Independent Child Death Review Panel
For Washoe County and Rural Nevada

Report of
Findings and Recommendations
Child Deaths 2001-2004

Presented to

Michael J. Willden, Director
Nevada Department of Health and Human Services

December 1, 2006

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Michael Willden
Director
Nevada Department of Health and Human Services
505 East King Street, Room 600
Carson City, NV 89701-3708

Dear Director Willden:

Enclosed is the report of the Independent Child Death Review Panel for the thirty-seven child deaths reviewed for Washoe County and the fifteen child deaths reviewed for rural Nevada. These deaths occurred in the years 2001-2004.

The report includes more than 74 findings on the individual cases and on the functioning of the county child death review team. More importantly it includes 87 recommendations that the panel hopes will be discussed, analyzed and debated. The panel hopes that in many instances they will be approved, funded and implemented. The Panel has been very impressed with the scope of actions proposed and implemented as a result of the Clark County reviews conducted earlier in the year, and hope that this report will also guide your efforts to improve the child welfare system for children.

It was a great privilege for all of the panel members to participate in this review process. All of us come from communities that also struggle with many of the same issues identified in our reviews. Many of us again went back to our home states and are working to implement some of the changes identified through the reviews of your state's children.

The review panel approached their work with an incredible degree of professionalism, integrity, determination and hard work. I also want to acknowledge the contribution made by your own staff in staffing the panel. For these reviews, Barbara, Caroline and Karla were invaluable in helping to obtain the right case information, stay organized and interpret Nevada laws and policies.

In speaking for the entire panel, thank you again for the opportunity. We were once again touched by the stories of the children and their short, tragic lives. We hope that our report will make a difference for Nevada's children.

Sincerely,

Theresa M. Covington, Panel Chair
Director of the National Center for Child Death Review

Nothing is as inappropriate as the death of a child; nothing makes the universe seem quite so bitter and senseless, nothing so shakes the throne of God. For the child who is taken has not had a life of disappointment that death will clear. He has not had time to reflect upon the inadequacies of natural and social systems savage and unkind enough to require the death of children.

He has not had lessons in courage, building it over years and decades as he learns to risk, to lose, to come back, and to win. He has not seen and understood things that are almost indistinguishable from miracles.

He has not learned either to endure pain or to understand that all pain comes to an end. He has not had his fill of life. He cannot say, "I have done right and my task is complete." He still fears the darkness, and monsters, and ghosts. He has no one to carry forward for him in this world, and no one to care for him in the next, for in leaving his father and mother behind he cannot enjoy even the illusion that they will be waiting to take him in their arms, much less the chance that it will be so.

Foreword excerpted from *Only Spring: on mourning the death of my son,*
by Gordon Livingston and foreword by Mark Helprin.

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Introduction

Children are affirmations of life. We do not expect children to die. When they do, we lose memories, dreams, innocence and some of our future. Our world is often poorer for their absence. Their deaths often present painful questions and bewildering dilemmas. When we work to answer the questions and understand the dilemmas in order to save the lives of other children, we are honoring the memories of our youngest victims.

In December of 2005, the Nevada Department of Health and Human Services took a bold step to implement a comprehensive process to address child fatalities statewide. This resulted from an analysis of child abuse fatality data that found that potential child abuse deaths were often under-investigated and underreported in various state records.

The initial analysis found a number of concerns related to child welfare practices that the state wanted to explore in more depth and find solutions. Examples of some of the early findings in this analysis include:

- An increasing number of child deaths in Nevada involve maternal drug use. The data reported in this area for 2003-2004 is significantly higher than that reported for 2001-2002.
- Child fatality information has not been entered timely or consistently into record systems such as the UNITY and CANS systems. Additionally, conflicting information exists between the systems.
- Communication gaps among medical, law enforcement and child welfare systems seem to exist in that deaths are not uniformly defined and classified.
- Oftentimes, when a child dies from maltreatment, and there are no siblings or other children in the home, no child protective services investigation is warranted, per state regulations. Further, these deaths are often not reported in the UNITY or CANS systems, and therefore are not included in state/federal death reports. Other agencies have investigated these deaths; however, communication was lacking in many of these deaths between agencies.

The State decided that one approach to identify concerns raised through this analysis would be to conduct a review of a select set of child fatalities from throughout the state. Deaths of children from Clark County were selected for the first round of reviews. The state identified 79 Clark County child deaths from the years 2001-2004 that they believed warranted close attention, and a review was conducted and report released of these deaths in the spring of 2006. This report addresses the additional 52 deaths identified for Washoe county and rural Nevada. All of the deaths had probable elements of maltreatment associated with them.

The state contracted with the National Center for Child Death Review to manage this review process. A panel of child welfare experts, all but one of who reside and work outside of the state was selected. The panel in this report was the same as that in Clark County, with the exception of three panelists. Schedules prevented these three panelists from attending, and they assisted in selecting two alternates. The panel met in northern Nevada over five days and closely reviewed each one of the 52 cases. They also conducted interviews with key agency leaders from both Washoe county and areas of rural Nevada.

The following report is the Panel's set of findings and recommendations, which the Panel believes may help to improve the systems in Nevada that are designed to keep children healthy, safe and protected. Many of these recommendations will require a long-term commitment to children and funding that may require a significant shifting in priorities towards those children most at risk in Nevada. The findings and recommendations are divided separately for both Washoe county and rural Nevada. As was expected, the findings are somewhat different. They ordered by the type of response taken when a child dies or is found to be in need of child protection services. Some of the recommendations may seem redundant, however all of the findings and recommendations are based on actual case findings in the 52 deaths. The experiences of the panels, many of who come from communities also struggling with the same issues identified in this report, used their expert knowledge and national experience to guide their thinking in crafting recommendations for Nevada.

It takes an act of courage to open up your case records to an outside panel. It is also an act of courage to acknowledge that most of the deaths of the children in the Silver State can and must be prevented. We hope this report furthers the awareness and action of Nevada and northern Nevada officials as well as citizens on how to work together to *keep kids alive*.

This report is dedicated to the children whose lives the panel members were so privileged to know a little of, however fleeting. We hope that their life and death lessons may bring improvements to the systems in Nevada so that other children may have long and happy childhoods.

Independent Child Death Review Panel

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The Independent Review Process

The Child Death Cases Selected for Panel Review

This review focused on 52 child deaths that occurred in Nevada from January 2001 to December 2004. Thirty-seven of these occurred to children residing or visiting in Washoe County and fifteen deaths occurred to children living in the rest of Nevada, excluding Clark County. The Department of Health and human Service's (DHHS) Division of Child and Family Services (DCFS) selected the cases following an analysis of all child deaths that occurred in Clark County in this period.[*] That analysis included:

1. Creation of a database of child fatalities in Nevada, 2001 through 2004, developed with source data from state death records, the state's Child Abuse and Neglect Reporting System (CANS), Unified Nevada Information Technology for Youth (UNITY); the courtesy death notifications database[+]; and regional CDR team data.

2. A review to determine which deaths had CPS substantiations through prior and post-death CANS entries, open UNITY cases, prior CPS involvement, prior state juvenile justice system involvement and/or prior mental health system involvement.

3. A crosscheck of DCFS source data with state death records to evaluate initial data quality and identify areas needing improvement within the data collection process.

The data analysis did not include a review of paper files, nor interviews with individual caseworkers. The purpose of the data analysis was not intended to review case practice. The intent of the data analysis was to determine as accurately as possible: total child fatalities, fatalities of children currently being served or previously being served by the programs established to help protect children from maltreatment, the accuracy of reporting systems and whether child fatalities are being classified appropriately.

