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THE STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU

July 21, 2026

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 the child welfare agencies between January 1 and December 31, 2025.

The three child welfare agencies in Nevada are Clark County Family Services, Washoe County Human Services Agency, and the Division of Child and Family Services - Rural Region. We would like to express our appreciation to personnel at these agencies for their cooperation and recognize their continued efforts to protect vulnerable children in our State.

Results in Brief

In 5 of 55 cases reviewed where the child welfare agency concluded the fatality or near fatality was the result of abuse or neglect, we had concerns about the child welfare agency's actions prior to the fatality or near fatality. Additionally, for one case reviewed where the child welfare agency concluded the fatality or near fatality was not the result of abuse or neglect, we had concerns about the child welfare agency's actions prior to the fatality or near fatality. For these cases, we found several issues where the child welfare agencies' actions prior to the fatality or near fatality did not comply with statewide policies. Areas of concern observed during our review of cases included: (1) oversight of placement and supervision of children was inadequate to control safety threats; (2) safety assessments not adequately performed; (3) allegation decision did not adequately reflect significant evidence discovered; (4) information insufficiently gathered and utilized to appropriately assess caregiver protective capacities, impending dangers, safety, or substantiation determinations; (5) persistent efforts guidelines were not followed; (6) public disclosure not issued timely; and (7) reports of abuse or neglect were not adequately screened at intake.

For calendar year 2025 cases reported to the Legislative Auditor, we issued three letters to child welfare agencies to express our concerns to management about how several cases were handled. After expressing our concerns, child welfare agency officials indicated they performed their own internal review of the cases and identified the need for additional improvements, such as clarifying and reinforcing policy and practice, improving the quality and completeness of

documentation, and providing training for staff. As we perform case reviews in the future, we will continue to monitor child welfare agencies' efforts to help ensure improvement and sustained implementation of the corrective actions reported.

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 to the Legislative Auditor case files 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, the reviews were not conducted in accordance with generally accepted government auditing standards.

Our work consisted of reviewing case information stored electronically in the centralized child welfare system and copies of the case files provided to us by the child welfare agencies. We also discussed the cases with personnel from the child welfare agencies when necessary. These procedures enabled us to obtain an understanding of agencies' actions concerning the families prior to the fatalities or near fatalities. Additional information is provided below concerning the number of fatalities and near fatalities, and the results of our case reviews. Our reviews are limited to cases provided to us and are dependent on child welfare agencies reporting all required cases in accordance with statutes.

Number of Fatality and Near Fatality Incidents

From January 1 to December 31, 2025, we reviewed 148 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. Child welfare agencies did not investigate 37 (25%) of these cases, which were coded as Information Only reports that did not require a response from the child welfare agencies. These 37 incidents were attributed to other factors such as conditions due to congenital medical issues, suicide, drug overdoses, or other accidents. The child welfare agencies began investigations of the other 111 cases, of which 4 were still pending an investigation outcome. In 52 of the 111 investigated cases, the child welfare agencies determined that abuse or neglect was not the primary factor in the fatality or near fatality. The following table provides a breakdown of the remaining 55 cases 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.

Abuse or Neglect Fatalities and Near Fatalities of Children Having Prior Contact With Child Welfare Agency January 1 to December 31, 2025

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County Family Services	11	35	46
Washoe County Human Services Agency	4	1	5
Division of Child and Family Services - Rural Region	1	3	4
Totals	**16**	**39**	**55**

Source: Auditor compilation based on records provided by child welfare agencies.

Results From 2025 Case Reviews by the Legislative Auditor

In our review of 148 cases, there were 6 where we expressed concerns to child welfare agency officials about how the cases were handled. Based on our reviews, we observed child welfare agencies did not always comply with laws, regulations, or statewide policies. For additional information regarding child welfare agency criteria and definitions, see Attachment A. This lack of compliance prior to the incident may have increased the risk a child welfare agency did not properly intervene when an allegation of abuse or neglect was received. The following table summarizes the six cases for which we identified concerns, by area of noncompliance and jurisdiction.

Legislative Auditor Concerns by Issue and Child Welfare Agency
January 1 to December 31, 2025

Deficiency	Clark County Family Services	Washoe County Human Services Agency	Division of Child and Family Services - Rural Region	Totals
Oversight of Placement and Supervision of Children Was Inadequate to Control Safety Threats	2	1	0	3
Safety Assessments Not Adequately Performed[1]	2	1	0	3
Allegation Decision Did Not Adequately Reflect Significant Evidence Discovered[1]	1	0	1	2
Information Insufficiently Gathered and Utilized to Appropriately Assess Caregiver Protective Capacities, Impending Dangers, Safety, or Substantiation Determinations[1]	0	1	1	2
Persistent Efforts Guidelines Were Not Followed	1	0	0	1
Public Disclosure Not Issued Timely	1	0	0	1
Reports of Abuse or Neglect Were Not Adequately Screened at Intake[1]	0	0	1	1
Totals by Jurisdiction	**7**	**3**	**3**	**13**

Source: Auditor compilation based on records provided by child welfare agencies.
[1] Similar concerns noted in our review of case files from January to December 2024.
Note: During our review of these cases several deficiencies were sometimes observed, which resulted in the higher number of deficiencies than case files reviewed.

