



# **Nebraska Citizen Review Panel for Child Protective Services Annual Report**

Reporting Period:  
April 1, 2020 through March 31, 2021

Nebraska Commission for the Protection of Children

Submitted April 1, 2021

**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

**Hon. Linda Bauer** - Judge, Juvenile Court

**Jeanne Brandner** - Deputy Administrator, Office of Probation Administration

**Nicole Brundo** - Douglas County Attorney’s Office

**Hon. Michael Burns** - Judge of the County Court, 10<sup>th</sup> District

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**Melissa Hilty** - Governor's Policy Research Office

**Melody Hobson** - Office of Early Childhood, Nebraska Department of Education

**Amy Hoffman** - Nebraska Crime Commission

**Lynelle Homolka** - Merrick County Attorney

**Michael Jepsen** – Sherman County Sheriff

**Corrie Kielty** - Nebraska CASA Association

**Julia R Keown** – Health Professional

**Erin Konecky** – Parent Representative

**Joshua Midgett** - Integrated Life Choices

**Tracy Scherer** - Omaha Police Department

**B. Gail Steen** - Steen Law Office, Attorney working with children

**Bill Tangeman** - Office of the Nebraska Attorney General

**Bobbi Taylor** – Youth Engagement Consultant

**Mark Unvert** - Lincoln Police Department

**Jamie Vetter** – Director, Family Advocacy Network Child Advocacy Center

**Cassie Wegelin** – Nebraska State Patrol

**Nebraska Citizen Review Panel Members:**

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**The Nebraska Citizen Review Panel Annual Report was prepared on behalf of the Commission by:**

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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 over the timeframe April 1, 2020 to March 31, 2021. During this period, the Citizen Review Panel conducted case reviews of 14 serious injuries and near fatalities due to child abuse or neglect that occurred between May and September 2019.

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.

### 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. From 2017 to 2020, the CRP conducted 71 case reviews of serious injuries and near fatalities.

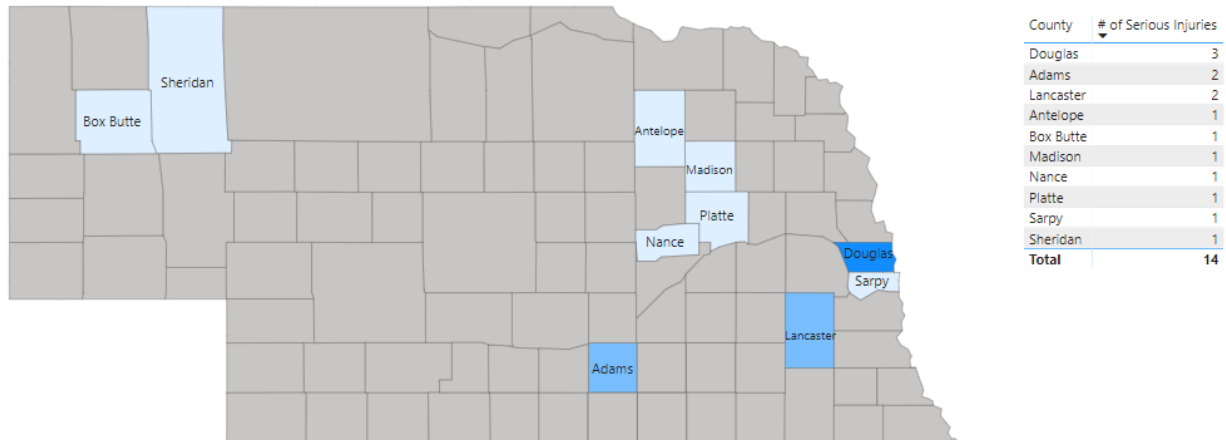
Due to the COVID-19 pandemic, the CRP's activities and meetings were limited this year. The Committee worked on protocols and structures that would allow meetings and case reviews to occur safely and confidentially. The CRP met virtually to revise the survey form. During January and February 2021, the CRP was able to conduct 14 staggered, socially-distanced case reviews. The CRP then met virtually to review results, discuss trends, and identify topics of interest.

In the coming year, the CRP is attempting to conduct reviews for all serious injuries and near fatalities that occurred between October 2019 and the end of 2020. The CRP has also identified changes and improvements to the review form that will allow it to capture more accurate data.

## Serious Injury Review Results

The following section provides details on the 14 serious injuries and near fatalities that the CRP reviewed. Figure 1 provides the location where the injuries occurred in Nebraska.

Figure 1. Location of Serious Injuries Reviewed



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. The full results of non-identifying survey information can be found in Appendix A. Appendix B contains a copy of the review form.

### 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:

- Over 70% (10 of 14) of the children seriously injured were under the age of 2 years old. Two additional children who were injured were between 2 and 4 years old. In total, 85% of children injured were under the age of 5.
- Only half of children seriously injured (7 of 14) were white. Black and American Indian children were disproportionately represented in the injuries relative to their percentage of the population.
- Five of 14 children had a diagnosed condition prior to their injury. Three had medical diagnoses and two had mental health diagnoses.
- Female children made up 57% of the children who were injured (8 of 14).

### 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:

- 42% of injuries (6 of 14) were caused by abusive head trauma. Other types of physical abuse, including fractures and strangulation, were noted in 5 additional cases.

- Approximately two-thirds of serious injuries (9 of 14) occurred in the child’s household. Two additional injuries occurred in other households. Only one serious injury occurred in a child care setting.
- Over 70% of the injuries were caused by the child’s caregiver at the time (10 of 14), most often their parent or guardian.
- In 4 cases, the party responsible for the abuse or neglect was not able to be determined.
- Although use of substances has been identified as a concern in prior CRP reviews, it was determined to be a factor in only one of 14 injuries in this set of reviews.

The CRP identified gathering more precise information about the injuries themselves as a priority for future reviews.

### 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 all but one case, both DHHS child protective services and at least one law enforcement agency were involved in the investigation of the injury.
- Medical providers were **not included** in over 20% of investigations (3 of 14), and child advocacy centers were only used in 4 investigations.
- Criminal charges related to the injury were filed in less than 15 % of cases (2 of 14).
- Approximately two-thirds of serious injuries (9 of 14) resulted in an ongoing child welfare case - 6 with court involvement and 3 through voluntary or non-court services.
- Reviewers generally felt that agencies fulfilled their responsibilities during and after the investigation of the serious injury. Only one review related to a failure to thrive case was flagged as one where errors were made.