The analysis identified the cases that were selected for review in Clark County. Following that review and report, Nevada DHHS identified a cluster of 52 cases from Washoe County and rural Nevada that they believed might also have issues related to maltreatment and neglect (see tables in Appendix A).

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[*] *The Preliminary Findings of the Child Fatality Data Analysis* were reported to the public through a Press Release from the Director's Office, December 1, 2005. (http://www.hr.state.nv.us/directors/pressrelease/PR_2005-12-01.pdf)

[+] In January 2005, the state DCFS requested, and the county child welfare agencies began providing voluntary "courtesy death notifications" on open child welfare/child protective services cases. On May 3, 2005, a memorandum of understanding (MOU) was executed between the state DCFS, Washoe County Department of Social Services and Clark County Department of Family Services. The MOU established an agreement that courtesy notifications would be submitted to the state agency, DCFS, within 24 hours of a county child welfare agency Director or DCFS Rural Region Manager learning of a child fatality in which an open child welfare or child protective services case or child welfare system involvement existed within the past two years.

It is these 52 cases that were reviewed by the Independent Panel

The official certification of death for the 52 cases included a wide range of causes and all five possible manners of death. They included:

Table Two: Types of Deaths Reviewed by the Panel for *Washoe County*

Type of Death	Manner					Total
	Natural	Accident	Homicide	Suicide	Undeter-mined	
Fetal Demise with Drug Intoxication					3	3
Fetal Demise: Cord Complications	1					1
Infants with Medical Conditions	6					6
Children >Age one with Medical Conditions	6				1	7
SIDS	3					3
Infant Asphyxia While Sleeping	-				1	1
Infant Undetermined While Sleeping	-				4	4
Car Crash	-	4				4
Physical Abuse	-		3			3
Shot by Firearm	-		2			2
Hanging				1	1	2
Overdose	-		-	1		1
Total	16	4	5	2	10	37

Table Three: Types of Deaths Reviewed by the Panel for *Rural Nevada*

Type of Death	Manner					Total
	Natural	Accident	Homicide	Suicide	Undeter-mined	
Children >Age one with Medical Conditions	2					2
SIDS					2	2
Infant Asphyxia While Sleeping		1				1
Entrapment		1				1
Car Crash		6				6
Drowning		1				1
Fire		1				1
Skiing/Snowboard		1				1
Total	2	11	0	0	2	15

For Washoe County, all but one death was referred to the Washoe County Coroner. For rural Nevada, all of the deaths were under the purview of the county coroner's office in the county the death occurred. The coroner offices made the determination of cause and manner in each of these 51 cases, with a range of completion of an autopsy, scene investigation, medical history review and interviews. Hospital physicians made the determinations in the other one death and this death did not have a forensic investigations.

Unlike Clark County, the range in deaths reviewed included a larger number of children over the age of one. The ages of the deaths reviewed included:

Table Four: Age of Children Reviewed for *Washoe County*

Age of Child	Number of Cases
Fetal	4
1-29 days	5
1-6 months	10
7-11 months	1
1 year	2
2-4 years	1
5-7 years	2
8-11 years	6
12-16 years	6

Table Five: Age of Children Reviewed for *Rural Nevada*

Age of Child	Number of Cases
Fetal	0
1-29 days	0
1-6 months	3
7-11 months	0
1 year	1
2-4 years	2
5-7 years	0
8-11 years	2
12-16 years	7

For Washoe County, the cases included 22 males and 15 females. For rural Nevada, there were seven males and eight females.

The race of the children for Washoe County was: 27 of the children were white, seven were black, two were Asian or Pacific Islander, and one child was an American Indian.

Three of the children were of Hispanic ethnicity. For rural Nevada, all of the children were white and none were of Hispanic ethnicity.

All but a few of the children who died were residents of Nevada. The non-resident children were either visiting relatives in the county or traveling from California or Arizona through Nevada at the time of their deaths.

It is important to note that the findings and recommendations of this report pertain only to the 52 cases reviewed. The deaths occurred from 2001-2004. There were at total of 504 deaths of children ages 0-17 in rural Nevada and Washoe County combined during this period.[1] Thus the reviews represent 10.3% of all deaths during this time period. There was a total of 1,340 child deaths in the entire state of Nevada from 2001-2004, with most deaths occurring in Clark County. Thus assumptions should not be made that these reviews are indicative of the entire State of Nevada, including Clark County. Individually for Washoe County, there were 341 deaths ages 0-17 from 2001-2004, so the reviews represent 10.8% of all these deaths. For rural Nevada, there were 163 total deaths, so the reviews represent 9.2% of all these deaths. The review panel did not have any case information on the remaining 452 deaths in Washoe and rural Nevada and conducted no reviews of these deaths. *Thus there is selection bias in choosing these 52 cases for review, i.e. DCFS believes these cases merit more intense reviews because of probable maltreatment and potential systems problems. The 52 children reviewed by the panel probably had a significantly higher proportion of risk factors than the total 452children or the total living population of children in Washoe County and Rural Nevada.* For example, of the 52 deaths, the case records suggest the following:

- Drug and alcohol use by the caregivers or perpetrators and/or drug exposure in the children was a significant or underlying factor in at least 17 of the 37 deaths in Washoe County, it was not a factor in at least three deaths and no information was available on the remaining 17 deaths. Drugs and alcohol were a factor in only three of the rural cases; not a factor in two cases and in 10 rural cases, no information on parent or child drug or alcohol use was available in the records.

- Only four of the Washoe county children and two of the rural children did ***NOT*** have prior CPS reports, substantiations or significant involvement with the system.

- For Washoe County, all but four of the 37 children had siblings. For rural Nevada, all of the children had siblings, except for child wherein the information on siblings was not available.

- It appeared from the case readings, that the majority of the children came from or lived in impoverished households.

[1] Nevada Interactive Health Database, Center for Health Data and Research, Bureau of Health Planning and Statistics, Nevada state Health Division: http://health2k.state.nv.us/nihds/

Thus the information presented in this report cannot be extrapolated to any of the other 504 deaths, including the circumstances leading to the other deaths or the systems responses to those deaths. However, the findings and recommendations have their own merit, especially those that cut across the different causes and manners of deaths reviewed and involve multiple systems issues. And of course, every single child death is a great loss that deserves a full and comprehensive review.

The panel also believes that one of the best ways to honor the memory of every one of the 504 children who died in Washoe County and Rural Nevada from 2001-2004 is to learn from the sad stories of these special 52 young people whose deaths are presented in this report.

Selection of Panel Members

On December 28, 2005, the Division of Child and Family Services issued an *Announcement of Request for Qualifications* for the potential panel members for the Clark County review. The panel was to be composed of two representatives from each of the following disciplines, with additional expertise in child protection and/or child fatality investigation:

- Law enforcement
- Pediatric Medicine
- Legal/Criminal Justice
- Education
- Child Welfare
- Coroner/Medical Examiner

Working in consultation with the National Center for Child Death Review*, a list of national experts was compiled. All persons on this list were not only nationally recognized experts in their field but had extensive experience in child fatality review. Applications were accepted and reviewed by DCFS. The final panel was comprised of persons meeting the criteria for the expert panel as well as willing to pre-review case abstracts and donate a week of time in Las Vegas for the review panel proceedings. This panel met in Clark County and completed those reviews. All but three panelists agreed to return to northern Nevada for another week to complete the reviews described in this report. Expertise on the panel included:

Law Enforcement	2
Pediatric Forensic Medicine	2
Legal/Criminal Justice	2
Child Welfare	4
Forensic Pathology/Medical Examiner	2

* The National Center for Child Death Review is funded by the U.S. Department of Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau to provide technical assistance and training to state and local CDR programs.

