*ACTION PLAN FOR THE WASHOE COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

Please note that this action plan specifically addresses Washoe County recommendations only.

RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 1. Clarify and if necessary strengthen state laws and policies regarding definitions for abuse and neglect in fetal and infant deaths caused in part by maternal drug use or other lifestyle issues that could cause harm to infants.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	County Workgroup: Mike Capello or designee (WCDSS); Dick Gammick or designee (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Medical Examiner's Office); Kristen Erickson Ben Graham State: Marji Walker	Bill draft language will be reviewed by Washoe County.	1.1 Analyze recommendation for feasibility. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible, 1.2 AG's Office in collaboration with DA draft Bill Request. 1.3 Submit bill request to DHHS for review. 1.4 DHHS to submit to LCB in accordance with scheduling requirements. If appropriate: Revise PIP Policy. Substantiation Guidelines. 1.5 Review new PIP policies for revision. Establish action plan to accomplish the following: 1.6 Initiate revision process as determined necessary. 1.7 Analyze existing curriculum for revision and revise as determined necessary. 1.8 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 1.9 Initiate revised Training Plan. 1.10 Establish QI monitoring process and feedback loop.	COMPLETED. Bill passed by the 2007 Nevada Legislature.	BDRs	n/a

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A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 2. Clarify and if necessary strengthen state law and policy to require mandatory reporting to CPS when a child dies due to part to neglect or abuse, even though there are no surviving siblings, and provide training on this to mandatory reporters.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	County Workgroup: John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Dick Gammick or designee (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Medical Examiner's Office); State: Marji Walker Kristen Erickson Ben Graham	Bill draft language will be reviewed by Washoe County.	2.1 Establish MOU that outlines purpose, roles and responsibilities noted in this recommendation in conjunction with the child welfare decision-making group 2.2 Convene a statewide workgroup to research and analyze this recommendation to report back to the decision - making group. Establish an action plan to accomplish the following: 2.3 Develop strategies to facilitate law and policy changes If appropriate: 2.4 Assess legal capability. 2.5 Establish countywide Law Enforcement Policy Team. 2.6 Develop county policy. 2.7 Complete policy approval Process. 2.8 Curriculum development. 2.9 Training. 2.10 Establish QI monitoring process and feedback loop. 2.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to DCFS Administrative Team	COMPLETED. Bill passed by the 2007 Nevada Legislature.	BDRs	n/a

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A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 3. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.	Interagency Collaboration Action	State: Marji Walker Social Services: Jeanne Marsh and Kim Schweickert	County Workgroup: John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Dick Gammick or designee (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Medical Examiner's Office);		3.1 Evaluate current training for mandatory reporters. 3.2 Identify trainee group and training needs 3.3 Convene curriculum development group 3.4 Revise curriculum 3.5 Establish training plan	DCFS 3.1: The current mandated reporter training was reviewed and evaluated on March 7, 2007, by the Division of Child and Family Services training and grants management team. The training is based on the Signs and Symptoms of Child Abuse and Neglect course, and uses *The Reporting Child Abuse and Neglect Handbook*, which was updated August 2006. The training is available to the public and consideration is being made for the training to be web-based and placed on the State's website to increase accessibility. DCFS 3.2: The trainee group is identified as "required" or mandated reporters listed in NRS 432B.220. These required reporters include professionals, like a physician, podiatrist, nurse, physician's assistant, hospital personnel, coroner, medical examiner, clergymen, attorney, social worker, psychologist, probation officer, teacher, librarian of a school, school counselor, persons licensed to conduct a foster care home, persons who work with children in any public facility, volunteers who work with children, and other professionals. Training needs have been identified for such professionals. DCFS 3.3: The curriculum development group was convened on April 4, 2007, with the goals to develop the training, fiscal spending plan, and web-based	New curriculum Training Roster Evaluation Report	3.1 3/31/07 3.2 4/30/07 3.3 5/31/07 3.4 6/30/07 3.5 7/31/07

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						curriculum. DCFS 3.4: The original curriculum was reviewed and revisions are being made to accommodate web-based training. DCFS 3.5: COMPLETED. An online course will be offered on the Nevada Training Partnership for Training website. The course, which can be taken in about an hour from any computer with internet access, covers the history of the law, national and state mandates for reporting, how to recognize abuse, and how to file a report. The course is required for all DCFS employees; however, the target audience of mandatory reports extends far beyond DCFS, and includes school personnel, health care workers, law enforcement officers, and many others. An extensive marketing campaign to target mandated reporters is underway including statewide dissemination of postcards, posters, and a press release for news story. The course will remain online indefinitely and updated as necessary. WCDSS 3.2: WCDSS conducted mandated reporting training to approximately 200 school nurses and counselors and is scheduled to conduct training with Washoe County Sheriff's Office Detectives on May 9, 2007. Additionally, staff are currently working with each law enforcement agency (Reno Police Department, Sparks Police		

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						Department and Sheriff's Office) to conduct 28 briefing with patrol officers during the months of May and June. WCDSS 3.5: COMPLETED. WCDSS staff trained school counselors, child care staff, and all three local law enforcement agencies regarding mandated reporting during the spring/early summer 2007. Additionally, WCDSS partnered with Prevent Child Abuse (PCA) Nevada to train various members of the community in a statewide initiative to provide mandated reported training via videoconference. WCDSS and PCA Nevada intend to offer this training at least once more in the next fiscal year. The Washoe County Strategic Plan requires WCDSS to conduct a minimum of 30 trainings per year which may include mandated reporter requirements. Additionally, staff may begin to access the newly-available DCFS online training.		
A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 4. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Child Advocacy Center model.	Inter-Agency Collaboration	District Attorney: Dick Gammick or designee WCDSS: Mike Capello or designee	County Workgroup: Dick Gammick or designee (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Medical Examiner's Office)	Washoe County received a HUD appropriation and has broken ground to build a comprehensive center to respond to both adult and child sexual assault cases. The adult program is known as SART and the children's program is known as CARES. Washoe County has a strong	4.1 Determine the feasibility of the recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish an action plan to accomplish the following: 4.2 Determine fiscal impact and	WCDSS 4.1 and 4.2: Washoe County has an interest in exploring future expansion of the facility/program to form a child advocacy center. A physician currently working with the existing program, Dr. Cathy Wagoner, has extensive experience and is interested in pursuing a fellowship as a forensic pediatrician.		4.1 3/31/07 4.2 6/30/07 Action plan