### 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.

- Six of the children (42%) had been involved with the child welfare system through an ongoing case or investigation in the twelve months prior to their injury. Three children (21%) had a closed case or investigation and three were actively involved with the child welfare system.
- Five of the children (36%) had no prior child welfare system involvement at the time of their injury.
- All ten children injured by caregivers had at least one risk factor noted and most had multiple risk factors. In 7 cases there was a family history of trauma and abuse/neglect. In 6 cases there was a history of domestic and family violence.
- Only nine children’s families had protective factors noted.
- One-third of the children (2 of 6) involved with the child welfare system in the twelve months prior to their injury scored as high or very high risk for future abuse on the DHHS

structured decision making (SDM) tool. In 4 of 6 cases, reviewers noted prior safety concerns and family struggles paralleled the circumstances around the serious injury.

## Issues for Further Study

### Current Report

Given the small number of serious injury and near fatality cases reviewed, the Citizen Review Panel was not comfortable making formal recommendations to the Department of Health and Human Services and the State of Nebraska at this time. However, through the reviews, the CRP did find a number of concerns and issues that it will monitor in future reviews and note for further study.

### *Lack of Documentation*

Many of the DHHS case files were missing medical and law enforcement records related to the injury, although it is DHHS policy and preference that staff request and review those records as they assess the family's safety and determine the child welfare system response. This made the reviews less comprehensive and was also noted as a concern of where policy may not be followed in the field.

### *Services and Supports for Families with Young Children*

The large majority of children who were seriously injured due to abuse were under the age of 2. In some cases, children had no known prior contact with the child welfare system and had received no services. This could suggest that additional prevention efforts could be focused on families with young children.

### *Families with Chronic Needs and Child Welfare Involvement*

In many of the cases of serious injury, the children and families were well known to the child welfare system and/or had documented risk factors that elevated the risk of serious injury. The case reviews highlighted a number of challenges the system has in responding to and working with families in these circumstances to ensure child safety and well-being. Reviewers noted a number of specific concerns, including:

- A lack of services and interventions offered to high and very-high risk families, when allegations of child abuse or neglect are not able to be substantiated;
- A reluctance by families to engage in voluntary child welfare services;
- Premature case closure, when family needs have not truly been met; and,
- Appropriate engagement and services for caregivers with serious mental health and/or substance use histories.

### *Responding to Failure to Thrive*

Failure to thrive was a contributing factor or existing diagnosis prior to injury in two cases reviewed by the CRP. In one case, a reviewer felt that there were gaps in DHHS policy, practice, and knowledge that a review of an injury exposed.

### *Responding to Domestic and Family Violence*

Histories of domestic and family violence were noted as a risk factor in half of the serious injuries reviewed this year. Reviewers also noted concerns with barriers to accessing protection orders and other services for caregivers who were seeking to protect their children in the aftermath of injury at the hands of a non-custodial parent.

### *2019-2020 CRP Report Recommendations*

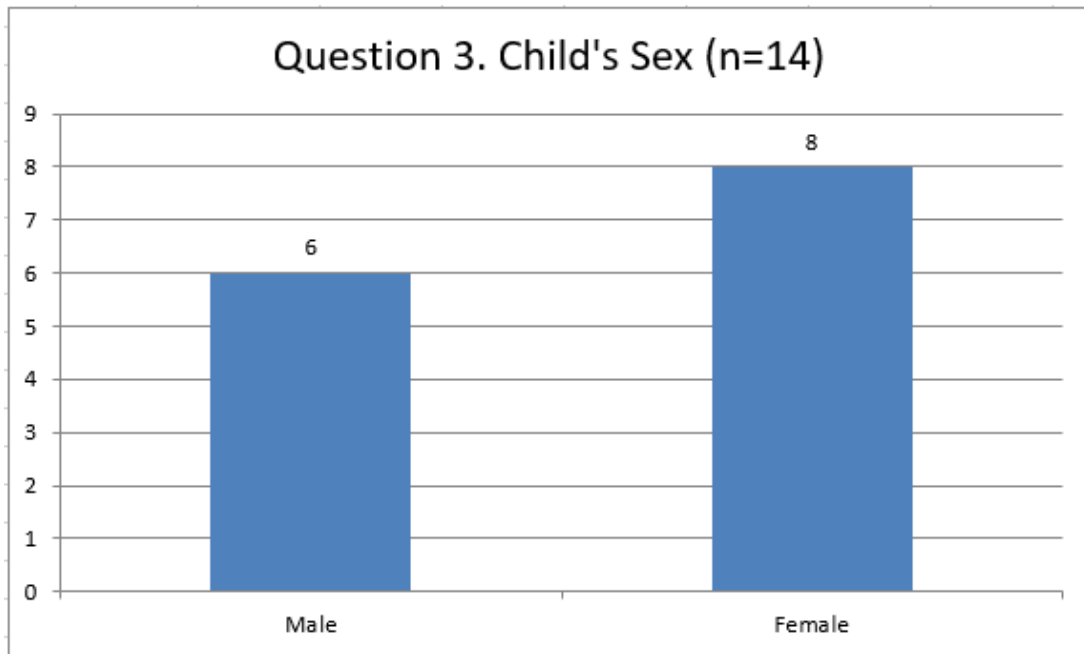
In April 2020, the CRP submitted its annual report which included two recommendations to Nebraska DHHS:

- Expand and refine mandatory collateral contact requirements at the Child Abuse and Neglect Hotline; and,
- Address methamphetamine use through increased public awareness.

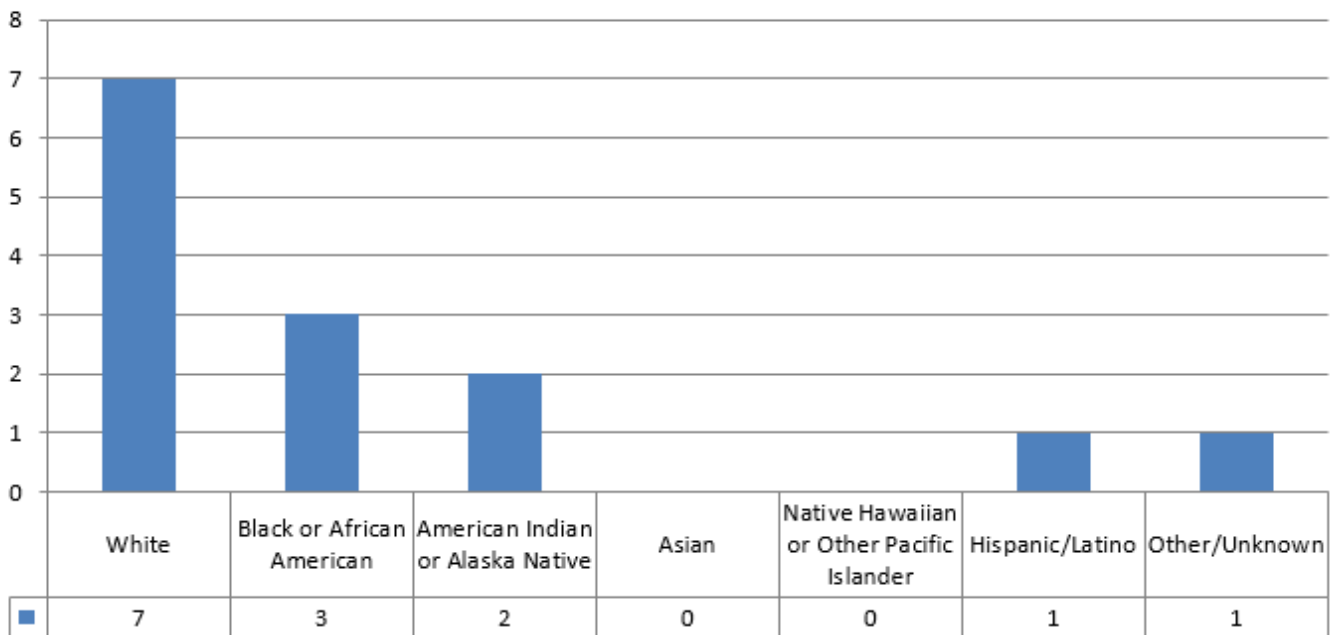
The CRP continues to monitor these two issues. DHHS reports that in 2020 they contracted with the creators of Structured Decision Making (SDM) to work with them to assess all SDM tools, including those used at the Child Abuse Hotline. This process is currently underway. On the topic of methamphetamine use, DHHS had to put aside plans for public awareness as public health efforts have been focused on the response to COVID-19. However, DHHS plans to revisit this topic in the coming year.