The panel was designated as a multi-disciplinary team, under NRS 432B.403- 432B.407, thereby allowing the panel to meet, have access to confidential case records and meet in a closed, confidential setting. The National Center for Child Death Review was contracted with funding from *Victims Crime Assistance* to supervise and chair the review process and manage the travel and meeting logistics.

DCFS also selected five persons from Nevada with extensive knowledge and experience with the Nevada child protection system. These abstractors, through contracts with DCFS, compiled all available case records and prepared written abstracts for the review panel.

All team members and abstractors signed letters of agreement, statements of confidentiality and statements related to HIPAA Privacy considerations prior to reviewing and/or abstract the cases. These agreements and statements are on file with DCFS. The listing of members and abstractors is presented in the opening pages of this report. Their contact information is available through DCFS.

Three staff persons from DCFS assisted in gathering case records, assisting in the meeting logistics, arranging for the key constituent interviews and serving as experts on child welfare in Nevada. They attended all of the review panel proceedings and were invaluable in providing information and answering panel member questions related to specific cases and to Nevada child welfare law, policy and practice.

The Case Reviews

Several weeks prior to the review panel meeting, a number of steps were taken to develop a complete case record for review: DCFS staff worked with Washoe County and rural counties to obtain case records on the 52 deaths, they contracted with the five abstractors and they developed abstract forms.

Two forms were developed for use by the case abstractors: the *Child Death Case Review Instrument* and the *Child Fatality Review Case Abstract Form* (Appendix A). The *Case Review Instrument* is an audit of the actions taken by CPS relative to the child and/or other case participants, such as parents, other caretakers, other family members and siblings. The Instrument documents all actions preceding, as a result of and/or occurring after the death. It addresses intake, case management, pre-placement, placement, case planning, and legal responsibilities. This abstract was only completed on cases in which the child, the family or in some cases the perpetrator had involvement with CPS.

The second instrument, the *Case Abstract* Form, summarizes available records on the death of the child. In most cases, this included the autopsy report, the toxicology report, CPS records, and the county coroner's reports.

The abstractors reviewed all available case information and completing the two abstract forms. A case file was then compiled for each death. These were mailed to the review

panel members two weeks prior to the meeting. All members read through their cases before arriving in Reno and then mailed their files back to DCFS. They were then made available again at the panel meetings.

DCFS also obtained copies of the complete CPS case file, the coroner records, and a limited number of police investigation reports for the 52 deaths. These were also available at the panel review meetings. It should be noted that unlike the Clark county reviews, the DHS available for this review was much more extensive and complete.

The review panel met for 4.5 days, from October 22-27, 2006. For two days, the 8 hour proceedings included interviews with key constituents from county agencies and then case-by-case reviews of the deaths.

Key Constituent Interviews

One of the perils in having an outside, independent panel of experts review cases from outside of their own jurisdiction, is that they will not understand nor appreciate the context of the community in which the deaths occurred. For Washoe County, this includes:

- Not understanding the rapidly changing community demographics;
- The unique challenges faced by a community experiencing profound growth;
- The concomitant strain on resources;
- The different agency systems in place to protect children and respond to fatalities;
- Other special features of a county different from one's own.

For rural Nevada it also included the panel members not having experience with the difficulties in providing services in frontier communities and the distances required for staff travel and the limited resources in rural areas.

To help the panel understand some of the context of both Washoe County and the rural areas, the panel requested interviews with key persons from agencies having responsibility for child protection, law enforcement, forensic investigations, certification of cause and manner of deaths, health and child death review. Persons generously gave of their time to meet with the panel and made themselves available for further questions throughout the week. The panel was very impressed with the willingness of these persons to passionately and candidly share their own perspectives on the workings of their own agencies, their relationships with other agencies, and their participation on the Child Death Review Team. The panel believed that the interviews were as important as the case reviews in helping the panel understand the child protection system and in identifying strengths in agency systems and areas for improvement. Although all individual statements from these interviews are confidential, the panel in developing the findings and recommendations, especially related to systems improvements, used them.

The persons interviewed by the panel included the following:

Table Seven: Key Constituent Interviews

Washoe County	
Washoe County District Attorney's Office	Jeff Martin, Civil Division
	Dave Clifton, Criminal Division
Washoe County Sheriff	Sergeant. Sylvia Redmond
Reno Police	Sergeant Doug Evans
	Detective Randy Saulnier
Sparks Police	Sergeant Charles Alt
Washoe County Coroner	Vern McCarty
Washoe County Forensic Pathologists	Dr. Ellen Clark
	Dr. Katherine Raven
Washoe County Department of Social Services	Mike Capello
	Jean Marsh
	Michelle Lucier
	Becky Gebhardt, nurse practitioner
Washoe County Public Health	Candace Hunter
Rural Nevada	
State of Nevada: Rural Human Services	Pat Hedgecoth: District Office
	Larry Robb: Elko
	Novia Anderson: District Office
	Paula Achurra: Fallon
	Tricia Sheridan: Winnemucca
Winnemucca Police Department	Detective Sergeant Ed Killgore

Findings and Recommendations

A significant amount of time was spent reviewing each child's death, during which panel members analyzed, discussed and debated their opinions on the case. During each case review, every panel member was responsible for recording specific findings and recommendations in their area of expertise. For example, the two law enforcement experts recorded panel findings and recommendations related to the law enforcement investigations on every case reviewed.

The panel chair compiled and totaled all of these findings and recommendations into one document. On the final day of the session, the panel reviewed, revised and agreed by consensus to the final set of findings and recommendations that are included in this report. The panel chair authored this report.

The panel was very diligent in "sticking to the facts" of each case. All findings are based only on the available case information. When information was not available, the panel did not make assumptions on the circumstances of a case or on actions taken by an agency. The review discussions were hampered by the lack of information on a number of cases. For these reviews, the panel felt that they usually had adequate information to make informed recommendations and often had complete case files from CPS, medical records, and police reports.

Because the actual case file information is confidential, this report does not link individual cases to findings. However, the panel is able to verify that every finding is linked to a specific case(s), and this confidential document is being provided to DCFS as a separate report.

What is provided, however, for each finding, is the total number of cases in which that specific finding was made. This number is in parenthesis at the end of each finding. So for example, if the finding states that "a report to CPS should have been, but was not made by a mandatory reporter (6)", the panel identified 6 of the 52 deaths in which this finding was true.

In reviewing the deaths, and when information was available, the panel focused their reviews not only on the circumstances surrounding the death events, but also on circumstances occurring prior to and after the deaths, sometimes in the distant past or future. For example, in reviewing a prematurity death of an infant related to methamphetamine exposure, the review panel might have assessed early intervention services for the mother on this birth and later services if the mother became pregnant again.

The panel organized their findings and recommendations according to a continuum of services and activities that usually occur when identifying at risk children and responding to the deaths. Thus the findings are organized according to the following:

- Identification of and the reporting to CPS, of suspected child abuse and child deaths.
- Investigation by law enforcement of suspected abuse and of child deaths.
- Investigations of child deaths by the Coroner's Office.
- Case intake and investigation by CPS of suspected child abuse and of child deaths.
- CPS substantiation of child abuse.
- Provision of Services by CPS.
- Actions taken by the civil and criminal divisions of the District Attorney's Office and the Courts.