As stated above, we had concerns with the handling of six cases. After expressing our concerns, child welfare agency officials indicated they performed their own internal review of the cases and identified the need for additional improvements, such as clarifying and reinforcing policy and practice, improving the quality and completeness of documentation, and providing training for staff. As we perform case reviews in the future, we will continue to monitor child welfare agencies' efforts to help ensure improvement and sustained implementation of the corrective actions reported.

If you have any questions regarding this letter, please contact Jennifer Otto, Audit Manager, or me at (775) 684-6815 or audit@lcb.state.nv.us.

Sincerely,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:dm
Enclosure
cc: Laura Rich, Director, Department of Human Services (DHS)
Kimberly Abbott, Administrator, Division of Child and Family Services, DHS
Abigail Frierson, Interim Director, Clark County Family Services
Pamela Mann, Director, Washoe County Human Services Agency

Attachment A

Relevant Definitions

Allegation Decision	A report can comprise one or more allegations and each allegation may have a different finding. When the assigned worker is able to complete the investigative process and has gathered sufficient evidence, the assigned worker shall make an allegation finding of substantiated or unsubstantiated. This finding shall be based upon whether the information gathered during the investigation and from direct observations made by the assigned worker constitutes that the preponderance of evidence exists and supports that child abuse or neglect occurred.
Caregiver Protective Capacity	A caregiver's personal (individual) parenting characteristics; including behavioral, cognitive, and emotional; specifically and directly associated with being protective of one's child. Diminished caregiver protective capacity can contribute to a state of danger that a child is routinely exposed. 1. Behavioral: Specific action, activity, or performance resulting in parenting and protective guidance. 2. Cognitive: Specific intellect, knowledge, understanding and perception resulting in parenting and protective vigilance. 3. Emotional: Specific feelings, attitudes, identification with a child, and motivation resulting in parenting and protective vigilance.
Impending Danger	Family conditions, situations, behaviors, emotions, intentions, perceptions, and motives that are out of control; are imminent with respect to the certainty as a direct threat to a vulnerable child; can likely result in severe harm; and are specific, observable, and describable.
Information Only Report	A report alleging child abuse or neglect is made to a child welfare agency with the intent for an investigation to be conducted; however, after reviewing the information, it is determined that the report does not meet the screening criteria and is therefore screened out and dispositioned as "Information Only."
Intake Screening	The process of determining whether a report will be accepted for further assessment based on indicated present or impending danger, and/or allegations meeting the maltreatment criteria as defined by Nevada Revised Statutes (NRS). All reports screened-in must be assigned a priority response time according to alleged maltreatment and present and impending danger.

Maltreatment	Maltreatment of a child occurs if a child has been subjected to harmful behavior that is terrorizing, degrading, painful, or emotionally traumatic; has been abandoned; is without proper care, control, or supervision; or lacks the subsistence, education, shelter, medical care, or other care necessary for the well-being of the child because of the faults or habits of the person responsible for the welfare of the child or the neglect or refusal of the person to provide them when able to do so.
Persistent Efforts	Attempted face-to-face contacts each business day until contact is made or the supervisor determines a resolution has been reached. In addition to face-to-face contact, several other reasonable attempts to locate a family must be completed weekly as determined through supervisory consultation including contacting schools, state agencies, and completing diligent searches.
Preponderance of Evidence	The standard of proof in most civil cases in which the party bearing the burden of proof must present evidence which is more credible and convincing than that presented by the other party or which shows that the fact to be proven is more probable than not.
Present Danger	An immediate, significant, and clearly observable family condition that is actively occurring or in the process of occurring and will likely result in serious harm to a child.
Public Disclosure	A Public Disclosure (PD) is required when a report is received regarding a child fatality or near fatality and that child has been the subject of a report of possible abuse or neglect at any time prior to or including the report of the fatality or near fatality. The PD must be submitted by the child welfare agency in the jurisdiction where the fatality or near fatality occurred. The PD must provide all information required by NRS 432B.175. Public disclosures are to be submitted within 48 hours of a child fatality, and within 5 business days of a child near fatality.
Safety Assessment	An assessment that evaluates family functioning to determine whether there are negative family conditions that are out of control and therefore pose an imminent safety threat (present or impending danger) to a child.
Safety Assessment Conclusion	The conclusion that a child is safe or unsafe based upon the assessment of safety threats, and evaluation of child vulnerability and caregiver protective capacities.
Safety Threat	The following five criteria must apply and be met: 1. Out of control family conditions that can directly affect a child and are unrestrained; unmanaged; without limits or monitoring; not subject to influence, manipulation, or internal power; are out of the family's control. 2. Severity is consistent with anticipated harm that can result in pain, serious injury, disablement, grave/debilitating physical

health conditions, acute/grievous suffering, terror, impairment, or death.