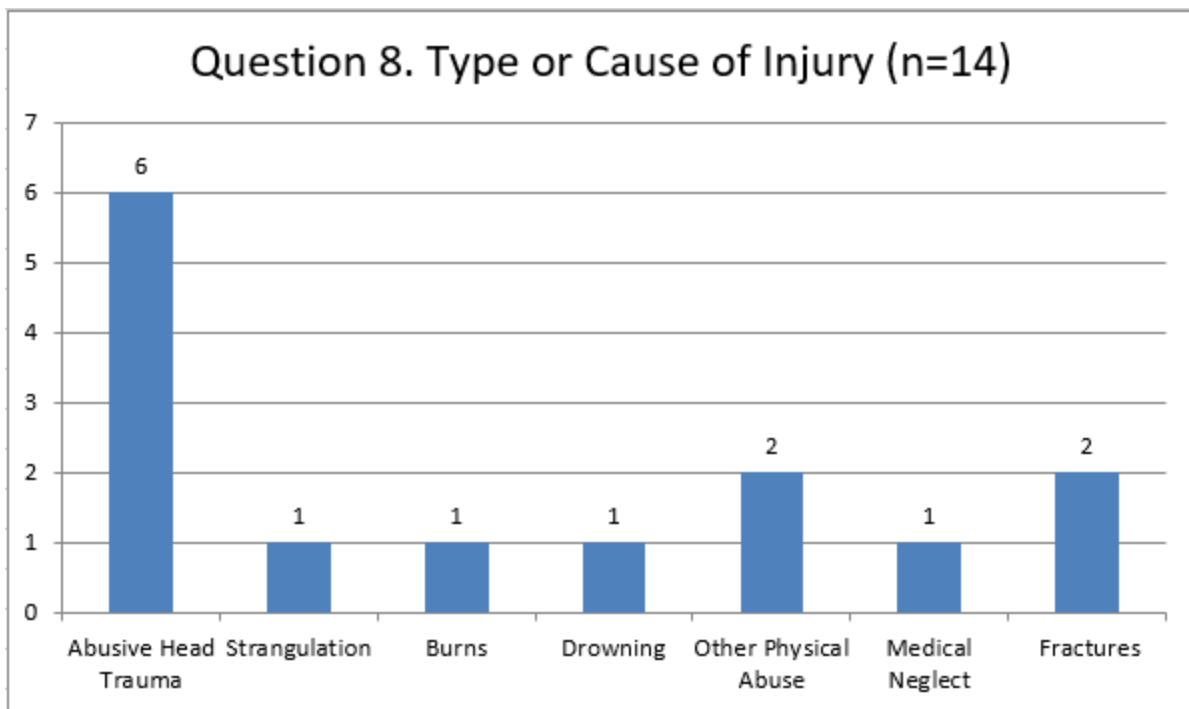
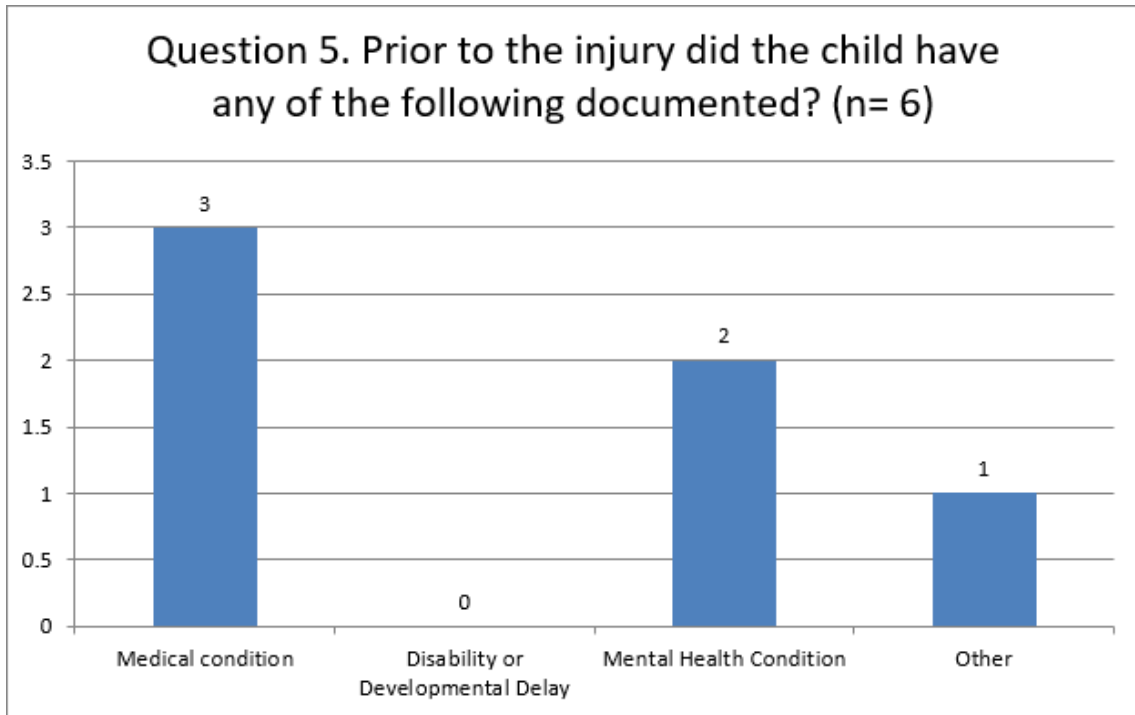