The panel also came up with a set of findings, based in part on the key informant interviews, that although not linked to specific cases, seemed pervasive and in need of attention. These included findings and recommendations related to:

- Overarching, multi-system issues that impact the ability of agencies to protect children.
- Child Death Review Team functioning.

The following pages detail the specific findings and recommendations. Some of the findings are based on a large number of cases; some are based on one case. The panel did not prioritize the recommendations, but believe that some of those based on one case may be as important as those based on many cases. The panel encourages those responsible for reviewing and responding to this report to give equal attention to all of the recommendations prior to making decisions on what actions to take as a result of this report.

It would help the reader understand the context in which many recommendations are made if the reader knew the circumstances of a case. However, because of the relatively small number, it is not possible to provide this information because it could too easily be linked to an identified case. The following though, are representative of the types of cases reviewed by the team. They include:

- An infant is still born at 26 weeks gestation. There is evidence of methamphetamine intoxication in the infant. There is a long history of substance abuse on mother and little information available on father, although it is known that the mother is a victim of long-term domestic violence. There are other children either in home or "with relatives", or "in another state." The death is ruled natural. It is not reported to CPS or law enforcement, therefore no investigation is conducted and no other services are provided to the mother. If reported, the case probably would have been recorded as an information-only case by CPS.

- An infant dies in his sleep in a seemingly unsafe sleep environment, sleeping with multiple caregivers. There is no autopsy conducted, the death is ruled a SIDS, and no report is made to CPS. Upon review it is determined that there had been multiple CPS reports on the family in another state.

- A school-aged child has a chronic illness and is living in foster care. There had been a number of complaints related to the foster home's ability to provide care for critically ill children. The child dies a natural death from complications of her illness but questions persist as to whether her care was appropriate.

- A child dies in a traffic crash. She was not restrained in a car seat and the driver of her car, her parent, was intoxicated at the time of the crash. The driver is criminally charged, but no one reports the incident to CPS.

- His father shakes an infant to death. During the investigation it is found that this is the ninth child of the mother, and that she had her rights terminated on all previous children. This baby was not known to the system.

- A teenager hangs himself. There had been an extensive CPS history in the family and the child had experienced significant losses. There is no evidence that the child was obtaining mental health services. Surviving siblings do not receive safety assessments by CPS.

While the number of findings may seem daunting, there are some similarities among them, and the systems recommendations at the end of this report will encompass many of the issues addressed in the specific case findings.

One very important caveat in reviewing these findings and recommendations is the fact that the deaths occurred from 2001-2004. In the two to five years since, there have certainly been changes made to Nevada state laws, agency policies, practices and resources. We also heard during the interviews that a number of changes have already been implemented as a result of this panel's first report to Clark County. For example, Washoe County is now opening CPS investigations on siblings in child death cases and using higher chains of command in some former "information only" case decisions. We anticipate that some readers will review this report and respond with, "Well, we've already made improvements related to this issue." The panel hoped that through the interviews with key constituents, our knowledge on improvements would be up to date, but is also certain that many were missed. The panel was made aware of many improvements during the interviews and for that we commend the State of Nevada and congratulates the agencies for recognizing and responding to the need.

The findings are organized such that all of the findings and recommendations for Washoe County are presented first followed by those for rural Nevada. Because many of the systems issues identified by the panel are the same, a discussion incorporating both rural and Washoe County follows the findings.

Findings for Washoe County

A. Identification of and the reporting to CPS, of suspected child abuse and child deaths.

Findings:

Generally there appears to be a well working system for reporting abuse and neglect in Washoe County. The panel made a call to the CPS reporting line on a state holiday, and the call was answered immediately and appropriately. The primary problems in reporting appeared to be a lack of understanding on what type of case should be reported by mandatory reporters and the lack of trained child abuse medical providers in the Reno area hospitals. The panel reviewed a number of cases in which no report was made to CPS by other agencies, even though there were possible abuse and/or neglect elements in a death. The panel heard that the local forensic pathologist is usually called upon to assess possible abuse and neglect in a clinical setting, and numerous interviewees remarked on the lack of a trained forensic (or child abuse) pediatrician in northern Nevada. Several key informants remarked that the lack of quality medical exams for non-verbal children is troubling for them. At this time Dr. Ellen Clark and R.N. Becky Gebhardt are the only regular consultative resources for law enforcement and the child death review team. Dr. Clark has numerous other responsibilities, including serving as the county's forensic pathologist. Ms. Gebhardt is also responsible for conducting sexual assault forensic exams for child victims in the county. Thus the county lacks the expertise of a board certified forensic pediatrician (child abuse pediatrician) to examine injuries in live patients. Specific case findings include:

1. Doctors failed to notify CPS of possible, and in one case obvious, child abuse. These included positive maternal drug toxicology, recurrent and unexplained infections, a premature infant positive for drugs, and suspected shaken baby syndrome in a sibling. (4)

2. Coroner did not report possible abuse or neglect to CPS. (2)

3. Police did not notify CPS of suicides when there were highly suspicious behaviors on the part of parents and there were surviving siblings. (2)

4. Police did not report a death with implications of abuse and neglect to CPS. (2)

5. Domestic violence issues were not adequately addressed by police and the prosecutor and not reported to CPS. (2)

Recommendations

1. Clarify and if necessary strengthen state laws and policies regarding definitions for abuse and neglect in fetal and infant deaths caused in part by maternal drug use or other lifestyle issues that could cause harm to infants.

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.

3. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.

4. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Children's Advocacy Center model.

5. Identify funding for and recruit a trained forensic pediatrician.

B. Investigation by law enforcement of suspected child abuse and child deaths.

Findings: The panel was impressed with the apparent quality of the death investigation reports in the case files, including scene investigations; and with the coordination among the Reno, Sparks and sheriff department with CPS and the district attorney's office. All of the agencies interviewed commented on the quality of their multi-disciplinary investigations and the sharing across agencies of information on cases. There was evidence in the case files that referrals and contacts were routinely made during investigations.

Law enforcement have scene protocols in place, although they were not conducting doll reenactments, a relatively new technique. There also appeared to be excellent working relationships between police and CPS, including co-working on investigations. Law enforcement asks for and obtains CPS histories on families under their investigation and provides CPS with criminal histories on a regular basis. The Child Protection Enforcement Team (CPET) is an excellent example of multidisciplinary coordination around children's safety issues. The findings presented here include a few cases that seemed to fall though the crack, especially because they were not typical child abuse cases, but rather involved accidental or natural deaths in which there were significant family histories or parental neglect/abuse issues not necessarily directly related to the deaths. Specific case findings include:

1. Law enforcement did a good investigation including interviews and evidence collection in SIDS and other infant sleep-related deaths. Shortfall was lack of a doll reenactment to assess the infant's position in sleep-related deaths. (7)

2. Despite a well-done investigation, law enforcement did not forward the case to the district attorney, even though there are obvious signs of neglect and/or abuse in these cases. (2)

3. Despite a well-done investigation, law enforcement failed to notify CPS of possible egregious neglect and parental mental health problems. (1)

4. County and city law enforcement conducted excellent traffic crash reconstructions. (3)

Recommendations

1. The state should adopt, provide training on and enforce the utilization of the the new national guidelines for Sudden and Unexplained Infant Death Investigation and provide training throughout the state to law enforcement and death investigators. These guidelines include reenactment of the death event using dolls.

2. Two cases of possible abuse and/or neglect should be submitted to the district attorney's office for review and further investigation conducted.

