ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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 NEGLECT 3. Develop interagency coordinated investigation protocols for deaths involving abuse and neglect. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Representative County: CCDFS representatives, Clark County (CC) Coroner, Law Enforcement representatives, Washoe County Department of Social Services (WCDSS) representatives, Washoe County (WC) Coroner		Establish an action plan to complete the following: 3.1 Establish statewide Policy Team. 3.2 Develop statewide policy. 3.3 Complete policy approval process. 3.4 Curriculum development. 3.5 Staff Training. 3.6 Establish Quality Improvement (QI) monitoring process and feedback loop. 3.7 Establish reporting requirements and reporting responsibilities for submission to Department of Health and Human Services (DHHS) or other identified entity.	DCFS: The CDR-MDT training plan on coordinated interagency protocols is being developed and a recommendation for trainers has been provided by the National Center for Child Death Review. DCFS is developing a contract/sub-grant for provision of training by summer or fall of 2007. The QI monitoring process is being developed, but is dependent upon the completion of the Child Fatality policies and instruments, and agency protocols. These policies and instruments have been drafted and are being revised based on agency feedback. The revised policies and instruments will be submitted for administrative review and approval no later than July 31, 2007. CCDFS: The Clark County Multi-Disciplinary Task Force is in the process of developing interagency protocols.	Action Plan QI Report	Action Plan Completion Date: 12/1/06

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Nevada Department of Health and Human Services
Division of Child & Family Services
Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT 4. Provide direct access to the reporting hotline for hospital emergency departments, labor and delivery units and the child protection units; and for all law enforcement agencies.	Inter-Agency Collaboration Action	State: N/A County: Nancy McLane and Thomas Morton	State: DCFS fiscal representative County: County Manager's Office representative, fiscal representative CCDFS representative	CCDFS advises that telephone technology is being upgraded at the Hotline. The automated answer recording is being revised and phone lines added.	Establish an action plan to complete the following: 4.1 Determine feasibility of the recommendation. 4.2 Determine staffing impact and budget capability. 4.3 Submit budget requests. 4.4 Upon approval, establish contracts and purchase telephone equipment. 4.5 Install equipment and establish phone lines. 4.6 Market new phone contact info to identified agencies. 4.7 Establish QI monitoring process & feedback loop. 4.8 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.	CCDFS: All steps are complete. CCDFS is Working with Sprint to create direct access phone line(s) that will be recorded and part of the Management Information System. Letters have been sent to all area hospitals informing them of the availability of the back line. This line is not recorded, so reports cannot be taken on it. When a mandated reporter calls this line, he or she is immediately transferred to or called back from a recorded line to take the report. Monthly records are reviewed in the form of data from the telephone system. The average wait until answered was 2:09 in September and 2:04 in October. Additional QA/I activity will be developed in accordance with program changes made as a result of the recent review of the Hotline.	Action Plan QI Report	Action Plan Completion Date: 12/1/06
B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 5. Persons associated with a child's death (witnesses and caretakers) in all coroner child death cases should have a full law enforcement and Child Protection Services (CPS) *history* review.	Inter-Agency Collaboration Action	State: N/A County: Nancy McLane and Thomas Morton, John Fudenberg, Brian Evans and Lisa Teele	State: N/A County: CCDFS representative, County Manager's Office Other: Law enforcement representatives	An informal process has been implemented by CCDFS. Will formalize this process with this action item.	5.1 Obtain clarification from the national expert panel regarding definition of "coroner child death cases", "full law enforcement and CPS history review" and the role of law enforcement in this recommendation. 5.2 Establish MOU and written protocol between all parties for sharing and collaborating regarding CPS history reviews.	CCDFS: CCDFS has established a process for providing a CPS history review of Coroner cases. CCDFS will insure that this practice in incorporated into all appropriate items of the intake policies and procedures that are currently being revised. Coroner: This Action Step has been included as part of the protocol for investigating suspicious child fatalities currently under development by the Clark County Child Fatality Taskforce.	MOU Protocol	Action Plan Completion Date: 12/1/06

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 6. Establish a protocol and utilize available forensic interviewing resources, such as the county child advocacy center, for child witness interviews.	Inter-Agency Collaboration Action	State: N/A County: Nancy McLane and Thomas Morton, Brian Evans and Lisa Teele	State: N/A County: Identified CCDFS, Law enforcement representatives Other: CJA representative	CCDFS is in the process of requesting an external assessment regarding the capacity, use and best practice regarding the Child Advocacy Center (CAC).	Establish an action plan to complete the following: 6.1 Establish MOU and written protocol between all parties for utilization of the advocacy center for forensic interviewing and child witness interviews. 6.2 Educate staff on the use of the advocacy center. 6.3 Establish QI monitoring process and feedback loop. 6.4 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS CJA Task Force.	CCDFS: In December 2006, the Department of Family Services contracted with Charles Wilson, Director of the Chadwick Center for Children and Families in San Diego, California, and a nationally recognized expert on Children's Advocacy Centers, to conduct a site visit and preliminary needs assessment of Clark County's CAC. Through discussions with key child welfare, law enforcement, court officials, and medical personnel, Mr. Wilson's initial findings confirmed the current realities of Clark County's CAC. Despite the initial vision of community leaders, the Children's Advocacy Center has devolved into a shadow of its originally conceived design. Limited administrative support, lack of community ownership and shifting community priorities saw the transformation of the CAC's fundamental mission in providing multidisciplinary intervention and treatment services to child sexual abuse victims into primarily offering a child friendly daytime "interview room". On February 23, 2007, a Community Stakeholder Meeting was held to discuss the future direction of Clark County's Children's Advocacy Center. Approximately 25 stakeholders convened representing law enforcement, medical personnel, child and victim advocates, the District Attorney's office, mental health and	MOU QI Report	Action Plan Completion Date: 12/1/06

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						child welfare. Stakeholders agreed that there continues to be value in having a CAC in Clark County, the CAC was not functioning within its intended mission or at full capacity and the CAC should be restructured to expand its capacity and ensure it fulfills its intended mission. Stakeholders established a CAC Planning Committee to address identified challenges and to develop a strategic/business plan for revitalizing Clark County's CAC. At this time, the CAC Planning Committee has recommended maintaining the CAC under the current County structure to include a full time CAC Director and multi-disciplinary governing body. A budget request for a full time CAC director and two (2) forensic interviewers has been submitted to the County. The CAC Planning Committee, through technical assistance from the Western Regional CAC, is assessing other national models to inform the strategic planning process for restructuring Clark County CAC. CAC Planning Committee members conducted a site visit of the Houston Assessment Center on April 13, 2007 and will visit the Sacramento CAC on May 7, 2007. Houston and Sacrament CACs are government based models similar to Clark County's CAC. If the budget request is approved, recruitment and hiring of the full time		

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						CAC Director and all positions will commence. It is the ardent position of the CAC Planning Committee that a dedicated position to lead the CAC as well as allocating full time specialized forensic interviewers is critical to successfully operating Clark County's CAC. **This recommendation is also addressed in Safe Futures (Strategy 3.9 - Improving Investigative Capacity) and Nevada Program Improvement Plan (PIP Item 3.3.14)**		
B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 7. Work to establish a coordinated investigation protocol with CPS, hospital child protection and the Coroner's Office. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton, John Fudenberg, Brian Evans and Lisa Teele	State: DCFS Policy Team representative County: Policy Team, Coroner's Office representative Other: WCDSS Policy Team representative, Hospital representatives, Law enforcement representatives, CRP representative, Citizen's Review Panel (CRP) representative		Establish an action plan to complete the following: 7.1 Establish MOU and written protocol between all parties to facilitate coordinated investigations. Refer MOU and protocol developed to DCFS for possible replication statewide. 7.2 CCDFS lead development of statewide policies and procedures for child welfare staff. 7.3 Complete policy approval process. 7.4 Curriculum development. 7.5 Training. 7.6 Establish QI monitoring process & feedback loop. 7.7 Establish reporting requirements and reporting responsibilities for submission to DCFS CRP.	DCFS: Nancy McLane, Assistant Director of Clark County Department of Family Services, reports that they are preparing a comprehensive update on the action grid that will include this information. They will provide this information when it is completed. CCDFS: The Clark County Multi-Disciplinary Task Force is in the process of developing interagency protocols. Coroner: This Action Step has been included as part of the protocol for investigating suspicious child fatalities currently under development by the Clark County Child Fatality Taskforce. County Manager: The Clark County Child Fatality Taskforce was formed and currently meets bi-weekly. The	MOU Protocol QI Report	Action Plan Completion Date: 12/1/06

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						Taskforce includes the Clark County Coroner's Office, Clark County Family Services, Clark County District Attorney's Office, Cities of Boulder City, Henderson, Las Vegas, North Las Vegas Police Departments, and a Pediatric Physician. The County Manager's Office of Organization Effectiveness Office facilitates the meetings. The Taskforce has developed both short-term and long-term goals and actions steps and is currently drafting a comprehensive system protocol for investigating and reviewing suspicious child fatalities.		
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 1. Establish a county based, multidisciplinary committee (coroner, district attorney, law enforcement, CPS), meeting quarterly, to discuss policy and procedure relating to the scene, autopsy and circumstantial investigation of all fatalities, and to discuss issues related to law enforcement and district attorney disposition of cases. See Appendix B for a sample protocol from Riverside County, California.	Inter-Agency Collaboration Action	State: N/A County: Vicki Monroe	State: N/A County: CCDFS Director, Law enforcement representatives, Coroner Other: CJA representative		Establish an action plan to complete the following: 1.1 Establish MOU that outlines purpose, roles and responsibilities noted in this recommendation for the establishment of a multidisciplinary committee. 1.2 Review Appendix B for applicability. 1.3 Establish protocol. 1.4 Implement protocol. 1.5 Establish QI monitoring process and feedback loop. 1.6 Establish reporting requirements and reporting responsibilities for submission to the CJA Task Force.	DA: The Clark County Child Abuse Task Force was started in August 2006 and members of law enforcement, the Coroner's Office, CPS, medical, the County Manager's Office, and the DA's office attended. We have held monthly meetings. In November 2006, we asked a member of the County Manager's Office to come as a facilitator and try to focus where we were headed as a Task Force. We also wanted to know what authority the Task Force had as to recommendations. We are presently in the process of working on a checklist for all of the disciplines to use in all child homicides. In January 2007 we hope to have	MOU QI Report	Action Plan Completion Date: 8/1/2006

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						several examples and then break down into groups for input from each of the disciplines as to things that should be on the checklist as it affects that group. Once all of the disciplines have established what they believe should be on the checklist, we will decide as a group the final form of the checklist. We have the cooperation of all law enforcement agencies at the present time in Clark County and will make sure that all law enforcement agencies are involved. We are also discussing the matter of case assessment and screening for child homicides and are working towards having one person screen all child homicides presented for prosecution. Other actions include the future implementation of an early response team comprised of myself, CPS, the appropriate law enforcement agency, the Coroner's Office, and a medical component to discuss a case within 12 hours of presentation. The Task Force is also looking into possible legislative changes pertaining to children left in automobiles and drownings.		

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 9. Acknowledge and utilize CPS as a routine and vital contributor to infant and child death investigation, and utilize their case information in death certification. CPS information (positive or negative) should be routinely included in the Coroner's investigative report. Likewise, recommend that Coroner acquire law enforcement reports prior to death certification of unexplained death in infancy and childhood.	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: N/A County: CCDFS Director Other: Executive Committee representative, Law enforcement representatives,		Establish an action plan to complete the following: 9.1 Establish and implement a protocol for the exchange of information 9.2 Establish QI monitoring process and feedback loop. 9.3 Establish reporting requirements and reporting responsibilities for submission to the DCFS Executive Committee.	Coroner: The Clark County Coroner's Office utilizes CPS and law enforcement investigative information when certifying death. This practice will be formalized through the newly formed Child Fatality Task Force.	Protocol QI Report	Action Plan Completion Date: 10/15/06
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 10. Require input from child death review team agencies, including law enforcement and child protective service, prior to Coroner death certification of infant and child fatalities for cases involving suspicious circumstances, drug exposure and other high risk factors. Maintain cases on the child death review list from month to month until such time that the information becomes available.	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: DCFS representative County: CCDFS representative Other: Executive Committee representative, Administrative Team representative, CC Child Death Review (CDR) Multidisciplinary Team (MDT) representatives, District Attorney		10.1 Establish coroner office and CC CDR MDT protocol for the collaborative process. 10.2 Establish Coroner office protocol tickler system for pending death certifications. 10.3 Establish QI monitoring process and feedback loop. 10.4 Establish reporting requirements and reporting responsibilities for submission to the DCFS Executive Committee.	Coroner: This recommendation has been implemented at the Clark County Coroner's Office.	Protocol QI Report	Action Plan Completion Date: 8/31/2006