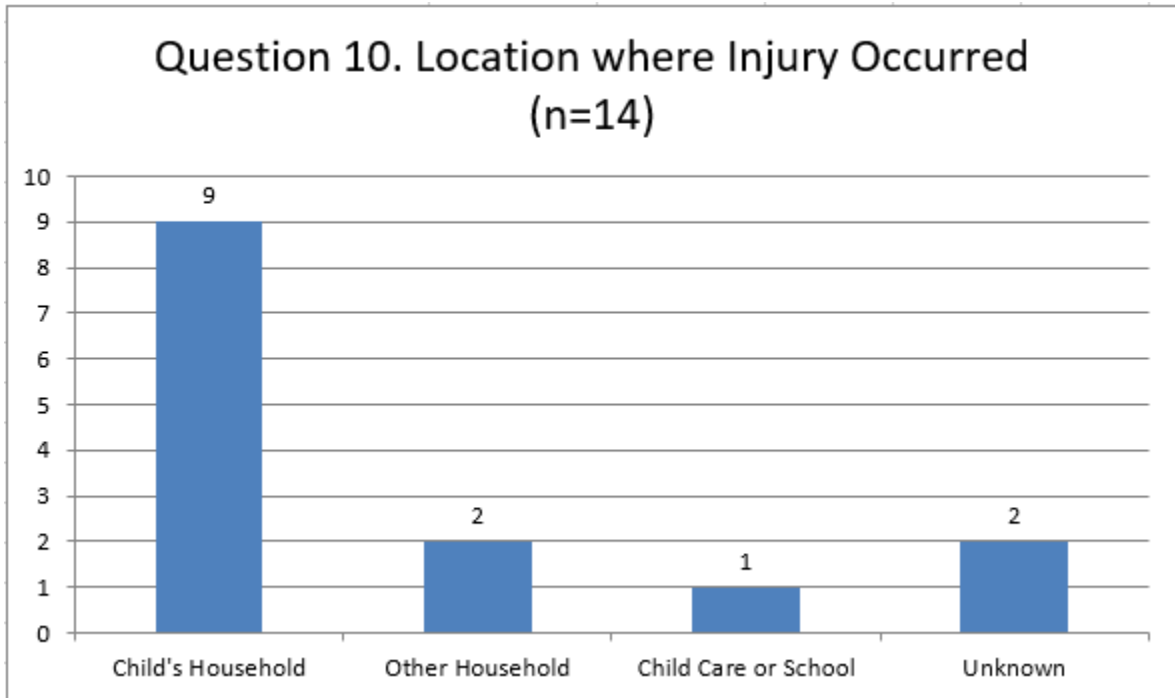
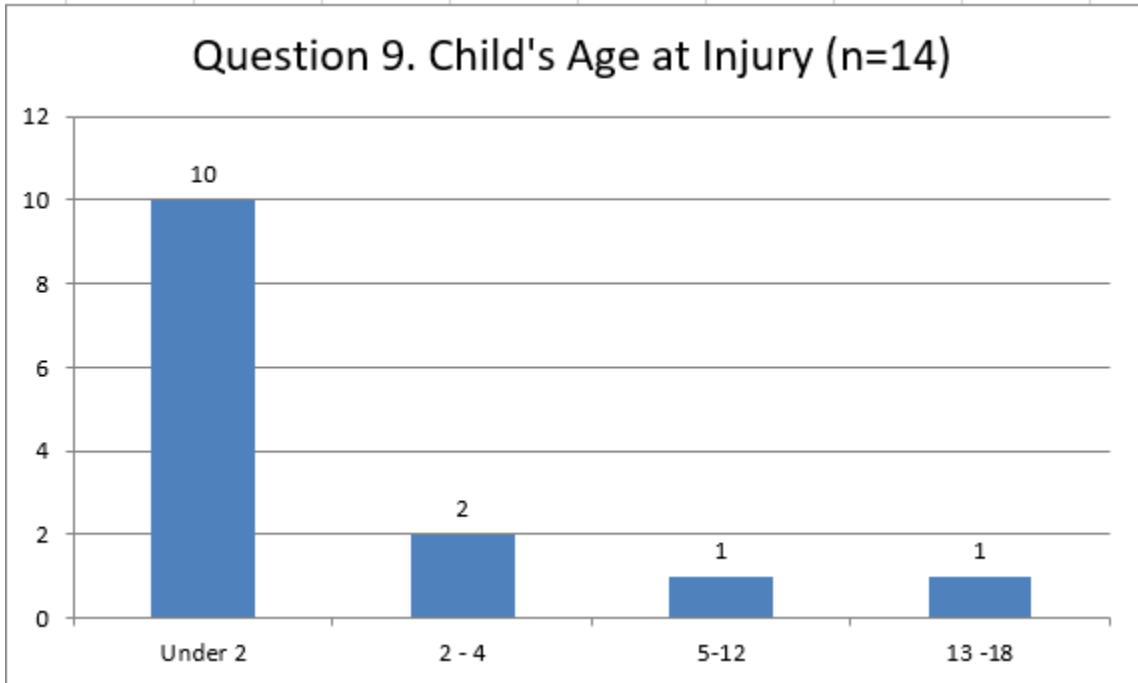
## Appendix A. Full Data from Case Reviews



