

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
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT</p> <p>3. Develop interagency coordinated investigation protocols for deaths involving abuse and neglect.</p> <p>(Also recommended by the National Resource Center on Legal and Judicial Issues)</p>	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		<p>Establish an action plan to complete the following:</p> <p>3.1 Establish statewide Policy Team.</p> <p>3.2 Develop statewide policy.</p> <p>3.3 Complete policy approval process.</p> <p>3.4 Curriculum development.</p> <p>3.5 Staff Training.</p> <p>3.6 Establish Quality Improvement (QI) monitoring process and feedback loop.</p> <p>3.7 Establish reporting requirements and reporting responsibilities for submission to Department of Health and Human Services (DHHS) or other identified entity.</p>	<p>DCFS: The Statewide Policy Team/CPS investigation workgroup established in July includes invited representatives from the CDR Executive Committee, Coroner's Office, DA, Citizen Review Panel, and reviews all policy related to child protective services, including child fatalities. Statewide policy on interagency protocols was included in the 9/28/2006 review as part of the CDR Manual reviewed by the Statewide Policy Team (see also item I-1). The approved manual will be part of CDR-MDT training to be scheduled in 2007. The QI monitoring process and feedback loop consist of the Child Fatality Quarterly Reports submitted by local CDR MDTs to the CDR Administrative Team and DHHS as requested.</p> <p>CCDFS: CCDFS conducted Investigative Protocol training with a contractor in October and November 2006. CCDFS has staff who are now trained</p>	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

ACRONYMS USED IN THIS ACTION PLAN:
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						<p>as trainers and will conduct sessions for the remaining units and new investigative units, beginning in January 2007.</p> <p>CCDFS continues with its internal case review process of all child fatalities. CCDFS adheres to statewide policy regarding notification to DCFS of child fatalities and case review of child fatalities due to abuse or neglect.</p>		
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT</p> <p>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.</p>	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.	<p>Establish an action plan to complete the following:</p> <p>4.1 Determine feasibility of the recommendation.</p> <p>4.2 Determine staffing impact and budget capability.</p> <p>4.3 Submit budget requests.</p> <p>4.4 Upon approval, establish contracts and purchase telephone equipment.</p> <p>4.5 Install equipment and establish phone lines.</p> <p>4.6 Market new phone contact info to identified agencies.</p>	<p>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</p>	Action Plan QI Report	Action Plan Completion Date: 12/1/06

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					4.7 Establish QI monitoring process & feedback loop. 4.8 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.	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.		
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) <i>history</i> 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	CCDFS: CCDFS has established a process for providing a CPS history review of Coroner cases. CCDFS will insure that this practice is incorporated into all appropriate items of the intake policies and procedures that are currently being revised. Coroner: This will be accomplished through the recently formed Child Fatality Task Force. Las Vegas Metro PD: No update received.	MOU Protocol	Action Plan Completion Date: 12/1/06

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					history reviews.	North Las Vegas PD: No update received. Henderson PD: No update received.		
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: A national expert will be conducting an assessment of the current use of the CAC and make recommendations. The assessment will begin in December 2006 and will include meeting with internal and external stakeholders. An action plan will be developed upon completion of the assessment. Las Vegas Metro PD: A written protocol cannot be developed at this time to address this recommendation as the Advocacy Center is not yet available 24 hours. Once the Center can be accessed after hours, law enforcement will be able to develop a standardized protocol. North Las Vegas PD: No	MOU QI Report	Action Plan Completion Date: 12/1/06

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						update received. Henderson PD: No update received.		
<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH</p> <p>7. Work to establish a coordinated investigation protocol with CPS, hospital child protection and the Coroner's Office.</p> <p>(Also recommended by the</p>	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		<p>Establish an action plan to complete the following:</p> <p>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.</p> <p>7.2 CCDFS lead development of statewide policies and procedures for child welfare staff.</p> <p>7.3 Complete policy approval process.</p> <p>7.4 Curriculum development.</p> <p>7.5 Training.</p>	<p>DCFS: CCDFS has a CPS Investigation workgroup that includes invited representatives from five law enforcement agencies, Coroner's Office, DA, Citizen Review Panel, hospital, WCDSS, and DCFS, that is working to establish a coordinated investigative protocol and MOUs with law enforcement, Coroner's Office, hospital, and other agencies as indicated. The team meets on a regular basis and specific law enforcement MOUs should be completed by spring of 2007. The workgroup reviews all policy related to CPS and child</p>	MOU Protocol QI Report	Action Plan Completion Date: 12/1/06

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National Resource Center on Legal and Judicial Issues)					7.6 Establish QI monitoring process & feedback loop. 7.7 Establish reporting requirements and reporting responsibilities for submission to DCFS CRP.	<p style="color: red;">fatality investigations. 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 and the Child Fatality Quarterly Summary Reports submitted by the local CDR MDTs.</p> <p style="color: red;">CCDFS 7.1: The local MultiDisciplinary Task force is in the process of developing this action plan.</p> <p style="color: red;">CCDFS 7.5: This is addressed in the Investigative Protocol training conducted by CCDFS.</p> <p style="color: red;">Coroner: This will be accomplished through the recently formed Child Fatality Task Force.</p> <p style="color: red;">Las Vegas Metro PD: No update received.</p> <p style="color: red;">North Las Vegas PD: No update received.</p>		

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						Henderson PD: No update received.		
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	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.	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	MOU QI Report	Action Plan Completion Date: 8/1/2006

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protocol from Riverside County, California.					1.6 Establish reporting requirements and reporting responsibilities for submission to the CJA Task Force.	<p>recommendations.</p> <p>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 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.</p> <p>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.</p>		

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						<p>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.</p> <p>The Task Force is also looking into possible legislative changes pertaining to children left in automobiles and drownings.</p>		
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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</p>	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: N/A County: CCDFS Director Other: Executive Committee representative, Law enforcement representatives,		<p>Establish an action plan to complete the following:</p> <p>9.1 Establish and implement a protocol for the exchange of information</p> <p>9.2 Establish QI monitoring process and feedback loop.</p> <p>9.3 Establish reporting requirements and reporting responsibilities for submission to the DCFS Executive Committee.</p>	<p>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.</p>	Protocol QI Report	Action Plan Completion Date: 10/15/06

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enforcement reports prior to death certification of unexplained death in infancy and childhood.								
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	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		<p>10.1 Establish coroner office and CC CDR MDT protocol for the collaborative process.</p> <p>10.2 Establish Coroner office protocol tickler system for pending death certifications.</p> <p>10.3 Establish QI monitoring process and feedback loop.</p> <p>10.4 Establish reporting requirements and reporting responsibilities for submission to the DCFS Executive Committee.</p>	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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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	Inter-Agency Collaboration Action	State: N/A County: John Fudenberg	State: N/A County: CCDFS Director, District Attorney Other: Administrative Team Representative		<p>11.1 Establish Coroner office protocol for CPS notification and develop more, as necessary.</p> <p>11.2 Establish QI monitoring process and feedback loop.</p> <p>11.3 Establish reporting requirements and reporting responsibilities for submission to the DCFS Administrative Team.</p>	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
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	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		<p>Obtain clarification from the national expert panel regarding this recommendation. Need definition of "children who are developmentally delayed and medically challenged".</p> <p>12.1 Review clarification and determine feasibility of the recommendation.</p> <p>Upon clarification, and determination of the feasibility of the recommendation, establish an action plan to complete the following:</p> <p>12.2 Establish MOU and written</p>	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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					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 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			