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 11. Ensure mandatory reporting by Coroner's staff to child protective service, of deaths relating to child abuse and/or neglect, especially "occult" homicides of infants and children who are initially thought to be "natural", and decedents with illicit drug or alcohol detected in postmortem toxicology tests.	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: N/A County: CCDFS Director, District Attorney Other: Administrative Team Representative		11.1 Establish Coroner office protocol for CPS notification and develop more, as necessary. 11.2 Establish QI monitoring process and feedback loop. 11.3 Establish reporting requirements and reporting responsibilities for submission to the DCFS Administrative Team.	Coroner: In accordance with our child fatality checklist, all fatalities of persons under the age of 18 are reported to the Clark County CPS/DFS by the Clark County Coroner's Office.	Protocol QI Report	Action Plan Completion Date: 8/31/2006
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 12. Work with the hospital community to ensure appropriate referrals to the coroner's office and that a minimum of external examination, or autopsy, of decedents from child care or foster care facilities, and fatalities of infants and children who are developmentally delayed or medically challenged.	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: N/A County: County Manager's Office representative(s) Other: County-wide Hospital representation		Obtain clarification from the national expert panel regarding this recommendation. Need definition of "children who are developmentally delayed and medically challenged". 12.1 Review clarification and determine feasibility of the recommendation. Upon clarification, and determination of the feasibility of the recommendation, establish an action plan to complete the following: 12.2 Establish MOU and written protocol between all parties to facilitate referral process. 12.3 Determine fiscal impact and budget capability to establish minimum external examinations or autopsies of decedents from child care or foster care facilities, and fatalities of infants and children who are developmentally delayed or medically challenged. 12.4 Determine staffing impact and budget	Coroner: The Clark County Coroner's Office has implemented a new policy ordering local area hospitals to report all child deaths to our office. This policy has been distributed to all local hospitals.	Action Plan QI Report	12.1 7/31/06 Action Plan completion date: 12/1/2006

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					capability to establish minimum external examinations or autopsies of decedents from child care or foster care facilities, and fatalities of infants and children who are developmentally delayed or medically challenged. 12.5 Establish contracts or increase personnel 12.6 Develop policy and protocol 12.7 Train Staff. 12.8 Establish QI monitoring process and feedback loop. 12.9 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS or other identified entity.			
D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 14. Coroner and law enforcement records should be obtained and referenced in the CPS file on CPS investigations of deceased children and their families.	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Representative County: CCDFS and WCDSS Policy team members; Coroner's Office representative, Law Enforcement representative(s)		14.1 Develop and implement strategies to improve communication between all entities. 14.2 Establish statewide Policy Team. 14.3 Develop statewide policy. 14.4 Complete policy approval process. Establish an action plan to accomplish the following: 14.5 Curriculum development. 14.6 Training. 14.7 Establish QI monitoring process and feedback loop.	DCFS: Nancy McLane, Assistant Director, Clark County Department of Family Services, reports that they are preparing a comprehensive update on the action grid that will include this information. They will provide this information when it is completed. CCDFS: Coroner records are obtained and placed in the case file. They are also documented in case notes. Law enforcement records are obtained and placed in the case file when accessible. The two Four-and-Under units dedicated to investigating child fatalities are trained and responsible for this procedure.	Policy QI Report	14.1 7/31/06 14.2 8/30/06 14.3 10/31/06 14.4 12/1/06 Action Plan due date 12/1/06

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F. PROVISION OF SERVICES BY CPS 5. Require supervisor and/or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, parenting classes or domestic violence treatment services.	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS staff County: CCDFS and WCDSS representatives, Deputy Attorney General (DAG) and District Attorney (DA) representatives, Court Improvement Project (CIP) representative, judicial representatives Other: CJA Representative		Program Improvement Plan (PIP): Case closure policy. Safety Assessment Policy. Risk Assessment Policy Case Planning Policy. 5.1 Analyze the feasibility of the recommendation. If determined feasible, establish an action plan to accomplish the following: 5.2 Assess legal capability. 5.3 Establish statewide Policy Team 5.4 Develop statewide policy 5.5 Complete policy approval process 5.6 Curriculum development 5.7 Training 5.8 Establish QI monitoring process and feedback loop 5.9 Establish reporting requirements and reporting responsibilities minutes for submission to the DCFS CJA Task Force.	DCFS: The recommendation to require supervisor approval prior to allowing reunification of parents who do not complete required substance abuse treatment, parenting classes, or domestic violence treatment is currently a requirement for supervisor review. The recommendation will be emphasized in future supervisor training. The recommendation to require judicial approval for cases in the court process is already an action within the purview of the court system. It is not a current practice in most cases to allow reunification when required service activities are not completed by the parent(s). Usually when parents are resistant to completion of required services and there is no feasible explanation, the matter becomes the basis for a recommendation for permanency planning and may lead to a termination of parental rights. Thus the recommendation is not feasible for consideration as it is already a system requirement that needs reinforcement at the supervisor training level. This training recommendation has been made to the training coordinator for inclusion in the 2007 training. CCDFS: It is current practice at CCDFS that a Child and Family Team meeting is required prior to all reunifications. The CFT includes the unit supervisor and a party from outside of the unit that is, at minimum, a supervisory level	Action Plan QI Report	5.1 11/1/06 Action Plan completion date: 12/1/06

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
						position. Additional update on statewide items is provided by DCFS.		
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS 5. DA should hold the dependency judge accountable for following state laws.	Inter-Agency Collaboration Action	State: N/A County: Vicki Monroe	State: Attorney General's Office (AG) representative County: County Manager's Office representatives, CCDFS representatives, CIP representatives, Judicial member		5.1 Identify and verify issues. 5.2 Develop strategies. 5.3 Consult with CIP regarding issues and strategies and method of delivery to dependency judge. Establish an action plan to accomplish the following: 5.4 Meeting with judge and other appropriate parties to discuss issues. 5.5 Develop feedback loop to the CIP.	DA: Chief Deputy Teresa Lowry, head of the Juvenile Division of the District Attorney's Office, has determined that anytime one of the Deputy District Attorneys assigned to Juvenile disagree with a court ruling and believe that the Judge has incorrectly interpreted the law in any way, the decision will be immediately appealed to the Nevada Supreme Court.	Action Plan QI Report	5.1 7/31/06 5.2 8/31/06 5.3 10/31/06 Action Plan due date 12/1/06

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H. OVERARCHING SYSTEMS ISSUES 1a. Establish a county based, multidisciplinary committee (coroner, DA, law enforcement, CPS), meeting quarterly, to discuss policy and procedure relating to the scene, autopsy and circumstantial investigation of all child fatalities, and to discuss issues related to law enforcement and DA disposition of cases.	Inter-Agency Collaboration Action	State: N/A County: Darryl Martin	State: N/A County: Coroner, DA, Law Enforcement, CCDFS Director Other: Administrative Team representative, External stakeholders as identified		1a.1 Establish a county multidisciplinary committee and outline purpose, roles and responsibilities noted, development and implementation of strategies to address this recommendation. 1a.2 Establish reporting requirements and reporting responsibilities such as minutes for submission to DCFS Administrative team.	County Manager: The Clark County Child Fatality Taskforce was formed and currently meets bi-weekly. The Taskforce includes the Clark County Coroner's Office, Clark County Family Services, Clark County District Attorney's Office, Cities of Boulder City, Henderson, Las Vegas, North Las Vegas Police Departments, and a Pediatric Physician. The County Manager's Office of Organization Effectiveness Office facilitates the meetings. The Taskforce has developed both short-term and long-term goals and actions steps and is currently drafting a comprehensive system protocol for investigating and reviewing suspicious child fatalities.	Committee Reports	1a.1 8/31/06 1a.2 10/31/06

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H. OVERARCHING SYSTEMS ISSUES 1f. Each agency should designate one unit to conduct all of the child death investigations and then adequately fund, staff, and train these units together. Panel suggests that the CPS 0-3 unit and the Las Vegas (LV) Metro Police Department (PD) Child Abuse and Neglect (CAN) detail be designated and resourced. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Inter-Agency Collaboration Action	State: N/A County: Nancy McLane and Thomas Morton	State: N/A County: Identified CCDFS staff, LV Metro PD and other Law Enforcement representatives	CCDFS has allocated additional positions for the 3 and Under unit.	Establish an action plan to accomplish the following: 1f.1 Research and analyze other states processes of designating one unit to conduct all child death investigations. 1f.2 Determine fiscal impact and budget Capability. 1f.3 Determine staffing impact and budget capability. 1f.4 Request funding If appropriate: 1f.5 Hire new positions. 1f.6 Establish Policy Team. 1f.7 Develop policy and procedures. 1f.8 Complete policy approval process. 1f.9 Curriculum development. 1f.10 Training. 1f.11 Establish QI monitoring process. 1f.12 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS and other identified entity.	CCDFS: All items are complete. Supervisor and Investigators have been selected for a second unit. The original 0-3 unit and the new unit will be designated as CPS 0-4. These units will investigate child fatalities. Specialized training has been provided to these units. CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect.	Action Plan QI Report	Action Plan completion date: 12/1/2006

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H. OVERARCHING SYSTEMS ISSUES 2a. Consider convening a statewide joint task force of persons from the DA, CPS, law enforcement, coroner, and pediatric forensic medicine to meet and reach agreement on state laws, policies and standards related to the investigation and prosecution of infants born drug exposed, infants who die from drug exposure, children who die from egregious acts of neglect, and children who die in situations of domestic violence.	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS representative County: Coroner representative, DA representative, law enforcement representative, pediatric forensic medicine representative, WC representatives as identified above, CC CDR MDT representative, Administrative Team representative, other external stakeholders, as identified.		Establish an action plan to accomplish the following: 2a.1 Establish a statewide joint task force and outline purpose, roles and responsibilities noted, development and implementation of strategies to meet the intent of this recommendation 2a.2 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	DCFS: Based on current laws and standards set forth by the Nevada Revised Statutes, there have been no further considerations for developing a task force to address this recommendation. CCDFS: Update on statewide items is provided by DCFS.	Action Plan Report	Action Plan completion date: 7/31/2006
H. OVERARCHING SYSTEMS ISSUES 4b. Conduct case audits of CPS cases to address other agency perceptions that CPS under-substantiates cases; and develop a multi-agency CAN team to help in the review of cases and the development of Services Plan. All agencies involved in child welfare should develop strategies to improve communication, collaboration, cooperation and coordination.	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: QI Team County: QI Team, WC DSS representative, Other: External stakeholders as identified	CCDFS initiated an Administrative Case Review process pilot through contract beginning with cases with children, ages 3 and under. This will provide information to support implementation of a permanent Administrative Case Review process. Quality Assurance (QA),QI Manager has been selected, an additional management analyst position is allocated for the QA/QI team. DCFS Feedback: The statewide CAPTA Corrective Action Plan requires the development of policy for agency case review of	PIP: Items 31.1, 31.2, 31.3, 31.3, 31.4, 31.5, 31.6 Establish an action plan to accomplish the following: 4b.1 Determine schedule to conduct QI review. 4b.2 Identify 2005 cases for review and replicate current QI process for additional CCDFS cases. 4b.3 Identify 2005 cases to be reviewed. 4b.4 Conduct joint review with DCFS QI Team and CCDFS QI staff. 4b.5 Expand feedback loop to include DCFS QI Steering Committee and statewide joint task force (H2a). 4b.6 Work with the QI Steering Committee and statewide joint task force to	DCFS: CCDFS QI scheduled and selected cases from 2005 for an internal case review that should be completed by the end of November. The purpose of the review is to dispel the perception that CCDFS CPS under-substantiates cases. In addition, the State QI and Administrative Review process will conduct its review pursuant to the State QI Review Schedule established by the State's PIP. The State QI and Administrative Review process will select a number of cases from 2005 and conduct an on-site and case record review. The State QI review team will include members from the CCDFS staff and other related agencies (NAC 432B.030). The results	Action Plan QI Report	Action Plan completion date: 12/1/2006

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				fatalities and near fatalities. This policy is in the finalization stages, after receiving input from the Administration for Children and Families, the National Resource Center for Legal and Judicial Issues and the Office of the AG. It will be submitted to the policy team for final edits and submitted to the Decision Making Group (DMG) for final review.	develop strategies to improve communication, collaboration, cooperation and coordination among agencies.	from the review will be provided to the DCFS QI Steering Committee and other designated entities for further discussion on improving the child welfare interagency communication, collaboration, cooperation and coordination. CCDFS: DFS contracted with Ed Cotton to complete an administrative review of child abuse and neglect investigations and permanency cases. Mr. Cotton's report was released in December 2007. DFS submitted a report to DCFS in March 2007 detailing the agency's actions in response to Mr. Cotton's recommendations. Many of the recommendations in Mr. Cotton's reports are contained in Safe Futures, Nevada's Program Improvement Plan and the Youth Law Center Resolution. These recommendations were cross walked in DFS' report to DCFS.		