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				partnership with the Northern Nevada Medical Center who donated the land to build the facility.	budget capability. 4.3 Determine staffing impact and budget capability. 4.4 Determine availability of grants to support recommendation and submit proposal. 4.5 Submit budget request to County Commissioners.	Current Washoe County funding limitations will prevent developing an independent center until at least 2010. Limited assessment services will continue to be provided by Dr. Wagoner.		
A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 5. Identify funding for and recruit a trained forensic pediatrician.	Inter-Agency Collaboration	District Attorney: Dick Gammick or designee WCDSS: Mike Capello or designee	District Attorney: Dick Gammick or designee WC Manager's Office: John Berkich State: Chris Lovass-Nagy	Washoe County will work with Drs. Cathy Wagoner, Ellen Clark, and Kathy Raven to consult on child abuse and neglect cases as requested.	5.1 Determine the feasibility of the recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish an action plan to accomplish the following: 5.2 Determine fiscal impact and budget capability. 5.3 Determine availability of grants to support recommendation and submit proposal. 5.4 Submit budget request to County Commissioners.	WCDSS 5.1: Northern Nevada Medical Center has been an active partner in recruitment of physicians. Dr. Cathy Wagoner currently is involved with the CARES program. Dr. Wagoner has experience and is willing to participate in a fellowship to become a forensic pediatrician. WCDSS 5.2: WCDSS and the District Attorney's submitted a jointly prepared a proposal for the Board of County Commissioners (BCC) to hire a pediatrician. Dr. Cathy Wagoner is interested in the position. It is Dr. Wagoner's intention to become trained as a forensic pediatrician. The BCC will hear this matter on August 14, 2007. WCDSS 5.3 and 5.4: COMPLETED. The BCC did approve the position and Dr. Wagoner began employment December 31, 2007.		5.1 3/31/07 5.2 6/30/07 Action Plan

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 1. The state should adopt, provide training on and enforce the utilization of the new national guidelines for Sudden and Unexplained Infant Death Investigation and provide training throughout the state to law enforcement and death investigators. These guidelines include reenactment of the death event using dolls.	Inter Agency Collaboration	Medical Examiner: Ellen Clark, M.D.	County Workgroup: Mike Capello or designee (WCDSS); Dick Gammick or designee (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Medical Examiner's Office); Other Medical Examiners	The Coroner's Office has initiated a daily reporting process to CPS of all deaths of children. In addition a reporting form has been developed to transmit detailed information on suspicious cases.	1.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 1.2 Determine fiscal impact and budget capability. 1.3 Determine staffing impact and budget capability. 1.4 Determine availability of grants to support recommendation and submit proposal. 1.6 Submit budget request to County Commissioners.	Coroner 1.1: Per discussion with Rural and other Nevada agencies at State Training Seminars (held 09/17, 18, 25, and 27) a protocol has been developed by the Clark County Coroner's Office, to be presented at the 10/18/07 rural CDR process meeting. Washoe and rural counties should consider using this format and protocol **rather than rewriting a second "Northern State Protocol"** (pending receipt from Clark County – presentation set for 10/18/07). Coroner 1.2 through 1.6: COMPLETED. Nevada sent a delegation of six specialists in child death investigation to a CDC-funded national SUIDI Train-the-Trainer week- long course in Seattle, WA (May 12-16, 2008). This delegation, headed by Medical Examiner Dr. Katherine Raven, includes representatives from Clark and Washoe Counties, who will return to present training throughout Nevada using curricula and materials gleaned from the national SUIDI program course and case experience, commencing in 2008. Clark County protocols (referenced in 1.1 above) were area specific, and not adaptable to much of rural Nevada. Clark County sponsored several excellent courses through their Coroner's Office. Washoe County anticipates offering additional courses for Northern Nevada and rural agencies.		1.1 3/31/07 1.2 6/30/07 Action Plan

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 2. Two cases of possible abuse and/or neglect should be submitted to the district attorney's office for review and further investigation conducted.	Legal/Law/Policy and Procedure Action	District Attorney: Dick Gammick or designee	District Attorney: Dick Gammick or designee Law Enforcement: representation to be determined depending upon jurisdiction upon receipt of individual case names.		2.1 Obtain case names from the national expert panel. 2.2 Evaluate recommendation. 2.3 Review cases 2.4 Develop plan of action in response to the recommendation.	After extensive correspondence, the cases still have not been identified. No further action contemplated.		2.1 2/28/07 2.2 4/30/07 2.3 6/30/07 2.4 8/31/07
B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 3. Law enforcement should establish a policy to notify CPS on every child death they investigate, regardless of cause and manner.	Inter Agency Collaboration	Law Enforcement: Dave Evans, Reno Police Department, Kim Myers, Washoe County Sheriff's Office, Sylvia Redmond, Washoe County Sheriff's Office, Steve Fiori, Sparks Police Department. Social Services: Michelle Lucier, Washoe County Social Services; Dorothy Meline, Washoe County Social Services	District Attorney: Dick Gammick or designee WCDSS: Mike Capello or designee Law Enforcement: Reno Police Department (RPD); Sparks Police Department (SPD); Washoe County Sheriff Office (WCSO)	Through Child Protection Enforcement Team (CPET) all law enforcement agencies were provided with pocket cards to guide field officers in decision-making. In addition CPET provided training on child abuse and neglect to all LEA officers last year.	3.1 Clarification is needed regarding "notify" versus "report" from the national expert panel. 3.2 Designate multidisciplinary policy team members to develop policy. 3.3 Convene policy team 3.4 Analyze existing policy 3.5 Develop new or modified policy 3.6 Develop a training plan	WCDSS 3.1: In a conference call conducted March 27, 2007, with members of the National Panel, it was clarified that the intent of this recommendation was to have a practice of notifying CPS of all investigated child deaths versus a policy. All three LEA's confirmed that CPS will be notified of all investigated child deaths. One agency, the Reno Police Department, is co-located with CPS and has initiated investigations with CPS as a first responder. WCDSS 3.2, 3.3, and 3.4: The Child Protection Enforcement Team (CPET) agreed to review and recommend standard protocol between law enforcement and WCDSS. Protocols have been researched and distributed to committee members. WCDSS 3.5 and 3.6: Policy review was started by a subcommittee of the Child Protection Enforcement Team in September, 2007. Polices and procedures regarding notification to	New Policy	3.1 2/28/07 3.2 3/31/07 3.3 4/30/07 3.4 5/31/07 3.5 6/30/07 3.6 7/31/07

