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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 the child welfare agencies between January 1, 2021, and December 31, 2022.

Results in Brief

In 27 of 69 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 statutes, regulations, and statewide policies. Areas of concern observed during our review of cases included: (1) child protective services history in other states not properly reviewed when known; (2) all children in home not properly assessed; (3) present or impending danger assessments not adequate; (4) all caregivers or caregiver capacity not adequately assessed; (5) additional allegations or information not investigated; (6) reports of abuse or neglect not properly screened at intake; and (7) public disclosures not prepared or fatalities and near fatalities not reported to Legislative Auditor.

After expressing our concerns, child welfare agency officials indicated corrective action was performed to reduce the risk of these issues occurring in the future. Additional information is provided below concerning the number of fatalities and near fatalities, the results of our case reviews, and agencies' corrective actions.

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.

Number of Fatality and Near Fatality Incidents

From January 1, 2021, through December 31, 2022, we reviewed 137 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 68 (50%) of the cases, the child welfare agencies determined that abuse or neglect was not the primary factor in the fatality or near fatality. These 68 incidents were caused by other factors such as conditions due to congenital medical issues, SIDS, co-sleeping, drug ingestion, suicide, or other accidents. The following table provides a breakdown of the remaining 69 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 (Clark County Department of Family Services [DFS], Washoe County Human Services Agency [HSA], and the Division of Child and Family Services [DCFS] – Rural Region).

Abuse or Neglect Fatalities and Near Fatalities of Children Having Prior Contact With Child Welfare Agency January 1, 2021 to December 31, 2022

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County DFS	26	36	62
Washoe County HSA	1	3	4
DCFS – Rural Region	1	2	3
Totals	**28**	**41**	**69**

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

Results From 2021 and 2022 Case Reviews by the Legislative Auditor

In our review of 69 cases, there were 27 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, regulations, and statewide policies. 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, 2021 to December 31, 2022

Deficiency	Clark County DFS	Washoe County HSA	DCFS Rural Region	Totals
Child Protective Services History In Other States Not Properly Reviewed When Known	1	0	0	1
All Children in Home Not Properly Assessed	3	1	0	4
Present or Impending Danger Assessments Not Adequate	13	2	0	15
All Caregivers or Caregiver Capacity Not Adequately Assessed	10	1	0	11
Additional Allegations or Information Not Investigated	0	3	0	3
Reports of Abuse or Neglect Not Properly Screened at Intake	1	0	0	1
Public Disclosures Not Prepared or Fatalities or Near Fatalities Not Reported to Legislative Auditor	0	0	6	6
Totals by Jurisdiction	**28**	**7**	**6**	**41**

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

As stated before, we had concerns with the handling of 27 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.

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 policy related to the deficiencies we observed:

- NRS 218G.550 (1) — requires a child welfare agency to notify the Legislative Auditor any time a child who has had contact with, or who has been in the custody of, an agency which provides child welfare services suffers a fatality of a near fatality. In addition, the child welfare agency must forward any files, notes, or other relevant information concerning the child and manner in which the case was handled.

- NRS 432B.175 (1) — requires certain information related to reports and investigations of child fatalities and near fatalities be made public when abuse or neglect is suspected, and no later than 48 hours after a fatality or 5 business days after a near fatality.

- NAC 432B.180 — requires an assessment of risk to a child as part of each significant decision made in a child welfare case. This assessment must be future-oriented rather than based solely on the child's injuries or current condition.

- DCFS Statewide Policy 0508 — governs the investigation process and requires the following:

    - All children in the home must be interviewed, in person, and outside the presence of caregivers.

    - All caregivers or adults in the home with decision making responsibilities must be interviewed individually and in person.

    - When assessing a caregiver's capacities, child welfare agency staff must collect and document enough information to support the judgment made about the caregiver's protective capacities.

    - In addition to law enforcement records and other pertinent information, out-of-state child protective services history records should be reviewed, if this information is known.

    - Child welfare agency staff must assess for present danger at the initial contact and continually during the investigation process including, but not limited to, any contact with the family, when new information is learned, and when a new screened-in report is received within the first 30 days of the current investigation. The present danger assessment must be documented.

    - 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.

During the biennium, we issued five letters to child welfare agencies to express our concerns to management. The child welfare agencies indicated employee turnover and lack of training contributed to the noncompliance reported. To improve compliance, the agencies indicated various policies and procedures have been updated, additional training provided, and new procedures created. 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.

We would like to express our appreciation to personnel at Clark County DFS, Washoe County HSA, and DCFS – Rural Region for their cooperation, and recognize their continued efforts to protect vulnerable children in our State.

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

Sincerely,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
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