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					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.			
<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>14. Coroner and law enforcement records should be obtained and referenced in the CPS file on CPS investigations of deceased children and their families.</p>	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)		<p>14.1 Develop and implement strategies to improve communication between all entities.</p> <p>14.2 Establish statewide Policy Team.</p> <p>14.3 Develop statewide policy.</p> <p>14.4 Complete policy approval process. Establish an action plan to accomplish the following:</p> <p>14.5 Curriculum development.</p> <p>14.6 Training.</p> <p>14.7 Establish QI monitoring process and feedback loop.</p>	<p>DCFS: DCFS representatives met with CCDFS on 7/19/2006 to develop strategies for improving CPS investigations. CCDFS will use contract services to establish a CPS Investigations work group that will review all investigative procedures including receipt of appropriate reports and documentation from law enforcement and the coroner's office for child fatality reports. This work group was convened on 8/1/2006 and made recommendations to obtain and reference coroner and law enforcement records on deceased children in the CPS file. These recommendations are included in the statewide</p>	Policy QI Report	<p>14.1 7/31/06</p> <p>14.2 8/30/06</p> <p>14.3 10/31/06</p> <p>14.4 12/1/06</p> <p>Action Plan due date 12/1/06</p>

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						<p>policy on child abuse investigations. 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.</p> <p>CCDFS 14.3 and 14.4: The MultiDisciplinary Task Force is in the process of developing countywide policy regarding multidisciplinary investigations in Clark County.</p> <p>CCDFS 14.5: Additional update on statewide items is provided by DCFS.</p> <p>CCDFS 14.6: This is addressed in the Investigative Protocol training conducted by CCDFS.</p> <p>CCDFS 14.7: 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</p>		

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						to abuse or neglect.		
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 WCDFS 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	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	Action Plan QI Report	5.1 11/1/06 Action Plan completion date: 12/1/06

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					feedback loop 5.9 Establish reporting requirements and reporting responsibilities minutes for submission to the DCFS CJA Task Force.	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 position. Additional update on statewide items is provided by DCFS.		

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS</p> <p>5. DA should hold the dependency judge accountable for following state laws.</p>	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		<p>5.1 Identify and verify issues.</p> <p>5.2 Develop strategies.</p> <p>5.3 Consult with CIP regarding issues and strategies and method of delivery to dependency judge.</p> <p>Establish an action plan to accomplish the following:</p> <p>5.4 Meeting with judge and other appropriate parties to discuss issues.</p> <p>5.5 Develop feedback loop to the CIP.</p>	<p>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.</p>	Action Plan QI Report	<p>5.1 7/31/06</p> <p>5.2 8/31/06</p> <p>5.3 10/31/06</p> <p>Action Plan due date 12/1/06</p>
<p>H. OVERARCHING SYSTEMS ISSUES</p> <p>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.</p>	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		<p>1a.1 Establish a county multidisciplinary committee and outline purpose, roles and responsibilities noted, development and implementation of strategies to address this recommendation.</p> <p>1a.2 Establish reporting requirements and reporting responsibilities such as minutes for submission to DCFS Administrative team.</p>	<p>County Manager - 1a.1: A multidisciplinary committee has been established under the direction and leadership of the Clark County District Attorney's office. Members include County management, Department of Family Services, Metro Police Department, Henderson Police Department, North Las Vegas police department, Coroner's office, and members of the Child Death Review committee. The committee has met three times and is in the process of developing its</p>	Committee Reports	<p>1a.1 8/31/06</p> <p>1a.2 10/31/06</p>

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						<p>purpose and mission statement. The group will continue to meet on a monthly basis until it formalizes its purpose and then may meet on a less routine basis. Vicki Monroe, Chief Deputy District Attorney, is the chair of the committee.</p> <p>County Manager - 1a.2: A multi-disciplinary committee has been formed and has been actively meeting since August. The committee is chaired by the Clark County District Attorney's office. Process recommendations coming out of the committee will be forwarded to the appropriate lead agencies for changes to operating protocols (i.e. Sheriff; North Las Vegas, Henderson, Boulder City and Mesquite police chiefs; County Manager and District Attorney). The purpose and mission statement for the group is being formed and will be presented at the December meeting for approval of the group. The group is now being facilitated by staff of the</p>		

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						County Manager's Office. Minutes are being recorded for each meeting and will be made available to the State Administrative Team chair, Mike Capello.		
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.	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.	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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(Also recommended by the National Resource Center on Legal and Judicial Issues)					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.			

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<p>H. OVERARCHING SYSTEMS ISSUES</p> <p>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.</p>	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.		<p>Establish an action plan to accomplish the following:</p> <p>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</p> <p>2a.2 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.</p>	<p>DCFS: This recommendation to convene a statewide task force for the purpose of meeting and agreeing upon state laws, policies, and standards related to:</p> <p>1) The investigation and prosecution of substance abusing mothers who give birth to drug exposed infants - has been reconsidered because this provision would be a violation of the Child Abuse Prevention and Treatment Act, Section 106(b)(2)(A)(ii - iii), that was added to Nevada Revised Statutes (NRS 432B.220(3)) in Senate Bill 296 during the 2005 Legislative session.</p> <p>2) Children who die from egregious acts of neglect - has been reconsidered because this is addressed in NRS Chapter 200, Crimes Against the Person. This chapter has provisions for child abuse and related crimes. Law enforcement investigates these crimes.</p> <p>3) Children who die in situations of domestic</p>	Action Plan Report	Action Plan completion date: 7/31/2006

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						<p>violence - has been reconsidered because NRS Chapter 217, Aid to Certain Victims of Crime (NRS 217.475), addresses death related to domestic violence. This statute states that a "court or an agency of a local government may organize or sponsor one or more multidisciplinary teams to review the death of the victim of a crime that constitutes domestic violence pursuant to NRS 33.018." This MDT may meet with a CDR MDT established under Child Protection Statute, NRS 432B.405. A child welfare agency may also receive a referral from a court regarding assessment of a child who may be in need of counseling as a result of domestic violence (NRS 432B.640). NRS Chapter 200, Crimes Against the Person, subsection .485 addresses domestic violence and penalties for battery. Law enforcement investigates these crimes.</p> <p>CCDFS: Update on statewide</p>		

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						items is provided by DCFS.		
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.	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: 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	Action Plan QI Report	Action Plan completion date: 12/1/2006

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				DCFS Feedback: The statewide CAPTA Corrective Action Plan requires the development of policy for agency case review of 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.	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 develop strategies to improve communication, collaboration, cooperation and coordination among agencies.	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 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: CCDFS contractor completed a pilot case review of all cases with children ages 3 and under, followed by a review of all Permanency cases (Foster Care and In-Home, totaling 1500). CCDFS contractor completed a review of 250 completed investigations conducted January 2006 through June 2006. A permanent case review process will be established with full staffing of the QA/I unit. Additional update is provided by DCFS.		