3. Law enforcement should establish a policy to notify CPS on every child death they investigate, regardless of cause and manner.

C. Investigation by Coroner/ Medical Examiner

Findings:

There appears to be a significant lack of training in death investigation for the coroner's investigators/first responders in rural Washoe County; therefore, recommend allotting time and money to allow death investigators to attend local, regional, state and national meetings. Trained deputy coroners are not available in outlying, rural areas. The Coroner does not follow nationally developed and recommended protocols for scene investigation and autopsy performance and is opposed to his investigators using "check list" guidelines for use in the field. Coroner investigators are not allowed to perform doll re-enactments, even though re-enactments may be very helpful for investigators who are working to answer questions about the scene and circumstances. Such information may help to achieve accurate cause and manner of death determinations.

There appears to be no daily triage mechanism in place to make decisions on disposition of cases; a triage mechanism requires the expertise of a forensic pathologist, in concert with other members of the "triage team," to ensure consistency within the office. It appears that the coroner is making cause and manner determinations, sometimes in

conflict with the recommendations of the forensic pathologists. The forensic pathologists do not usually make cause and manner of death statements on their autopsy reports and do not usually have access to the complete "story" of the death circumstances. It also appears that scene investigation results and toxicology test results are not routinely making their way to the pathologists for consideration in their assessment of cause and manner of death. The pathologists conducting the autopsies are not allowed to complete death certificates.

The coroner will, on occasion, overrule decisions by coroner staff who want to perform appropriate toxicology and other supplemental tests and he has a blanket policy of "no autopsies on adolescent suicides."

SIDS referrals for grief counseling are not routinely implemented.

Specific case findings include:

1. It does not appear that toxicology tests were performed, when they should have been (7).

2. Only limited metabolic tests are routinely done, when more comprehensive panels should be done. (Most autopsies)

3. Pathologist did not appear privy to findings from the law enforcement and CPS investigations in conducting the autopsy. (2)

4. Autopsy reports are generally quite competent, thorough and well organized. Very good built-in autopsy quality assurance in having a second pathologist review and countersign the autopsy protocols. (Most autopsies)

5. Pathologists did not fix the brain in autopsy, although final findings seemed accurate. (2)

6. Child in a group foster care with significant medical history and/or psychological history did not have an autopsy or full examination by coroner's office. (1)

7. Case reported to coroner but denied by coroner for full investigation, even though there were physician concerns regarding overmedication by parent. (1)

8. Autopsy opinion submitted by forensic pathologist substantially different than cause of death certification by coroner's office. (Sudden unexplained death in infancy vs. SIDS). (1)

9. Mother's extensive history of and use of methamphetamine was not associated with the cause of death listed as fetal demise due to placental abruption and therefore not reported to CPS. (1)

10. Organ procurement was successful. (1)

Recommendations:

1. Establish a state level study group and consult with experts from the National Association of Medical Examiners and the U.S. Centers for Disease Control to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system. This would allow for oversight on death investigation and certification to physicians rather than lay appointees.

2. All children in state custody should have full death investigations through the coroner's office, regardless of suspected cause and manner.

3. Cause of death statements should always be listed by forensic pathologists on autopsy reports, prior to review by the coroner's office.

4. Coroner should not change cause and/or manner statements from forensic pathologists without first meeting with pathologists to address scene circumstances and autopsy together prior to certification and consider a mechanism to also have a deputy coroner available to "sign off" on all cases.

5. Establish improved communication and collaboration between the coroner and pathologists, and between coroner and CPS and law enforcement. Recommend that all deputy coroner investigative reports to the pathologists include mention of CPS and law enforcement involvement, as this information must be provided to the pathologist prior to death certification. The pathologist should not be working in a vacuum.

6. Allot time and money to allow death investigators to attend local, regional, state and national trainings and meetings.

7. Comprehensive toxicology testing and metabolic studies (e.g., Pediatrix) should be conducted rather than the basic panel tests currently being conducted, on most infants and children under the age of 18 years

8. Nuropathology consultation on formalin fixed brains should be obtained especially on potential abusive head injury deaths and for instances of hypoxic/ischemic encephalopathy.

9. Consider using terms on death certificate other than SIDS, such as "sudden unexplained death in infancy/undetermined" when intense petechiae, CPS issues, cosleeping or other unsafe sleep environment issues are present.

10. Re-open for investigation at least one case.

11. Establish a policy and procedure with reference to organ procurement, and involve law enforcement and the district attorney.

D. Case intake, investigation and assessment by CPS of suspected child abuse and of child deaths.

Findings:

The most significant findings across the board in these cases seems to be the number of times a death was reported to CPS but the intake was accepted as an "information only" event. The bar did not seem to be raised among workers or supervisors in child deaths, to set in motion more extensive and rigorous CSP investigation. Because of these information only cases, siblings were also not assessed.

Another major finding is that CPS defers to law enforcement for investigations. In the law enforcement interviews, it was made clear that law enforcement prefers this, but it is removing the role and perspective of CPS from the complete investigation into the deaths and sometimes preventing access to or assessment of siblings. There were times when even supervisors waived immediate contact with families until law enforcement had completed their investigations.

Safety assessments were routinely marked as "safe" even when risk factors were present. It appears that in most of these cases, it was because of the need to enter the closed cases into the new "unity" system. The deceased child cases could not be closed unless the assessments were marked as safe. This is more a fault of the programming, but needs to be fixed. In only one case was it found that incorrect assessments were made based on the existing circumstances in the case. The more significant problem as described above was the failure to conduct assessments because CPS was not notified of the death.

The lack of a forensic pediatrician hampers the assessment work of CPS, while efforts to use a nurse practitioner have some merit. However, it does not appear that other agencies hold this nurse practitioner position in as much esteem as they would a physician. For example, it was stated "If we used her in court, the defense would simply bring in a physician to counter any of her statements." There does seem to be some confusion among agencies as to the role and responsibilities of the nurse practitioner.

There is currently a dedicated CPS staff person responsible for investigating child deaths, which is an excellent practice, even though this was not in place at the time of these deaths. Specific case findings include:

1. Cases reported to CPS but accepted as information only should have been investigated and there was also no evidence of supervisory oversight on these cases. (8) For example:

- Child dies of a preventable infection. When a report for possible medical neglect came in on the surviving sibling a few months later, it was taken as information only.

- Infant dies of preventable infection and sibling still at home.

- Child in extreme pain at home for several days and untreated, later dies of a preventable infection that should have been identified.

- Baby dies with unexplained marks/discoloration on body with and 13 previous reports.

- Baby dies of SIDS with suspicious circumstances and 18 month-old still in home.

- Child hurt in MVA related accident, with intoxicated perpetrator, and story suspicious. Case taken as "assessment only" a term which does not seem to be in policy.

- Inconclusive but probable inflicted trauma of an infant.

- Suicide in a child whose family has multiple risk factors including father as a convicted sex offender.

2. An undetermined infant death with some marks on body, but CPS deferred investigation to law enforcement. (1)

3. Siblings not checked. (5)

4. CPS did not investigate infant deaths that had maternal substance abuse and perinatal drug exposure. Two other siblings were at home but no CPS investigation because it was not a live birth. (1)

5. The risk and safety assessments were done well (4), but in one case appeared to be done in a cursory, informal manner.

Recommendations

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. This should include:
    a. CPS must investigate subsequent reports on cases where another child in the family had died.
    b. CPS should investigate all reports of possible medical neglect, regardless of if the death occurs in a hospital.

c. A full CPS on- scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision,
d. All deaths designated as undetermined by the Coroner's Office.
e. All deaths with prior CPS substantiations or at least three prior reports.

