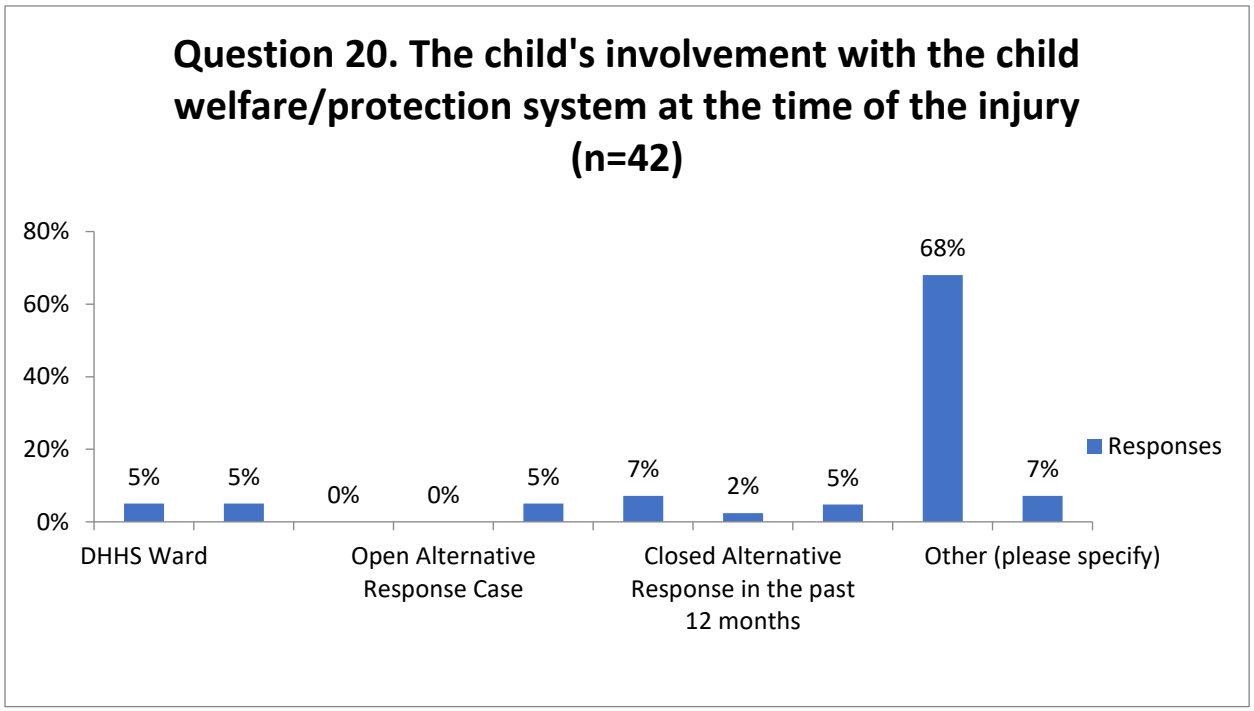

Question 14. Location where Injury Occurred (n=44)
80%
60%
40%
20%
0%
66%
16%
2%
7%
9%
Child's Household
Other Household
Child Care or School
Other Community Location
Unknown
Responses


Question 15. Child's Age at Injury (n=44)
80%
60%
40%
20%
0%
73%
14%
9%
5%
Under 2
2 - 4
5-12
13 -18
Responses


Question 16. What parties were involved in the investigation of the injury? (n=44)
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
100%
86%
2%
91%
14%
18%
DHHS
Local Law Enforcement
State Patrol
Medical Providers
Child Advocacy Center
Other (please specify)
Responses