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I. CHILD DEATH REVIEW (MDT) ISSUES 1. The panel believes that an effective CDR team *is* being prevention focused, when it works to improve investigative system as well as to identify primary and secondary prevention strategies for the community and state. State and county leadership is needed to reinforce this purpose of CDR, in accordance with Nevada State laws. The panel recommends that the county CDR team chairs convene a meeting of key value to the county and state. This group should assess and re-define membership, agency responsibilities at the meetings, and records that will be shared at the meeting.	Inter-Agency Collaboration Action	State: Caroline Thomas and Marjorie Walker County: Darryl Martin	State: Identified DCFS Staff County: CCDFS Director, DA Other: CC CDR MDT members, AG Office representative, DA office representative, Coroner representative, Executive Committee representative(s), WC DSS representatives		1.1 Convene meeting to review statutes and interpretation regarding role and function of the local CDR MDT. 1.2 Review bylaws developed by the Executive Committee. 1.3 Determine any needed changes to statute and bylaws to clarify role and responsibilities of CDR MDT's and collaborative process with all county agencies involved (coroner, law enforcement, child welfare) and the Executive Committee and Administrative Team. 1.4 Assess current CDR MDT membership and determine appropriateness. 1.5 Review "A Program Manual for Child Death Review" by the National Maternal Child Health (MCH) Center for Child Death Review for applicability and incorporate best practices into protocol development. 1.6 Determine protocol for meetings, including, but not limited to identification of persons to attend, information sharing, confidentiality. 1.7 Implement protocol 1.8 Establish mechanism for training new CDR MDT chairpersons on protocols. 1.9 Establish QI process to assess effectiveness of protocols. 1.10 Develop QI feedback loop to the CDR MDT and Executive Committee.	DCFS: A joint meeting of the CDR Executive Committee and Administrative Team was convened on 5/23/2006. The members reviewed statutes related to the purpose and roles of the CDR MDT. Executive Committee Bylaws were reviewed and approved on 5/23/2006. The Administrative Team met on 8/21/2006 and the Executive Committee met on 8/28/2006. Both groups' agendas included a review of the language of the bill draft request and revisions were suggested to improve clarity of the groups' purpose and role. On 9/28/2006 a meeting was held with Clark County CDR MDT and Regional CDR MDTs for Washoe County, Rural Region DCFS, and representatives were present from the Clark County Coroner's office, DA, Assistant Clark County Manager, UNLV, Citizen Review Panel/CJA Task Force, Attorney General's Office, and DCFS. They discussed membership required by State law and inclusion of other members and ways to improve participation. They also reviewed the Program Manual based on national standards developed for Nevada entitled *Nevada Child Fatality Review Operating Protocol Manual* and made suggestions for incorporating best practices through jurisdictional referral protocol. In addition, meeting attendance protocols and information sharing was discussed. The workgroup	Protocol QI Report	1.1 7/1/06 1.2 7/31/06 1.3 8/31/06 1.4 9/30/06 1.5 9/30/06 1.6 9/30/06 1.7 10/31/06 1.8 11/30/06 1.9 12/1/06 1.10 12/1/06

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						made recommendations for revising protocols that must be approved by the Executive Committee to Review the Death of Children and the Administration Team. The Administrative Team met on 11/13/2006 and recommended changes to the data collection form used by local CDR MDTs. The Executive Committee met 11/29/2006 and approved the recommended changes from the 9/28/2006 workgroup on the Nevada CDR Manual, including jurisdictional protocols. The new protocol will be implemented in the first quarter of 2007. Election of a Chairperson also occurred at this meeting. Training of the new Chair and the CDR MDTs is part of an ongoing annual training process already established by the CDR teams. Training will be scheduled by the first quarter. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP and the Child Fatality Quarterly Summary Reports submitted by the local CDR MDTs. QI feedback will be provided to the CDR MDTs and the Executive Committee to Review the Death of Children. County Manager: Per the National Panel, the Assistant County Manager Darryl Martin, and the CDR co-chairs Dr. Mehta and Ms. Sauchak, the County's		

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						Office of Organization Effectiveness Administrator has been reviewing of the Clark County Child Death Review Team's processes, procedures, structure, etc. Over the past several months, team members have been interviewed and best practices reviewed. A report (due for release the beginning of June) will highlight a number of simple recommendations that can be implemented to meet the Action Step recommendation and strengthen the CDR Team's overall efficiency and effectiveness.		

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I. CHILD DEATH REVIEW (MDT) ISSUES 2. Recommend that an outsider or Clark County executive facilitate an open and honest discussion that is bidirectional and encourages the open exchange of ideas between Coroner and members of CDR team to enhance positive rapport between members and agencies, and to enhance the efficiency of the review process. Recommend regular input by Coroner on child death review cases, with input by one or more pathologists at each meeting.	Inter-Agency Collaboration Action	State: N/A County: Darryl Martin	State: N/A County: Coroner, CCDFS representative(s), CC CDR MDT representative(s) Other: Executive Committee representative(s), County representative		2.1 Determine need for external consultant to facilitate meeting. 2.2 Convene meeting. 2.3 Develop strategies to establish open and honest bidirectional discussion, enhance positive rapport, and efficiency of the review process. 2.4 Determine strategies to facilitate regular input by Coroner on all child death review cases. 2.5 Determine strategies to facilitate attendance by one or more pathologists at all CDR MDT meetings. 2.6 Establish QI monitoring of strategies and their effectiveness. 2.7 Establish feedback loop of QI monitoring to County Manager, and Executive Committee.	County Manager: In order to maintain the effective and efficient exchange between the Clark CDR Team and the Coroner's Office, the County's Office of Organization Effectiveness will periodically work with the CDR Team, Coroner's Office, County Manager, and Executive Committee to ensure that the recommendations established by the 2006 Independent Child Death Review Panel are successfully being fulfilled.	QI Report	2.1 7/31/06 2.2 8/31/06 2.3 9/30/06 2.4 9/30/06 2.5 9/30/06 2.6 11/28/06 2.7 11/28/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 7. Adequately fund the Coroner's Office to increase pathology staffing to maintain a reasonable workload per pathologist, including limiting the number of autopsies to 300 or less per year (without additional academic or other responsibilities), or 250 or less per year (with significant academic or other responsibilities). Limit the number of autopsies for the chief medical examiner due to management and other responsibilities. (Reference the staffing guidelines of the National Association of Medical Examiners.)	Other Action (Fiscal, training, etc)	State: N/A County: John Fudenberg	State: N/A County: County Manager office representative		7.1 Assess staffing needs. 7.2 Determine feasibility of this recommendation including fiscal impact and budget building capability. If feasible, 7.3 Draft budget request, as appropriate. Establish an action plan to accomplish the following: 7.4 Pending approval, hire staff. 7.5 Analyze medical examiner positions to ensure chief identifies and handles oversight of other medical examiners. 7.6 Ensure pathologists and medical examiner maintain 250 or less autopsies per year through appropriate budgeting and staffing. 7.7 Analyze National Association of Medical Examiners (NAME) guidelines and Determine changes needed to meet These guidelines and their feasibility. 7.8 Incorporate, if feasible, identified NAME guidelines. 7.9 Provide reporting and feedback loop to DHHS or other identified entity.	Coroner: Clark County management approved a fifth Medical Examiner position in fiscal year 06/07. After an exhaustive recruitment, the Coroner's Office filled this position in January 2007.	Report	7.1 7/31/06 7.2 8/30/06 7.3 9/1/06 Action Plan completion date: 12/1/06

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 7. 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. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Other Action (Fiscal, training, etc)	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Representative, County: CCDFS and WCDSS Policy Team members Other: Law enforcement representatives, Administrative Team representatives		Establish an action plan to accomplish the following: 7.1 Establish statewide policy. 7.2 Complete policy approval process. 7.3 Curriculum development. 7.4 Training. 7.5 Establish QI monitoring process and feedback loop. 7.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	DCFS: State law, NRS 432B, and State regulation, NAC 432B.150, outline requirements for conducting a CPS investigation that is already incorporated into investigative policy procedures for intake, substantiation, and documentation. The policy approval process was not applicable for this recommendation. A training curriculum for child abuse investigation already exists. The trainers will place an emphasis on investigation requirements to be carried out by the worker in the new training offered in January 2007. Training for Intake and Substantiation include the requirement for investigation of reports. The QI monitoring process, feedback loop, and reporting requirements have already been established as part of the State's PIP. The State QI report will provide information on these data elements to the DMG and CDR Administrative Team. CCDFS: CCDFS is working collaboratively with DCFS on all statewide policy items.	QI Report	Action Plan completion date: 10/1/06

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 11. Specialty medical exams should be mandatory for unexplained injuries on children. Exams should be required before a case can be unsubstantiated and the state should develop a system to fund these exams in full.	Other Action (Fiscal, training, etc)	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Representative, DCFS Representative County: CCDFS and WCDSS Policy Team members and fiscal representatives, DCFS fiscal representatives, medical experts		Establish an action plan to accomplish the following: 11.1 Analyze recommendation for feasibility, fiscal impact and budget building capability. If feasibility is determined, establish an action plan to accomplish the following: 11.2 Determine staffing impact and budget capability. 11.3 Submit budget request. If appropriate: 11.4 Establish statewide Policy Team. 11.5 Develop statewide policy. 11.6 Complete policy approval process. 11.7 Curriculum development. 11.8 Training. 11.9 Establish QI monitoring process and feedback loop.	DCFS: The inclusion of a requirement for mandatory specialty medical exams for unexplained injuries in the Bill Draft Request was initially added, but was deleted because of an anticipated statewide funding decrease. No fiscal note was developed. CCDFS: Update on State-funded items is provided by DCFS.	QI Report	11.1 11/1/06 Action Plan completion date: 12/1/06
H. OVERARCHING SYSTEMS ISSUES 1e. The CCDFS CAC should be funded and utilized for coordinated forensic interviewing of surviving siblings.	Other Action (Fiscal, training, etc)	State: N/A County: Nancy McLane and Thomas Morton	State: DCFS Grant Management Unit (GMU) representative County: Identified CCDFS staff Other: Law enforcement, Neha Mehta, M.D.	CCDFS is in the process of requesting an external assessment regarding the capacity, use and best practice regarding the CAC.	1e.1 Determine the feasibility of the recommendation, fiscal impact and budget building capability. If the recommendation is determined feasible, establish an action plan to complete the following: 1e.2 Explore all funding sources. 1e.3 Submit budget requests to county. If necessary, establish an action plan to accomplish the following: 1e.4 Facilitate CCDFS applications for external grant sources to expand services.	CCDFS: Please see update for recommendation B-6 on page 3.	Action Plan QI Report	1e.1 9/30/2006 Action Plan completion date: 12/1/06

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Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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H. OVERARCHING SYSTEMS ISSUES 3a. Completely assess and overhaul the Hotline system, adequately fund the proposed improvements, develop back door methods for mandatory reporters, and develop a paper reporting system for follow-up, tracking and quality assurance.	Other Action (Fiscal, training, etc)	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: Policy team members County: Policy Team members Others: Hotline representatives		3a.1 Determine fiscal impact and budget capability to overhaul Hotline. 3a.2 Explore all funding sources to fund improvements. 3a.3 Submit budget requests. 3a.4 Purchase Hotline system improvements. 3a.5 Establish statewide policy and protocol team. 3a.6 Develop and implement statewide protocol and paper reporting system. 3a.7 Develop and implement marketing new paper reporting protocol and hotline improvements to mandatory reporters. 3a.8 Develop curriculum for internal staff training. 3a.9 Internal staff training. 3a.10 Establish QI monitoring process and feedback loop for policy and protocol compliance; use of paper reporting protocol and Hotline improvements. 3a.11 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.	DCFS: The Report form, NVDCFS Form 432, will be included in the revised mandated reporting guide, when the legislative session ends, to include any new requirements. At that time, an Instructional Memo will be provided to staff. CCDFS: An independent consultant, John Goad, completed a case review of the Hotline. Since this review, several improvements have been made. The Hotline is fully staffed with 18 positions; DFS staff were directed to refrain from calling the Hotline for general information or inquiries; two Public Information Officers were hired to field staff inquiries; new equipment was purchased to increase efficiency; and a backline number was established to field hospital and law enforcement reports. The State did not fund DFS request for additional QA staff. DFS requested funding additional QA positions in the to the County 08 budget.	QI Report	3a.1-3a.4 9/28/06 3a.5 7/31/06 3a.6 9/28/06 3a.7 10/31/06 3a.8 11/28/06 3a.9 12/1/06 3a.10 12/1/06 3a.11 12/1/06

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H. OVERARCHING SYSTEMS ISSUES 4a. Child welfare has to be accepted as a community priority. Conduct a comprehensive analysis of resource allocations and funding relative to the pressing needs of the entire child welfare system and push for additional funding, staffing and training. Consider holding community forums to garner public support and to highlight the needs of the county's children.	Other Action (Fiscal, training, etc)	State: N/A County: Darryl Martin	State: DCFS representative County: County Manager's office representative fiscal representative Other: WC DSS representative and fiscal representative, Regional Policy Group, identified external stakeholders		Establish an action plan to accomplish the following: 4a.1 Determine funding to conduct comprehensive analysis of resource allocations and funding of child welfare agencies. 4a.2 Determine entity(ies) to conduct analysis. 4a.3 Analyze findings and develop strategies to facilitate additional funding, staffing and training. 4a.4 Develop budget requests and submit to Legislature. 4a.5 Conduct public forums to educate public on findings and budget requests to generate public support.	County Manager – 4a.1 and 4a.2: A comprehensive analysis of resource allocation and funding of child welfare was completed internally by CCDFS with the assistance of the State and Clark County Department of Finance. County Manager – 4a.3: The result of the analysis was completed as part of the Safe futures document prepared by the management of CCDFS. The document was presented to the Clark County Board of Commissioners in September. An initial infusion of funds was committed to the agency as Phase One of the Plan in September and October from the State and Clark County to hire a number of positions in CCDFS and the Special Public Defenders Office. Funds were also committed to the agency from the Department of Social Service to CCDFS to provide emergency rental and utility assistance for families in need. Future phases of the plan will involve funding services to families and additional positions for in-home care case managers. County Manager – 4a.4: Meetings are being held the months of December and January with members of the Child Welfare task force chaired by Speaker Buckley and Commissioner Rory Reid. The ad-hoc group is tasked with developing and recommending funding requests to go before the legislature to fund an array of supportive services in Clark County. The committee consists	Action Plan	Action Plan completion date: 12/1/06

