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THE STATE OF NEVADA
LEGISLATIVE COUNSEL BUREAU

May 19, 2025

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, 2024.

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 (DCFS) - 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 7 of 43 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. For these cases, we found several issues where the child welfare agency's 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) present or impending danger assessments not adequately performed or documented; (2) reports of abuse or neglect not properly screened at intake; (3) other safety threats not mitigated; (4) allegation decision did not adequately reflect significant evidence discovered; (5) insufficient information gathered to assess allegations; (6) home environment not observed; (7) monthly face-to-face child contact not adequately performed or documented; (8) all children in home not properly assessed; (9) caregiver follow-through with services not adequately monitored; and (10) all caregiver protective capacities not adequately assessed.

For calendar year 2024 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 some disagreement with our conclusions. One child welfare agency indicated there were no direct policy violations, but recognized that some concerns stemmed from different interpretations of policy application. While we may differ in interpretation of policy, we feel that our concerns are warranted. For example, in one case the child welfare agency received two reports prior to the near fatality related to the natural mother possessing and wielding a firearm in unsafe circumstances in front of her children. Ultimately, the child obtained

access to an unsecured firearm and suffered a gunshot wound resulting in a near fatality. For the investigation prior to the near fatality, a firearm was noted to be a part of the incident listed in the report of neglect, but the location and security of the firearm was not investigated by the child welfare agency. The child welfare agency responded to our concern with a statement that gun safety education is not required by policy. While this is true, DCFS Statewide Policy 0508 requires that sufficient information is obtained during an investigation to properly assess caregiver protective capacities and child safety. These assessments require observations and contacts to obtain appropriate knowledge. Because the firearm was part of initial allegations in the report, sufficient information should have been gathered relevant to the firearm's location and security.

To improve compliance, the agencies indicated their intent to ensure alignment with statewide policy guidance by conducting a comprehensive review of county and agency policies, identifying areas for clarification or revision, and implementing a refresher training program 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.

Number of Fatality and Near Fatality Incidents

From January 1 to December 31, 2024, we reviewed 74 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. In 31 (42%) of the cases, the child welfare agencies determined that abuse or neglect was not the primary factor in the fatality or near fatality. These 31 incidents were caused by other factors such as conditions due to congenital medical issues, suicide, drug overdoses, or other accidents. The following table provides a breakdown of the remaining 43 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, 2024

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County Family Services	10	28	38
Washoe County Human Services Agency	1	2	3
Division of Child and Family Services - Rural Region	0	2	2
Totals	**11**	**32**	**43**

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

Results From 2024 Case Reviews by the Legislative Auditor

In our review of 43 cases, there were 7 where we expressed concerns to child welfare agency officials about how the cases were handled. A summary of our concerns is explained further below, along with a summary of the agencies' responses to our concerns, including actions the agencies have taken to reduce the risk of these issues occurring in the future.

Based on our reviews, we observed child welfare agencies did not always comply with laws or statewide policies. For additional information regarding child welfare agency criteria, 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 shows a count of cases by area of noncompliance and jurisdiction.

Legislative Auditor Concerns by Issue and Child Welfare Agency
January 1 to December 31, 2024

Deficiency	Clark County Family Services	Washoe County Human Services Agency	Division of Child and Family Services Rural Region	Totals
Present or Impending Danger Assessments Not Adequately Performed or Documented[1]	1	1	0	2
Reports of Abuse or Neglect Not Properly Screened at Intake	1	1	0	2
Other Safety Threats Not Mitigated	2	1	0	3
Allegation Decision Did Not Adequately Reflect Significant Evidence Discovered	1	1	0	2
Insufficient Information Gathered to Assess Allegations	2	0	0	2
Home Environment Not Observed	1	0	0	1
Monthly Face-to-Face Child Contact Not Adequately Performed or Documented[1]	1	0	0	1
All Children in Home Not Properly Assessed	1	0	0	1
Caregiver Follow-Through With Services Not Adequately Monitored	1	0	0	1
All Caregiver Protective Capacities Not Adequately Assessed[1]	1	1	0	2
Totals by Jurisdiction	**12**	**5**	**0**	**17**

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 2023.