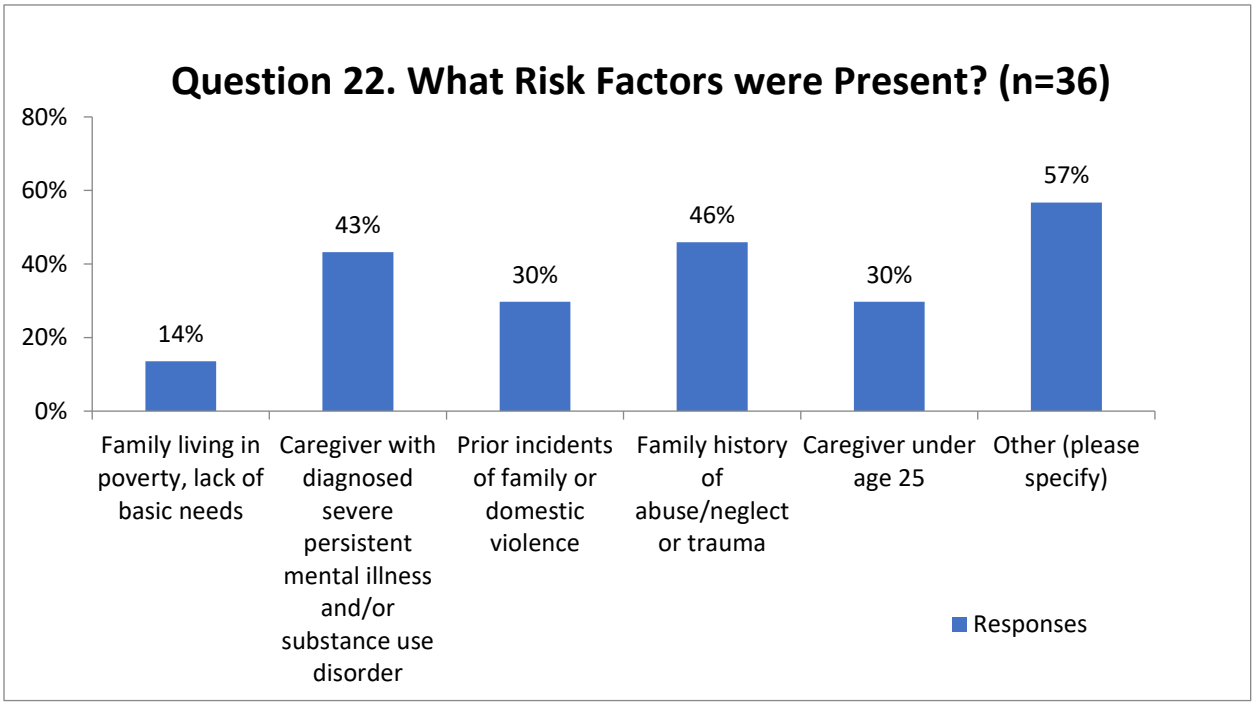

Question 17. To what degree did the investigating agencies coordinate during the investigation? (n=43)
80%
60%
40%
20%
0%
14%
21%
30%
35%
None at all
A little
A moderate amount
A great deal
Responses


Question 18. Do you have recommendations to improve the investigation and system response to the injury? (n=41)
80%
60%
40%
20%
0%
54%
46%
Yes
No
Responses


Question 20. The child's involvement with the child welfare/protection system at the time of the injury (n=42)
80%
60%
40%
20%
0%
5%
5%
0%
0%
5%
7%
2%
5%
68%
7%
DHHS Ward
Open Alternative Response Case
Closed Alternative Response in the past 12 months
Other (please specify)
Responses

Question 21. If the child and family was involved with DHHS, please respond to the following questions about safety and risk. (n=36)

If the child and family was involved with DHHS, please respond to the following questions about safety and risk:									
	Yes		No		Unsure		N/A		Total
Were there calls to the child abuse and neglect hotline in the prior 12 months involving the child?	25.00%	9	11.11%	4	0.00%	0	63.89%	23	36
Was there an active safety plan in place when the injury occurred?	8.33%	3	25.00%	9	0.00%	0	66.67%	24	36
Was there a safety plan in place for the child at any point in the twelve months before the injury?	8.33%	3	22.22%	8	2.78%	1	66.67%	24	36
Was the family classified as high or very high risk in the twelve months before the injury?	11.11%	4	16.67%	6	2.78%	1	69.44%	25	36
Was the child welfare case meeting the family needs and child safety?	11.11%	4	8.33%	3	5.56%	2	75.00%	27	36
Comments:									3