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						of county budget and department staff, staff from the Legislative Counsel Bureau and a representative from WCDSS. County Manager – 4a.5: The Area Health Education Center (AHEC), the state's designated National Prevent Child Abuse Chapter, is currently holding community forums to generate public education and support around the state of child welfare in Clark County. The first forum was held in October and the second forum is scheduled for 12/10/2006. At the conclusion of the forums in early February, AHEC will be developing a White Paper to present to the legislature.		
J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 1. Eleven child deaths in out of home care should be reviewed by DHHS or other identified entity.	Other Action (Fiscal, training, etc)	State: County:	State: County:	These cases were reviewed by DCFS internal experts and report of findings will be provided to DHHS or other identified entity. Two of the eleven child deaths were reviewed by the national expert panel.	N/A	N/A	N/A	N/A

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J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 2. Solicit opinions from case workers involved with the 79 children's cases.	Other Action (Fiscal, training, etc)	State: None County: Nancy McLane and Thomas Morton	State: DCFS Representative County: Identified CCDFS staff		2.1 Determine opinion questions for Caseworkers in consultation with the panel and national experts. 2.2 Submit written questions to caseworkers for written response. 2.3 Review responses and identify strategies, as appropriate. Establish an action plan to accomplish the following: 2.4 Facilitate strategy implementation	CCDFS: 37 disputed cases have been reviewed. Findings have been incorporated into CCDFS Investigative Protocol training.	Action Plan	2.1 7/31/06 2.2 8/30/06 2.3 9/30/06 Action Plan completion date 12/1/06
J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 3. Evaluate the qualifications of current staff and hiring requirements.	Other Action (Fiscal, training, etc)	State: N/A County: Darryl Martin, Nancy McLane and Thomas Morton	State: N/A County: Identified CCDFS staff, County Human Resources (HR) staff		Obtain clarification from the Blue Ribbon Panel on their recommendation and the purpose of the evaluation. Once clarified, as appropriate, establish an action plan to accomplish the following: 3.1 Request County Personnel office to conduct an occupational study of current and vacant CCDFS positions to determine job competencies and work demands. 3.2 Request county personnel staff to compile information on existing staff qualifications and minimum qualifications for CCDFS positions. 3.3 Request county personnel staff to conduct a comparative analysis of other child welfare agency minimum qualifications for comparable positions and provide a report to county administration for analysis. 3.4 Develop and implement strategies.	CCDFS and County Manager – 3.1: CCDFS has completed a review of investigative and permanency caseload averages and other related workload indicators for January through September 2006. This information was presented to the Child Welfare Steering Committee in November 2006. This information was also used to help analyze the department's staffing needs and to justified newly approved positions as well as to support coming requests for additional positions. CCDFS and County Manager – 3.2: CCDFS has compiled pertinent education and experience qualifications for investigative, permanency, supervisory, and management staff. CCDFS and County Manager – 3.3: Clark County employees are unionized and are covered by a collective bargaining agreement. CCDFS staff qualifications are set as part of a larger County-wide	Action Plan	Action Plan completion date: 12/1/06

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						classification and compensation system. Additionally, changes to staff qualifications could result in labor and contractual issues. However, to improve our ability to hire and retain qualified child welfare employees, CCDFS has worked with the CC Human Resources Department to revise existing recruitment processes. We will be implementing a formal assessment process for select positions as well as reinstituting oral board interview processes for all positions. Doing this will allow us to better select qualified candidates while adhering to existing labor contract guidelines. The formal assessment process will be piloted with the next round of Supervisor recruitment efforts in January 2007. We are currently in the process of contracting out the development and purchase of the assessments and instruments with Dennis Joiner and Associates. CCDFS and County Manager – 3.4: Revised recruitment processes will be in place by January 2007. CCDFS and County Manager: A revised recruitment process that includes a formal assessment process and oral review board is currently in place.		

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J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 4. Need Additional resources from management. What is happening at the leadership level?	Other Action (Fiscal, training, etc)	State: N/A County: Darryl Martin	State: N/A County: County Manager's Office representatives, CCDFS representatives	CCDFS is in the process of implementing recommendations of external evaluation conducted regarding management structure. Two additional manager positions have been hired. One is for the Neighborhood Family Services and one is for QA/QI.	4.1 Request County management to assess leadership and management needs. 4.2 Request County management to report planning and budgeting efforts to support current and projected leadership, management and child welfare agency needs to meet the service delivery needs of the child welfare population. Establish an action plan to accomplish the following: 4.3 DHHS or other identified entity to analyze report and make recommendations to agency management review and implementation, as appropriate. 4.4 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.	County Manager - 4.3: The Safe Futures plan was presented to the Board of County Commissioners on 9/19/2006. The Commissioners at this meeting declared child welfare as a priority for the County. DHHS management was at the meeting to support and endorse the plan and efforts to secure additional resources. County Manager – 4.4: The Commissioners at the 9/19/2006 meeting requested routine updates on progress of the department and meeting the goals of the plan. Updated reports on the progress of the plan will be presented to DHHS. Regular updates will be made to the federal government by DHHS on the progress.	Action Plan	4.1 9/30/06 4.2 11/28/06 Action Plan completion date: 12/1/06

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A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT 5. Reform and staff the Hotline to eliminate all waits over 3 minutes.	Agency Technical Action	State: None County: Nancy McLane and Thomas Morton	State: None County: County Manager's Office, DA's Office	CCDFS indicates that additional positions have been allocated for the hotline. Technology is being upgraded.	5.1 Determine fiscal impact and budget capability. 5.2 Determine staffing impact and budget capability. 5.3 Establish contracts and purchase telephone equipment. 5.4 Install equipment and establish phone lines. 5.5. Market new phone contact info to identified agencies. 5.6 Establish QI monitoring process. 5.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS or other identified entity.	CCDFS: Additional line staff were added thereby reducing the average wait times from 3.57 minutes (January 2006) to 0.57 minutes (December 2006). **This recommendation is also included in Safe Futures Strategy 1.2: Improving Hotline Capacity.**	QI Report	5.1 - 5.2 7/31/06 5.3 8/30/06 5.4 9/30/06 5.5 10/31/06 5.6 10/31/06 5.7 11/30/06

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 1. Develop a countywide policy for law enforcement that clarifies when and how fetal and infant deaths due in part to drug intoxication will be investigated.	Agency Technical Action	State: None County: Brian Evans and Lisa Teele	State: None County: DA's Office, County Manager's Office Other: Law Enforcement, Medical staff person, CC CDR MDT representative.		Establish an action plan to accomplish the following: 1.1 Assess legal capability. 1.2 Establish countywide Law Enforcement Policy Team 1.3 Develop county policy. 1.4 Complete policy approval process. 1.5 Curriculum development. 1.6 Training. 1.7 Establish QI monitoring process and feedback loop. 1.8 Establish reporting requirements and reporting responsibilities such as minutes for submission to CC CDR MDT.	Las Vegas Metro PD: Based on the recommendations of the Blue Ribbon Panel, a Child Fatality Task Force has been developed. This task force is addressing this issue with District Attorney Vicki Monroe. County Manager: The Clark County Child Fatality Task Force is currently discussing infant deaths due in part to drug intoxication. While fetal deaths due in part to drug intoxication will be reviewed, there appears to be no legal avenues that would allow for prosecution of these cases.	Action Plan QI Report	Action Plan completion due date: 12/1/06

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 4. Obtain screens and Blood Alcohol Contents (BAC's) on all suspicious persons and/or witnesses to a child's death when evidence of illicit drug or alcohol use is present.	Agency Technical Action	State: None County: Vicki Monroe Other: Brian Evans and Lisa Teele	State: None County: County Manager's Office Representative Other: Law Enforcement, Medical and hospital representatives, CC CDR MDT representative.		4.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 4.2 Assess legal capability. 4.3 Establish countywide Law Enforcement Policy Team. 4.4 Develop county 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 such as minutes for submission to CC CDR MDT.	DA: There are many concerns with this recommendation. I believe that a search warrant has to be obtained if a person doesn't consent to having his/her blood drawn. It has been decided that myself and members of law enforcement will check into whether a standard search warrant can be created so that if there is suspicion that a caretaker is on something a sample of blood can be taken. Assuming that probable cause can be determined in order to get a warrant then there must be a place where the person/persons can be taken to have the blood drawn. This blood must be drawn and then sealed and placed in a secure area so that it can be tested by the LVMPD lab. That means there are issues regarding chain of custody. There must be forms created to determine who drew the blood and that the blood was in a secure place so that it could not be tampered with by anyone. There is a program in place for DUI blood draws but not for cases of child homicide. Additionally, there are questions as to who will pay for the blood draws and testing. These are questions that must be answered by LVMPD and we will work on this in the coming year. Las Vegas Metro PD: Unless it is volunteered, the above recommendation cannot be enacted as it is a violation of the 4th amendment right. Just because a person is under	Action Plan QI Report	4.1 10/31/06 Action Plan completion due date: 12/1/06

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						suspicion of a crime does not justify intrusion into their person to effect a blood draw. Additionally, law enforcement must be able to articulate facts that a person is under the influence of a controlled substance in order to obtain a search warrant to draw blood from the suspected person. In order for us to implement the above recommendation, legislative changes would have to be enacted in order for law enforcement to test a person in the type of situation described above. The only authority which allows us to forcibly draw blood from a person is legislated in the DUI Statutes. Another concern will be funding barriers such as paying for an on-call phlebotomist and laboratory fees. North Las Vegas PD: No update received. Henderson PD: The Henderson Police Department agrees with the response given by LVMPD for this Action Item. We would further add that if legislative changes are made in any form to mandate blood draws, that this would further stress the ability of the local crime labs to process this evidence in a timely manner, and would add time delays to the ability of the investigating agencies to bring these cases to a close. If these BACs are made mandatory, then it is an unfunded mandate for the agencies conducting the investigation and some		

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						consideration for funding these exams should be made.		

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Nevada Department of Health and Human Services
Division of Child & Family Services
Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 4. Develop a systemic approach to the death certification of fetuses, infants and children. Utilize "undetermined" cause and/or manner of death when appropriate, and cause of death statements with disclaimers such as "undetermined, cannot exclude overlay", "undetermined, cannot exclude homicidal violence."	Agency Technical Action	State: None County: John Fudenberg	State: None County: Medical Examiners Other: CC CDR MDT representative, Executive Committee representative.		4.1 Analyze feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 4.2 Assess legal capability. 4.3 Establish countywide Policy Team. 4.4 Develop county 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 such as minutes for submission to the DCFS Executive Committee.	Coroner: This recommendation has been implemented by the Coroner's Office and a new policy has been formalized.	Action Plan QI Report	4.1 9/30/06 Action Plan completion due date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 6. Replace the use of the phrase "no history of SIDS in the family" from the Coroner's investigative report, with "no history of sudden unexplained death."	Agency Technical Action	State: None County: John Fudenberg	State: None County: Medical Examiners, CC CDR MDT representative Other: Executive Committee representative.		Establish an action plan to accomplish the following: 6.1 Assess legal capability. 6.2 Establish Policy Team. 6.3 Develop policy. 6.4 Complete policy approval process. 6.5 Complete training delivery process. 6.6 Establish QI monitoring process and feedback loop. 6.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Executive Committee.	Coroner: The recommended verbiage will be used in the revised child fatality checklist used by the Clark County Coroner's Office.	QI Report	Action Plan completion due date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 8. Utilize a qualified forensic neuropathologist for the examination of formalin fixed brains of infants at the age of one year, and the examination of most or all infant and child brains, eyes and spinal cords, as deemed appropriate, for known or suspected cases of child abuse and/or neglect.	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Medical Examiners, CC CDR MDT representative.		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. 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 such as minutes for submission to the CC CDR MDT.	Coroner: The Clark County Coroner's Office has begun obtaining consultations from a forensic neuropathologist.	Action Plan QI Report	8.1 9/30/06 Action Plan completion due date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 13. Obtain full body, postmortem x-rays of all fetal deaths, and all unexplained deaths in infancy and childhood.	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Medical Examiners, CC CDR MDT representative.		13.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 3.2 Determine fiscal impact and budget capability. 13.3 Determine staffing impact and budget capability. 13.4 Submit budget request. If appropriate: 13.5 Assess legal capability. 13.6 Establish Policy Team. 13.7 Develop county policy. 13.8 Complete policy approval process. 13.9 Complete training delivery process. 13.10 Establish QI monitoring process and feedback loop. 13.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.	Coroner: This has always been the practice of our office and will remain as such.	Action Plan QI Report	13.1 9/30/06 Action Plan completion date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 14. Require that all in-hospital child deaths signed out by hospital physicians are reported to Coroner's Office, and then ensure that a Coroner supervisor and pathologist review all of these "medical sign outs".	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Hospital and Medical Community representatives, CC CDR MDT.		14.1 Determine feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 14.2 Determine fiscal impact and Budget capability. 14.3 Determine staffing impact and budget capability. 14.4 Submit budget request If appropriate: 14.5 Assess legal capability. 14.6 Establish Policy Team. 14.7 Develop county policy. 14.8 Complete policy approval process. 14.9 Complete the training delivery process. 14.10 Establish QI monitoring process and feedback loop. 14.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.	Coroner: Effective 8/1/2006, the Clark County Coroner's Office distributed a policy to all local area hospitals that directed them to report all child deaths to our office.	Action Plan QI Report	14.1 9/30/06 Action Plan completion date: 12/1/06