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						CPS on all child related deaths are still being compiled and researched. The Subcommittee did review and consider the guidelines established by the Southern Nevada Child Fatality Task Force (SNCFTF), but they were not adaptable based on Washoe County's needs. Once uniform policies and procedures are finalized, staff will be trained. Notifications are ongoing while the policies and procedures are being developed. Additionally, it is the practice of the DA's Office to make referrals to WCDSS for cases involving child death.		
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 1. Establish a state level study group and consult with experts from the national Association of Medical Examiners and the U.S. Centers for Disease Control to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system. This would allow for oversight on death investigation and certification to physicians rather than lay appointees.	Agency Technical	Medical Examiner: Ellen Clark, M.D., other Medical Examiners	District Attorney: Dick Gammick or designee Washoe County will reconvene the Coroner/Medical Examiner Transition Panel	Analysis of this recommendation was initiated prior to the national expert panel review process. Key considerations include issues and differences faced by large counties and rural counties with this type of system and the type of funding and personnel support necessary. Statutory language will require review and modification, as appropriate.	1.1 Determine the feasibility of the Recommendation for statewide implication. If feasible, establish an action plan to accomplish the following: 1.2 Determine fiscal impact and budget capability. 1.3 Determine staffing impact and budget capability. 1.4 Determine availability of grants to support recommendation and submit proposal. 1.5 Submit budget request to County Commissioners.	COMPLETED. This was implemented in Washoe County on July 1, 2007.		1.1 3/31/07 1.2 7/31/07 Action Plan

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 2. All Children in state custody should have full death investigations through the coroner's office, regardless of suspected cause and manner.	Agency Technical	Medical Examiner: Ellen Clark, M.D. District Attorney: Dick Gammick or designee	County Workgroup: Dick Gammick or designee (DA); Mike Capello or designee (WCDSS); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office); Other Medical Examiners State: Marji Walker	Clarification is made to this recommendation in interpreting the phrase "state custody" in the recommendation to mean "governmental agency" custody. Further discussion about the need for "automatic" full death scene investigation is under discussion. With the implementation of the Medical Examiner model further discussion about the feasibility will need to occur.	2.1 Obtain individual case names in order to determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 2.2 Determine fiscal impact and budget capability. 2.3 Determine staffing impact and budget capability. 2.4 Determine availability of grants to support recommendation and submit proposal. 2.5 Submit budget request to County Commissioners. 2.6 Develop policy 2.7 Implement policy	Coroner 2.1 and 2.2: There are few cases of this type, therefore no substantial fiscal impact is anticipated. Will re-assess after one year of new policy practice. Coroner 2.6: Policy development by Forensic Pathologists and Medical Examiners is in process. All reported cases will be reviewed by the Medical Examiner. Most will require an autopsy. Coroner 2.7: Implementation pending management change on July 9, 2007. Coroner 2.6 and 2.7: COMPLETED. Cases are investigated and reviewed by Medical Examiners. Disposition is case specific, with full review at local CDR team.		2.1 3/31/07 2.2 7/31/07 Action Plan
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 3. Cause of death statements should always be listed by forensic pathologist on autopsy reports, prior to review by the coroner's office.	Agency Technical	Washoe County will reconvene the Coroner/Medical Examiner Transition Panel Medical Examiner: Ellen Clark, M.D.	Medical Examiner: Ellen Clark, M.D., other Medical Examiner designees	The Sheriff/Coroner system in rural counties present several concerns in reference to this recommendation and will be addressed in the rural region action plan.	3.1 Assess current practice 3.2 Review existing policy and protocol. 3.3 Modify or write new policy 3.4 Implement policy	WCDSS 3.1: The transition to the Medical Examiner model will resolve this issue. Coroner 3.3 and 3.4: Forensic Pathologist and Medical Examiner will write COD and MOD statements, and prepare and sign death certificates. Implementation is scheduled for July 9, 2007. WCDSS 3.1 through 3.4: COMPLETED.	New Policy	3.1 3/31/07 3.2 6/30/07 3.3 9/30/07 3.4 12/31/07

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 4. Coroner should not change cause and/or manner statements from forensic pathologists without first meeting with pathologists to address scene circumstances and autopsy together prior to certification and consider a mechanism to also have a deputy coroner available to "sign off" on all cases.	Agency Technical	Medical Examiner: Ellen Clark, M.D. District Attorney: Dick Gammick or designee	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners District Attorney: Dick Gammick or designee	Review of this issue involved a single case in which transitional language was subsequently developed.	4.1 Assess current practice 4.2 Review existing policy and protocol. 4.3 Modify or write new policy 4.4 Implement policy	WCDSS: COMPLETED. Coroner: COMPLETED. Change in process through ordinance and office structure revisions.	New Policy	4.1 3/31/07 4.2 6/30/07 4.3 9/30/07 4.4 12/31/07
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 5. Establish improved communication and collaboration between the coroner and pathologists, and between coroner and CPS and law enforcement. Recommend that all deputy coroner investigative reports to the pathologists include mention of CPS and law enforcement involvement, as this information must be provided to the pathologist prior to death certification. The pathologist should not be working in a vacuum.	Inter Agency Collaboration	Law Enforcement: Dave Evans, Reno Police Department, Sylvia Redmond, Washoe County Sheriff's Office, Steve Fiori, Sparks Police Department. Medical Examiner: Ellen Clark, M.D.; other Medical Examiners WCDSS: Mike Capello or designee	County Workgroup: Mike Capello or designee (WCDSS); Dick Gammick or designee (DA); Ellen Clark, M.D. (Medical Examiner's Office)	The transition to the Medical Examiner model will resolve this issue. In addition the Corners office and the Pathologists have implemented an expanded and timely case staffing process to insure information is shared.	5.1 County Management to convene multidisciplinary workgroup to review issues of this recommendation and conduct assessment to determine validity of the recommendation. 5.2 County Management to facilitate development of a plan of action to address recommendation. 5.3 Determine need to establish MOU. 5.4 Develop MOU, as determined 5.5 Implement MOU	Coroner: COMPLETED. Implementation pending approval by local county supervisors. WCDSS 5.1 through 5.5: COMPLETED. Approved by Washoe County Board of County Commissioners effective July 1, 2007.	Workgroup convened MOU	5.1 3/31/07 5.2 4/30/07 5.3 6/15/07 5.4 As determined 5.5 As determined

