STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU
LEGISLATIVE BUILDING
401 S. CARSON STREET
CARSON CITY, NEVADA 89701-4747

RICK COMBS, *Director*
(775) 684-6800

LEGISLATIVE COMMISSION (775) 684-6800
MICHAEL ROBERSON, *Senator, Chairman*
Rick Combs, *Director, Secretary*

INTERIM FINANCE COMMITTEE (775) 684-6821
JOYCE WOODHOUSE, *Senator, Chair*
Mark Krmpotic, *Fiscal Analyst*
Cindy Jones, *Fiscal Analyst*

BRENDA J. ERDOES, *Legislative Counsel* (775) 684-6830
ROCKY COOPER, *Legislative Auditor* (775) 684-6815
SUSAN E. SCHOLLEY, *Research Director* (775) 684-6825

February 16, 2017

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 NRS 218G.550, we reviewed case files provided by child welfare agencies between January 1, 2015, and December 31, 2016.

Results in Brief

Based on our review of the case files provided to us through December 31, 2016, 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. However, we had concern about how one case was handled where agency policy was not followed. The agency took various steps to address the concern and other concerns noted from an internal review and from an external party. The case is discussed further below under the section titled, "Lack of Face-to-Face Contact." 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 A.B. 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, and therefore, they were not conducted in accordance with generally accepted government auditing standards.

Number of Incidents

From January 1, 2015, through December 31, 2016, we reviewed 86 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 58 (67%) 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 58 incidents were caused by other factors such as medical conditions due to congenital medical issues, accidents (motor vehicle and home), and SIDS. 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 Department of Social Services, and the Division of Child and Family Services/DCFS – Rural Region).

Abuse/Neglect Fatalities and Near Fatalities of Children Having Prior Contact With Child Welfare Agency January 1, 2015, to December 31, 2016

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County DFS	13	9	22
Washoe County DSS	2	1	3
DCFS – Rural	1	2	3
Totals	**16**	**12**	**28**

Results From Latest Case Reviews by Legislative Auditor

We reviewed case documentation for the 28 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. 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 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 had concerns about how one case was handled, which is discussed below.

Lack of Face-to-Face Contact

Based on our review of a case for a child who died in 2015 and discussions with agency personnel, we had a concern about how the case was handled by the DCFS Rural Region. Our concern related to the lack of face-to-face contact with the child in the 8 weeks prior to the fatality. Agency policy requires face-to-face contact with children at least once each month. Additional concerns were noted in the Division's internal review of the case after the fatality, as well as a case review performed by an independent contractor. As a result of the concerns identified, the Division took various actions in the Rural Region to improve the quality of services being provided. These actions included policy changes, additional staff training, and management and supervisory changes to address concerns of high turnover and lack of consistency in decision making. We believe the Division took appropriate action to address the concerns noted in the handling of this case. (The Division's written response to our concerns is enclosed.)

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

Please contact Rick Neil or me at (775) 684-6815 if you have any questions regarding this letter.

Sincerely,

Rocky Cooper, CPA
Legislative Auditor

RC:sy
Enclosure
cc: Paula Hammack, Acting Director, Clark County Department of Family Services
Amber Howell, Director, Washoe County Department of Social Services
Richard Whitley, MS, Director, Department of Health and Human Services (DHHS)
Betsy Crumrine, Rural Region Manager, Division of Child and Family Services (DCFS), DHHS
Kelly Wooldridge, Administrator, DCFS, DHHS
Reesha Powell, Deputy Administrator, DCFS, DHHS

BRIAN SANDOVAL
Governor

STATE OF NEVADA

RICHARD WHITLEY
Director

KIRSTEN COULOMBE
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF CHILD AND FAMILY SERVICES
4126 Technology Way – 3rd Floor
Carson City, Nevada 89706
(775) 684-4400

November 9, 2015

Rick Neil, CPA
Audit Division
Legislative Counsel Bureau
401 S. Carson Street
Carson City, NV 89701

Dear Mr. Neil:

Thank you for the opportunity to address the concerns raised upon your review of Division of Child and Family Services (DCFS) case #1396247. As noted in your letter, DCFS has taken many steps to understand the circumstances that lead to the unfortunate outcome in this case and to improve services based on the results of the multiple reviews of the case.

Most of the recommendations in the independent case review indicated a need for more training, which had been previously identified through internal assessment and quality improvement activities in the months leading up to the fatality. As such, the Division implemented such trainings, which are listed below.

Training	Dates
Court Report Writing	11/4/14
Present Danger Consultation	11/5/14 and 11/19/14
Safety Plan Determination	12/31/14 and 1/6/15
Supervisor/Manager Summit	1/28/15 and 1/29/15
Present Danger Planning	2/11/15
NIA Decision Making	3/11/15, 3/25/15 and 7/15/15
Confirming Safe Environments	4/8/15, 4/22/15 and 8/11/15
Present Danger Planning	7/1/15

DCFS feels the recommendation to train staff in the areas of initial assessment, enhancing supervisory skills, and safety planning were met due to the above mentioned

training activities. A second recommendation indicated a family's history should be considered and incorporated into the initial assessment which is the current policy and expectation for DCFS practice. Staff involved in this incident were counselled on this expectation at the time of the incident, and the requirement for quality assessment was addressed in the aforementioned trainings. The final concern noted in the letter was in regard to the lack of face-to-face contact with the child and family in the eight weeks preceding the fatality. The Division was equally concerned as this was in direct violation of policy and procedure. The lack of in-person contact was addressed directly with the staff involved in the incident, and also discussed in the trainings. Such an issue is expected to be reviewed during case consultations between supervisors and workers, and workers must be held accountable when the standards are not met.

The independent case review, and the DCFS assessment, highlighted concerns the DCFS administration had with the supervisory and management structure of the Carson District Office. The identified opportunities for improvement in this situation primarily related to a need to enhance and restructure management of the rural region, and the Carson District Office in particular. Therefore, several management and supervisory changes have occurred in the Carson District Office to address concerns of high turnover and lack of consistency in decision making, which also led to some of the safety concerns noted in the review of this case. Since those changes have occurred, there has been a notable decrease in staff turnover, and staff generally report a more productive work environment, thus allowing for improved case work.

The additional trainings, along with the changes and additions to the staffing levels are believed to be having a positive impact on the quality of services being provided to children and families in the Carson District Office. If there are additional questions or concerns you would like me to address, please feel free to contact me at (702) 486-7712 or jmarano@dcfs.nv.gov.

Sincerely,

Jill Marano, LCSW
Deputy Administrator

Cc: Richard Whitley, Director, DHHS
Kirsten Coulombe, Administrator, DCFS