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I. CHILD DEATH REVIEW (MDT) ISSUES 1. The panel believes that an effective CDR team <i>is</i> 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	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	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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					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.	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 <i>Nevada Child Fatality Review Operating Protocol Manual</i> and made suggestions for incorporating best practices through jurisdictional referral protocol. In addition, meeting attendance protocols and information sharing was discussed. The workgroup 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,		

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						<p>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.</p> <p>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.</p> <p>County Manager: The Director of the Office of Organization Effectiveness for Clark County has been asked by the Chairs of the Clark CDR Team and the Assistant County Manager to interview all members of the Clark CDR Team. Upon</p>		

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						<p>interviewing all of the team members, the OOE will submit team membership recommendations and other structural improvements that may be needed in order to enhance the team's overall effectiveness. Interviews will occur through November and be completed in December. Recommendations will be forwarded to the State Administrative Review Team for their approval and inclusion into the CDR operating manual.</p> <p>Once the findings and recommendations have been completed and submitted for review to the Clark CDR Team members, County Management, applicable County Departments, DCFS, various stakeholder organizations, and the State Executive and Administrative Teams' guidance and direction will be provided in order to facilitate the development of an ongoing mechanism to train CDR MDT Chairpersons as well</p>		

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						as respective CDR MDT members. In order to ensure that the CDR process and the protocols continues to be both effective and efficient, the County's Office of Organization Effectiveness will institute an annual survey and review to ensure that the Team and the process are operating successfully and being fulfilled and within the guidelines set forth in the Nevada State Statues and Action Plan recommendations established by the 2006 Independent Child Death Review Panel. The results of the survey and review will then be forwarded to all applicable parties for review, discussion, and possible process and protocol revisions and enhancements if needed.		

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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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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.)</p>	Other Action (Fiscal, training, etc)	State: N/A County: John Fudenberg	State: N/A County: County Manager office representative		<p>7.1 Assess staffing needs.</p> <p>7.2 Determine feasibility of this recommendation including fiscal impact and budget building capability. If feasible,</p> <p>7.3 Draft budget request, as appropriate.</p> <p>Establish an action plan to accomplish the following:</p> <p>7.4 Pending approval, hire staff.</p> <p>7.5 Analyze medical examiner positions to ensure chief identifies and handles oversight of other medical examiners.</p> <p>7.6 Ensure pathologists and medical examiner maintain 250 or less autopsies per year through appropriate budgeting and staffing.</p> <p>7.7 Analyze National Association of Medical Examiners (NAME) guidelines and Determine changes needed to meet These guidelines and their</p>	<p>Coroner: Clark County Management approved a fifth medical examiner position. The Clark County Coroner's Office is currently recruiting to fill this position.</p>	Report	<p>7.1 7/31/06</p> <p>7.2 8/30/06</p> <p>7.3 9/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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					feasibility. 7.8 Incorporate, if feasible, identified NAME guidelines. 7.9 Provide reporting and feedback loop to DHHS or other identified entity.			
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	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	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.	QI Report	Action Plan completion date: 10/1/06

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Legal and Judicial Issues)					as minutes for submission to the DCFS Administrative Team.	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.		

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	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		<p>Establish an action plan to accomplish the following:</p> <p>11.1 Analyze recommendation for feasibility, fiscal impact and budget building capability.</p> <p>If feasibility is determined, establish an action plan to accomplish the following:</p> <p>11.2 Determine staffing impact and budget capability.</p> <p>11.3 Submit budget request.</p> <p>If appropriate:</p> <p>11.4 Establish statewide Policy Team.</p> <p>11.5 Develop statewide policy.</p> <p>11.6 Complete policy approval process.</p> <p>11.7 Curriculum development.</p> <p>11.8 Training.</p> <p>11.9 Establish QI monitoring process and feedback loop.</p>	<p>DCFS: The feasibility for funding mandatory specialty medical exams for unexplained injuries of children is a matter for discussion by the Legislature and has been included in the Bill Draft Request. At the present time, such examinations specifically related to child maltreatment are paid by the family's own medical insurance, if available, or Medicaid, if appropriate. A fiscal note for such a requirement will be developed as requested by BDR process.</p> <p>CCDFS: Update on State-funded items is provided by DCFS.</p>	QI Report	11.1 11/1/06 Action Plan completion date: 12/1/06

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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: CCDFS is working with law enforcement to arrange 24/7 access to the CAC for joint use in conducting forensic interviews. A national expert will be conducting an assessment of the current use of the CAC and make recommendations. The assessment will begin in December 2006 and will include meeting with internal and external stakeholders. An action plan will be developed upon completion of the assessment.	Action Plan QI Report	1e.1 9/30/2006 Action Plan completion date: 12/1/06

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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	DCFS: On 7/19/2006, DCFS representatives met with CCDFS and developed strategies on improving child abuse investigation through the establishment of a CPS Investigation workgroup that will review related policies and procedures. This will include a review of the requirements for mandatory reporting. This work group convened on 8/1/2006. The Statewide reporting form and protocol was drafted 9/28/2006. Reporting abuse and neglect by paper will not significantly change the current reporting system, but will expand reporting opportunities. Tracking of reporters already occurs in the UNITY system. The paper documents will confirm electronic or other types of reports that are allowed by statute. However, mandated reporting requirements allow any person to anonymously make a report. The effective date of use of paper reporting will be 1/1/2007. This method of reporting will not	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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					improvements. 3a.11 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.	<p>supersede NRS 432B.220, but will provide an additional mechanism for reporting abuse or neglect. Information and the form will be posted on the DCFS website by 12/20/2006. The form may be copied and faxed or mailed to the Central Office of DCFS for appropriate distribution. This information will be included in the Required Reporters handbook which lists child abuse reporting hotline numbers.</p> <p>Training about the new reporting mechanism to staff will be done through an Instructional Memo. Information about the number of reports received through the reporting system will be in the annual DCFS statewide statistical report.</p> <p>CCDFS 3a.6 and 3a.7: CCDFS is working collaboratively with DCFS on all statewide items.</p> <p>CCDFS 3a.8: Update on statewide items is provided by DCFS.</p>		

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						<p>CCDFS 3a.9: CCDFS has entered into a contract to establish Hotline and Intake policies and procedures. Training of staff will follow. QI will be included.</p> <p>CCDFS 3a.10 and 3a.11: Established reporting requirements and responsibilities will be adhered to by CCDFS.</p>		

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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	Action Plan	Action Plan completion date: 12/1/06

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						<p>additional positions for in-home care case managers.</p> <p>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 of county budget and department staff, staff from the Legislative Counsel Bureau and a representative from WCDSS.</p> <p>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</p>		

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						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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<p>J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06</p> <p>2. Solicit opinions from case workers involved with the 79 children's cases.</p>	Other Action (Fiscal, training, etc)	State: None County: Nancy McLane and Thomas Morton	State: DCFS Representative County: Identified CCDFS staff		<p>2.1 Determine opinion questions for Caseworkers in consultation with the panel and national experts.</p> <p>2.2 Submit written questions to caseworkers for written response.</p> <p>2.3 Review responses and identify strategies, as appropriate.</p> <p>Establish an action plan to accomplish the following:</p> <p>2.4 Facilitate strategy implementation</p>	CCDFS: 37 disputed cases have been reviewed. Findings have been incorporated into CCDFS Investigative Protocol training.	Action Plan	<p>2.1 7/31/06</p> <p>2.2 8/30/06</p> <p>2.3 9/30/06</p> <p>Action Plan completion date 12/1/06</p>
<p>J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06</p> <p>3. Evaluate the qualifications of current staff and hiring requirements.</p>	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		<p>Obtain clarification from the Blue Ribbon Panel on their recommendation and the purpose of the evaluation.</p> <p>Once clarified, as appropriate, establish an action plan to accomplish the following:</p> <p>3.1 Request County Personnel office to conduct an occupational study of current and vacant CCDFS positions to determine job competencies and work demands.</p> <p>3.2 Request county personnel staff to</p>	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.	Action Plan	Action Plan completion date: 12/1/06