### Question 4. Child's Race and Ethnicity (n=14)

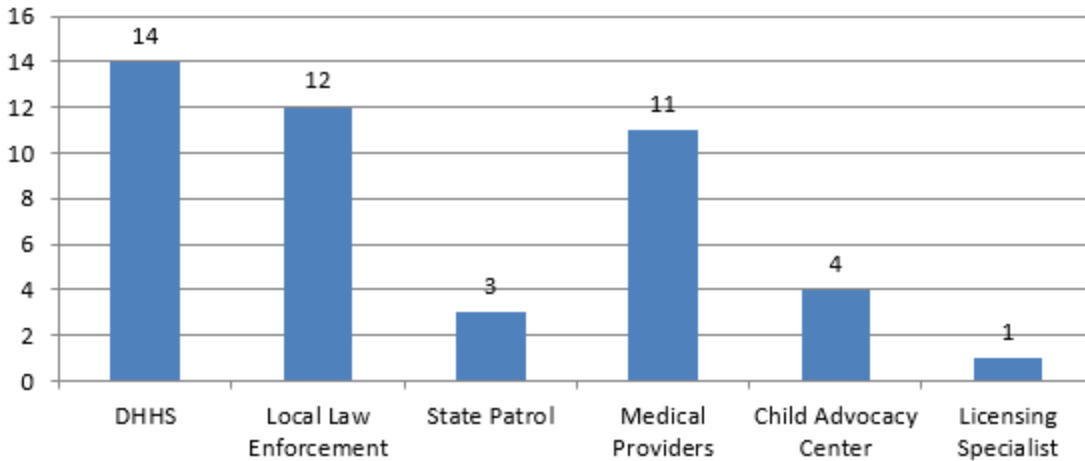




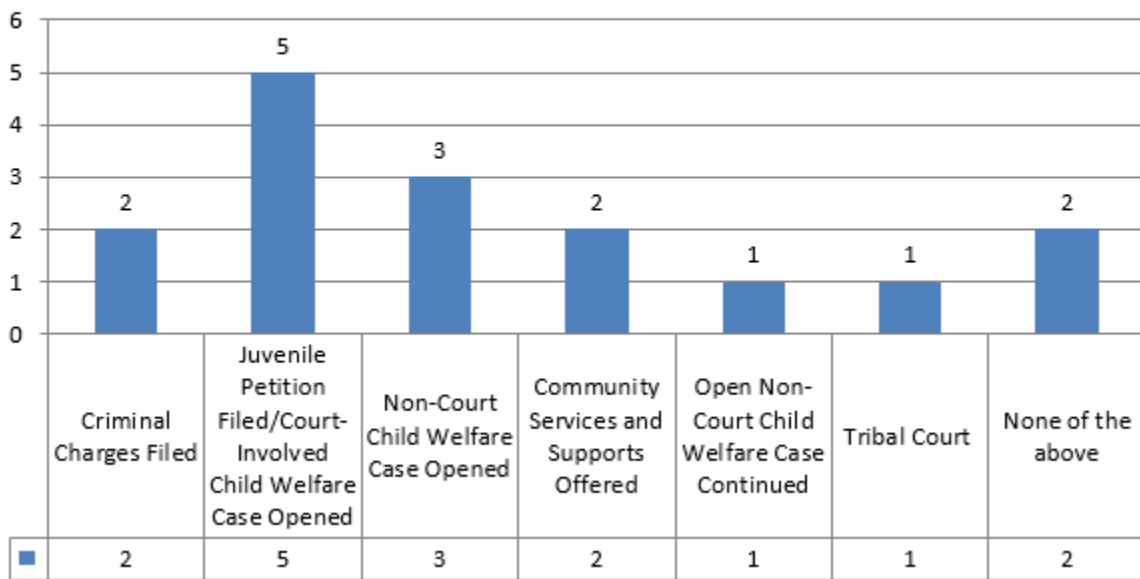


### Question 12. What parties were involved in the investigation of the injury?

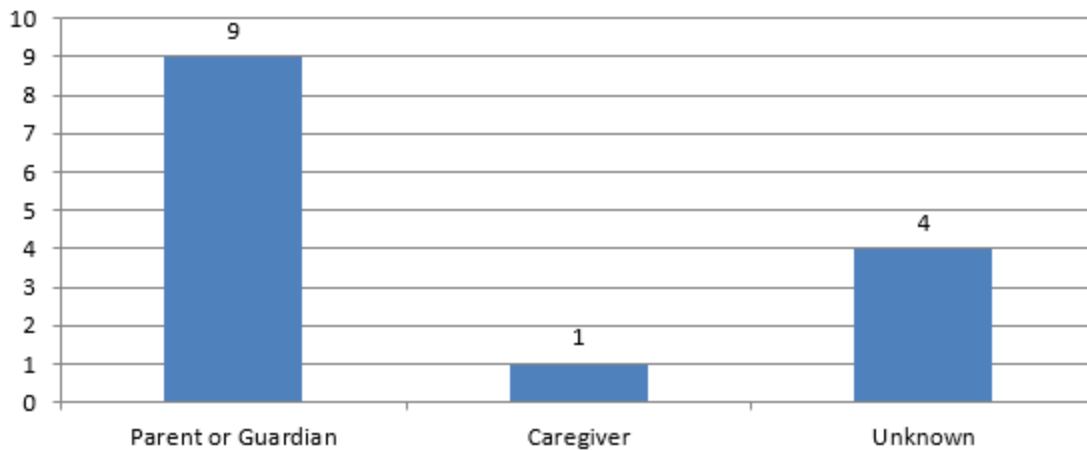
(n=14; multi-select)



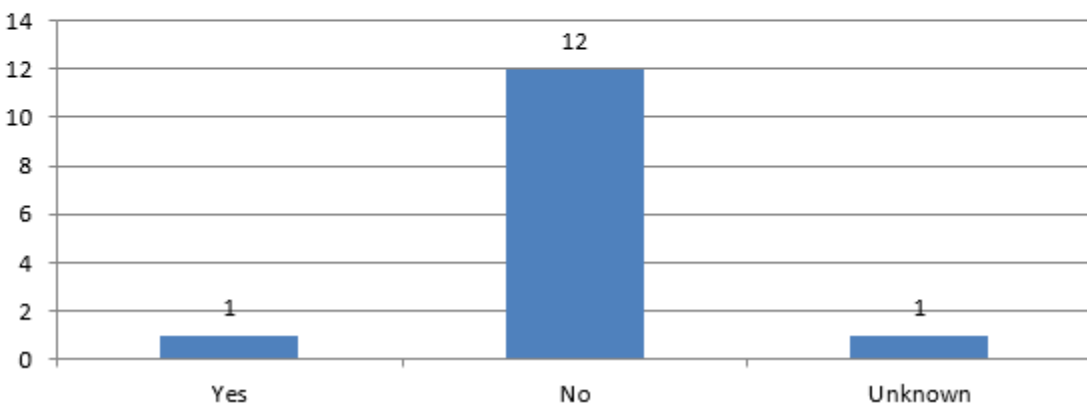
### Question 13. What was the outcome of the investigation? (n=14, multi-select)



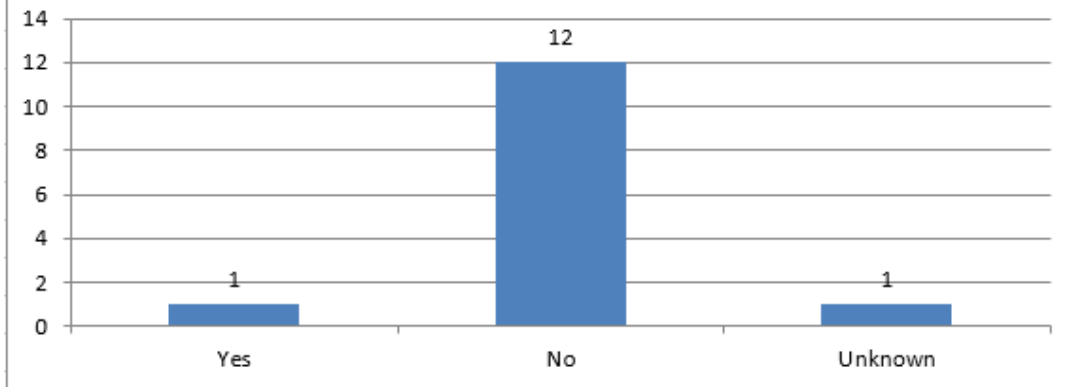
**Question 14. Child Relationship to Part(ies)  
Determined Responsible for Abuse or Neglect  
resulting in Injury (n=14)**