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 6. Allot time and money to allow death investigators to attend local, regional, state and national trainings and meetings.	Agency Technical	Medical Examiner: Ellen Clark, M.D.	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners District Attorney: Dick Gammick or designee	Seven out of ten investigators have national credentials; some training is self-funded; funds were provided from past legislative efforts for training. Training and funding is needed in the rural counties.	6.1 Determine training needs 6.2 Determine fiscal impact and budget capability. 6.3 Determine availability of grants to support recommendation and submit proposal. 6.4 Submit budget request to County Commissioners, as appropriate.	Coroner: The Coroner's office disagrees with the finding as it pertains to Washoe County. Efforts will continue to ensure future training opportunities for the staff.		6.1 6/30/07 6.2 8/31/07 6.3 10/31/07 6.4 12/31/07
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 7. Comprehensive toxicology testing and metabolic studies (e.g., Pediatrix) should be conducted rather than the basic panel tests currently being conducted, on most infants and children under the age of 18 years.	Agency Technical	Medical Examiner: Ellen Clark, M.D.	Ellen Clark, M.D. Medical Examiners District Attorney: Dick Gammick or designee	This is viewed as a policy issue and in reviewing most of the cases in this review had full toxicology testing, but some did not. Under the Medical Examiner model there are plans to expand the pool of cases that would receive such testing.	7.1 Assess current practice 7.2 Review existing policy and protocol. 7.3 Modify or write new policy 7.4 Determine fiscal impact and budget capability. 7.5 Submit budget request to County Commissioners 7.6 Implement policy	Coroner 7.1 through 7.6: Pediatrix and comprehensive drug testing are conducted on every infant death for Washoe County and those referred from other counties, as internal office protocol. Written procedure is still under development. Procedure document completion date is now set for 12-21-2007. Coroner 7.1 through 7.6: COMPLETED. Toxicology and metabolic screens are conducted on all unexplained infant deaths and for the majority of cases under 18 years, unless circumstances preclude, i.e., prolonged hospitalization, specimen not available.		7.1 2/28/07 7.2 3/31/07 7.3 5/31/07 7.4 6/30/07 7.5 7/31/07 7.6 9/30/07
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 8. Neuropathology consultation on formalin fixed brains should be obtained especially on potential abusive head injury deaths and for instances of hypoxic/ischemic encephalopathy.	Agency Technical Action	Medical Examiner: Ellen Clark, M.D.	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners District Attorney: Dick Gammick or designee	This decision will be evaluated by the Medical Examiner on a case-by-case basis. However, one of the Medical Examiners will be trained in neuropathology.	8.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 8.2 Determine fiscal impact and budget capability. 8.3 Determine staffing impact and budget capability. 8.4 Submit budget request.	Coroner: COMPLETED. A neuropathology specialist, Dr. Katherine Raven, will be locally available to evaluate cases. Most will not require a formal independent consultation. Cost for special stains may be as high as $600 per case (estimate 3 such cases annually). Cases that need formal consultation	Action Plan QI Report	8.1 3/31/07 8.2 7/31/07 Action Plan

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					8.5 Establish Policy Team 8.6 Develop county policy. 8.7 Complete policy approval process. 8.8 Complete the training delivery process. 8.9 Establish QI monitoring process and feedback loop. 8.10 Establish reporting requirements and reporting responsibilities	will be billed at $1,200 each by neuropathology at the Office of the Medical Investigator (OMI) in Albuquerque, NM (estimate 3 such cases annually). These costs will be absorbed by the contract budget allowance (already factored into pro-forma). Implemented Summer, 2007. Coroner: COMPLETED. Other off-site neuropathologists are also now available for referrals, at a similar cost.		
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 9. Consider using terms on death certificate other than SIDS, such as "sudden unexplained death in infancy/undetermined" when intense petechiae, CPS issues, co-sleeping or other unsafe sleep environment issues are present.	Agency Technical	Medical Examiner: Ellen Clark, M.D.	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners District Attorney: Dick Gammick or designee	The transition to the Medical Examiner model will resolve this issue as there will be a standardization of death certification processes in Washoe County. Note this seems to relate to a single case in 2002.	9.1 Assess current practice 9.2 Review existing policy and protocol. 9.3 Modify or write new policy 9.4 Develop a training plan	Coroner: COMPLETED. Forensic Pathologist and Medical Examiner will write COD and MOD statements, and prepare and sign death certificates. Implemented July, 2007.		9.1 3/31/07 9.2 4/30/07 9.3 5/31/07 9.4 6/30/07

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 10. Re-open for investigation at least one case.	Agency Technical	Medical Examiner: Ellen Clark, M.D. District Attorney: Dick Gammick or designee	Ellen Clark, M.D.; Medical Examiners District Attorney: Dick Gammick or designee Law Enforcement: representation to be determined depending upon jurisdiction upon receipt of individual case names.	WCDSS policy "INVESTIGATION, STATE NOTIFICATION AND UNITY DOCUMENTATION OF CHILD FATALITIES OR NEAR FATALITIES" drafted and submitted for final approval. Policy pending approval.	10.1 Obtain case names from the national expert panel. 10.2 Evaluate recommendation. 10.3 Review cases 10.4 Develop plan of action in response to the recommendation.	After extensive communication, case has not been identified. No further action contemplated.		10.1 2/28/07 10.2 4/30/07 10.3 6/30/07 10.4 7/31/07 Action Plan
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 11. Establish a policy and procedure with reference to organ procurement, and involve law enforcement and the district attorney.	Agency Technical	Medical Examiner: Ellen Clark, M.D. District Attorney: Dick Gammick or designee Law Enforcement: Dave Evans, Reno Police Department, Sylvia Redmond, Washoe County Sheriff's Office, Steve Fiori, Sparks Police Department.	District Attorney: Dick Gammick or designee Law Enforcement: RPD; SPD; WCSO	Policy currently exists. Most offices currently have the appropriate forms for tracking and identification of harvesting restrictions. An additional one page form has been developed to enhance the existing process. Note there is a pending BDR on this issue.	11.1 Assess current practice 11.2 Review existing policy and protocol. 11.3 Modify or write new policy 11.4 Develop a training plan	Coroner: COMPLETED. The current policy is under revision. The Coroner has received a model policy from other offices and met with Donor Agencies. Implementation is scheduled for 09/07 under the Medical Examiner system. Coroner: COMPLETED. An internal (ME/CO) form is used for all Washoe County organ and tissue donor cases. The Medical Examiner reviews and signs off prior to proceeding with donation or procurement. Implemented September, 2007.		11.1 3/31/07 11.2 4/30/07 11.3 5/31/07 11.4 6/30/07
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 1. Create clear standards on what constitutes a child death case that must be open for investigation, and	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS Policy team, AG County: CCDFS policy team, WCDSS policy team, DA State Lead: Marji	DCFS has implemented a new statewide Program Improvement Plan (PIP) policy on this topic. WCDSS trained and designated an experienced social worker to serve as primary	PIP: Revise PIP Policy. Intake Response Policy. CFSP: Goals 1,2 1.1 Assess legal capability. 1.2 Establish statewide Policy Team. 1.3 Develop statewide policy. Establish an action plan to accomplish the	WCDSS 1.4 through 1.7: COMPLETED. The WCDSS policy entitled *Investigation, State Notification, and UNITY Documentation of Child Fatalities or Near Fatalities* was submitted and approved by the DMG on August 10, 2007.	Action Plan QI Report New Policy	3/31/07 Action Plan