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					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 - 3.2: 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 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 reinstating oral board interview processes for all positions. Doing this will		

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						<p>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.</p> <p>CCDFS and County Manager - 3.4: Revised recruitment processes will be in place by January 2007.</p>		

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<p>J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06</p> <p>4. Need Additional resources from management. What is happening at the leadership level?</p>	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.	<p>4.1 Request County management to assess leadership and management needs.</p> <p>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.</p> <p>Establish an action plan to accomplish the following:</p> <p>4.3 DHHS or other identified entity to analyze report and make recommendations to agency management review and implementation, as appropriate.</p> <p>4.4 Establish reporting requirements and reporting responsibilities for submission to DHHS or other identified entity.</p>	<p>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.</p> <p>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.</p>	Action Plan	<p>4.1 9/30/06</p> <p>4.2 11/28/06</p> <p>Action Plan completion date: 12/1/06</p>

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<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT</p> <p>5. Reform and staff the Hotline to eliminate all waits over 3 minutes.</p>	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.	<p>5.1 Determine fiscal impact and budget capability.</p> <p>5.2 Determine staffing impact and budget capability.</p> <p>5.3 Establish contracts and purchase telephone equipment.</p> <p>5.4 Install equipment and establish phone lines.</p> <p>5.5. Market new phone contact info to identified agencies.</p> <p>5.6 Establish QI monitoring process.</p> <p>5.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS or other identified entity.</p>	<p>CCDFS - 5.5: 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.</p> <p>CCDFS - 5.6: Monthly records are reviewed in the form of data from the telephone system. The average wait until answered in September 2006 was 2:09. Additional QA/I activity will be developed in accordance with program changes made as a result of the recent review of the hotline.</p> <p>CCDFS - 5.7: Established reporting requirements and responsibilities will be adhered to by CCDFS.</p>	QI Report	<p>5.1 - 5.2 7/31/06</p> <p>5.3 8/30/06</p> <p>5.4 9/30/06</p> <p>5.5 10/31/06</p> <p>5.6 10/31/06</p> <p>5.7 11/30/06</p>

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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. North Las Vegas PD: No update received. Henderson PD: No update received.	Action Plan QI Report	Action Plan completion due date: 12/1/06

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<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH</p> <p>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.</p>	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.		<p>4.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>4.2 Assess legal capability.</p> <p>4.3 Establish countywide Law Enforcement Policy Team.</p> <p>4.4 Develop county policy.</p> <p>4.5 Complete policy approval process.</p> <p>4.6 Curriculum development.</p> <p>4.7 Training.</p> <p>4.8 Establish QI monitoring process and feedback loop.</p> <p>4.9 Establish reporting requirements and reporting responsibilities such as minutes for submission to CC CDR MDT.</p>	<p>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</p>	Action Plan QI Report	<p>4.1 10/31/06</p> <p>Action Plan completion due date: 12/1/06</p>

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						<p style="color: red;">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.</p> <p style="color: red;">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 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</p>		

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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
						<p>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.</p> <p>North Las Vegas PD: No update received.</p> <p>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 consideration for funding</p>		

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						these exams should be made.		

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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."</p>	Agency Technical Action	State: None County: John Fudenberg	State: None County: Medical Examiners Other: CC CDR MDT representative, Executive Committee representative.		<p>4.1 Analyze feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>4.2 Assess legal capability.</p> <p>4.3 Establish countywide Policy Team.</p> <p>4.4 Develop county policy.</p> <p>4.5 Complete policy approval process.</p> <p>4.6 Curriculum development.</p> <p>4.7 Training.</p> <p>4.8 Establish QI monitoring process and feedback loop.</p> <p>4.9 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Executive Committee.</p>	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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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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."</p>	Agency Technical Action	State: None County: John Fudenberg	State: None County: Medical Examiners, CC CDR MDT representative Other: Executive Committee representative.		<p>Establish an action plan to accomplish the following:</p> <p>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.</p>	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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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Medical Examiners, CC CDR MDT representative.		<p>8.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>8.2 Determine fiscal impact and budget capability.</p> <p>8.3 Determine staffing impact and budget capability.</p> <p>8.4 Submit budget request.</p> <p>8.5 Establish Policy Team</p> <p>8.6 Develop county policy.</p> <p>8.7 Complete policy approval process.</p> <p>8.8 Complete the training delivery process.</p> <p>8.9 Establish QI monitoring process and feedback loop.</p> <p>8.10 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.</p>	Coroner: The Clark County Coroner's Office is currently in negotiations with a neuropathologist consultant.	Action Plan QI Report	8.1 9/30/06 Action Plan completion due date: 12/1/06

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>13. Obtain full body, postmortem x-rays of all fetal deaths, and all unexplained deaths in infancy and childhood.</p>	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Medical Examiners, CC CDR MDT representative.		<p>13.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>13.2 Determine fiscal impact and budget capability.</p> <p>13.3 Determine staffing impact and budget capability.</p> <p>13.4 Submit budget request.</p> <p>If appropriate:</p> <p>13.5 Assess legal capability.</p> <p>13.6 Establish Policy Team.</p> <p>13.7 Develop county policy.</p> <p>13.8 Complete policy approval process.</p> <p>13.9 Complete training delivery process.</p> <p>13.10 Establish QI monitoring process and feedback loop.</p> <p>13.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.</p>	Coroner: This has always been the practice of our office and will remain as such.	Action Plan QI Report	<p>13.1 9/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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".</p>	Agency Technical Action	State: None County: John Fudenberg	State: None County: County Manager's Office, Hospital and Medical Community representatives, CC CDR MDT.		<p>14.1 Determine feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>14.2 Determine fiscal impact and Budget capability.</p> <p>14.3 Determine staffing impact and budget capability.</p> <p>14.4 Submit budget request</p> <p>If appropriate:</p> <p>14.5 Assess legal capability.</p> <p>14.6 Establish Policy Team.</p> <p>14.7 Develop county policy.</p> <p>14.8 Complete policy approval process.</p> <p>14.9 Complete the training delivery process.</p> <p>14.10 Establish QI monitoring process and feedback loop.</p> <p>14.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.</p>	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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LAST UPDATED: 12/11/2006

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	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	<p>PIP: Revise PIP Policy. Intake Response Policy. CFSP: Goals 1,2</p> <p>1.1 Assess legal capability. 1.2 Establish statewide Policy Team. 1.3 Develop statewide policy.</p> <p>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.</p>	<p>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.</p> <p>CCDFS - 1.4: CCDFS adheres to this standard as directed in statewide policy.</p> <p>CCDFS - 1.5 and 1.6: Additional updates on statewide items provided by DCFS.</p> <p>CCDFS - 1.7: All reports on child deaths and surviving siblings are distributed for</p>	Action Plan QI Report	<p>1.1 8/31/06 1.2 9/30/06 1.3 10/31/06</p> <p>Action Plan completion due date: 12/1/06</p>

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						notification to CCDFS Management and to DCFS.		