2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.

3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation.

4. Implement a policy that decisions to initiate an investigation when a child dies are made within 24 hours.

5. Consider amendments to state policy so that all infants born positive for illicit drugs or with evidence of fetal alcohol are substantiated and remain open for at least 6 months.

6. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.

7. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires three days.

8. A forensic interview protocol should be developed for surviving siblings and siblings should be interviewed according to forensic techniques, separately from other siblings and away from parents and potential perpetrators; consider using a Child Advocacy Center model for all of these sibling interviews.

9. Supervisors should ensure that due diligence is followed in locating out of state CPS records at least five years prior to the death in suspicious cases, including identifying prior addresses, contacting states, and reviewing and incorporating out of state information into the case file.

E. CPS substantiation of child abuse or neglect

Findings

The review panel was asked specifically by DCFS to make a determination through the case reviews on whether the panel believes the death should have resulted in substantiation for child abuse or neglect. The panel concluded the following:

1. An investigation should have at least been opened for more information: (6)
2. Should have been substantiated but was not: (14)
3. Was substantiated: (3)
4. Evidence is sufficient that the death should not be substantiated and it wasn't. (14)

The panel believed that in the 14 cases that should have been substantiated but were not, families could have received services to prevent future risks to other children. Such services that the case reviews indicated were needed included parenting training, substance abuse treatment, and domestic violence support services.

Recommendations

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.
2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.

F. Provision of Services by CPS

Findings

Generally the panel was impressed with the thoroughness of not only the case notes, but also the casework completed on a number of very complicated cases involving multiple perpetrators and victims. Many of these involved domestic violence, substance abuse, neglect and physical injuries. In only a limited number of cases did the panel feel that due diligence was not followed in providing services to the families.

Generally it was difficult to read many of the case files, because worker notes were not organized in a chronological order, rarely were there genograms available on the families, and it was difficult to identify the service plans and actions required for reunification and/or termination. Suggestions for services are made, some referrals are made but the case records do not document where the referrals were made. For example, in some case notes, worker reports that they told parent where they could get substance abuse treatment, but it's unclear if worker helped make the referral or appointment, to where, and if parent followed up.

There was also a few cases in which the families had repeated contact with CPS and the children were frequently removed, returned, removed, returned, etc. without any indication of permanency plans in the cases files.

There were a number of cases in which surviving children were removed from the homes and placed for adoption following the deaths due to abuse in the death or unsafe home environments; or in later years when other neglect or abuse was identified.

There were four deaths of children in foster homes in Washoe County. In all four of these deaths, there had been repeated reports against the foster homes. The panel is concerned that the need for homes is outweighing some safety factors. There had been "U" waivers for the homes to have extra children, despite the reports and deaths. One foster home had 22 complaints and two other deaths of medically fragile children and five complaints since the death reviewed by this panel. Since the death there are now adopted children in the home and an older son with a felony conviction. In another home with six high risk and medically fragile children, a child had seizures throughout the day but was not taken to the hospital. Another home has 11 CPS substantiations and a death of a child from a possibly preventable infection: this home has since been closed. Finally there was a natural death of a child in a home that has since closed.

Finally, in the key informant interviews we heard repeatedly of the frustration felt by CPS and law enforcement at the lack of medical professionals trained in forensic pediatrics, "we need pediatric specialists at our hospital."

Specific case findings include:

1. Long term and extensive domestic violence does not seem to be addressed in developing service plans. (6)

2. Substance abuse does not seem to be addressed in developing service plans. (2)

3. Significant mental health problems in parents not addressed in case records (2), in one case children returned although parent not taking meds for bi-polar disorder.

4. The child of a couple dies, and it becomes known that the over-thirty father had impregnated the mother when she was under the age pf 15. Mother repeatedly

victimized by domestic violence. Children were removed following the death but no actions were taken against the father. (1)

5. Natural mother allowed very abusive bio-father back in home against CPS agreement. Following death no actions were taken against him.

6. Multiple priors for abuse and neglect and DV before death, siblings finally removed after death. (1)

7. Long CPS history with children in and out of the home with no permanency plan in record and some records seem to be missing in the files. (1)

Recommendations

1. Revise the Case Reporting System for CPS to clearly delineate intake, investigation , case plans, referrals and services.

2. Require a written service plan for all cases that are substantiated.

3. Create a way to more clearly log all CPS contacts with the families.

4. Require supervisor and or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, mental health treatment, or domestic violence services.

5. Require tracking and follow-up on all referrals for service.

6. Require that when a death occurs on open cases, a new investigation/case record be created.

7. Require that all cases being closed have complete documentation in the case file describing the justifications for closing the case.

8. Establish a high level, independent review (separate from licensing and CPS) of all deaths and serious injuries occurring in any licensed foster homes and in adoptive homes that have more than one special needs and/or medically fragile child.

G. Actions taken by the civil and criminal divisions of the district attorney's office and the courts

Findings:

During the interviews the panel learned much about the county's Child Protection Enforcement Team, led by an attorney in the criminal division. This group meets monthly and addresses systems issues. This presents an excellent opportunity for multi-disciplinary investigations and coordination and seems to be working to help with coordinated investigations. In spite of this, multiple key informants commented on what is perceived as a "lack of urgency" from the district attorney's office in prosecuting cases of abuse and especially of neglect. One person stated, "we've had bad luck in getting the DA to prosecute cases for us." Another stated, "We'll package the whole case up and they just decide not to prosecute." Another remarked "the DA's Office won't prosecute the tough cases." In reviewing cases, the panel did identify several cases that we felt could possibly have been successfully prosecuted but were not.

It appeared that a number of cases were not presented to the DA's office by law enforcement. It is unclear if this is because of the perception that the DA would not take up these cases anyways.

One reason given to the panel on why certain cases of young children are not prosecuted is that Nevada evidence statutes related to "corpus delecti" makes it difficult to proceed when the only evidence is a perpetrator confession and a child's statements. Review of the statute by panel members led them to believe that the evidence statutes on corpus delecti should *not prevent* prosecution in abuse and neglect cases.

The DA office had at one time established a position to respond to child fatalities on a 24/7 basis. This position has since been eliminated. There are well-trained and experienced attorneys in child abuse whose roles include responding to abuse and neglect cases, but during off hours, these cases get assigned to other attorneys working after hour shifts.

The pediatric nurse practitioner, who has been in her role for two years, has never been asked to testify at trial for child abuse or neglect.

Specific case findings include:

1. Civil DA refused to file domestic violence in a case due to mom "recanting." (1)

2. Mother allows her boyfriend to abuse her child. Boyfriend sent to prison, gets out and returns to mother and subsequently murders her daughter. Mother not prosecuted for the murder despite overwhelming evidence and arrest/request for prosecution by law enforcement. (1)

3. The juvenile court had issued a "no contact" order by a sex abuse perpetrator in family. Contact continued and child ultimately took her own life. No follow up by DA on case. (1)

4. Very well done services provided by guardian ad litem in advocating for child. (1)

5. Undetermined cause of death with physical marks and history of father shaking child. No review by DA's office (1)

6. An undermined cause of death but manner homicide not accepted by DA office for investigation or action. (1)

Recommendations

1. Institute a policy that all cases investigated by law enforcement, the coroner and CPS be brought to the DA for their review.