**Question 15. Did the use of controlled  
substances, alcohol, or prescription  
medication contribute to the injury?  
(n=14)**



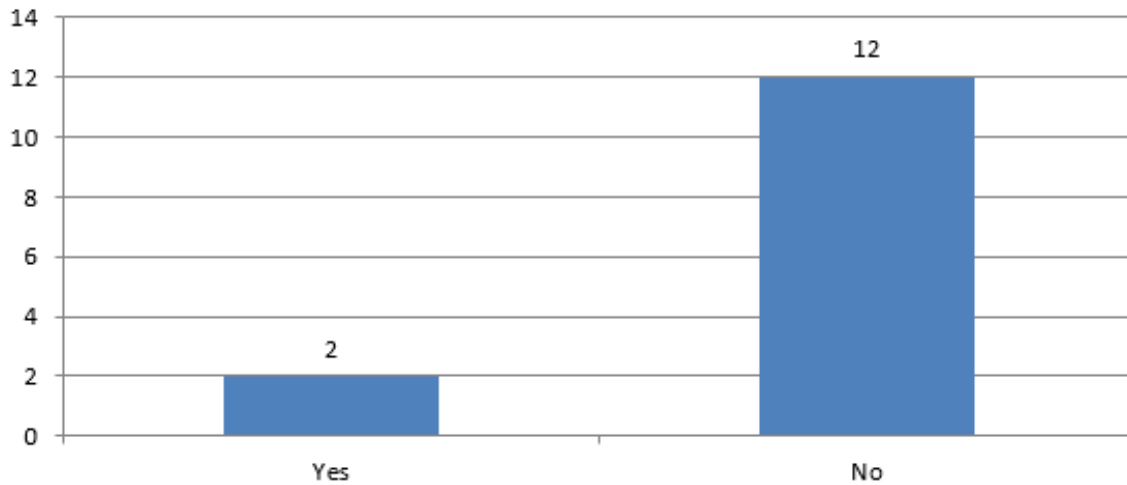
Question 16. Do the records indicate that support and counseling or an opportunity to debrief was offered to the agencies and personnel responding to the injury? (n=14)



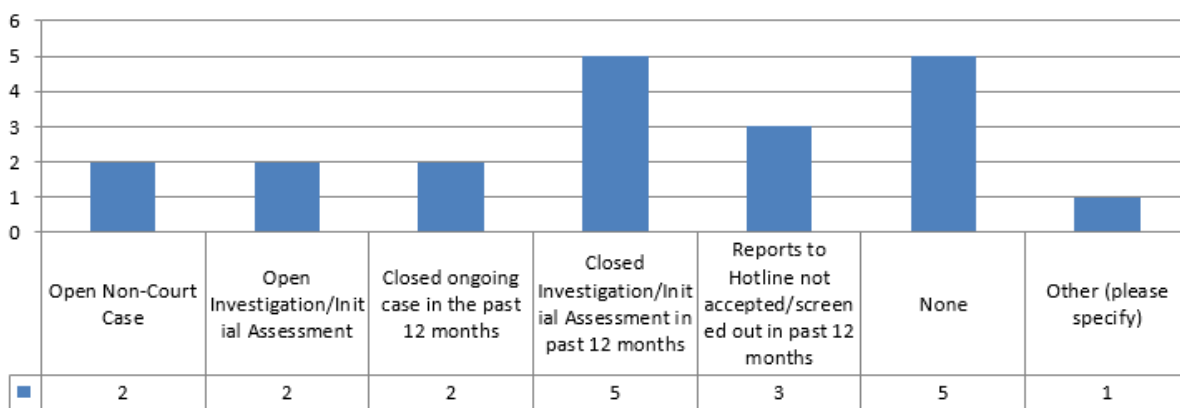
Question 17. Please respond to the following questions about the agencies participating in the investigation of the injury

	NO, DEFINITELY NOT	NO, MOSTLY NOT	UNSURE	YES, MOSTLY	YES, DEFINITELY	TOTAL	WEIGHTED AVERAGE
In your judgment, were law enforcement responsibilities fulfilled?	0.00% 0	0.00% 0	7.69% 1	46.15% 6	46.15% 6	13	4.38
In your judgment, were DHHS's investigative responsibilities fulfilled?	0.00% 0	7.14% 1	0.00% 0	57.14% 8	35.71% 5	14	4.21
In your judgment, did DHHS offer appropriate services and intervention after the investigation of the injury?	0.00% 0	7.69% 1	7.69% 1	30.77% 4	53.85% 7	13	4.31
In your judgment, were other agencies' responsibilities fulfilled?	0.00% 0	0.00% 0	25.00% 3	33.33% 4	41.67% 5	12	4.17

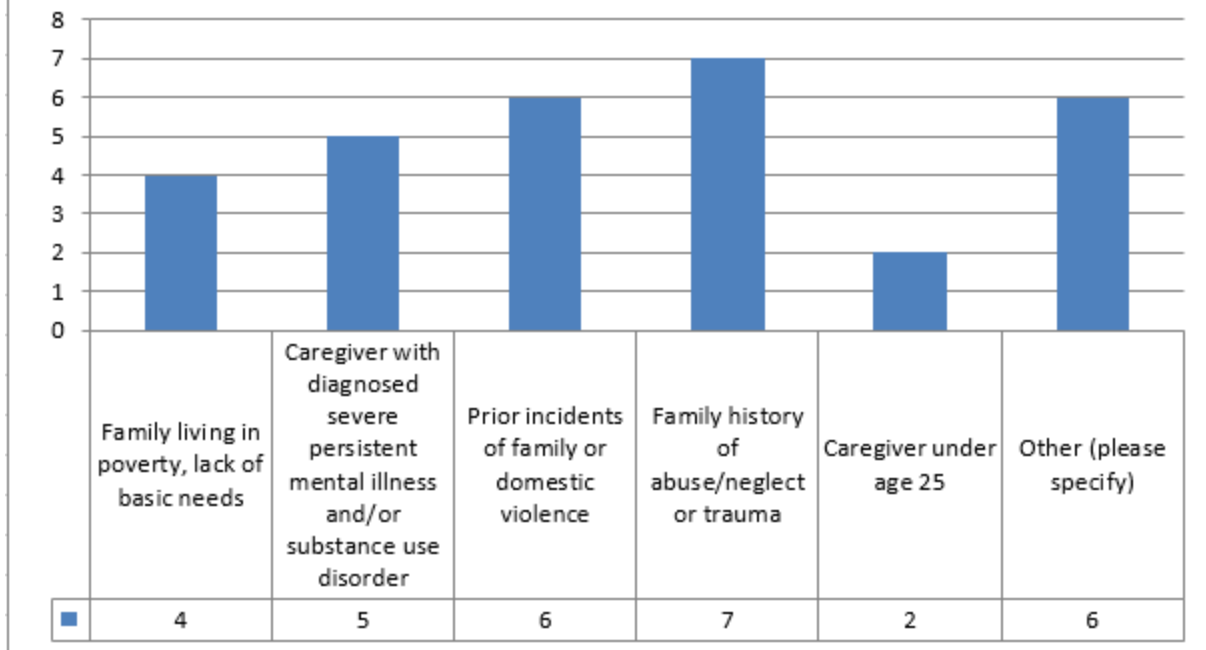
Question 18. Do you have recommendations to improve the investigation and system response to the injury? (n=14)