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p> <p>(Also recommended by the National Resource Center on Legal and Judicial Issues)</p>	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.	<p>CCDFS - 5.6: CCDFS Hotline and Investigative Units are informed of this expectation.</p> <p>CCDFS - 5.7: All reports on child deaths and surviving siblings are distributed for notification to CCDFS Management and to DCFS.</p> <p>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.</p>	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

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>8. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.</p>	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.	<p>Establish an action plan to accomplish the following:</p> <p>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.</p>	<p>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.</p> <p>CCDFS - 8.1 through 8.6: Update on statewide items is provided by DCFS.</p> <p>CCDFS - 8.7: 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.</p>	QI Report	Action Plan completion date: 12/1/06

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p> <p>(Also recommended by the National Resource Center on Legal and Judicial Issues)</p>	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	<p>PIP: Safety Assessment Policy.</p> <p>9.1 Review new PIP policies for revision.</p> <p>9.2 Initiate revision process as determined necessary.</p> <p>9.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>9.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>9.5 Initiate revised Training Plan.</p> <p>9.6 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>9.1 7/1/06</p> <p>9.2 7/31/06</p> <p>9.3 10/1/06</p> <p>9.4 11/1/06</p> <p>Action Plan completion date 12/1/06</p>

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						<p>feedback loop consist of the State's internal QI system reported in the State's PIP.</p> <p>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.</p> <p>CCDFS - 9.5 and 9.6: Update on statewide items is provided by DCFS.</p>		

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ACTION PLAN FOR THE CLARK COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	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	<p>PIP: Diligent Search Policy.</p> <p>13.1 Review new PIP policies for revision.</p> <p>13.2 Initiate revision process as determined necessary.</p> <p>13.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>13.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>13.5 Initiate revised Training Plan.</p> <p>13.6 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>13.1 7/1/06</p> <p>13.2 7/31/06</p> <p>13.3 10/31/06</p> <p>13.4 11/28/06</p> <p>Action Plan completion date: 12/1/06</p>

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						reported in the State's PIP. CCDFS: Update on statewide items is provided by DCFS.		
E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT 1. Very specific guidelines should be developed and training provided to intake and caseworkers to define substantiation criteria in cases involving child deaths and surviving siblings. Supervisor sign off should be required in these cases.	Agency Technical Action	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	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	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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(Also recommended by the National Resource Center on Legal and Judicial Issues)					accomplish the following: 1.5 Initiate revised Training Plan. 1.6 Establish QI monitoring process and feedback loop.	<p>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.</p> <p>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.</p> <p>CCDFS - 1.6: Additional update on statewide items is provided by DCFS.</p>		

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
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.	Action Plan QI Report	Action Plan completion date: 12/1/06

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						CCDFS: Update on statewide and UNITY items is provided by DCFS.		

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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	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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						<p>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.</p> <p>CCDFS - 2.3: Current DFS policy requires that all cases that are substantiated and opened for services have a written case plan.</p> <p>CCDFS - 2.4 and 2.5: Update on statewide items is provided by DCFS.</p>		

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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	QI Report	Action Plan completion due date: 12/1/06

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						<p style="color: red;">all QI monitoring and provides reports on specific data elements that constitute a feedback loop to policy and training.</p> <p style="color: red;">CCDFS: Update on statewide and UNITY items is provided by DCFS.</p>		

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<p>F. PROVISION OF SERVICES BY CPS</p> <p>4. Disallow relative placements without going through the formal, legal system, especially when safety assessments are not conducted for those relatives.</p>	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	<p>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.</p> <p>DCFS has implemented a new statewide PIP policy on this topic</p>	<p>PIP: Case Planning Policy.</p> <p>4.1 Review new PIP policies and jurisdictional policies for revision.</p> <p>4.2 Initiate revision process as determined necessary.</p> <p>Establish an action plan to accomplish the following:</p> <p>4.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>4.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>4.5 Initiate revised Training Plan.</p> <p>4.6 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>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</p>	Action Plan QI Report	<p>4.1 7/1/06</p> <p>4.2 7/31/06</p> <p>6</p> <p>Action plan completion date: 12/1/06</p>

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						<p>feedback loop consist of the State's internal QI system reported in the State's PIP.</p> <p>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 Protection Team meetings on a monthly basis and these issues are addressed during those meetings.</p>		

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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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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
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	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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						<p>feedback loop consist of the State's internal QI system reported in the State's PIP.</p> <p>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.</p> <p>CCDFS - 7.4 and 7.6: Updates on statewide items is provided by DCFS.</p>		
<p>F. PROVISION OF SERVICES BY CPS</p> <p>8. Require that all cases being closed have complete documentation in the case record describing the justification for closing the case.</p>	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	<p>The CCDFS Agency Improvement plan (AIP) will address this.</p> <p>DCFS has implemented a new statewide PIP policy on this topic</p>	<p>PIP: Case Closure Policy.</p> <p>8.1 Review new PIP policies for revision.</p> <p>8.2 Initiate revision process as determined necessary.</p> <p>8.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>8.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>8.5 Initiate revised Training Plan.</p>	<p>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,</p>	QI Report	<p>8.1 7/31/06</p> <p>8.2 8/30/06</p> <p>8.3 10/31/06</p> <p>8.4 11/15/06</p> <p>8.5 11/15/06</p> <p>8.6 12/1/06</p>

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					8.6 Establish QI monitoring process and feedback loop.	<p>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.</p> <p>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</p>		

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						recommendations made from case 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	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	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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Legal and Judicial Issues)						<p>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.</p> <p>CCDFS - 9.6: CCDFS has implemented this practice. Any exceptions require Assistant Manager approval. CCDFS will insure that this practice is 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.</p>		

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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
<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS</p> <p>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.</p>	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Other: CJA representative.		<p>Establish an action plan to accomplish the following:</p> <p>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.</p>	<p>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 to ascertain by the facts. Those cases will be vigorously pursued.</p>	QI Report	Action Plan completion date: 12/1/06

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS</p> <p>3. Re-open the 2002 Shaken Baby Syndrome case and evaluate the cause of death.</p>	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Coroner Other: CC CDR MDT representative.		<p>3.1 DA's office to review this case and reopen Shaken Baby Syndrome case as determined appropriate.</p> <p>If appropriate,</p> <p>3.2 Evaluate cause of death.</p> <p>3.3 Pursue appropriate legal actions.</p> <p>3.4 Establish feedback loop, such as _____ minutes for submission to the CC CDR MDT.</p> <p>If not appropriate, provide written explanation on the lack of appropriateness to the Blue Ribbon Panel.</p>	<p>DA: I have tried repeatedly to find out which cases are being referred to in these sections. I have been unable to ascertain the perpetrator's name in order to find out what happened to these cases in my office. No one seems to have the information as to whom the perpetrator was and without that information I am unable to follow up on this. My office has case information by defendant's name or our case number. I am told that CPS has the name of the victim. My suggestion is that a system be implemented where this information is available to all agencies under a common system. However, I also believe that the agencies are working together more now, and that a victim's case will be repeatedly evaluated before it is denied for any reason.</p>	TBD	<p>3.1 6/30/06</p> <p>3.2 7/31/06</p> <p>3.3</p> <p>10/31/06</p> <p>3.4</p> <p>11/30/06</p> <p>3.5 12/1/06</p>

