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Members of the Nevada State Legislature
Legislative Building
Carson City, Nevada

The purpose of this letter is to summarize the results of the Legislative Auditor's review of child fatalities and near fatalities when a child welfare agency had prior contact with the child or family. Pursuant to Nevada Revised Statutes (NRS) 218G.550, we reviewed case files provided by child welfare agencies between January 1, 2017, and December 31, 2018.

## Results in Brief

Based on our review of the case files provided to us through December 31, 2018, we found no evidence that the fatalities and near fatalities were caused by the agencies not complying with state and federal laws. In addition, we did not identify any measures, procedures, or protocols that could have assisted in preventing the fatality or near fatality. Additional information is provided below concerning the number of fatalities and near fatalities and the results of our case reviews.

## Introduction

Several bills passed during the 2007 Legislative Session to improve child welfare services in Nevada, including Assembly Bill 261. This bill included a requirement, effective July 1, 2007, for child welfare agencies to submit case files to the Legislative Auditor of children who suffer a fatality or near fatality if the agencies had prior contact with the child or family. The Legislative Auditor is required to review the information to determine whether: (1) the case was handled in a manner consistent with state and federal law, and (2) any measures, procedures, or protocols could have assisted in preventing the fatality or near fatality. This requirement is codified in NRS 218G.550. Our case file reviews were not audits; therefore, they were not conducted in accordance with generally accepted government auditing standards.

## Number of Incidents

From January 1, 2017, through December 31, 2018, we reviewed 94 case files of children who suffered a fatality or near fatality where a child welfare agency had prior contact with the child or a member of the child's family or household. In 43 (46%) of the cases, the files did not have any indication that abuse or neglect was the primary factor in the fatality or near fatality. These 43 incidents were caused by other factors such as medical conditions due to congenital medical issues, SIDS, co-sleeping, or other accidents. The following table shows the number of case files we reviewed where abuse or neglect was found to be a primary factor in the fatality or near fatality from each of the child welfare agencies in Nevada (Clark County Department of Family Services, Washoe County Human Services Agency, and the Division of Child and Family Services – Rural Region).

**Abuse/Neglect Fatalities and Near Fatalities of Children Having Prior Contact With Child Welfare Agency January 1, 2017, to December 31, 2018**

| Agency | Number of Fatalities | Number of Near Fatalities | Totals |
|---|---|---|---|
| Clark County DFS | 24 | 21 | 45 |
| Washoe County HSA | 3 | 2 | 5 |
| DCFS – Rural | 0 | 1 | 1 |
| **Totals** | **27** | **24** | **51** |

## Results From Latest Case Reviews by Legislative Auditor

We reviewed case documentation for the 51 fatalities or near fatalities caused by abuse or neglect where a child welfare agency in Nevada had prior contact with the family or members of the household at the time of the fatality. Our examination consisted of reviewing copies of the case file provided to us by the child welfare agencies. We also discussed the cases with personnel from the child welfare agencies, when appropriate. These procedures enabled us to obtain an understanding of the agency's actions concerning the family prior to the fatality. The primary purpose of our review was to determine whether there was any noncompliance with laws, regulations, or policies that could have contributed to the fatality. We also determined whether the child welfare agency could have taken any reasonable measures to prevent the fatality.

Our review found in some cases the agency had prior contact with certain members of the household, but did not have any contact with the person who committed the abuse or neglect that caused the fatality. Therefore, we do not believe that the agency's actions regarding allegations

prior to the fatality could have prevented the fatality. In other cases, we reviewed the adequacy of the agency's investigations into allegations of abuse or neglect prior to the fatality, including whether there was evidence of supervisory oversight in making decisions. Based on our review of the case files provided to us, we found no evidence that the 51 fatalities or near fatalities were caused by the agencies not complying with state and federal laws. In addition, we did not identify any measures, procedures, or protocols that could have assisted in preventing the fatality or near fatality.

We would like to express our appreciation to personnel at the Clark County Department of Family Services, the Washoe County Human Services Agency, and the Division of Child and Family Services for their cooperation.

Please contact Todd Peterson, Audit Supervisor, or me at (775) 684-6815 if you have any questions regarding this letter.

Sincerely,

Rocky Cooper, CPA
Legislative Auditor

RC:da

cc: Tim Burch, Administrator of Human Services, Clark County Department of Family Services
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