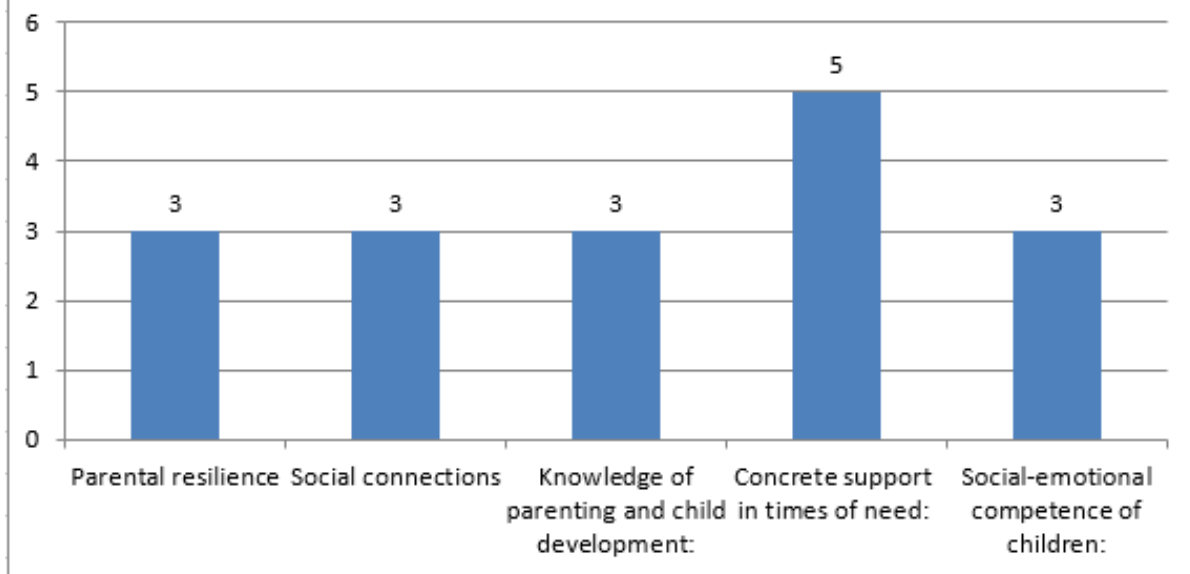
Question 19. What was the child's involvement with the child welfare/protection system at the time of the injury? (mark all that apply; n=12)



Question 20. What risk factors were present?  
(n=10)



Question 21. What protective factors were present?  
(n=9)





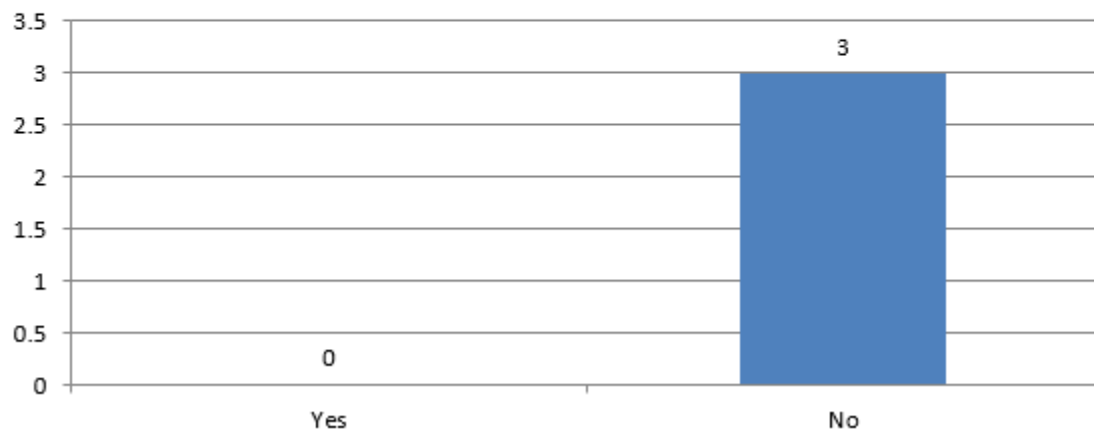
Question 22. Please respond to the following questions about the child's current child welfare involvement.

	YES	NO	UNSURE	TOTAL
Was there an active safety plan in place?	0.00% 0	66.67% 2	33.33% 1	3
Was the family classified as high or very high risk?	66.67% 2	33.33% 1	0.00% 0	3
Was the child welfare case meeting the family needs and child safety?	33.33% 1	0.00% 0	66.67% 2	3

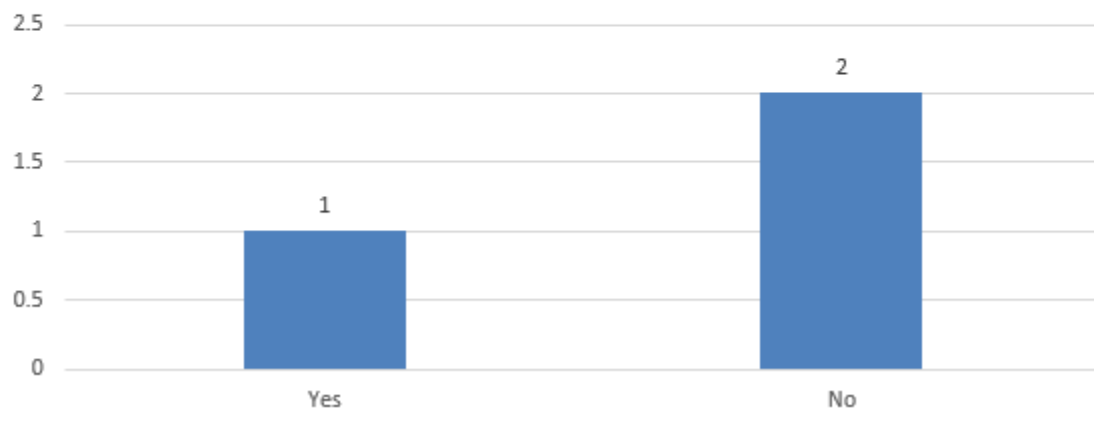
Question 23. Please respond to the following questions about the child's current child welfare involvement.