2. Restate the position of a dedicated DA for child abuse and neglect cases on a 24/7 basis.

3. Reinvestigate cases described above and consider for prosecution.

4. Require mandatory training on domestic violence laws and polices for attorneys.

5. Review and utilize Nevada Evidence Code Sections that allow for prosecution in corpus delicti cases.

6. District Attorney's office should take county leadership in aggressively pursuing establishment of a child advocacy center for multidisciplinary, coordinated child abuse investigations and in hiring a county-funded forensic pediatrician.

Findings for Rural Nevada

A. Identification of and the reporting to CPS, of suspected child abuse and child deaths.

Findings

By nature of the huge distances separating rural communities in Nevada, the panel expected to find significant problems with the reporting and investigations of child deaths. Generally there did not appear to be significant problems in the larger towns in rural Nevada (Elko, Fallon, Winnemucca, Pahrump) but there did seem to be problems once removed from these areas.

Specific case findings include:

1. A child dies in an accident with apparent lack of parental supervision, multiple prior CPS referrals, but death was not reported to CPS.

2. In motor vehicle crashes that involved poor supervision and alcohol use, neither the police or coroners office notified CPS of the deaths. (4)

3. CPS not notified of a suspicious deaths until one week later (1)

Recommendations

1. 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.

2. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.

3. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Children's Advocacy Center model.

B. Investigation by law enforcement of suspected child abuse and child deaths.

Findings

Generally it seemed that law enforcement did an excellent job investigating motor vehicle deaths but infant deaths in sleeping environments were not well investigated. There appears to be wide ranges in competencies of investigations across rural Nevada, with more remote locations not having skills for infant death scene investigations. Specific findings include:

1. Law enforcement was aware of the death but did not notify CPS (3)

2. Law enforcement conducted a scene reenactment, but had the parents use their deceased child to demonstrate sleep position. (1)

3. Scene investigation conducted, but no reenactment conducted. (2)

4. No scene investigation done by law enforcement when circumstances should have required one. (4)

5. Little coordination between law enforcement, CPS and coroner systems (3)

Recommendations

1. The state should adopt, provide training on and enforce the utilization of the new national guidelines for Sudden and Unexplained Infant Death Investigation and provide training throughout the state to law enforcement and death investigators. These guidelines include reenactment of the death event using dolls and never actual children.

2. One case of possible abuse and/or neglect should be submitted to a multidisciplinary team for possible neglect or abuse charges.

3. State should provide rural law enforcement with training on mandatory reporting and need to notify CPS on every child death they investigate, regardless of cause and manner.

C. Investigation by Coroner/ Medical Examiner

Findings

There was a wide range of quality across the state as was expected. Cases that were referred to Reno or Las Vegas had better investigations and autopsies.

1. No toxicology screens completed at autopsy (2).

2. Autopsy conducted in private mortuary, but CPS case records had no autopsy or corner reports. Question on quality of autopsy. (1)

3. No autopsy conducted in a SIDS death. Determination made based on appearance of child in a mortuary. Case had multiple risk factors and prior CPS. (1)

4. Grandmother permitted to waive autopsy in one death.

Recommendations

1. Establish a state level study group and consult with experts from the National Association of Medical Examiners and the U.S. Centers for Disease Control to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system. This would allow for oversight on death investigation and certification to physicians rather than lay appointees.

2. Allot time and money to allow death investigators to attend local, regional, state and national meetings.

3. Comprehensive toxicology testing and metabolic studies (e.g., Pediatrix) should be conducted rather than the basic panel tests currently being conducted, on most infants and children under the age of 18 years

4. Re-open for investigation at least one case.

D. Case intake, investigation and assessment by CPS of suspected child abuse and of child deaths.

Findings: The most significant and prevalent finding was that CPS almost always deferred investigations to law enforcement in the rural areas. This may be a resource issue, but it was common in most of the deaths. As a result, safety assessments were

delayed in a number of cases. There were a number of policy violations apparent in the safety assessments as well.

1. Safety Assessment not conducted in accordance with policy:

    - Safety assessment not conducted in a timely manner, including one case in manager waived contact. (3)

    - Safety assessment not signed by supervisor with (3).

    - S.A. listed as unsafe, but case closed (1)

    - One assessment conducted for two children. (2)

2. Paternal grandparent who was primary sitter not interviewed during investigation.

3. CPS did not conduct investigation, using law enforcement findings to make case determinations (1)

4. Child died of undetermined cause, but siblings not seen by CPS. (1)

5. Children visiting from other states had prior CPS histories, but it did not appear that due diligence went into obtaining those histories and maintaining contact with the other states. (2)

Recommendations

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. This should include:
    a. CPS must investigate subsequent reports on cases where another child in the family had died.
    b. A full CPS on- scene investigation is required on all deaths of children under 18 that are accidental but involve lack of appropriate parental supervision,
    c. All deaths designated as undetermined by the Coroner's Office.
    d. All deaths with prior CPS substantiations or at least three prior reports.

2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.

3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation. If this is a resource issue, adequately fund CPS investigators.

4. Implement a policy that decisions to initiate an investigation when a child dies are made within 24 hours.

5. Re-open a possible homicide case.

6. Review policies regarding contact with other states and develop a quality improvement plan to address out-of-state referrals and notification.

7. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.

8. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires three days.

9. A forensic interview protocol should be developed for surviving siblings and siblings should be interviewed according to forensic techniques, separately from other siblings and away from parents and potential perpetrators; consider using a Child Advocacy Center model for all of these sibling interviews.

E. CPS substantiation of child abuse or neglect

Findings

The review panel was asked specifically by DCFS to make a determination through the case reviews on whether the panel believes the death should have resulted in substantiation for child abuse or neglect. The panel concluded the following:

1. An investigation should have at least been opened for more information: (4)

2. Should have been substantiated but was not: (7)

3. Was substantiated: (0)

4. Evidence is sufficient that the death should not be substantiated and it wasn't. (4)

The panel believed that in the 7 cases that should have been substantiated but were not, families could have received services to prevent future risks to other children. Such services that the case reviews indicated were needed included removal of other children

from dangerous households, substance abuse and mental health services, and follow-up in other states.

Recommendations

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.

2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.

F. Provision of Services by CPS

Findings

Generally the panel was impressed with the thoroughness of not only the case notes, but also the casework completed on a number of very complicated cases involving multiple perpetrators and victims. Many of these involved domestic violence, substance abuse, neglect and physical injuries and families that moved throughout the state. In only a few cases did it appear that due diligence was not followed in providing services to the families.

Generally it was difficult to read many of the case files, because worker notes were not organized in a chronological order, rarely were there genograms available on the families, and it was difficult to identify the service plans and actions required for reunification and/or termination. Suggestions for services are made, some referrals are made but the case records do not document where the referrals were made. For example, in some case notes, worker reports that they told parent where they could get substance abuse treatment, but it's unclear if worker helped make the referral or appointment, to where, and if parent followed up.

Of the fifteen deaths reviewed by the panel, substance abuse, mental health and domestic violence problems were pervasive in the families and there was little or no access to services.

In the rural region cases, more than 20% of the babies/children were physically disabled or had chronic physical and mental health issues. Children with disabilities are not only at risk because of the health factors attributed to or resulting from the disabilities themselves but they are also at much greater risk of abuse and neglect. Based on research and the current literature, children who are physically, cognitively or mentally disabled are abused at rates ranging from approximately twice to ten times the rates of typical children. The following issues are cited as contributing risk factors:

- Due to limited communication, children with disabilities can be "easy targets" for abuse.
- Disabled children often have many different caregivers.
- Many children with disabilities have not been taught any self-protection skills; compliant behavior is expected of them even if they are being hurt.
- Symptoms of abuse may not be easily discernable from symptoms of the disability.
- Commercially produced communications system do not include "language" for being physically or sexually abused.
- Medical neglect is often overlooked by both medical providers and CPS.
- Children with disabilities are sometimes very difficult to care for, can promote family stress and seriously affect the family's resources making them targets for anger.