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D. CASE INTAKE AND INVESTIGATION 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 ensure that supervisors are unable to code down any case that meets these criteria.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide Program Improvement Plan (PIP) policy on this topic	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 following: 1.4 Complete policy approval process. 1.5 Curriculum development. 1.6 Training. 1.7 Establish QI monitoring process and feedback loop.	DCFS: The Statewide Policy Team was established on 8/1/2006. They assessed the legal capability of child welfare agencies to include standards in the intake policy related to child death investigations. A new section was added to the Intake Policy on child death investigations and also incorporated into the Child Fatality Policy that require all child death reports to be handled as separate child death investigations. In addition, there is no provision for any supervisor or manager to code down any child fatality case. CCDFS – 1.4: CCDFS adheres to this standard as directed in statewide policy. CCDFS – 1.5 and 1.6: Additional updates on statewide items provided by DCFS. CCDFS – 1.7: All reports on child deaths and surviving siblings are distributed for notification to CCDFS Management and to DCFS.	Action Plan QI Report	1.1 8/31/06 1.2 9/30/06 1.3 10/31/06 Action Plan completion due date: 12/1/06

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 5. All child deaths and all reports on surviving siblings previously known to CPS that are called into the Hotline, should be screened in for at least a preliminary investigation. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Agency Technical Action	State: None County: Nancy McLane and Thomas Morton	State: None County: CCDFS Policy Team, Washoe County DSS, Administrative Team representative		5.1 Assess legal capability. 5.2 Establish countywide Policy Team. 5.3 Develop countywide policy. 5.4 Complete policy approval process. 5.5 Curriculum development. 5.6 Training. 5.7 Establish QI monitoring process and feedback loop. 5.8 Assess need for statewide policy.	CCDFS – 5.6: CCDFS Hotline and Investigative Units are informed of this expectation. CCDFS – 5.7: All reports on child deaths and surviving siblings are distributed for notification to CCDFS Management and to DCFS. CCDFS – 5.8: CCDFS is collaborating with DCFS on all statewide policy items. The policy group is in the process of completing a statewide policy to address all such reports where abuse or neglect is suspected.	QI Report	5.1 6/30/06 5.2 8/30/06 5.3 9/30/06 5.4 10/31/06 5.5 11/28/06 5.6-5.8 12/1/06
D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 8. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	CCDFS has completed an Agency Improvement plan in 02/2005 that was submitted to the DMG for approval and ongoing monitoring.	Establish an action plan to accomplish the following: 8.1 Assess legal capability. 8.2 Establish statewide Policy Team. 8.3 Develop statewide policy. 8.4 Complete policy approval process . 8.5 Curriculum development. 8.6 Training. 8.7 Establish QI monitoring process and feedback loop.	DCFS: A QI plan that requires supervisory oversight and written approval of actions on all child death investigations will be developed in concert with the State's PIP on QI. The plan will develop coding on the QI review instrument that notes whether supervisory oversight and approval has been obtained for child fatality cases. QI review process will evaluate the results in the QI report. CCDFS: Clark County DFS Agency Improvement Plan (AIP) was approved on February 12, 2007. Clark County's AIP, generated from the Nevada PIP, details action steps ensuring supervisory oversight and review of key practice areas. DFS is constructing a new tracking and accountability system through the use of management	QI Report	Action Plan completion date: 12/1/06

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						reports. Supervisor and managers will monitor data outcomes and trends in key program and practice areas to conduct analysis and implement course corrections based on data analysis. Also, DFS supervisors are participating in statewide training labs focused on strengthening competencies in supervisory oversight and management. Finally, Clark County DFS contracted with Jess McDonald and Associates to provide skill based mentoring and coaching to DFS Managers and Assistant Managers in management and accountability practices. Accountability must also consider appropriate training, reasonable caseloads and clearly written policies and procedures. **This recommendation is also included in the "Cotton Reports."**		

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 9. 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 3 days, but has reported earlier most were done months later. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Safety Assessment 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: New PIP policies, including safety and risk, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan State Department and National Expert Child Fatality Review Panel member, reviewed all PIP policies and submitted recommendations on 6/27/2006. The revision process was initiated 7/26/2006 as part of the CPS Investigation review. The Statewide Policy team met on 8/17/2006 and made recommendations to ensure that a safety assessment of surviving siblings was included in policy revisions. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 9.4: Both units that conduct investigations on child deaths are aware of this requirement and have been provided with training specifically on child fatalities. CCDFS will insure that this practice in incorporated into all appropriate items of the intake policies and procedures that are currently being revised.	Action Plan QI Report	9.1 7/1/06 9.2 7/31/06 9.3 10/1/06 9.4 11/1/06 Action Plan completion date 12/1/06

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						CCDFS - 9.5 and 9.6: Update on statewide items is provided by DCFS.		

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 13. 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 states, and reviewing and incorporating out of state information into the case file.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Diligent Search Policy. 13.1 Review new PIP policies for revision. 13.2 Initiate revision process as determined necessary. 13.3 Analyze existing curriculum for revision and revise as determined necessary. 13.4 Determine updated training needs and training mechanism regarding revisions. Establish an action plan to accomplish the following: 13.5 Initiate revised Training Plan. 13.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including diligent search, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Diligent Search Policy Team on 7/27/2006, as part of the CPS Investigation review. The training curriculum has been analyzed in view of the renegotiated PIP and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS: Update on statewide items is provided by DCFS.	Action Plan QI Report	13.1 7/1/06 13.2 7/31/06 13.3 10/31/06 13.4 11/28/06 Action Plan completion date: 12/1/06

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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. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS 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.	DCFS: New PIP policies, including substantiation and all recommendations, were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. Substantiation will be part of the review by the CPS Investigation workgroup. The Statewide policy team reviewed this recommendation 8/17/06 and initiated revision of the substantiation policy to include child death criteria in existing categories of abuse. Supervisor signature is already required to approve a substantiation finding. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 1.5: CCDFS is working collaboratively as a member of the statewide workgroup on this item. CCDFS will establish Department policy in accordance with State policy. CCDFS – 1.6: Additional update on statewide items is provided by DCFS.	Action Plan QI Report	1.1 7/31/06 1.2 8/30/06 1.3 10/31/06 1.4 11/28/06 Action Plan completion date: 12/1/06

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Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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F. PROVISION OF SERVICES BY CPS 1. Revise the Case Reporting System for CPS (UNITY) to clearly delineate intake, investigation and services. Current reports from the UNITY system are difficult to read.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, IMS County: CCDFS Policy Team, WCDSS Policy Team, IMS		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.	DCFS: A statewide Joint Application Design (JAD) and IMS Policy team was established 3/31/2005 to address revisions concerning the UNITY program. This team meets on a bi-weekly basis to address the 21 items contained in the State's PIP. They developed a project plan 3/31/2005 that concurrently reviews the Program Policy changes and IMS revisions for modification of the computer system applications. This project plan includes the elements contained in this recommendation to delineate intake, investigation, and services. UNITY modifications are electronically communicated to all staff statewide through regular Training Releases. UNITY training is scheduled on a regular basis for new staff and for extensive modifications to the UNITY system. UNITY is the basis for all QI monitoring and provides reports on specific data elements that constitute a feedback loop to policy and training. CCDFS: Update on statewide and UNITY items is provided by DCFS.	Action Plan QI Report	Action Plan completion date: 12/1/06

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F. PROVISION OF SERVICES BY CPS 2. Require a written service plan for all cases that are substantiated.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS 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.	DCFS: New PIP policies, including case planning, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations to the team on 6/27/2006. The Statewide Policy Team reviewed these recommendations on 8/17/2006 and initiated revision of the substantiation and case planning policies to include a requirement for written service plans in substantiated cases as appropriate. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 2.3: Current DFS policy requires that all cases that are substantiated and opened for services have a written case plan. CCDFS – 2.4 and 2.5: Update on statewide items is provided by DCFS.	QI Report	2.1 7/31/06 2.2 8/30/06 2.3 10/31/06 2.4 11/15/06 2.5 11/15/06 2.6 12/1/06

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F. PROVISION OF SERVICES BY CPS 3. Create a way to more clearly log all CPS contacts with the families in the UNITY System.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG , IMS County: CCDFS Policy Team, WCDSS Policy Team, DA, IMS		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.	DCFS: A statewide Joint Application Design (JAD) and IMS Policy team was established 3/31/2005 to address revisions concerning the UNITY program. This team meets on a bi-weekly basis to address the 21 items contained in the State's PIP. They developed a project plan 3/31/2005 that concurrently reviews the Program Policy changes and IMS revisions for modification of the computer system applications. This project plan includes the logging of CPS contacts that makes the type of contact easily identifiable. Enhancements to the UNITY system are dependent upon funding and will be scheduled for 2007. UNITY modifications are electronically communicated to all staff statewide through regular Training Releases. UNITY training is scheduled on a regular basis for new staff and for extensive modifications to the UNITY system. UNITY is the basis for all QI monitoring and provides reports on specific data elements that constitute a feedback loop to policy and training. CCDFS: Update on statewide and UNITY items is provided by DCFS.	QI Report	Action Plan completion due date: 12/1/06

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F. PROVISION OF SERVICES BY CPS 4. Disallow relative placements without going through the formal, legal system, especially when safety assessments are not conducted for those relatives.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Vicki Monroe	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	CCDFS in October 2004 implemented background checks prior to the emergency placement with relatives. Three policies are in place: Access and Dissemination of NCIC and NCJIS Information; Use of NCJIS for Background Checks of Alleged Perpetrators and Parents; Use of NCIC for Emergency Placements. These will be reviewed as part of this process. DCFS has implemented a new statewide PIP policy on this topic	PIP: Case Planning Policy. 4.1 Review new PIP policies and jurisdictional policies for revision. 4.2 Initiate revision process as determined necessary. Establish an action plan to accomplish the following: 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.	DCFS: New PIP policies, including case planning and relative placement, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Case Planning Policy Team on 7/27/2006 as part of the CPS Investigation review. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. DA: Ronald Cordes has been assigned to handle child homicide cases and is involved with placement of abused children or siblings of abused children. He is actively involved in child protection and placement of children. Additionally, we are now doing Child	Action Plan QI Report	4.1 7/1/06 4.2 7/31/06 Action plan completion date: 12/1/06

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						Protection Team meetings on a monthly basis and these issues are addressed during those meetings.		

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F. PROVISION OF SERVICES BY CPS 6. Require tracking follow-up, and written documentation on all referrals for service.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, County: CCDFS Policy Team, WCDSS Policy Team,	DCFS has implemented a new statewide PIP policy on this topic	PIP: Documentation 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.	DCFS: This requirement of tracking follow-up and providing written documentation on all referrals for services is contained in the existing documentation policy and these action steps are not necessary to accomplish this recommendation. However, this aspect of the documentation policy will be emphasized in future training. CCDFS – 6.3 through 6.5: Update on statewide items is provided by DCFS. CCDFS – 6.6: It is CCDFS policy that Supervisors must review and approve all closures. CCDFS participates in periodic state case reviews and is in the process of establishing ongoing case reviews in accordance with recommendations made from case reviews to be completed through a contract.	QI Report	6.1 7/31/06 6.2 8/30/06 6.3 10/31/06 6.4 11/15/06 6.5 11/15/06 6.6 12/1/06

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F. PROVISION OF SERVICES BY CPS 7. Require that when a death occurs on open cases, a new investigation /case record be created.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Intake Response 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. 7.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including intake procedures, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The Statewide Policy Team met on 8/17/2006 and initiated revision of the intake policy to include a section on opening a new case for a child death investigation. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 7.3: This has been implemented in practice. The agency is in the process of revising all Intake policies and procedures and will insure the incorporation of this practice in all appropriate items. CCDFS – 7.4 and 7.6: Updates on statewide items is provided by DCFS.	QI Report	7.1 7/31/06 7.2 8/30/06 7.3 10/31/06 7.4 11/15/06 7.5 11/15/06 7.6 12/1/06

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F. PROVISION OF SERVICES BY CPS 8. Require that all cases being closed have complete documentation in the case record describing the justification for closing the case.	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	The CCDFS Agency Improvement plan (AIP) will address this. DCFS has implemented a new statewide PIP policy on this topic	PIP: Case Closure Policy. 8.1 Review new PIP policies for revision. 8.2 Initiate revision process as determined necessary. 8.3 Analyze existing curriculum for revision and revise as determined necessary. 8.4 Determine updated training needs and training mechanism regarding revisions. 8.5 Initiate revised Training Plan. 8.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including case closure practice as part of court monitoring, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The Statewide Policy Team met on 8/17/2006 and initiated revision of the case closure policy requiring justification for case closure in the Closing Summary that is signed off by the supervisor. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 8.6: It is CCDFS policy that Supervisors must review and approve all closures. CCDFS participates in periodic state case reviews and is in the process of establishing ongoing case reviews in accordance with recommendations made from case	QI Report	8.1 7/31/06 8.2 8/30/06 8.3 10/31/06 8.4 11/15/06 8.5 11/15/06 8.6 12/1/06

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						reviews to be completed through a contract. Additional update on statewide items is provided by DCFS.		
F. PROVISION OF SERVICES BY CPS 9. Open cases should not be closed on current children with a mother who is pregnant. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Agency Technical Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic.	PIP: Case Closure 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. 9.5 Initiate revised Training Plan. 9.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including case closure policy, and all recommendations were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The Statewide Policy Team met on 8/17/2006 and initiated revision of the case closure policy adding criteria to specifically review the service needs of pregnant women. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007.	QI Report	9.1 7/31/06 9.2 8/30/06 9.3 10/31/06 9.4 11/15/06 9.5 11/15/06 9.6 12/1/06