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS</p> <p>4. Resubmit the probable murder allegedly caused by the toddler for thorough investigation.</p>	Agency Technical Action	State: None County: Vicki Monroe	State: None County: County Manager's Office, Law Enforcement Coroner, Other: CC CDR MDT representative.		<p>4.1 DA's office to review this case and reopen case as determined appropriate.</p> <p>If appropriate,</p> <p>4.2 Evaluate cause of death.</p> <p>4.3 Pursue appropriate legal actions</p> <p>4.4 Establish feedback loop, such as minutes for submission to the CC CDR MDT.</p> <p>If not appropriate, provide written explanation on the lack of appropriateness to the Blue Ribbon Panel.</p>	<p>DA: I have tried repeatedly to find out which cases are being referred to in these sections. I have been unable to ascertain the perpetrator's name in order to find out what happened to these cases in my office. No one seems to have the information as to whom the perpetrator was and without that information I am unable to follow up on this. My office has case information by defendant's name or our case number. I am told that CPS has the name of the victim. My suggestion is that a system be implemented where this information is available to all agencies under a common system. However, I also believe that the agencies are working together more now, and that a victim's case will be repeatedly evaluated before it is denied for any reason.</p>	TBD	<p>4.1 6/30/06</p> <p>4.2 7/31/06</p> <p>4.3 10/31/06</p> <p>4.4 11/30/06</p> <p>4.5 12/1/06</p>

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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 - 1d.2: A countywide MultiDisciplinary Team/Task Force has been established and has met. CCDFS - 1d.3: CCDFS CPS is currently an active participant in investigations and no longer defers investigations to law enforcement.	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
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	Continue to monitor the PIP Training Plan via quarterly reports to ACF.		PIP quarterly reports.	In accordance with PIP reporting due dates.

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				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.				
<p>J. BLUE RIBBON PANEL AND PUBLIC COMMENT RECOMMENDATIONS on 4/20/06</p> <p>6. Evaluate the supervision requirements/job duties in child welfare offices.</p>	Agency Technical Action	State: None County: Darryl Martin, Nancy McLane and Thomas Morton	State: None County: CCDFS representatives, County Manager's Office, Union representative		<p>6.1 Request study by county personal for child welfare agency supervisor and manager positions.</p> <p>6.2 Request desk audit of supervisors and managerial staff.</p> <p>Establish an action plan to accomplish the following:</p> <p>6.3 Assess minimum qualifications for supervisors and managers.</p> <p>6.4 Assess work performance standards for supervisors and managers.</p> <p>6.5 Assess mandatory training requirements for supervisors</p>	<p>CCDFS and County Manager - 6.3: CCDFS has compiled pertinent education and experience qualifications for investigative, permanency, supervisory, and management staff.</p> <p>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</p>	Action Plan Report	<p>6.1 6/30/06</p> <p>6.2 6/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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					and managers. 6.6 Report findings to the Decision Making Group	effort to both investigative and hotline services in 2007. Under the collective bargaining agreement, labor and management have agreed upon performance standards for supervisory 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		

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						to revise existing recruitment processes. We will be implementing a formal assessment process for select positions as well as reinstating 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.		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>9. Share the Safety Assessment findings with NRC CPS.</p>	Agency Technical Action	State: County:	State: County:	<p>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</p>	<p>9.1 Determine additional need for UNITY modification.</p> <p>Establish an action plan to accomplish the following:</p> <p>9.2 Complete UNITY changes, as appropriate.</p> <p>9.3 Complete an Instructional Memorandum (IM) to all Child Welfare Staff.</p> <p>9.4 Distribute IM to all Child Welfare Staff Statewide.</p> <p>9.5 Establish QI monitoring process and feedback loop.</p>		Action Plan QI Report	<p>9.1 8/31/06</p> <p>Action Plan completion date: 12/1/06</p>
<p>*Due Dates: All interim status update reports and verifying documents safety assessments 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 and 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.dcf.state.nv.us.</p>								

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<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND NEGLECT</p> <p>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.</p>	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		<p>2.1 Establish MOU that outlines purpose, roles and responsibilities noted in this recommendation in conjunction with the child welfare decision-making group</p> <p>2.2 Convene a statewide workgroup to research and analyze this recommendation to report back to the decision - making group.</p> <p>Establish an action plan to accomplish the following:</p> <p>2.3 Develop strategies to facilitate law and policy changes</p> <p>If appropriate:</p> <p>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.</p>	<p>DCFS: The Policy Team has reviewed this provision on 8/17/2006 and made recommendations for the Bill Draft Request, provided to the DMG, to contain provisions which clarify NRS 432B.220 to include reporting of child death by required reporters. The BDR will be reviewed by the Legislative Counsel Bureau for the 2007 Legislative Session. If the legislation is approved, information and training will be provided to the public and staff regarding this requirement.</p>	MOU Action Plan QI Report	<p>2.1 8/31/06 2.2 9/30/06</p> <p>Action Plan completion date 12/1/06</p>

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					2.11 Establish reporting requirements and reporting responsibilities such as minutes for submission to DCFS Administrative Team			

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<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH</p> <p>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.</p>	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		<p>2.1 Assess legal capability.</p> <p>2.2 Establish Policy Team.</p> <p>2.3 Develop policy.</p> <p>2.4 Complete policy approval process.</p> <p>2.5 Establish QI monitoring process and feedback loop.</p> <p>2.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the County Manager.</p>	<p>Coroner: Law enforcement is always notified of these cases. The new Child Fatality Task Force is currently working on countywide policy recommendations.</p> <p>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.</p> <p>North Las Vegas PD: No</p>	QI Report	<p>2.1 6/30/06</p> <p>2.2 8/30/06</p> <p>2.3 9/30/06</p> <p>2.4 10/31/06</p> <p>2.5 12/1/06</p> <p>2.6 12/1/06</p>

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						<p>update received.</p> <p>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 then notified for a specialized investigative response.</p>		

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<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATH</p> <p>3. Develop countywide law enforcement policy to ensure that all child death autopsies are attended by law enforcement.</p>	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		<p>3.1 Determine budget impact.</p> <p>3.2 Seek additional funding if necessary.</p> <p>As appropriate, establish an action plan to accomplish the following:</p> <p>3.3 Establish countywide Policy Team.</p> <p>3.4 Develop countywide policy.</p> <p>3.5 Complete policy approval process.</p> <p>3.6 Complete training delivery process as needed.</p> <p>3.7 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>North Las Vegas PD: No update received.</p> <p>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.</p> <p>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</p>	Action Plan QI Report	<p>3.1 7/31/06</p> <p>3.2 8/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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						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.		
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	Legal/Law Policy and Procedure Action	State: None County: John Fudenberg	State: None County: County Manager's office, medical examiners Other: CC CDR MDT.		<p>2.1 Analyze the structure and function of the Coroner's office and supervisory role of the Coroner and medical examiners.</p> <p>2.2 Identify specific roles, responsibilities, and job duties for the chief medical examiner.</p> <p>2.3 Determine fiscal and staffing impact and budget capabilities.</p> <p>2.4 Determine feasibility of recommendation.</p>	<p>Coroner: On 7/26/2006 the Clark County Coroner's Office appointed a medical examiner team leader.</p>	<p>Analysis Action Plan QI Report</p>	<p>2.1 7/31/06 2.2 8/30/06 2.3 8/30/06 2.4 12/1/06</p> <p>Action plan due date: 12/1/06</p>

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					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.			