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ensure that supervisors are unable to code down any case that meets these criteria. This should include: a. CPS must investigate subsequent reports on cases where another child in the family had died. b. CPS should investigate all reports of possible medical neglect, regardless of if the death occurs in a hospital. c. A full CPS on-scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision. d. All deaths designated as undetermined by the Coroner's Office. e. All deaths with prior CPS substantiations or at least three prior reports.			Walker	investigator or child deaths. Through increased dialogue with all three (3) local LEA's, CPS staff are involved early in investigations and have been among first responders. This practice change has improved the exchange of information between the agencies and has allowed CPS staff direct participation in investigations.	following: 1.4 Complete policy approval process. 1.5 Curriculum development. 1.6 Training. 1.7 Establish QI monitoring process and feedback loop.			
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.	Agency Technical	District Attorney: Civil Division WCDSS: Mike Capello or designee	WCDSS: Mike Capello or designee Civil DA; AG Office; Ellen Clark, M.D. (Coroner's Office); Other Medical Examiners; Washoe County Health Department	In partnership with WCDSS CPS social workers, Washoe County District Health Department Public Health Nurses (PHNs) provide education, grief counseling and community resource referral for families who lose a child to SIDS or unexplained infant death. Sibling interviews and physical exams are not conducted by the nurses.	2.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 2.2 Determine fiscal impact and budget capability. 2.3 Determine staffing impact and budget capability. 2.4 Submit budget request. 2.5 Establish Policy Team 2.6 Develop county policy. 2.7 Complete policy approval process.	WCDSS: WCDSS is seeking a legal opinion regarding CPS ability to compel an interview and exam when the cause of death is undetermined. Current policy requires assessment of other siblings when indicated. WCDSS makes every attempt to comply with current policy related to the investigation of child deaths.	Action Plan QI Report New Policy	3/31/07 Action Plan

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					2.8 Complete the training delivery process. 2.9 Establish QI monitoring process and feedback loop. 2.10 Establish reporting requirements and reporting responsibilities			
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation.	Other Action (Fiscal, training, etc.)	District Attorney: Civil Division WCDSS: Mike Capello or designee	State: DCFS representative County: WCDSS: Mike Capello or designee; WCDSS policy team members; CCDFS reps; Civil DA Other: Law enforcement representatives, Executive Team representatives	CCDFS has initiated this process and has advised the state that information is able to be shared with other jurisdictions. WCDSS implemented new policy following CCDFS review. Historically CPS only deferred in homicide cases but now CPS is actively involved in reported cases from the onset.	Establish an action plan to accomplish the following: 3.1 Establish statewide policy. 3.2 Complete policy approval process. 3.3 Curriculum development. 3.4 Training. 3.5 Establish QI monitoring process and feedback loop. 3.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	WCDSS 3.1 through 3.4: COMPLETED. WCDSS drafted policy and procedure to guide staff in this area. WCDSS works jointly with LEAs to conduct investigations of child deaths. Additionally, the new Nevada Initial Assessment (NIA) requires that a safety assessment be completed on surviving siblings within 24 hours. WCDSS 3.5 and 3.6: COMPLETED. WCDSS currently complies through completion of quarterly supervisory reviews as a QA measure and considers this sufficient. Additionally, bimonthly Washoe CDR Team meetings include a review of CPS actions in child death cases.	Action Plan QI Report New Policy	6/30/07 Action Plan

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D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 4. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours.	Legal/Law Policy and Procedure Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG County: WCDSS: Mike Capello or designee CCDFS policy team, WCDSS policy team members and agency technical action work group, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Intake Response Policy. 4.1 Review new PIP policies for revision. 4.2 Initiate revision process as determined necessary. 4.3 Analyze existing curriculum for revision and revise as determined necessary. 4.4 Determine updated training needs and training mechanism regarding revisions. 4.5 Initiate revised Training Plan. 4.6 Establish QI monitoring process and feedback loop.	WCDSS: COMPLETED. This policy is now in place.	QI Report	n/a
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 5. Consider amendments to state policy so that all infants born positive for illicit drugs or with evidence of fetal alcohol are substantiated and remain open for at least 6 months.	Legal/Law Policy and Procedure Action	State: DCFS policy team, AG WCDSS: Mike Capello or designee	State: DCFS policy team, AG County: WCDSS: Mike Capello or designee WCDSS policy team, CCDFS policy team, DA; Ellen Clark, M.D. (Coroner's Office) and other Medical Examiners	Requirements must adhere to CAPTA Section 106 (b) (2) (A) (ii) which states: policies and procedures (including appropriate referral to child protection service system and for other appropriate services) to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, including a requirement that health care providers involved in the delivery or are of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall NOT be construed to- (I) establish a definition under	PIP: Plan of Safe Care Policy 5.1 Review new PIP policy for revision. 5.2 Initiate revision process as determined necessary. 5.3 Analyze existing curriculum for revision and revise as determined necessary. 5.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 5.5 Initiate revised Training Plan. 5.6 Establish QI monitoring process and feedback loop.		Action Plan QI Report	n/a

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				(II) Federal law of what constitutes child abuse; or require prosecution for any illegal action. NRS 432B.310 (2) states: An agency which provides child welfare services shall not report to the Central Registry any information concerning a child identified as being affected by prenatal illegal substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure unless the agency determines that a person has abused or neglected the child. This means that substantiations (which are all reported in the Central Registry) cannot be made unless there are other reasons to substantiate besides a positive toxicology lab test. In order to address this issue, the Plan of Safe Care Policy has recently been implemented.				

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D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 6. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.	Agency Technical Action	WCDSS: Mike Capello or designee	State: State Leads: Marji Walker; DCFS policy team; AG County: WCDSS policy team, CCDFS policy team, DA	WCDSS has completed an Agency Improvement Plan in 08/2005 that was submitted to the DMG for approval and ongoing monitoring.	Establish an action plan to accomplish the following: 6.1 Assess legal capability. 6.2 Establish statewide Policy Team. 6.3 Develop statewide policy. 6.4 Complete policy approval process . 6.5 Curriculum development. 6.6 Training. 6.7 Establish QI monitoring process and feedback loop.	WCDSS: COMPLETED. WCDSS utilizes a multi-level case review and case staffing process in child fatalities to ensure proper oversight of casework decisions. A quarterly supervisory review report has been drafted for all child deaths assigned for investigation. This report documents compliance with required policy and UNITY timeframes.	QI Report	3/31/07 Action Plan
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 7. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires three days	Agency Technical Action	State: Marji Walker WCDSS: Mike Capello or designee	State: DCFS policy team County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Safety Assessment Policy. 7.1 Review new PIP policies for revision. 7.2 Initiate revision process as determined necessary. 7.3 Analyze existing curriculum for revision and revise as determined necessary. 7.4 Determine updated training needs and training mechanism regarding revisions. Establish an action plan to accomplish the following: 7.5 Initiate revised Training Plan. 7.6 Establish QI monitoring process and feedback loop.	DCFS 7.1 through 7.6: The National Resource Center for Child Protective Services (NRC-CPS) and the Statewide Policy Team reconvened in December 2006 to revise the Safety Assessment Policy. The workgroup, in consultation with the NRC-CPS, made revisions to the draft safety tools and procedures for conducting safety assessments. The drafts were approved by the Child Welfare Decision-Making Group (DMG) in January 2007. The training of supervisors has been scheduled for completion by February 28, 2007, and the curriculum was developed based on the revised policies. Upon completion of the training, the policy and tools will be field tested by child welfare case workers and overseen by supervisors beginning March 1, 2007. The policy and training workgroup will meet in mid-April to review field testing findings and will then finalize the policy and instruments and curriculum	Action Plan QI Report	2/28/07