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						The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 9.6: CCDFS has implemented this practice. Any exceptions require Assistant Manager approval. CCDFS will insure that this practice in incorporated into all appropriate items of the intake policies and procedures that are currently being revised. Additional update on statewide items is provided by DCFS.		
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS 1. Revise the practices established by former chief prosecutor (unless intent is shown, DA's office will not pursue prosecution) to a pro active pursuit of prosecution.	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Other: CJA representative.		Establish an action plan to accomplish the following: 1.1 Assess legal capability. 1.2 Establish countywide Policy Team 1.3 Develop county policy. 1.4 Complete policy approval process. 1.5 Implement policy and determine training needs. 1.6 Training. 1.7 Establish QI monitoring process and feedback loop. 1.8 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS CJA Task Force.	DA: I have been appointed the position of prosecuting all child homicides. I am actively involved in the screening process and in the initial phase of the cases. Law enforcement can notify me either at work, home, or on my cell phone for questions or advice. Contrary to what the public believes, there must be some intent shown for prosecution of cases of child abuse. The law requires that one knowingly and willfully do an act of child abuse. The better route to correct this would be to make a statutory change that would make certain cases strict liability offenses. There are of course certain cases where the intent is easy	QI Report	Action Plan completion date: 12/1/06

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						to ascertain by the facts. Those cases will be vigorously pursued.		
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS 3. Re-open the 2002 Shaken Baby Syndrome case and evaluate the cause of death.	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Coroner Other: CC CDR MDT representative.		3.1 DA's office to review this case and reopen Shaken Baby Syndrome case as determined appropriate. If appropriate, 3.2 Evaluate cause of death. 3.3 Pursue appropriate legal actions. 3.4 Establish feedback loop, such as minutes for submission to the CC CDR MDT. If not appropriate, provide written explanation on the lack of appropriateness to the Blue Ribbon Panel.	DA: The Coroner's Office is reviewing the cause and manner of death. Once the case has been reviewed, a determination will be made to leave the present cause and manner of death as is or to change it.	TBD	3.1 6/30/06 3.2 7/31/06 3.3 10/31/06 3.4 11/30/06 3.5 12/1/06

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Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS 4. Resubmit the probable murder allegedly caused by the toddler for thorough investigation.	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Coroner, Other: CC CDR MDT representative.		4.1 DA's office to review this case and reopen case as determined appropriate. If appropriate, 4.2 Evaluate cause of death. 4.3 Pursue appropriate legal actions 4.4 Establish feedback loop, such as minutes for submission to the CC CDR MDT. If not appropriate, provide written explanation on the lack of appropriateness to the Blue Ribbon Panel.	DA: LVMPD is preparing case materials to resubmit to the District Attorney's Office for possible prosecution. Once received, it will be reviewed by the Chief Deputy District Attorney for possible prosecution.	TBD	4.1 6/30/06 4.2 7/31/06 4.3 10/31/06 4.4 11/30/06 4.5 12/1/06
H. OVERARCHING SYSTEMS ISSUES 1d. CPS needs to be an active participant in investigation of possible abuse or neglect, and not defer their investigative responsibilities to the coroner or law enforcement.	Agency Technical Action	State: None County: Nancy McLane and Thomas Morton	State: DCFS representative County: CCDFS, WCDSS Policy Team, law enforcement, Coroner		1d.1 Assess legal capability. 1d.2 Establish countywide Policy Team. 1d.3 Develop countywide policy. 1d.4 Complete policy approval process. Establish action plan to accomplish the following: 1d.5 Curriculum development. 1d.6 Training. 1d.7 Establish QI monitoring process and feedback loop. 1d.8 Evaluate need for statewide policy. If needed, convene statewide policy team and complete the policy approval process, training delivery process and quality improvement monitoring process	CCDFS: CPS full on-scene investigation - CCDFS received approval from the BCC for 21 Emergency Response Team positions in October 2006. These positions became funded effective January 1, 2007. DFS recently launched Phase I of its 24/7 Emergency Response Teams (ERTs). Two ERTs are in place with full implementation of the remaining units targeted for June 2007. 24/7 Intake Placement and ERT protocols are finalized complete with staffing and training schedules. **This recommendation is also addressed in Safe Futures (Strategy 2 - Improving Emergency Response) and Nevada's Program Improvement Plan PIP Item 3.3).**	Action Plan QI Report	1d.1 7/31/06 1d.2 8/30/06 1d.3 10/31/06 1d.4 11/28/06 Action Plan completion date: 12/1/06

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J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 5. Evaluate the Training available to child welfare workers.	Agency Technical Action	State: N/A	State: N/A	PIP Item 33. The Child and Family Services Review resulted in the development of the statewide Program Improvement Plan (PIP). A large component of the PIP is a statewide, comprehensive training plan. During the last year, all child welfare agency staff, including field staff, supervisors and managers, have participated in mandatory training. Training reports are included in each PIP quarterly report submitted to the Administration for Families and Children (ACF). A detailed summary report is attached to this document with additional information.	Continue to monitor the PIP Training Plan via quarterly reports to ACF.		PIP quarterly reports.	In accordance with PIP reporting due dates.
J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06 6. Evaluate the supervision requirements/job duties in child welfare offices.	Agency Technical Action	State: None County: Darryl Martin, Nancy McLane and Thomas Morton	State: None County: CCDFS representatives, County Manager's Office, Union representative		6.1 Request study by county personal for child welfare agency supervisor and manager positions. 6.2 Request desk audit of supervisors and managerial staff. Establish an action plan to accomplish the following: 6.3 Assess minimum qualifications for supervisors and managers. 6.4 Assess work performance standards for supervisors and managers. 6.5 Assess mandatory training requirements for supervisors and managers. 6.6 Report findings to the Decision Making Group	CCDFS and County Manager – 6.3: CCDFS has compiled pertinent education and experience qualifications for investigative, permanency, supervisory, and management staff. CCDFS and County Manager – 6.4: CCDFS is currently evaluating work standards for all service areas. We have developed and are piloting a tool for permanency supervisors to use to evaluate critical worker performance. We will be expanding this review effort to both investigative and hotline services in 2007. Under the collective bargaining agreement, labor and management have agreed upon performance standards for supervisory	Action Plan Report	6.1 6/30/06 6.2 6/30/06 Action Plan completion date: 12/1/06

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						personnel, which are currently being implemented. Work performance standards for managers are part of a pay-for-performance compensation system adopted County-wide. CCDFS and County Manager – 6.5: Clark County supervisors are unionized and are covered by a collective bargaining agreement. CCDFS staff qualifications are set as part of a larger County-wide classification and compensation system. Additionally, changes to staff qualifications could result in labor and contractual issues. However, to improve our ability to hire and retain qualified child welfare employees, CCDFS has worked with the CC Human Resources to revise existing recruitment processes. We will be implementing a formal assessment process for select positions as well as reinstituting oral board interview processes for all positions. Doing this will allow us to better select qualified candidates while adhering to existing labor contract guidelines. The formal assessment process will be piloted with the next round of Supervisor recruitment efforts in January 2007. We are currently in the process of contracting out the development and purchase of the assessments and instruments with Dennis Joiner and Associates. CCDFS and County Manager: A revised recruitment process that includes a		

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						formal assessment process and oral review board is currently in place.		

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 9. Share the Safety Assessment findings with NRC CPS.	Agency Technical Action	State: County:	State: County:	The Safety Assessment window addresses the information in "Create Case/Add Participant" (CFS036) to determine who should be pulled into the Safety Assessment. So, to prevent a deceased child from appearing in Safety Assessments subsequent to the child's date of death, the worker should enter the date of death on the "Person Detail" (CFS016) window and then they must end the child's participation in the case by going to "Create Case/Add Participant" (CFS036), select the child's name in the "Case Participant/Associates" list box, enter the end date in the "End Date" field and then save the record. The NRCCPS assisted in the development of a standardized statewide safety assessment. As of 8/05 all child welfare staff have been trained on the appropriate use of the safety assessment instrument and process.	9.1 Determine additional need for UNITY modification. Establish an action plan to accomplish the following: 9.2 Complete UNITY changes, as appropriate. 9.3 Complete an Instructional Memorandum (IM) to all Child Welfare Staff. 9.4 Distribute IM to all Child Welfare Staff Statewide. 9.5 Establish QI monitoring process and feedback loop.		Action Plan QI Report	9.1 8/31/06 Action Plan completion date: 12/1/06

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT 2. Clarify and if necessary strengthen state law and policy to require mandatory reporting to CPS when a child dies due in 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	State: Caroline Thomas and Marjorie Walker County: N/A	State: DCFS Representative and DCFS Representative County: CCDFS Policy Team, WCDSS Policy Team, AG's Office and DA's Office, Coroner, Executive Committee Representative Other: Administrative Team Representative		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	DCFS: The recommendation to include child fatality was included in NRS 432B.220(6) of State Assembly Bill 263, Section 10. If the legislation is approved, information and training will be provided regarding this new requirement.	MOU Action Plan QI Report	2.1 8/31/06 2.2 9/30/06 Action Plan completion date 12/1/06

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 2. Develop policy to ensure that law enforcement is notified by either the coroner or hospitals and then conducts complete investigations in natural deaths that have elements of suspicion or in which an infant was in a high risk setting.	Legal/Law Policy and Procedure Action	State: NA County: John Fudenberg, Brian Evans and Lisa Teele	State: NA County: County Manager's Office Representative, DA Other: Law Enforcement Representatives, Hospital Representatives Other: County representative		2.1 Assess legal capability. 2.2 Establish Policy Team. 2.3 Develop policy. 2.4 Complete policy approval process. 2.5 Establish QI monitoring process and feedback loop. 2.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the County Manager.	Coroner: Law enforcement is always notified of these cases. The new Child Fatality Task Force is currently working on countywide policy recommendations. Las Vegas Metro PD: There are already policies and procedures in place which address this recommendation. At this time, dispatch notifies patrol for an initial response. If warranted, patrol notifies the specialized Abuse/Neglect unit, who are available for 24-hour call-out response. Abuse/Neglect then contacts the Coroner's Office and makes arrangements for a joint response. At this time, the Child Fatality Review Board is evaluating this policy to ensure a standardized process amongst all Clark county law enforcement agencies. In addition LVMPD has initiated a training brief with all patrol units reiterating the above policy. North Las Vegas PD: No update received. Henderson PD: The Henderson Police Department already has policies and procedures in place to address this concern. We have not perceived any problems in receiving notification from either the Coroner or the hospitals within our jurisdiction. Upon notification to our first responding Patrol units, the Detective Bureau is	QI Report	2.1 6/30/06 2.2 8/30/06 2.3 9/30/06 2.4 10/31/06 2.5 12/1/06 2.6 12/1/06

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						then notified for a specialized investigative response.		

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH 3. Develop countywide law enforcement policy to ensure that all child death autopsies are attended by law enforcement.	Legal/Law Policy and Procedure Action	State: N/A County: Brian Evans and Lisa Teele	State: N/A County: Coroner's Office, Law Enforcement Representatives		3.1 Determine budget impact. 3.2 Seek additional funding if necessary. As appropriate, establish an action plan to accomplish the following: 3.3 Establish countywide Policy Team. 3.4 Develop countywide policy. 3.5 Complete policy approval process. 3.6 Complete training delivery process as needed. 3.7 Establish QI monitoring process and feedback loop.	Las Vegas Metro PD: At this time, Metro's Abuse/Neglect Detail is complying with this recommendation. However, due to the foreseen growth in our county, we are actively researching other jurisdictional policies and procedures that reference the attendance of all child death autopsies. North Las Vegas PD: No update received. Henderson PD: The Henderson Police Department Investigations Bureau currently responds to, and attends, all child death autopsies that are a result of either suspected child abuse or of suspicious circumstances. The problem here is that situations could occur that a child death occurs in a hospital or at other locations, the child is transported to the Coroner's Office, and the autopsy completed without notification to our department. This would especially occur during attended deaths of the child that are not a result of suspected child abuse or of a suspicious nature. Steps need to be taken to ensure that the law enforcement agency of jurisdiction is notified in a timely basis so they can respond.	Action Plan QI Report	3.1 7/31/06 3.2 8/30/06 Action Plan completion date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 2. Appoint a chief medical examiner to set policy and procedure for the forensic division of the office, to assist in the development of office philosophy and the development of consistency amongst the pathologists in the certification of cause and manner of death for fetal, infant and child fatalities.	Legal/Law Policy and Procedure Action	State: None County: John Fudenberg	State: None County: County Manager's office, medical examiners Other: CC CDR MDT.		2.1 Analyze the structure and function of the Coroner's office and supervisory role of the Coroner and medical examiners. 2.2 Identify specific roles, responsibilities, and job duties for the chief medical examiner. 2.3 Determine fiscal and staffing impact and budget capabilities. 2.4 Determine feasibility of recommendation. Establish action plan, if determined feasible, to implement the following: 2.5 Submit budget requests. 2.6 If appropriate hire chief medical examiner. If appropriate: 2.7 Establish countywide Policy Team. 2.8 Develop countywide policy. 2.9 Complete policy approval Process. 2.10 Complete training delivery process as needed. 2.11 Establish QI monitoring process and feedback loop. 2.12 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT Chair.	Coroner: On 7/26/2006 the Clark County Coroner's Office appointed a medical examiner team leader.	Analysis Action Plan QI Report	2.1 7/31/06 2.2 8/30/06 2.3 8/30/06 2.4 12/1/06 Action plan due date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 3. Revise current investigative and autopsy protocols for the evaluation of infant and child fatalities, based on the new SUIDI form set forth by the US Centers for Disease Control (See Appendix C).	Legal/Law Policy and Procedure Action	State: None County: John Fudenberg	State: None County: County Manager, medical examiners Other: CC CDR MDT representative.		3.1 Analyze the structure and function of the Coroner's office and supervisory role of the Coroner and medical examiners. 3.2 Identify specific roles, responsibilities, and job duties for the chief medical examiner. 3.3 Determine fiscal and staffing impact and budget capabilities. 3.4 Determine feasibility of recommendation. Establish action plan, if feasible, to accomplish the following: 3.5 Submit budget requests. 3.6 If appropriate hire chief medical examiner. If appropriate: 3.7 Assess legal capability. 3.8 Establish countywide Policy Team. 3.9 Develop countywide policy. 3.10 Complete policy approval process. 3.11 Complete training delivery process 3.12 Establish QI monitoring process and feedback loop. 3.13 Establish reporting requirements and reporting responsibilities such as minutes for submission to CC CDR MDT.	Coroner: Revision of procedure is being developed by the Child Fatality Task Force and will be integrated with the Clark County Coroner's Office procedures.	Analysis Action Plan QI Report	3.1 7/31/06 3.2 8/30/06 3.3 9/30/06 3.4 10/31/06 Action plan due date: 12/1/06