	NO, DEFINITELY NOT	NO, MOSTLY NOT	UNSURE	YES, MOSTLY	YES, DEFINITELY	TOTAL	WEIGHTED AVERAGE
In your judgment, was the child welfare case addressing the child's safety?	0.00% 0	0.00% 0	33.33% 1	33.33% 1	33.33% 1	3	4.00
In your judgment, was the child welfare case addressing the family needs?	0.00% 0	0.00% 0	66.67% 2	33.33% 1	0.00% 0	3	3.33
In your judgment, could something have been done to make the injury less likely?	33.33% 1	33.33% 1	33.33% 1	0.00% 0	0.00% 0	3	2.00

Question 25. Do the records indicate that support and counseling or an opportunity to debrief was offered after the injury to child welfare staff involved with the family? (n=3)



Question 26. Do you have recommendations to improve the child welfare system response in this case? (n=3)



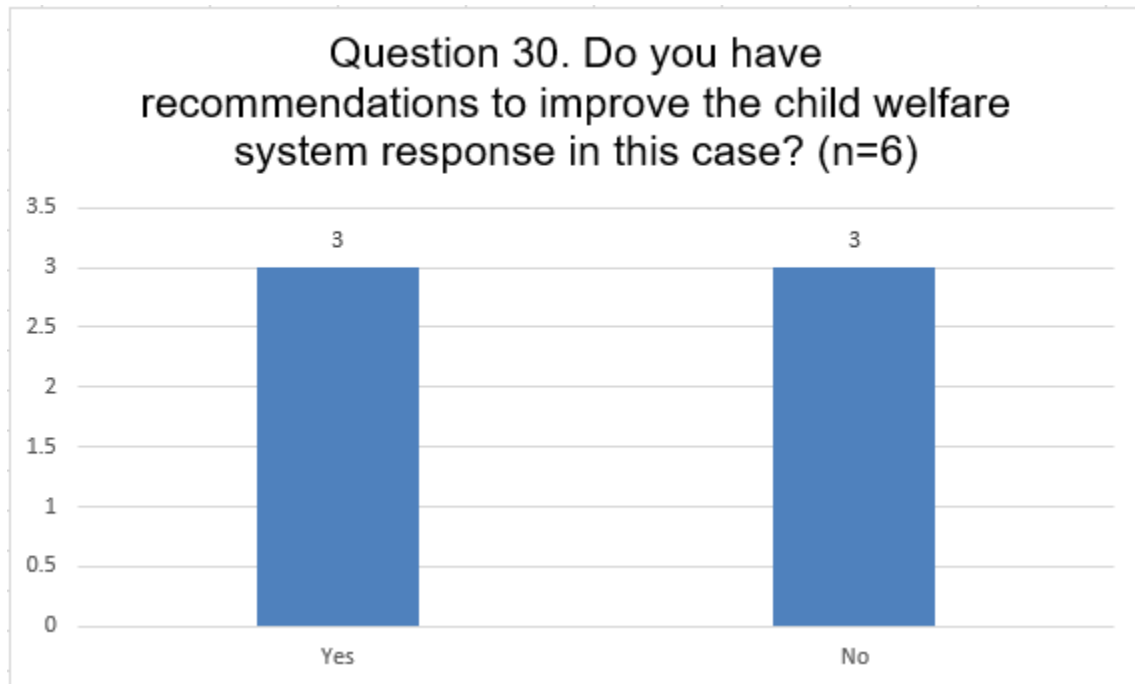
Question 27. How many child abuse reports were made in the following categories?				
Answer Choices	Average Number	Total Number	Range	Responses
Reports accepted alleging abuse/neglect of the child in the twelve months before the injury?	1.5	9	0-4	6
Reports accepted alleging abuse/neglect by the perpetrator in the twelve months before the injury?	1.29	9	0-4	7
Reports screened out alleging abuse/neglect of the child in the twelve months before the injury?	0.8	4	0-2	5
Reports screened out alleging abuse/neglect by the perpetrator in the twelve months before the injury?	0.8	4	0-2	5
			<b>Answered</b>	<b>7</b>

Question 28. Please respond to the following questions prior child welfare involvement.

	YES	NO	UNSURE	TOTAL
Did child welfare history relate to issues similar to those that caused the serious injury?	57.14% 4	42.86% 3	0.00% 0	7
Was the family classified as high or very high risk in the 12 months before the injury?	28.57% 2	57.14% 4	14.29% 1	7

Question 29. Please respond to the following questions prior child welfare involvement.

	NO, DEFINITELY NOT	NO, MOSTLY NOT	UNSURE	YES, MOSTLY	YES, DEFINITELY	TOTAL	WEIGHTED AVERAGE
In your judgment, were prior hotline reports screened appropriately?	0.00% 0	14.29% 1	42.86% 3	28.57% 2	14.29% 1	7	3.43
In your judgment, did DHHS fulfill its responsibilities to the child and family in prior cases?	0.00% 0	0.00% 0	42.86% 3	42.86% 3	14.29% 1	7	3.71
In your judgment, could something have been done to make the injury less likely?	0.00% 0	57.14% 4	28.57% 2	14.29% 1	0.00% 0	7	2.57



Question 31. Please respond to the following questions about this case review.

	NO, DEFINITELY NOT	NO, NOT REALLY	UNSURE	YES, MOSTLY	YES, DEFINITELY	TOTAL	WEIGHTED AVERAGE
▼ In your judgment, did Nebraska fulfill its responsibilities to this child before and after the injury?	0.00% 0	14.29% 2	14.29% 2	42.86% 6	28.57% 4	14	3.86
▼ In your judgment, did the case reveal any concerns about how our child protection system is working?	7.14% 1	42.86% 6	14.29% 2	28.57% 4	7.14% 1	14	2.86
▼ In your judgment, could something be done to make similar injuries less likely in the future?	7.14% 1	28.57% 4	35.71% 5	21.43% 3	7.14% 1	14	2.93
▼ In your judgment, were there strengths in the system response that should be used more broadly?	8.33% 1	16.67% 2	41.67% 5	33.33% 4	0.00% 0	12	3.00

## Appendix B. Case Review Tool 2020- 2021

Separate attachment