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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).</p>	Legal/Law Policy and Procedure Action	State: None County: John Fudenberg	State: None County: County Manager, medical examiners Other: CC CDR MDT representative.		<p>3.1 Analyze the structure and function of the Coroner's office and supervisory role of the Coroner and medical examiners.</p> <p>3.2 Identify specific roles, responsibilities, and job duties for the chief medical examiner.</p> <p>3.3 Determine fiscal and staffing impact and budget capabilities.</p> <p>3.4 Determine feasibility of recommendation.</p> <p>Establish action plan, if feasible, to accomplish the following:</p> <p>3.5 Submit budget requests.</p> <p>3.6 If appropriate hire chief medical examiner.</p> <p>If appropriate:</p> <p>3.7 Assess legal capability.</p> <p>3.8 Establish countywide Policy Team.</p> <p>3.9 Develop countywide policy.</p> <p>3.10 Complete policy approval process.</p> <p>3.11 Complete training delivery process</p> <p>3.12 Establish QI monitoring</p>	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	<p>3.1 7/31/06</p> <p>3.2 8/30/06</p> <p>3.3 9/30/06</p> <p>3.4 10/31/06</p> <p>Action plan due date: 12/1/06</p>

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					process and feedback loop. 3.13 Establish reporting requirements and reporting responsibilities such as minutes for submission to CC CDR MDT.			

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	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		<p>5.1 Analyze current practice in the Coroner's office.</p> <p>5.2 Determine feasibility of implementing recommendation.</p> <p>If appropriate:</p> <p>5.3 Assess legal capability.</p> <p>5.4 Establish countywide Policy Team.</p> <p>5.5 Develop countywide policy.</p> <p>Establish action plan to accomplish the following:</p> <p>5.6 Complete policy approval Process.</p> <p>5.7 Complete training delivery process.</p> <p>5.8 Establish QI monitoring process and feedback loop.</p> <p>5.9 Establish reporting requirements and reporting responsibilities such as minutes for submission to the CC CDR MDT.</p>	Coroner: This policy has been implemented by the Clark County Coroner's Office.	Analysis Action Plan QI Report	<p>5.1 7/31/06</p> <p>5.2 8/30/06</p> <p>5.3 9/30/06</p> <p>5.4 10/31/06</p> <p>5.5 11/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>2. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours.</p> <p>(Also recommended by the National Resource Center on Legal and Judicial Issues)</p>	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	<p>PIP: Intake Response Policy.</p> <p>2.1 Review new PIP policies for revision.</p> <p>2.2 Initiate revision process as determined necessary.</p> <p>2.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>2.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>2.5 Initiate revised Training Plan.</p> <p>2.6 Establish QI monitoring process and feedback loop.</p>	<p>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.</p>	QI Report	<p>2.1 7/31/06</p> <p>2.2 8/30/06</p> <p>2.3</p> <p>10/31/06</p> <p>2.4</p> <p>11/15/06</p> <p>2.5 12/1/06</p> <p>2.6 12/1/06</p>

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						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.		
<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	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	<p>PIP: Plan of Safe Care Policy</p> <p>3.1 Review new PIP policy for revision.</p> <p>3.2 Initiate revision process as determined necessary.</p> <p>3.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>3.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish</p>	<p>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</p>	Action Plan QI Report	<p>3.1 7/1/07</p> <p>3.2 7/31/06</p> <p>3.3 9/30/06</p> <p>3.4 10/31/06</p> <p>12/1/06 Action Plan completion date</p>

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

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(Also recommended by the National Resource Center on Legal and Judicial Issues)				<p>requirement that health care providers involved in the delivery or care 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-</p> <p>(I) establish a definition under Federal law of what constitutes child abuse; or</p> <p>(II) require prosecution for any illegal action.</p> <p>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</p>	<p>the following:</p> <p>3.5 Initiate revised Training Plan.</p> <p>3.6 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>CCDFS: Update on statewide items is provided by DCFS.</p>	N/A	N/A

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				<p>determines that a person has abused or neglected the child.</p> <p>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.</p> <p>In order to address this issue, the Plan of Safe Care Policy has recently implemented.</p>				

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDSS Policy Team, WCDSS Policy Team, DA, Coroner	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Intake Response Policy.</p> <p>4.1 Review new PIP policies for revision.</p> <p>4.2 Initiate revision process as determined necessary.</p> <p>4.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>4.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>4.5 Initiate revised Training Plan.</p> <p>4.6 Establish QI monitoring process and feedback loop.</p>	<p>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 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</p>	Action Plan QI Report	<p>4.1 7/31/06</p> <p>4.2 8/30/06</p> <p>4.3 10/31/06</p> <p>4.4 11/30/06</p> <p>Action plan completion date: 12/1/06</p>

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						<p>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.</p> <p>CCDFS - 3.5: This is current CCDFS practice when the death is accidental and neglect is suspected. It will be incorporated into the revised CCDFS policies and procedures. Positions have been allocated and a plan is being developed for CCDFS to provide 24/7 response. Additional update on statewide items is provided by DCFS.</p> <p>CCDFS - 3.6: CCDFS</p>		

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						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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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	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		<p>10.1 Determine fiscal impact and budget building capability.</p> <p>10.2 Explore all funding sources.</p> <p>10.3 Determine feasibility of recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility to the blue ribbon panel.</p> <p>If feasible, establish action plan to accomplish the following:</p> <p>10.4 Submit budget requests.</p> <p>10.5 If appropriate, facilitate CAC expansion statewide.</p> <p>Establish an action plan to accomplish the following:</p> <p>10.6 Assess legal capability.</p> <p>10.7 Establish statewide Policy Team</p> <p>10.8 Develop statewide policy.</p> <p>10.9 Complete policy approval process.</p> <p>10.10 Curriculum development.</p> <p>10.11 Training.</p> <p>10.12 Establish QI monitoring process and feedback loop.</p>	<p>CCDFS - 10.3: A national expert will be conducting an assessment of the current use of the CAC and make recommendations. The assessment will begin in December 2006 and will include meeting with internal and external stakeholders. An action plan will be developed upon completion of the assessment.</p> <p>CCDFS - 10.5: The MultiDisciplinary Task Force is establishing forensic interview protocols and will incorporate the findings of the assessment of the CAC.</p> <p>CCDFS - 10.11: Interview protocol is included in the Investigative Protocol training.</p> <p>CCDFS - 10.12: 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</p>	Action Plan QI Report	<p>10.1 8/31/06</p> <p>10.2 10/31/06</p> <p>10.3 11/30/06</p> <p>Action Plans due date: 12/1/06</p>

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						or neglect.		

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<p>D. CASE INTAKE AND INVESTIGATION BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDSS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Diligent Search Policy.</p> <p>12.1 Clarify with the national expert panel what the phrase "a petition for pick up" means.</p> <p>12.2 Review new PIP policies for revision.</p> <p>12.3 Initiate revision process as determined necessary.</p> <p>12.4 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>12.5 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>12.6 Initiate revised Training Plan.</p> <p>12.7 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>12.1 7/1/06</p> <p>12.2 7/1/06</p> <p>12.3 7/31/06</p> <p>12.4 11/1/06</p> <p>12.5 12/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>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.</p> <p>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 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.</p> <p>CCDFS - 12.6: Update on statewide items provided by DCFS.</p> <p>CCDFS - 12.7: CCDFS will ensure that this is incorporated into all</p>		

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						appropriate items of the intake and investigation policies and procedures that are currently being revised. Training will follow.		