3. Vulnerability is a child who is unable to protect him/herself and dependent on others for protection.
4. Imminence is a belief that threats to child safety could become active at any time; a certainty about occurrence within the immediate to near future.
5. Observable and specific is a family condition that exists as impending danger is observable and can be specifically described or explained; the danger is real; can be seen; can be reported; is evidenced in explicit, unambiguous ways.

Substantiation A report made pursuant to NRS 432B.220 was investigated, and it was determined by a preponderance of the evidence that the abuse or neglect occurred.

Criteria Governing Legislative Auditor Concerns

State laws, regulations, and policies govern how child welfare agencies handle the intake, investigation, and reporting of child fatalities or near fatalities. The following are laws, regulations, or statewide policies related to the deficiencies we observed:

- NRS 432B.175 – requires a public disclosure be issued no later than 48 hours or 5 business days in the event that a child who is the subject of a report of abuse or neglect suffered a fatality or near fatality.
- Nevada Administrative Code (NAC) 424 – governs foster care and requires the following:
    - NAC 424.200 – A licensing agency is to conduct an investigation when it has reason to believe a foster home is not conforming to the conditions of the license or requirements for foster home care. A licensing authority may issue a written notice and require a plan of corrective action, suspend a license, or revoke a license.
    - NAC 424.375 – Foster homes are to maintain certain sleeping accommodations including ensuring an infant sleeps on their back, is not placed on a soft or semisoft surface, and is not allowed to sleep with another person on a bed.
- Nevada Division of Child and Family Services (DCFS) Statewide Policy 0506 – governs the intake process and requires child welfare agency staff respond within 24 hours if impending danger is identified.
- DCFS Statewide Policy 0508 – governs the investigation process and requires the following:
    - Additional allegations of maltreatment that meet screening criteria identified by child welfare staff while conducting an investigation may be added to the current investigation. Alternatively, child welfare staff may create a new report for the additional allegation. Policy states the assigned caseworker must assess for present danger and impending danger continually during the Nevada Initial Assessment process including when new information is learned. It further requires collection of sufficient information which is qualified by enough detail, depth, and thoroughness

to adequately justify judgments and conclusions about the existence of maltreatment, existence of impending danger, quality of caregiver protective capacities, and the vulnerability of children. Collateral contacts are used to reach conclusions regarding maltreatment or impending danger and can include review of medical records.

- Child welfare agency staff must attempt face-to-face contact the next business day from the date of the first face-to-face attempt to contact the child, and each consecutive business day as part of persistent efforts.
- Child welfare agency staff should conduct a sufficient number of interviews of sufficient length and effort necessary to ensure that sufficient information is collected to assess maltreatment, impending danger, caregiver protective capacities, and the needs of children. Information collected and documented must be of sufficient detail, depth, and breadth to adequately answer an assessment question; to provide understanding to a third person; and to justify judgments and conclusions about the existence of maltreatment, the existence of impending danger, the quality and nature of caregiver protective capacities, and the vulnerability of children.
- Child welfare agency staff must interview as many collateral contacts as needed to reach conclusions regarding the alleged maltreatment or impending danger, which must include individuals with knowledge of or who may corroborate information, statements, or evidence regarding the allegations; and can include medical professionals or review of medical records. Case history must also be reviewed.
- Diminished caregiver protective capacities can contribute to a state of danger that a child is routinely exposed to. Impending danger is a result of ongoing diminished caregiver protective capacities resulting in caregivers who are unable or unwilling to provide protection. Alternatively, a child is safe when there are sufficient caregiver protective capacities to control existing threats.
- The purpose of the safety plan is to ensure protection of a child when impending danger is identified. The safety plan must be sufficient to manage and control impending danger based on a high degree of confidence that it can be implemented and sustained. A safety plan describes how impending danger is occurring within the family; safety services, providers, and their suitability to participate; and establishes how impending danger will be managed.

- DCFS Statewide Policy 0510 – governs the safety assessment process and requires the following:
  - Informal safety assessments be conducted throughout the life of the case during child, parent/caregiver, and collateral contacts. Information gathered during informal assessments help inform the caseworker whether the child is safe, if there are any concerns that need to be addressed, and prompts a formal safety assessment to be completed when safety concerns are identified.
  - Reassessment of child safety is required any time a significant event or change occurs that affects the household of a parent of the child or a foster parent or other care provider, and when case closure is imminent.

- DCFS Statewide Policy 0513 – governs the investigation findings and closure process and requires the following:
    - Prior to using the allegation finding of unable to locate, child welfare staff should consider whether a warrant or court order to assess the child is necessary, and must document persistent efforts.
    - Policy outlines types of evidence including direct evidence versus indirect evidence, corroborating evidence, and determining credibility of evidence. Direct evidence includes information provided by an expert and direct observations by the assigned worker. Corroborating evidence can make other evidence more credible by verifying information or providing support from independent sources. Policy specifies that the final step is using all evidence to reach an allegation finding. It states that a report can comprise one or more allegations and each allegation may have a different finding. This finding shall be based upon the information gathered during the investigation and from direct observations made by the assigned caseworker.
    - A caregivers' agreement to accept services should not impact an allegation finding.