Specific Findings include:

1. Substance abuse, mental health and/ or domestic violence issues not adequately addressed by CPS. (6)

2. Multiple complaints on all family members with little services provided (1)

3. Following death, surviving children returned to home with convicted sex offender grandfather but CPS not notified. Children later removed. (1)

4. Case closed despite conflicting stories and hazardous conditions. Does not appear interviews were conducted with all family members. (1)

5. Workers ignored mother's history in allowing contact and did not substantiate on case when grandmother was negligent. (1)

Recommendations

1. Specific recommendations that address children with disabilities:
    a. Have specially trained CPS staff who are familiar with the risk factors of abuse among children with disabilities. These staff should also have training in best practice of communicating with children with disabilities and importance of interviewing these children separate from their caregivers (professional or family.)
    b. Children with disabilities placed in foster care should be visited frequently to assess safety and well-being. Foster parents should be required to have special care training before children with disabilities are placed with them.
    c. Any reports of child abuse, physical or sexual, should be thoroughly investigated with interviews that support the child's communication abilities.

2. Revise the Case Reporting System for CPS to clearly delineate intake, investigation , case plans, referrals and services.

3. Require a written service plan for all cases that are substantiated.

4. Create a way to more clearly log all CPS contacts with the families.

5. Require supervisor and or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, mental; health treatment, or domestic violence services.

6. Require tracking and follow-up on all referrals for service.

7. Require that all cases being closed have complete documentation in the case record describing the justifications for closing the case.

G. Actions taken by the civil and criminal divisions of the district attorney's office and the courts

Findings: There were no findings in this are for rural Nevada.

Overarching Systems Issues

Findings:

Throughout the case review process and in the interviews, a number of issues seemed to be either pervasive across the systems or problematic enough that they impacted the ability of certain agencies to effectively protect children, adequately investigate child deaths and/or take actions as a result of the deaths. This next section includes findings that are not necessarily connected to specific cases but are findings the panel believes need to be addressed in the best interests of Nevada's children. Some of these findings may seem redundant from the previous sections, but the panel believes they are representative of systems issues and are worth repeating.

1. The panel was very impressed with the efforts in Washoe County and some rural areas to conduct coordinated investigations and involve the coroner's office, DA, law enforcement and CPS. There was often evidence of a coordinated child death investigation across all the agencies with responsibilities for death investigation. However there was not clarity on which deaths should come to the attention of a coordinated investigation, so that deaths which appeared to be accidental (but that have significant neglect and abuse underpinnings) were not adequately investigated in a comprehensives fashion.

2. The shortage of forensic pathologists and the reliance on a coroner death system was a factor in missing abuse and neglect in a number of cases.

3. The panel heard repeatedly from persons in both Washoe and rural Nevada that the lack of resources and the shortage of qualified medical professionals trained in child abuse and neglect detection and treatment leaves children at risk. In describing a new case, a panel stated: "a baby was brought in with a fracture and we did not have the resources to accurately identify the injury as abuse. One month later and we are now removing the children." The resource of the pediatric nurse practitioner, shared by the health department in Washoe County, is a laudable effort to address the problem, but the panel does not think it goes far enough to increase the level of medical expertise related to child abuse. Washoe County alone has enough cases to warrant additional resources.

4. The key informants expressed opinions that training opportunities for child death investigation were limited for all agencies.

5. Domestic violence is generally not taken into account in reviewing cases.

6. Agencies rely on other agencies to make decisions on taking action, e.g. CPS defers to law enforcement for investigations.

7. Nevada has a strong child endangerment statute, but there is a perception among law enforcement, CPS and others that the district attorney will not use the statute to prosecute cases.

8. Laws and the State's CPS Drug Baby Policy regarding fetal demise and drug-exposed infants are unclear.

9. Surviving siblings are often not assessed in a timely fashion.

10. The Unity system that requires death cases to be marked as "safe" on safety assessments in order to be closed causes confusion and may hamper efforts to provide additional services to families and protect surviving siblings.

11. The team reviewed deaths in which parents had rights previously terminated, and the new infant was not known to the system.

State-Level Recommendations:

1. Identify resources for, recruit and support medical experts in child abuse and neglect.

2. Develop a child advocacy center to service rural Nevada and Washoe County.

3. Joint investigative training should be provided to all agencies on child death investigation.

4. Adopt, train and enforce the national guidelines on Sudden and Unexplained Infant Death Investigation.

5. Develop a state medical examiner system and work to replace the coroner system with medical examiners.

6. 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.

7. Consider establishing a *New Birth Match* program, modeled after the State of Michigan's, which notifies CPS on all new births to the same parents who have had their rights terminated on other children or who have killed a previous child.

I. Child Death Review (MDT) Issues

DCFS asked the panel to also assess and provide recommendations to improve the Child Death Review Team process in place in Washoe County and rural Nevada. The key informants were asked for their perceptions related to CDR. Most are members of or have participated in CDR meetings. The chair of this panel has also provided training to the Washoe, Fallon and Elko teams and attended one state executive team meeting. All of the members of the panel have extensive involvement with CDR in their own states and communities.

The following findings and recommendations are based on the interviews conducted with staff and the panel members' own CDR experiences.

Findings

The Washoe team is highly functioning. The partnership between public health and social services allows for roles to be shared, cases to be well developed and prepared with good participation across agencies. All p[participating agencies freely share case information. The Washoe team seems clear and confident that the purpose of their reviews is prevention. Reno, Sparks and the Indian Colony police all attend the meeting that had led to joint investigations.

The pane was interested in how the CPET team in the DA's Office intersects with CDR. Interviewees reported that CPET is mainly an up- front investigative body and does not "bump" into the purpose of CDR, although many of the same persons attend both meetings.

The coroner's office does not use the review however in helping him make his own determinations of cause and manner. Cases are submitted for review to the Child Death Review Team only after the case in closed by the coroner. Reviews should be able to provide information law enforcement and CPS and other agencies prior to death certification. The corner does not believe however that nay new information has been obtained through CDR. Child Death Review Teams do not always have a coroner representative in attendance and autopsy reports are not usually shared with the team. What was troubling for the panel was the fact that the forensic pathologists often find out what the official cause and manner of the deaths they autopsy by attending the CDR meetings.

Two key informants were interviewed regarding the Elko team. The only concern voiced was that the team members provide a lot of input and information into the review meeting, but not a lot of prevention related strategies result from the reviews.

Persons describing the other rural CDR teams in Nevada are concerned that there are not enough staff in DCFS to manage the tasks of CDR, such as collecting records, setting

up the meetings, etc. The teams could also use more training on the CDR process and translating recommendations into action.

Recommendations:

a. Coroner files should also be available at the child death review team meetings for reference by the coroner staff attending the meeting and there should always be a coroner representative at meetings who is prepared to address issues related to the coroner investigation and autopsy.

b. The panel believes that an effective CDR team ***is*** 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.

c. The panel recommends that more training be provided to the rural teams to help them be more effective in identifying prevention strategies through their reviews.

Appendix A

Washoe County and Rural Nevada Data Analysis for Selection of Case for Review

Appendix B

Case Abstraction Forms

Appendix C

The CDC's Sudden and Unexplained Infant Death Investigation Reporting Form