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 5. Exclude Sudden Infant Death Syndrome for cases with "disconcerting" red flags in the history, including a significant threat of maternal or other adult overlay with the presence of intoxication, obesity, relatively small bed, or other significant competing unnatural causes of death.	Legal/Law Policy and Procedure Action	State: None County: John Fudenberg	State: None County: Medical Examiners, County Manager's Office Other: CC CDR MDT representative		5.1 Analyze current practice in the Coroner's office. 5.2 Determine feasibility of implementing recommendation. If appropriate: 5.3 Assess legal capability. 5.4 Establish countywide Policy Team. 5.5 Develop countywide policy. Establish action plan to accomplish the following: 5.6 Complete policy approval Process. 5.7 Complete training delivery process. 5.8 Establish QI monitoring process and feedback loop. 5.9 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.	Coroner: This policy has been implemented by the Clark County Coroner's Office.	Analysis Action Plan QI Report	5.1 7/31/06 5.2 8/30/06 5.3 9/30/06 5.4 10/31/06 5.5 11/30/06 Action Plan completion date: 12/1/06

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Nevada Department of Health and Human Services
Division of Child & Family Services
Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 2. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, CCDFS Agency Technical Action work group, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Intake Response 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.	DCFS: New PIP policies, including the decision to initiate an investigation when a child dies within 24 hours, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 2.6: CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect. Additional update on statewide items is provided by DCFS.	QI Report	2.1 7/31/06 2.2 8/30/06 2.3 10/31/06 2.4 11/15/06 2.5 12/1/06 2.6 12/1/06

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 3. 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. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	Requirements must adhere to CAPTA Section 106 (b)(2)(A)(ii) which states: policies and procedures (including appropriate referrals 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 Federal law of what constitutes child abuse; or (II) 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	PIP: Plan of Safe Care Policy 3.1 Review new PIP policy for revision. 3.2 Initiate revision process as determined necessary. 3.3 Analyze existing curriculum for revision and revise as determined necessary. 3.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 3.5 Initiate revised Training Plan. 3.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including a Plan of Safe Care for infants born affected by illegal substance abuse, and recommendations regarding the substantiation of a report were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated 6/27/2006 as part of the bill draft request for consideration as substance misuse. The curriculum will be revised to reflect approved amendments from the 2007 Nevada Legislative Session regarding substance abuse. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS: Update on statewide items is provided by DCFS.	Action Plan QI Report N/A	3.1 7/1/07 3.2 7/31/06 3.3 9/30/06 3.4 10/31/06 12/1/06 Action Plan completion date N/A

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				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 implemented.				
D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 4. Revise CPS policy so that a CPS full on-scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision and on all deaths designated as undetermined by the Coroner's office.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA, Coroner	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. Establish an action plan to accomplish the following: 4.5 Initiate revised Training Plan. 4.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policies, including the requirement to conduct a full on-scene investigation in cases where child maltreatment is suspected or indicated, and related recommendations were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The Statewide policy team met on 8/17/2006 and reviewed intake policy and this provision is covered. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are	Action Plan QI Report	4.1 7/31/06 4.2 8/30/06 4.3 10/31/06 4.4 11/30/06 Action plan completion date: 12/1/06

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						being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. With regard to the second recommendation to conduct a CPS full on-scene investigation on all deaths designated as "undetermined" by the coroner's office, the Statewide Policy Team decided that it was neither feasible nor cost effective for child protective services under NRS 432B to respond to all "undetermined child deaths" where child maltreatment was not a factor. CCDFS: CPS full on-scene investigation - CCDFS received approval from the BCC for 21 Emergency Response Team positions in October 2006. These positions became funded effective January 1, 2007. CCDFS recently launched Phase I of its 24/7 Emergency Response Teams (ERTs). Two ERTs are in place with full implementation of the remaining units targeted for June 2007. 24/7 Intake Placement and ERT protocols are finalized complete with staffing and training schedules. **This recommendation is also addressed in Safe Futures (Strategy 2 – Improving Emergency Response) and Nevada's Program Improvement Plan PIP Item**		

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 10. 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 the CCDFS CAC for all of these sibling interviews.	Legal/Law Policy and Procedure Action	State: None County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA, CAC Representative		10.1 Determine fiscal impact and budget building capability. 10.2 Explore all funding sources. 10.3 Determine feasibility of recommendation. If not feasible, provide written analysis of the lack of feasibility to the blue ribbon panel. If feasible, establish action plan to accomplish the following: 10.4 Submit budget requests. 10.5 If appropriate, facilitate CAC expansion statewide. Establish an action plan to accomplish the following: 10.6 Assess legal capability. 10.7 Establish statewide Policy Team 10.8 Develop statewide policy. 10.9 Complete policy approval process. 10.10 Curriculum development. 10.11 Training. 10.12 Establish QI monitoring process and feedback loop.	CCDFS: Please see update for recommendation B-6 on page 3.	Action Plan QI Report	10.1 8/31/06 10.2 10/31/06 10.3 11/30/06 Action Plans due date: 12/1/06

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D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 12. A formal policy and procedure should be developed and utilized when parents or potential perpetrators cannot be contacted, following the death of a child. This should include the filing of a petition for pick up if the death was due to potential abuse or neglect and automatic substantiation if the potential perpetrators have disappeared.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Diligent Search Policy. 12.1 Clarify with the national expert panel what the phrase "a petition for pick up" means. 12.2 Review new PIP policies for revision. 12.3 Initiate revision process as determined necessary. 12.4 Analyze existing curriculum for revision and revise as determined necessary. 12.5 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 12.6 Initiate revised Training Plan. 12.7 Establish QI monitoring process and feedback loop.	DCFS: Clarification for terminology "petition for pick-up" was submitted 6/27/2006. New PIP policies, including Diligent Search and all recommendations, were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Diligent Search Policy Team on 7/27/2006, as part of the CPS Investigation review to ensure that diligent efforts are made by child abuse investigators to locate a parent(s). Diligent search for parents who cannot be contacted and who may have abandoned a deceased child requires law enforcement intervention. This intervention may include the filing of a "petition for pick-up" for the parents for questioning by law enforcement. The automatic substantiation of potential perpetrators that have disappeared under NRS 432B must be analyzed by the Attorney General's Office before such a provision can be considered for placement in policy. The training curriculum for diligent search is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part	Action Plan QI Report	12.1 7/1/06 12.2 7/1/06 12.3 7/31/06 12.4 11/1/06 12.5 12/1/06 Action Plan completion date: 12/1/06

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						of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS - 12.6: Update on statewide items provided by DCFS. CCDFS – 12.7: CCDFS will ensure that this is incorporated into all appropriate items of the intake and investigation policies and procedures that are currently being revised. Training will follow.		

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E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT 2. Create a separate category of "unable to locate."	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Substantiation Guidelines. 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. Establish action plan to accomplish the following: 2.5 Initiate revised Training Plan. 2.6 Establish QI monitoring process and feedback loop. 2.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS or other identified entity.	DCFS: New PIP policy provisions, including substantiation guidelines and the category of "unable to locate," and related recommendations were reviewed by the DCFS Policy Team Leads and Policy coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations on 6/27/2006. The Statewide Policy Team met on 8/17/2006 and initiated review of the substantiation policy to clarify "unable to locate." Since this provision is related to NRS 432B.300-310 and the Central Registry in NAC 432B.170, this clarification was included in the Bill Draft Request as a corresponding change in the regulation. Upon approval by the 2007 Legislature, this provision will be included in the training curriculum and added to the QI process. CCDFS – 2.5 through 2.7: Update on statewide items is provided by DCFS.	Action Plan QI Report	2.1 7/31/06 2.2 8/30/06 2.3 10/31/06 2.4 11/30/06 Action plan completion date: 12/1/06

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G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS 2. Institute a policy that all cases investigated by law enforcement, the coroner and CPS be brought to the DA for their review.	Legal/Law Policy and Procedure Action	State: None County: Brian Evans and Lisa Teele	State: None County: County Manager, Coroner, CCDFS, DA, Law Enforcement Other: Administrative Team representative.		2.1 Assess legal capability. 2.2 Establish countywide Policy Team. 2.3 Develop countywide policy. 2.4 Complete policy approval process. 2.5 Establish QI monitoring process and feedback loop. 2.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.	Las Vegas Metro PD: This recommendation is already being enacted. All suspicious cases are submitted to the District Attorney's Office for review. Currently, the Child Fatality Task force is working closely with Deputy District Attorney Vicki Monroe to standardize this process amongst all Clark county law enforcement agencies. This task force is also developing a screening mechanism for the District Attorney's Office to ensure these cases are being reviewed in a fair and equitable manner. North Las Vegas PD: No update received. Henderson PD: This policy is already in place as upon completion of the investigation, all cases are sent to the District Attorney's Office for review and the request of charges to be filed against any identified suspects where probable cause exists. Also, in those cases where a suspect(s) are not immediately identifiable or probable cause does not appear to exist, or extensive and intricate investigation is involved, our Detectives maintain contact with the DA's Office to discuss issues as they develop in an effort toward better case submissions.	QI Report	2.1 7/31/06 2.2 8/30/06 2.3 9/30/06 2.4 10/31/06 2.5 11/28/06 2.6 12/1/06

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H. OVERARCHING SYSTEMS ISSUES 2b. Revise CPS policy to always fully investigate the safety of surviving siblings in potential child abuse and neglect fatalities, and change policy so that in the event of a child abuse death, a case is investigated and substantiated even when there are no siblings. (Also recommended by the National Resource Center on Legal and Judicial Issues)	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team and Agency Technical Action Work Group, WCDSS Policy Team, DA, Law Enforcement	DCFS has implemented a new statewide PIP policy on this topic	PIP: Intake Response Policy, Safety Assessment Policy. 2b.1 Review new PIP policies for revision. 2b.2 Initiate revision process as determined necessary. 2b.3 Analyze existing curriculum for revision and revise as determined necessary. 2b.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 2b.5 Initiate revised Training Plan. 2b.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policy provisions, including the safety assessment of siblings (intake response procedures) and substantiation of child abuse maltreatment when there are no siblings, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The Statewide policy team met on 8/17/2006 and initiated revision of the substantiation policy to emphasize NAC 432B.150-155 regarding the interview and evaluation of the safety needs of all children in the home. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. The recommendation to substantiate child maltreatment on a parent(s) when there are no siblings is under review by the Statewide Policy Team and legal counsel. When appropriate, this provision may be placed in policy.	Action Plan QI Report	2b.1 7/31/06 2b.2 8/30/06 2b.3 10/31/06 2b.4 11/30/06 Action Plan completion date: 12/1/06

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Nevada Department of Health and Human Services
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Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

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						CCDFS 2b.4: The units that investigate child deaths are aware of this requirement. It is also included in the CCDFS Investigative protocol training for all Investigators and Supervisors of Investigative units. CCDFS – 2b.5: Additional update on statewide items is provided by DCFS. CCDFS – 2b.6: CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect.		

