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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 and December 31, 2023.

Results in Brief

In 4 of 38 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 regulations or statewide policies. Areas of concern observed during our review of cases included: (1) safe sleep assessments and education not adequately performed or documented; (2) present or impending danger assessments not adequately performed or documented; (3) all caregivers or caregiver capacity not adequately assessed; (4) monthly face-to-face in-person visits with child not adequately performed or documented; and (5) reassessment of child safety not adequately performed or documented.

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 the agency's 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 to December 31, 2023, we reviewed 56 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 18 (32%) of the cases, the child welfare agencies determined that abuse or neglect was not the primary factor in the fatality or near fatality. These 18 incidents were caused by other factors such as conditions due to congenital medical issues, suicide, or other accidents. The following table provides a breakdown of the remaining 38 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 to December 31, 2023

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County DFS	14	20	34
Washoe County HSA	1	2	3
DCFS Rural Region	1	0	1
Totals	**16**	**22**	**38**

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

Results From 2023 Case Reviews by the Legislative Auditor

In our review of 38 cases, there were 4 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 agency's responses to our concerns, including actions the agency has taken to reduce the risk of these issues occurring in the future.

Based on our reviews, we observed a child welfare agency did not always comply with regulations or 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 to December 31, 2023

Deficiency	Clark County DFS	Washoe County HSA	DCFS Rural Region	Totals
Safe Sleep Assessment and Education Not Adequately Performed or Documented	1	0	0	1
Present or Impending Danger Assessments Not Adequately Performed or Documented [1]	3	0	0	3
All Caregivers or Caregiver Capacity Not Adequately Assessed [1]	3	0	0	3
Monthly Face-to-Face In-Person Visits With Child Not Adequately Performed or Documented	1	0	0	1
Reassessment of Child Safety Not Adequately Performed or Documented	2	0	0	2
Totals by Jurisdiction	**10**	**0**	**0**	**10**

Source: Auditor compilation based on records provided by child welfare agencies.
[1] Similar concerns noted in our review of case files from January 2021 to December 2022.

As stated before, we had concerns with the handling of four 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 regulations or statewide policy related to the deficiencies we observed:

- NAC 432B.185 – requires an agency to reassess safety any time, as determined by the agency, there is an indication that the safety of the child may be jeopardized.

- DCFS Statewide Policy 0205 – establishes standards for caseworker contact and requires monthly face-to-face in-person contact with the child in the family home or out-of-home placement.

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

    - Child welfare agency staff must assess for present danger at the initial contact and continually during the assessment process including, but not limited to, any contact with the family, when new information is learned, when a new screened-in report is received, when there is a reported crisis, or other indication of present danger. The present danger assessment must be documented.

    - When assessing present danger, the children's age, accessibility to a threatening person, and history of reports should be considered.

  - 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.

  - All activities conducted by workers are to be documented in UNITY.

  - 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 safety must be reassessed through a safety assessment any time there is an indication that a child's safety may be jeopardized.

- DCFS Statewide Policy 0513 – governs the investigation findings and closure process and requires the following:

  - Investigation findings are to be determined based on evidence collected. Corroborating evidence can make other evidence more credible by verifying information or by providing support from independent sources.

  - Factors that should not impact an allegation finding include whether the incident was isolated, the caregiver's intent to harm the child, or if the caregiver agrees to accept services from the agency.

- DCFS Statewide Policy 0518 – pertains to issues of safe sleep conditions in households/families and requires the following:

  - Child welfare workers must inspect the home and assess the sleep environment during an initial assessment or any time the worker is in the home where an infant between birth and age one resides. This must be documented in case notes.

  - Subsequent home visits should include assessment and education of safe sleep which should also be documented in case notes.

For calendar year 2023 cases reported to the Legislative Auditor, we issued a letter to a child welfare agency to express our concerns to management about how several cases were handled. The child welfare agency indicated a lack of clarification and training contributed to the noncompliance reported. To improve compliance, the agency indicated its intent to perform a review of overall practices, regular case reviews, supervisory consultations, and continuing training efforts. 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 Jennifer Otto, Audit Manager, or me at (775) 684-6815 if you have any questions regarding this letter.

Sincerely,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
cc: Richard Whitley, M.S., Director, Department of Health and Human Services (DHHS)
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