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						for the statewide worker training. WCDSS supervisors and key staff attended training on new policy and are piloting same in two assessment units with final policy and staff training completed in early Spring 2007. WCDSS: COMPLETED. Caseworker training for the NIA has been incorporated into the new Core CPS training required for all new caseworkers. All existing staff were required to attend statewide trainings provided by DCFS.		
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 8. A forensic interview protocol should be developed for surviving siblings and siblings should be interviewed according to forensic techniques, separately from other siblings and away from parents and potential perpetrators; consider using a Child Advocacy Center model for all of these sibling interviews.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee Social Services: Mike Capello Law Enforcement: Dave Evans, Reno Police Department, Sylvia Redmond, Washoe County Sheriff's Office, Steve Fiori, Sparks Police Department.	State: DCFS policy team, AG County: WCDSS: Mike Capello or designee WCDSS policy team, CCDFS policy team, RPD; SPD; WCSO; DA, CAC representative	Washoe County received a HUD appropriation and has broken ground to build a comprehensive center to respond to both adult and child sexual assault cases. The adult program is known as SART and the children's program is known as CARES. Washoe County has a strong partnership with the Northern Nevada Medical Center who donated the land to build the facility. Of concern is the establishment of a protocol that is the least intrusive to the victim and family, avoiding duplication of interviews or creation of prosecutory issues.	8.1 Determine fiscal impact and budget building capability. 8.2 Explore all funding sources. 8.3 Determine feasibility of recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish action plan to accomplish the following: 8.4 Submit budget requests. 8.5 If appropriate, facilitate CAC expansion statewide.	WCDSS: WCDSS staff are conducting research on a protocol with anticipated implementation by May 1, 2007. WCDSS 8.1 through 8.5: COMPLETED. Forensic interview protocols have been identified and have been adopted into practice. All siblings are being interviewed according to current policy approved 04/07. Caseworkers conduct interviews jointly with LEA staff. Additionally, WCDSS staff participated in the statewide forensic interviewing training conducted September 11 – 12, 2007.	Action Plan QI Report	8.1 4/30/07 6/30/07 Action plan

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D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 9. Supervisors should ensure that due diligence is followed in locating out of state CPS records at least five years prior to the death in suspicious cases, including identifying prior addresses, contacting state, and reviewing and incorporating out of state information into the case file.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG County: WCDSS policy team, CCDFS policy team, DA State Lead: Marji Walker	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Diligent Search Policy. 9.1 Review new PIP policies for revision. 9.2 Initiate revision process as determined necessary. 9.3 Analyze existing curriculum for revision and revise as determined necessary. 9.4 Determine updated training needs and training mechanism regarding revisions. Establish an action plan to accomplish the following: 9.5 Initiate revised Training Plan. 9.6 Establish QI monitoring process and feedback loop.	DCFS: DCFS has reviewed the cross-jurisdictional component of the Diligent Search Policy and has identified revisions that need to be made. These will be calendared into the policy revision process. Once the Diligent Search Policy has been revised, it will be disseminated to the regional child welfare jurisdictions for internal review and revisions.	Action Plan QI Report	In accordance with revision schedule

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E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT. 1. Very specific guidelines should be developed and training provided to intake and caseworkers to define substantiation criteria in cases involving child deaths and surviving siblings. Supervisor sign off should be required in these cases.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG; State Lead: Marji Walker County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Substantiation Guidelines. 1.1 Review new PIP policies for revision. 1.2 Initiate revision process as determined necessary. 1.3 Analyze existing curriculum for revision and revise as determined necessary. 1.4 Determine updated training needs and training mechanism regarding revisions. Establish an action plan to accomplish the following: 1.5 Initiate revised Training Plan. 1.6 Establish QI monitoring process and feedback loop.	WCDSS: DCFS contracted with John Goad to review allegation definitions. Cross-agency team provided feedback to report and final document was drafted to be approved by State. Substantiation criteria will be evaluated in comparison to approved allegation definitions. WCDSS: COMPLETED. Substantiation criteria were completed and incorporated into policy on February 23, 2006.	Action Plan QI Report New Policy	In accordance with revision schedule.
E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT. 2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.	Agency Technical Action	WCDSS: Mike Capello or designee	State: Marji Walker		2.1 Obtain clarification from the national expert panel on this recommendation, which is actually a statement.			2.1 2/28/07

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F. PROVISION OF SERVICES BY CPS. 1. Revise the CPS Case Reporting System including the Unity System so that intake, investigation, case plans, referrals and services are clearly delineated and can be catalogued on a time scale.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, IMS County: WCDSS policy team, CCDFS policy team, IMS State Lead: IMS Chief or designee		PIP: IMS Items - 31.1, 31.2, 2.3.3, 1.1.5, 1.2.3, 2.1.3, 2.2.2, 6.5.2, 2.4.3, 20.1.3, 19.1.3, 19.2.3, 31.5, 3.1.2, 6.2.3, 7.1.4, 9.7.5, 21.1.4, 22.1.3, 13.1.2, 15.2.3. Establish an action plan to accomplish the following: 1.1 Establish statewide Joint Application Design (JAD) /Policy Team. 1.2 Review PIP requirements and modify as needed, to include enhancements to the UNITY system. 1.3 As necessary, curriculum development on UNITY modifications. 1.4 As necessary, training on UNITY modifications. 1.5 Establish QI monitoring process and feedback loop.	WCDSS: WCDSS strives to comply with all UNITY documentation requirements. Staff was identified to serve on the statewide Joint Application Design/Policy Team.	Action Plan QI Report	3/31/07 Action Plan
F. PROVISION OF SERVICES BY CPS. 2. Require a written service plan for all cases that are substantiated.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG; State Lead: Marji Walker County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Substantiation Guidelines Case Planning Policy. 2.1 Review new PIP policies for revision. 2.2 Initiate revision process as determined necessary. 2.3 Analyze existing curriculum for revision and revise as determined necessary. 2.4 Determine updated training needs and training mechanism regarding revisions. 2.5 Initiate revised Training Plan. 2.6 Establish QI monitoring process and feedback loop.	WCDSS: COMPLETED. WCDSS has a policy requiring written case plans for all cases open for services including voluntary services. Currently the State law does not give authority to mandate families participate in case plans unless the Agency determines the child is in imminent harm.	QI Report New Policy	In accordance with revision schedule.