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H. OVERARCHING SYSTEMS ISSUES 2c. Consider establishing a *New Birth Match* program, modeled after the state of Michigan's. This program results in notification to CPS of new births from parents with a prior history of CPS when termination of parental rights and/or history of child fatality has occurred.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA, and Identified External Stakeholders		2c.1 Asses New Birth Match program and determine its applicability to Nevada. 2c.2 Write white paper on New Birth match and present to DMG for review and consideration. 2c.3 Determine feasibility of recommendation. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. 2c.4 Assess legal capability. If appropriate, establish action plan to accomplish the following: 2c.5 Establish statewide Policy Team. 2c.6 Develop statewide policy. 2c.7 Complete policy approval process. 2c.8 Curriculum development. 2c.9 Training. 2c.10 Establish QI monitoring process and feedback loop.	DCFS: This recommendation to establish a New Birth Match Program is not feasible for the State of Nevada at this time. To accomplish this recommendation, the following would have to be addressed: design of the data system to provide a list of cases with termination of parental rights and child fatality cases that have gone to court; establishment of a Memorandum of Understanding to obtain the new birth data from the Health Division; legal determination regarding the ability to do an automatic investigation; and assignment of staff to track cases through the court system, compare with Health data, and to notify agencies. This recommendation is one that the agency will include in future planning as feasible. CCDFS – 2c.5 through 2c.10: Update on statewide items is provided by DCFS.	White Paper Action Plan QI Report	2c.1 7/31/06 2c.2 9/30/06 2c.3 10/31/06 2c.4 11/30/06 Action Plan completion date: 12/1/06

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I. CHILD DEATH REVIEW (MDT) ISSUES 3. Revise state statute to permit public meetings to be closed at the state team level when needed to discuss confidential child specific cases.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: AG, DAG County: CCDFS and WCDSS representatives Other: Executive Committee and Administrative Team to Review Child Death	Consultation with the Office of the AG indicates that the statute be revised to "exclude" requirement for the Open Meeting Law rather than have a portion of the meeting "closed," due to the capability of access to information via the Freedom of Information Act.	3.1 Analyze recommendation for appropriateness and feasibility. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible: 3.2 DCFS and AG's Office draft bill request. 3.3 Submit bill request to DHHS for Review. 3.4 DHHS to submit to Legislative Counsel Bureau (LCB) in accordance with scheduling requirements.	DCFS: This recommendation was included in State Assembly Bill 263, Section 6 of Reprint 1. If the legislation is approved, information and training will be provided regarding this new requirement on closed meetings.	Analysis BDR	3.1 7/31/06 3.2 8/31/06 3.3 9/1/06 3.4 TBD
I. CHILD DEATH REVIEW (MDT) ISSUES 4. Revise state statute to create one state level review team rather than the existing Executive Committee and Administrative Team to assess local recommendations and allocate for improvements based on the state CDR funding resources. The state team should actively encourage local teams to identify and implement local prevention strategies. The state team focus should be on state policy and practice improvements.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: AG, DAG County: None Other: Representatives from the Executive Committee and Administrative Team to Review Child Death		4.1 Analyze recommendation for appropriateness and feasibility. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible: 4.2 DCFS and AG's Office draft bill request. 4.3 Submit bill request to DHHS for Review. 4.4 DHHS to submit to LCB in accordance with scheduling requirements.	DCFS: This specific recommendation for creating one State team was analyzed by the Attorney General's Office and it was determined that it would be a feasible action. However, when the State Child Death Review teams evaluated this recommendation, they rejected it because the two teams are now functioning as conceptualized and the teams voted to continue this process. The two teams will review their progress at their annual joint meeting in 2007 and if the current review process does not appear to be working, the teams will re-evaluate this possibility. CCDFS: Update on statewide items provided by DCFS.	Analysis BDR	4.1 7/31/06 4.2 8/31/06 4.3 9/1/06 4.4 TBD

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 2. Add to statute a new section defining maternal substance misuse. (Also recommended by the National Expert Panel.)	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: AG, County: CCDFS representative, WCDSS representative, DAs		2.1 DCFS and AG's Office draft Bill Request. 2.2 Submit bill request to DHHS for Review. 2.3 DHHS to submit to LCB in accordance with scheduling requirements.	DCFS: The recommendation for substance misuse was added to the bill draft and was reviewed by legal sources (public defender's office, Attorney General, and others) prior to final drafting by the Legislative Counsel Bureau. After much deliberation, it was decided to delete these provisions as they applied to a significantly small audience and created confusion with existing provisions in Nevada Revised Statutes.	BDR	2.1 7/31/06 2.2 8/31/06 2.3 TBD
K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 7. Educate mandatory reporters that they are required to report suspected child abuse and neglect when a child dies.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: None County: Executive Committee representative, Administrative Team representative, identified CCDFS Staff	Required by NRS 432B. 220 and the Mandated Reporter's Manual	7.1 Establish plan for the education of mandatory reporters emphasizing mandatory reporting of child fatalities related to suspected abuse or neglect.	DCFS: The legislation requiring reporting of child death in NRS 432B.220 is pending in State Assembly Bill 263, Section 10. If this bill is approved by the Legislature, training for mandatory reporters will be reviewed and added to the curriculum. CCDFS: CCDFS has partnered with the Area Health Education Center (AHEC) Prevent Child Abuse program to provide training to mandated reporters of suspected child abuse and neglect allegations. Additionally, DCFS is pursuing a contract to develop an on-line mandated reporter training that will be offered to all mandated reporters.	Plan	7.1 9/30/06

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 8. If maternal substance misuse is observed as a contributing factor on a child's death, this should be grounds for substantiation. Change statue and policy so that substantiation requirements are clearer on this issue. Reorganize all substance abuse statue information into one section in NRS.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA		8.1 Analyze recommendation for feasibility. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible, 8.2 AG's Office in collaboration with DA draft Bill Request. 8.3 Submit bill request to DHHS for review. 8.4 DHHS to submit to LCB in accordance with scheduling requirements. If appropriate: Revise PIP Policy. Substantiation Guidelines. 8.5 Review new PIP policies for revision. Establish action plan to accomplish the following: 8.6 Initiate revision process as determined necessary. 8.7 Analyze existing curriculum for revision and revise as determined necessary. 8.8 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 8.9 Initiate revised Training Plan. 8.10 Establish QI monitoring process and feedback loop.	DCFS: The recommendation for substance misuse was added to the bill draft and was reviewed by legal sources (public defender's office, Attorney General, and others) prior to final drafting by the Legislative Counsel Bureau. After much deliberation, it was decided to delete these provisions as they applied to a significantly small audience and created confusion with existing provisions in Nevada Revised Statutes.	Analysis BDR Action Plan QI Report	8.1 7/15/06 8.2 8/15/06 8.3 8/31/06 8.4 TBD 8.5 10/31/06 Action Plan completion date: 12/1/06

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 12. New legislation should include illegal drugs and alcohol. Propose legislative language revisions to 432B to expand prenatal illegal drug use to include alcohol misuse. (Also recommended by the National Expert Panel)	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA		12.1 Analyze feasibility. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible: 12.2 AG's Office in collaboration with DA draft Bill request. 12.3 Submit bill request to DHHS for Review. 12.4 DHHS to submit to LCB in accordance with scheduling requirements. 12.5 Review new PIP policies for revision. Establish action plan to accomplish the following: 12.6 Initiate revision process as determined necessary. 12.7 Analyze existing curriculum for revision and revise as determined necessary. 12.8 Determine updated training needs and training mechanism regarding revisions. 12.9 Initiate revised Training Plan. 12.10 Establish QI monitoring process and feedback loop.	DCFS: The recommendation for substance misuse was added to the bill draft and was reviewed by legal sources (public defender's office, Attorney General, and others) prior to final drafting by the Legislative Counsel Bureau. After much deliberation, it was decided to delete these provisions as they applied to a significantly small audience and created confusion with existing provisions in Nevada Revised Statutes.	Analysis BDR Action Plan QI Report	12.1 7/15/06 12.2 8/15/06 12.3 8/31/06 12.4 TBD 12.5 12/1/06 Action Plan completion date: 12/1/06

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 13. Safety assessments must be performed on surviving siblings within 24 hours of the fatality or near fatality.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, Agency Technical Action Work Group, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Safety Assessment Policy. 13.1 Determine feasibility of recommendation. If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel. If feasible: 13.2 Review new PIP policies for revision. 13.3 Initiate revision process as determined necessary. 13.4 Analyze existing curriculum for revision and revise as determined necessary. Establish action plan to accomplish the following: 13.5 Determine updated training needs and training mechanism regarding revisions. 13.6 Initiate revised Training Plan. 13.7 Establish QI monitoring process and feedback loop.	DCFS: This recommendation to conduct safety assessments on surviving siblings within 24 hours of fatality or near-fatality, was analyzed for feasibility with the Attorney General's Office on 6/27/2006. The Statewide Policy Team met on 8/17/2006 and initiated revision of the safety assessment policy and substantiation policy to emphasize NAC 432B.150-155 regarding the interview and evaluation of the safety needs of all children in the home. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 13.4: This is included in the Investigative Protocol training. CCDFS – 13.5: The CCDFS unit which conducts all such investigations is implementing this practice. CCDFS – 13.6: Additional update on statewide items is provided by DCFS. CCDFS – 13.7: CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect.	Action Plan QI Report	13.1 7/31/06 13.2 8/30/06 13.3 9/30/06 13.4 12/1/06 Action Plan completion date: 12/1/06

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 14. Add to Diligent Search policy on requirement for CPS records requests to other states for families residing in Nevada for less than 5 years.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Diligent Search Policy. 14.1 Review new PIP policies for revision. 14.2 Initiate revision process as determined necessary. 14.3 Analyze existing curriculum for revision and revise as determined necessary. 14.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 14.5 Initiate revised Training Plan. 14.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policy provisions, including Diligent Search, and all related recommendations were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Diligent Search Policy Team on 7/27/2006, as part of the CPS Investigation review. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 14.5 and 14.6: CCDFS will ensure that this is incorporated into all appropriate items of the intake and investigation policies and procedures that are currently being revised. Training will follow. Additional update on statewide items is provided by DCFS.	Action Plan QI Report	14.1 7/31/06 14.2 8/15/06 14.3 10/31/06 14.4 11/30/06 Action Plan completion date: 12/1/06

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 15. If one child dies, substantiate on all of the children due to emotional abuse of surviving siblings.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Substantiation Guidelines. 15.1 Review new PIP policies for revision. 15.2 Initiate revision process as determined necessary. 15.3 Analyze existing curriculum for revision and revise as determined necessary. 15.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 15.5 Initiate revised Training Plan. 15.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policy provisions, including substantiation guidelines for emotional abuse, and all related recommendations were reviewed by the DCFS Policy Team Leads and Policy Coordinator on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by 7/27/2006, as part of the CPS Investigation review. This recommendation is under review and consideration by legal counsel for applicability to children who were not present at the time of the abuse. This recommendation will be scheduled for review and discussion in 2007 by the Statewide Policy Team. If this provision is applicable, it may be added to the training curriculum. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 15.4 and 15.5: Update on statewide items is provided by DCFS. CCDFS – 15.6: CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification of child fatalities and case review of	Action Plan QI Report	15.1 7/31/06 15.2 8/15/06 15.3 10/31/06 15.4 12/1/06 Action Plan completion date: 12/1/06

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						child fatalities due to abuse or neglect.		

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 16. Substantiated cases should all have a case plan unless it is determined unnecessary by a supervisor.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, Agency Technical Action Work Group, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Case Planning Policy. 16.1 Review new PIP policies for revision. 16.2 Initiate revision process as determined necessary. 16.3 Analyze existing curriculum for revision and revise as determined necessary. 16.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 16.5 Initiate revised Training Plan. 16.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policy provisions, including case planning, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Case Planning Policy Team on 7/27/2006, as part of the CPS Investigation review. It has been the practice that cases that are substantiated and included in the ongoing CPS caseload must have an initial case plan. The Safety Plan does not count as a case plan. The policy for Supervisors will stress the importance of reviewing and approving any cases that are exceptions to policy standards. All approved policy changes related to supervisor training development and curriculum is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 16.5: It is currently CCDFS policy and practice to complete a case plan on all cases that are opened for services. Additional update on	Action Plan QI Report	16.1 7/31/06 16.2 8/15/06 16.3 10/31/06 16.4 12/1/06 Action Plan completion date: 12/1/06

***Due Dates: All interim status update reports and verifying documents are to be submitted electronically to andrew@azconsulting.us no later than the dates specified in this action plan. Updated action plans including this information will be posted on the DCFS website on a regular basis, no less than monthly. If no interim status update report is received, the updated document will reflect this lack of information. DCFS website: www.dcfs.state.nv.us.**

Nevada Department of Health and Human Services
Division of Child & Family Services
Blue Ribbon Panel Action Plan
Ref: Clark County Child Death Review Recommendations Response

ACRONYMS USED IN THIS ACTION PLAN:
Administrative Team = Administrative Team to Review the Death of Children
CC CDR MDT = Clark County Child Death Review Multidisciplinary Team
CDR = Child Death Review
CIP = Court Improvement Project
CJA Task Force = Children's Justice Act Task Force
CRP = Citizen Review Panel
Executive Committee = Executive Committee to Review the Death of Children
MDT = Multidisciplinary Team
QA = Quality Assurance
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						statewide items is provided by DCFS. CCDFS – 16.6: Supervisor approval and signature is required on all case plans.		

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K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES 17. A child death must be entered into UNITY as a new report. This should be added to the intake policy.	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Intake Response Policy. 17.1 Review new PIP policies for revision. 17.2 Initiate revision process as determined necessary. 17.3 Analyze existing curriculum for revision and revise as determined necessary. 17.4 Determine updated training needs and training mechanism regarding revisions. Establish action plan to accomplish the following: 17.5 Initiate revised Training Plan. 17.6 Establish QI monitoring process and feedback loop.	DCFS: New PIP policy provisions, including intake and child death, were reviewed by the NV CIP and recommendations were made in a final report submitted April 2006. The DCFS Policy Team Leads and Policy Coordinator reviewed all recommendations submitted on 6/22/2006. Mr. Steven Yeager, Policy Specialist from Michigan and National Expert Child Fatality Review Panel, reviewed all PIP policies and made recommendations 6/27/2006. The revision process was initiated by the Intake Policy Team on 7/27/2006, as part of the CPS Investigation review. The training curriculum is being analyzed in view of the renegotiated PIP. Training needs are being updated and will be revised to reflect the updated policy. All approved policy changes become part of the training development and curriculum that is scheduled to start in January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP. CCDFS – 17.5: Additional update on statewide items is provided by DCFS. CDDFS – 17.6: This is current CCDFS practice and will be incorporated accordingly in the revised policy and procedure manual. CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to	Action Plan QI Report	17.1 7/31/06 17.2 8/15/06 17.3 10/31/06 17.4 12/1/06 Action Plan completion date: 12/1/06

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						statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect.		

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