As stated before, we had concerns with the handling of seven cases. However, during our review of these cases several deficiencies were sometimes observed, which resulted in the higher number of deficiencies by type reported above.

Legislative Auditor Not Notified of Several Incidents

During the year, we became aware of 44 cases of fatalities or near fatalities where the child welfare agency had prior contact with the child, but the agency did not notify our office of the fatalities or near fatalities as required. After further inquiry, we were provided a list of an additional 70 cases that required notification to our office per NRS 218G.550. These cases were not provided initially because the child welfare agency did not issue a public disclosure, which was previously used as the means of notifying our office. The agency indicated public disclosures should be limited to those cases where there is a nexus between the abuse and neglect of a child and the fatality or near fatality of that child. However, this interpretation of law governing public disclosures does not supersede the requirement to notify the Legislative Auditor. Notification is required regardless of the outcome of any investigation of a fatality or near fatality of a child if the child had prior contact with the child

welfare agency. Because these cases were not provided timely, we did not review the additional 114 cases in 2024. We will continue communication with the child welfare agency to ensure proper case notification.

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: Richard Whitley, M.S., Director, Department of Health and Human Services (DHHS)
Marla McDade Williams, Administrator, Division of Child and Family Services (DCFS), DHHS
Beverly Brown, LMSW, Social Services Chief II, DCFS, DHHS
April Stahl, Social Services Program Specialist III, DCFS, DHHS
Audit Liaison, Director's Office, DHHS
Frank Prado, Director, Clark County Family Services
Ryan Gustafson, Director, Washoe County Human Services Agency

Attachment A

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 218G.550 – requires child welfare agencies to notify the Legislative Auditor of all fatality and near fatality cases in which the child welfare agency had prior contact with the child.
- Division of Child and Family Services (DCFS) Statewide Policy 0205 – establishes standards for caseworker contact and requires, at a minimum, monthly face-to-face in-person contact with the child in the family home or out-of-home placement.
- DCFS Statewide Policy 0506 – governs the intake process and requires the following:
    - Child welfare agency staff must respond within 24 hours if impending danger is identified. Impending danger is defined as 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.
    - Child welfare agency staff should document information collected from a reporting party in a Unified Nevada Information Technology for Youth (UNITY) referral screen as soon as reasonably practicable.
    - Policy allows for the same information regarding the same incident to be added as additional information to the same report. However, it does not specify that additional information from the same incident with additional allegations is added to the same report.
- DCFS Statewide Policy 0508 – governs the investigation process and requires the following:
    - Child welfare agency staff must develop a present danger plan any time present danger is identified. A present danger plan is an immediate, short term, specific plan that will manage the present danger and family conditions and behaviors to ensure child safety during the Nevada Initial Assessment (NIA) process.
    - Child welfare agency staff must review UNITY case history and records related to the family as part of the NIA process.
    - Child welfare agency staff must use first-hand observations when assessing for present danger.
    - Individual in-person interviews should be conducted with caregivers in the home and the home environment should be observed during the assessment period.
    - 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.

  - A child is determined to be unsafe if there is impending danger, which is the result of ongoing diminished caregiver protective capacities resulting in caregivers who are unable or unwilling to provide protection.

- DCFS Statewide Policy 0510 – governs the safety assessment process and requires that formal safety assessments must occur any time a significant event or change occurs that affects the household and when there is indication that the safety of the child may be jeopardized.
- DCFS Statewide Policy 0513 – governs the investigation findings and closure process and requires the following:
  - 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 worker.
  - Criteria for evidence includes determining credibility of evidence, quality of evidence, corroboration of evidence, and weighing direct versus indirect sources of information. Direct interest and motivation of collaterals is also to be considered. Policy specifies that the final step is using all evidence to reach an allegation finding.
  - A caregiver's agreement to accept services should not impact an allegation finding.