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F. PROVISION OF SERVICES BY CPS. 3. Create a way to more clearly log all CPS contacts with the families.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG, IMS County: WCDSS policy team, CCDFS policy team, DA, IMS; RPD; SPD; WCSO State Lead: IMS Chief or designee	Difficulty arose with the Clark County analysis in identifying common cases across jurisdictions since all use different identification numbers. The UNITY System does have the capacity to log all contacts. The extensive paper files reviewed by the panel made the process difficult.	Establish an action plan to accomplish the following: 3.1 Establish statewide JAD/Policy Team to assess and modify UNITY. 3.2 Develop statewide policy to include enhancements to the UNITY system. 3.3 Complete policy approval process. 3.4 Curriculum development. 3.5 Training. 3.6 Establish QI monitoring process and feedback loop. 3.7 Determine code changes 3.8 Modify code as necessary	WCDSS: COMPLETED. Statewide policy on the documentation of casework contacts was approved in 2006. WCDSS is striving to ensure both timeliness and consistency in the documentation of casework in compliance with the statewide policy. WCDSS purchased a dictation system and provided each caseworker with equipment to help meet this goal. This item is considered completed. Ongoing supervisor oversight required to monitor staff compliance.	QI Report	6/30/07 Action Plan
F. PROVISION OF SERVICES BY CPS. 4. Require supervisor and or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, mental health treatment, or domestic violence services.	Inter-Agency Collaboration Action	WCDSS: Mike Capello or designee	State Lead: DCFS staff; Marji Walker County: WCDSS and CCDFS representatives, Deputy Attorney General (DAG) and District Attorney (DA) representatives, Court Improvement Project (CIP) representative, judicial representatives Other: CJA representative	WCDSS reports to the Family Court on case plan progress. The caseworker with supervisor consultation and court oversight evaluate the participation of the family in case plan activities. Successful completions of the core activities that relate to child safety are necessary.	Program Improvement Plan (PIP): Case closure policy. Safety Assessment Policy. Risk Assessment Policy Case Planning Policy. 4.1 Analyze the feasibility of the recommendation. If determined feasible, establish an action plan to accomplish the following: 4.2 Assess legal capability. 4.3 Establish statewide Policy Team 4.4 Develop statewide policy 4.5 Complete policy approval process 4.6 Curriculum development 4.7 Training 4.8 Establish QI monitoring process and feedback loop 4.9 Establish reporting requirements and reporting responsibilities minutes for submission to the DCFS CJA Task Force.	WCDSS: COMPLETED. Supervisor or court oversight required to close a case and successful completion of required services is considered in decision.	Action Plan QI Report	6/30/07 Action Plan

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F. PROVISION OF SERVICES BY CPS. 5. Require tracking and follow-up on all referrals for service.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, IMS; State Lead: Chris Lovass-Nagy County: WCDSS policy team; IMS; CCDFS policy team; IMS	DCFS has implemented a new statewide PIP policy on this topic WCDSS requires confirmation of the status of referrals for required services.	PIP: Documentation Policy 5.1 Review new PIP policies for revision. 5.2 Initiate revision process as determined necessary. 5.3 Analyze existing curriculum for revision and revise as determined necessary. 5.4 Determine updated training needs and training mechanism regarding revisions. 5.5 Initiate revised Training Plan. 5.6 Establish QI monitoring process and feedback loop.	WCDSS: COMPLETED. Referrals for services are tracked as part of individual case plans, reviewed by Child and Family Teams, and reviewed by the Washoe County Family Court for court-ordered services.	QI Report	In accordance with revision schedule
F. PROVISION OF SERVICES BY CPS. 6. Require that when a death occurs on open cases, a new investigation/ case records be created.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, State Leads: Marji Walker, AG County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Intake Response Policy. 6.1 Review new PIP policies for revision. 6.2 Initiate revision process as determined necessary. 6.3 Analyze existing curriculum for revision and revise as determined necessary. 6.4 Determine updated training needs and training mechanism regarding revisions. 6.5 Initiate revised Training Plan. 6.6 Establish QI monitoring process and feedback loop.	WCDSS: COMPLETED. This requirement is contained in the current investigation policy.	QI Report New Policy	n/a
F. PROVISION OF SERVICES BY CPS. 7. Require that all cases being closed have complete documentation in the case file describing the justifications for closing the case.	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG County: WCDSS policy team, CCDFS policy team, DA Civil State Lead: Marji Walker	The WCDSS Agency Improvement Plan (AIP) will address this. DCFS has implemented a new statewide PIP policy on this topic.	PIP: Case Closure Policy. 7.1 Review new PIP policies for revision. 7.2 Initiate revision process as determined necessary. 7.3 Analyze existing curriculum for revision and revise as determined necessary. 7.4 Determine updated training needs and training mechanism regarding revisions. 7.5 Initiate revised Training Plan.	WCDSS: COMPLETED. WCDSS implemented the State policy on case closure and case documentation requirements.	QI Report New Policy	In accordance with revision schedule

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					7.6 Establish QI monitoring process and feedback loop.			
F. PROVISION OF SERVICES BY CPS. 8. Establish a high level, independent review (separate from licensing and CPS) of all deaths and serious injuries occurring in any licensed foster home and/or in adoptive home that have more than one special needs and/or medically fragile child.	Inter Agency Collaboration	State: Marji Walker, Amber Vestbie WCDSS: Mike Capello or designee	County Management: Executive Team: Administrative Team: CCDFS State: Marji Walker	A charter has been developed to initiate the review process.	8.1 Establish statewide Policy Team. 8.2 Develop statewide policy. 8.3 Complete policy approval process. 8.4 Establish QI monitoring process and feedback loop. 8.5 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	WCDSS 8.1: WCDSS staff members have been identified to serve on the Statewide Policy Team. DCFS 8.2 and 8.3: A draft statewide Institutional Investigation Policy was developed in September 2007 for investigating child abuse or neglect in residential institutions, which includes treatments homes (NAC 424.074) that provide services for children who require special care for physical, mental, or emotional reasons. This policy establishes independent review criteria as outlined in the National Panel's recommendation. Policy review by the AG was completed in mid-December 2007, and additional comments from the child welfare jurisdictions were received through January, 2008. The policy was approved by the DMG in June 2008 and disseminated to the regional child welfare jurisdictions in August 2008. DCFS 8.1 through 8.5: COMPLETED. There are three levels of review that could occur: 1) The State conducts an administrative review of all child fatalities and near fatalities of cases in which the child has had contact with or who has been in the custody of an agency that provides child welfare	New Policy	8.1 3/31/07 8.2 6/30/07 8.3 9/30/07 8.4 11/30/07 8.5 12/15/07

