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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]

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[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