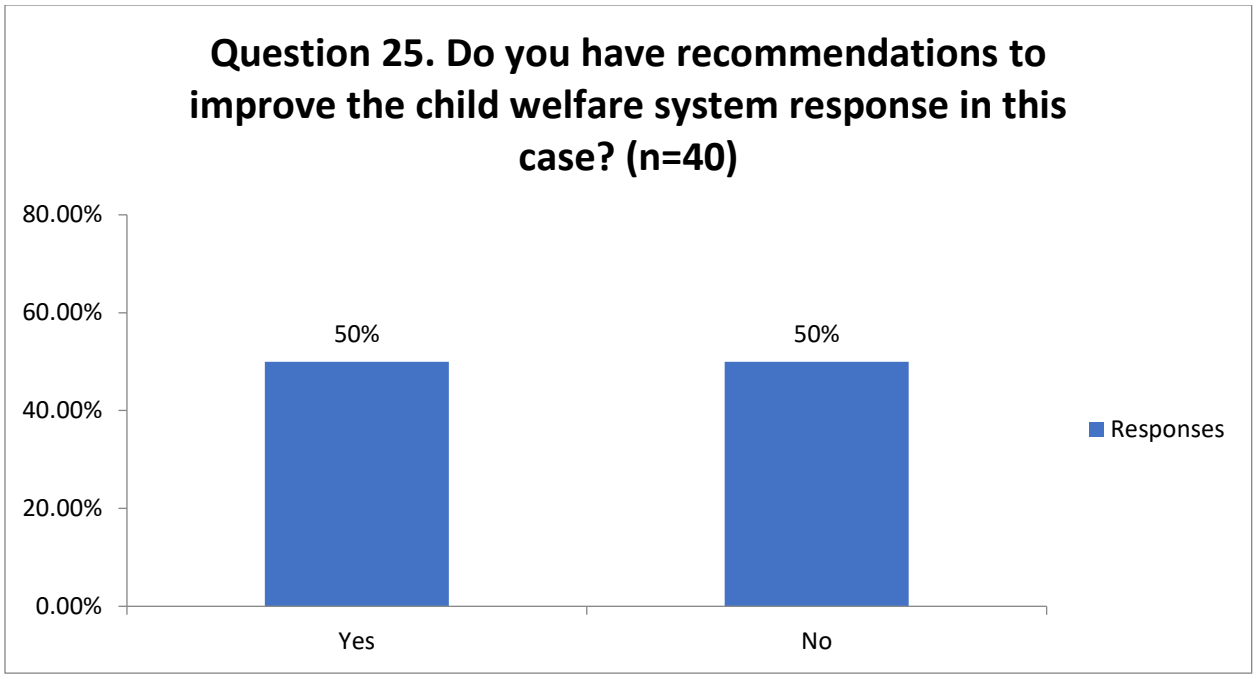


Question 23. What Protective Factors were present? (n=38)

Answer Choices	Responses	
Parental resilience: Manages stress and functions well when faced with challenges, adversity, and trauma	26.32%	10
Social connections: Builds positive relationships that provide emotional, informational, instrumental, and spiritual support	36.84%	14
Knowledge of parenting and child development: Understand child development and parenting strategies that support physical, cognitive, language, social, and emotional development	23.68%	9
Concrete support in times of need: Has access to support andor 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	57.89%	22
Social-emotional competence of children: Encourages family and child interactions that help children develop the ability t communicate clearly, recognize and regulate their emotions, and establish and maintain relationships	26.32%	10
Other (please specify)	34.21%	13

Question 24. What was the outcome of the investigation? (n=41)

Answer Choices	Responses	
Criminal Charges Filed	19.51%	8
Juvenile Petition FiledCourt -Involved Child Welfare Case Opened	29.27%	12
Non-Court Child WelfarCase Opened	7.32%	3
Child welfare case opior to injury continued	7.32%	3
Community Services an Supports Offered	7.32%	3
Child Removal	31.71%	13
None of the above	39.02%	16
Other (please specify)	34.15%	14


Question 25. Do you have recommendations to improve the child welfare system response in this case? (n=40)
80.00%
60.00%
40.00%
20.00%
0.00%
50%
50%
Yes
No
Responses

Appendix B. Case Review Tool 2022-2023

1. Separate attachment