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						services. 2) The second level of review is completed by the Legislative Council Bureau (LCB). Staff obtain copies of case file and utilize a case review tool to analyze cases and if questions or problems arise, they consult directly with the jurisdiction. An annual report is submitted to the Legislature on these audit findings. 3) The third level of possible review may be completed by convening a review team for the investigation of institutional abuse and neglect, based on the new Institutional Abuse and Neglect Investigation Policy.		
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 1. Institute a policy that all child death cases investigated by law enforcement, the coroner and CPS are brought to the DA for their review.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	County Workgroup: Dick Gammick or designee (DA); John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Ellen Clark, M.D. (Medical Examiner's Office); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Other: Administrative team representative	The Washoe County DA currently reviews all child deaths, except those that occur under a physician's care.	1.1 Determine feasibility of recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish action plan to accomplish the following: 1.2 Assess legal capability. 1.3 Establish countywide Policy Team. 1.4 Develop countywide policy. 1.5 Complete policy approval process. 1.6 Establish QI monitoring process and feedback loop. 1.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	DA 1.1: COMPLETED. District Attorney Dick Gammick personally reviews every death that occurs in Washoe County except those deaths attended by a physician. It is Mr. Gammick's practice to return for review any questionable report.	QI Report	1.1 4/30/07 6/30/07 Action Plan

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 2. Reinstate the position of a dedicated DA for child abuse and neglect cases on a 24/7 basis.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	County Workgroup: Dick Gammick or designee (DA); John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Ellen Clark, M.D. (Medical Examiner's Office); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD);	Discussions are currently occurring and in the process of evaluation regarding additional training for the current on call district attorney to address this recommendation. There is also a plan to provide additional training to the existing on-call.	2.1 Determine the feasibility of the recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish an action plan to accomplish the following: 2.2 Determine fiscal impact and budget capability. 2.3 Determine staffing impact and budget capability. 2.4 Submit budget request.	DA 2.1: The District Attorney's Office is developing a pilot program to determine the feasibility of several on-call options.		2.1 2/28/07 6/30/07 Action Plan
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 3. Reinvestigate cases described above and consider for prosecution.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	District Attorney: Dick Gammick or designee Law Enforcement: RPD; SPD; WCSO		Obtain clarification from the national expert panel in order to respond to this recommendation.	After extensive communication, the cases still have not been identified. No further action contemplated.		2/28/07

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G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 4. Require mandatory training on domestic violence laws and polices for attorneys.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	District Attorney: Dick Gammick or designee Court Improvement Project; Administrative Office of the Courts; WCDSS; CCDFS; AG; State Lead: Pete Galanowitcz	A multitude of training is currently provided in this area. The Washoe working group is unclear about the role of AOC in providing training of this type and suggests that the DA'S association or the Nevada Prosecutor's advisory panel be consulted.	4.1 Collaborate with the courts to determine feasibility of recommendation. 4.2 Assess training needs 4.3 Develop action plan with CIP/AOC to establish a training plan, as appropriate.	WCDSS 4.1: The Nevada Training Partnership though UNR drafted a Domestic Violence training program for Agency staff. The draft training program was distributed to staff for comment. Training is anticipated to be completed by September 2007. Additionally, the DV advocate co-located with CPS completed five training sessions for WCDSS staff on the current DV protocol. This training was co-facilitated by a Children's Services Coordinator. CIP: The CIP Coordinator advises that the CIP Select Committee provides direction as to what training areas will be focused on through the Administrative Office of the Courts (AOC). Based on this, CIP staff recommends that the DCFS Administrator, who is a member of the Select Committee, make a formal request for increased focus on domestic violence training for judges. Although a formal request has not been made, the AOC has recently provided two trainings that included sessions on domestic violence: *Focus on Kids*, which was held in December, 2007, and the *2008 Semi-Annual Meeting of the Nevada Judges of Limited Jurisdiction*, which was held in January 2008. The CIP Coordinator also advises that the distinction between training for judges versus training for attorneys be made more clear to stakeholders in the		4.1 4/30/07 4.2 9/30/07 4.3 12/31/07 Action Plan

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						child death review (CDR) process. The AOC/CIP focuses on training for judges, although recent efforts have been made to extend some training to attorneys as well. The State Bar of Nevada and/or the regional county bar associations are responsible for providing training and continuing education for attorneys, and DCFS should consider contacting these organizations to discuss training for attorneys in these areas.		
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 5. Review and utilize Nevada Evidence Code Section that allow for prosecution in corpus delicti cases.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	District Attorney: Dick Gammick or designee		5.1 Consult with the national expert panel to obtain additional information on this recommendation.	DA 5.1: COMPLETED. This recommendation was discussed in a teleconference with members of the National Child Death Review Panel. It was determined that this is not a Nevada Evidence Code issue, but instead it is a case law matter; therefore, the status of the recommendation is considered completed because the corpus delicti issue was reviewed with members of the National Panel.		5.1 4/30/07

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G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 6. District Attorney's office should take county leadership in aggressively pursuing establishment of a child advocacy center for multidisciplinary, coordinated child abuse investigations and in hiring a county-funded forensic pediatrician.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick or designee	County Workgroup: Dick Gammick or designee (DA); Mike Capello or designee (WCDSS); Ellen Clark, M.D. (Medical Examiner's Office); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD)	This is a duplicate recommendation. The Washoe County D.A. is currently involved in several multidisciplinary, coordinated child abuse/death programs with the major law enforcement and other concerned agencies, such as CPET (Child Protection Enforcement Team) and SKIP (Specialized Interview Protocols) which is aimed at child victims. Washoe County received a HUD appropriation, broke ground, and has completed the plans to build a comprehensive center, in a public-private partnership with Northern Nevada Medical Center to respond to adult (SART-Sexual Assault Response Team) and child (CARES-Child Assault Response and EvaluationS) sexual assault cases. In addition to examination rooms, the center will house conference rooms and a child area.	6.1 Determine the feasibility of the recommendation. 6.2 After it is operational, compare the new SART/CARES Center to the recommended Child Advocacy Center (CAC) functions to determine what needs to be changed or added. If feasible, establish an action plan to accomplish the following: 6.3 Determine fiscal impact and budget capability. 6.4 Determine staffing impact and budget capability. 6.5 Determine availability of grants to support recommendation and submit proposal. 6.6 Submit budget request to County Commissioners.	Please see recommendation A-5 for updates on hiring a county-funded forensic pediatrician.		6.1 3/31/07 6.2 6/30/07 Action Plan

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