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<p>E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT</p> <p>2. Create a separate category of "unable to locate."</p>	<p>Legal/Law Policy and Procedure Action</p>	<p>State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton</p>	<p>State: DCFS Policy Team, AG County: CCDFS Policy Team, WCDSS Policy Team, DA</p>	<p>DCFS has implemented a new statewide PIP policy on this topic</p>	<p>PIP: Substantiation Guidelines.</p> <p>2.1 Review new PIP policies for revision.</p> <p>2.2 Initiate revision process as determined necessary.</p> <p>2.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>2.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>2.5 Initiate revised Training Plan.</p> <p>2.6 Establish QI monitoring process and feedback loop.</p> <p>2.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to DHHS or other identified entity.</p>	<p>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.</p>	<p>Action Plan QI Report</p>	<p>2.1 7/31/06 2.2 8/30/06 2.3 10/31/06 2.4 11/30/06</p> <p>Action plan completion date: 12/1/06</p>

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						CCDFS - 2.5 through 2.7: 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 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	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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						<p>reviewed in a fair and equitable manner.</p> <p>North Las Vegas PD: No update received.</p> <p>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.</p>		

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<p>H. OVERARCHING SYSTEMS ISSUES</p> <p>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.</p> <p>(Also recommended by the National Resource Center on Legal and Judicial Issues)</p>	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	<p>PIP: Intake Response Policy, Safety Assessment Policy.</p> <p>2b.1 Review new PIP policies for revision.</p> <p>2b.2 Initiate revision process as determined necessary.</p> <p>2b.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>2b.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>2b.5 Initiate revised Training Plan.</p> <p>2b.6 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>2b.1 7/31/06</p> <p>2b.2 8/30/06</p> <p>2b.3 10/31/06</p> <p>2b.4 11/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>January 2007. The QI monitoring process and feedback loop consist of the State's internal QI system reported in the State's PIP.</p> <p>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.</p> <p>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.</p> <p>CCDFS - 2b.5: Additional update on statewide items is provided by DCFS.</p> <p>CCDFS - 2b.6: CCDFS continues with its internal case review process of all</p>		

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						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 <i>New Birth Match</i> 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: CCDSS 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 specific recommendation regarding NRS 432B.408 was analyzed by the Attorney General's Office and it was determined that it was feasible to revise this statute in the bill draft request (BDR) to exempt the Administrative Team from the Open Meeting Law. This BDR was approved in September by the DHHS and was referred to the Legislative Counsel Bureau for review and revision for the 2007 Legislative Session.	Analysis BDR	3.1 7/31/06 3.2 8/31/06 3.3 9/1/06 3.4 TBD

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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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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>2. Add to statute a new section defining maternal substance misuse.</p> <p>(Also recommended by the National Expert Panel.)</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: AG, County: CCDFS representative, WCDSS representative, DAs		<p>2.1 DCFS and AG's Office draft Bill Request.</p> <p>2.2 Submit bill request to DHHS for Review.</p> <p>2.3 DHHS to submit to LCB in accordance with scheduling requirements.</p>	DCFS: A bill draft request to add substance misuse was completed and sent to DHHS on 6/29/2006. The draft was reviewed 8/25/2006 and forwarded to the Legislative Counsel Bureau for review and revision for the 2007 Legislative Session.	BDR	<p>2.1 7/31/06</p> <p>2.2 8/31/06</p> <p>2.3 TBD</p>
<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>7. Educate mandatory reporters that they are required to report suspected child abuse and neglect when a child dies.</p>	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 plan for educating mandated reporters was established with the Nevada Partnership for Training as part of ongoing training scheduled to begin in January 2007 and is funded by CAPTA. The specific requirement to report child death under NRS 432B.220, submitted in the State's BDR, must be approved by the Nevada State Legislature before it can be added to the training. Required reporters may report a child's death that	Plan	7.1 9/30/06

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						<p>may be due to child maltreatment under the current statutes.</p> <p>CCDFS: CCDFS is collaborating with Prevent Child Abuse America, an organization which does extensive mandated reporter training and information dissemination.</p>		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>8. If maternal substance misuse observed as a contributing factor on a child's death, this should be grounds for substantiation. Change statute and policy so that substantiation requirements are clearer on this issue. Reorganize all substance abuse statute information into one section in NRS.</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: None	State: DCFS Policy Team, AG County: CCDSS Policy Team, WCDSS Policy Team, DA		<p>8.1 Analyze recommendation for feasibility.</p> <p>If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel.</p> <p>If feasible,</p> <p>8.2 AG's Office in collaboration with DA draft Bill Request.</p> <p>8.3 Submit bill request to DHHS for review.</p> <p>8.4 DHHS to submit to LCB in accordance with scheduling requirements.</p> <p>If appropriate: Revise PIP Policy. Substantiation Guidelines.</p> <p>8.5 Review new PIP policies for revision.</p> <p>Establish action plan to accomplish the following:</p> <p>8.6 Initiate revision process as determined necessary.</p> <p>8.7 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>8.8 Determine updated training</p>	<p>DCFS: A bill draft request to add substance misuse as a new child abuse definition was completed and submitted to DHHS for review on 6/29/2006. The draft was reviewed 8/25/2006 and sent to the Legislative Counsel Bureau for review and revision for the 2007 Legislative Session. Until the BDR is passed into legislation, it would not be feasible to develop policies and procedures. If the legislation is passed, appropriate training and QI will be developed.</p>	<p>Analysis BDR Action Plan QI Report</p>	<p>8.1 7/15/06 8.2 8/15/06 8.3 8/31/06 8.4 TBD 8.5 10/31/06</p> <p>Action Plan completion date: 12/1/06</p>

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					<p>needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>8.9 Initiate revised Training Plan.</p> <p>8.10 Establish QI monitoring process and feedback loop.</p>			

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>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.</p> <p>(Also recommended by the National Expert Panel)</p>	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		<p>12.1 Analyze feasibility.</p> <p>If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel.</p> <p>If feasible:</p> <p>12.2 AG's Office in collaboration with DA draft Bill request.</p> <p>12.3 Submit bill request to DHHS for Review.</p> <p>12.4 DHHS to submit to LCB in accordance with scheduling requirements.</p> <p>12.5 Review new PIP policies for revision.</p> <p>Establish action plan to accomplish the following:</p> <p>12.6 Initiate revision process as determined necessary.</p> <p>12.7 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>12.8 Determine updated training needs and training mechanism regarding revisions.</p> <p>12.9 Initiate revised Training Plan.</p>	<p>DCFS: A bill draft request to expand the definition of prenatal illegal drug use to include alcohol misuse was completed and submitted to DHHS for review on 6/29/2006. The draft was reviewed 8/25/2006 and sent to the Legislative Counsel Bureau for review and revision for the 2007 Legislative Session. Until the BDR is passed into legislation, it would not be feasible to develop policies and procedures. If the legislation is passed, appropriate training and QI will be developed.</p>	<p>Analysis BDR Action Plan QI Report</p>	<p>12.1 7/15/06 12.2 12/15/06 12.3 8/31/06 12.4 TBD 12.5 12/1/06 Action Plan completion date: 12/1/06</p>

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
					12.10 Establish QI monitoring process and feedback loop.			

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>13. Safety assessments must be performed on surviving siblings within 24 hours of the fatality or near fatality.</p>	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	<p>PIP: Safety Assessment Policy.</p> <p>13.1 Determine feasibility of recommendation.</p> <p>If not feasible, provide written analysis of lack of feasibility to the blue ribbon panel.</p> <p>If feasible:</p> <p>13.2 Review new PIP policies for revision.</p> <p>13.3 Initiate revision process as determined necessary.</p> <p>13.4 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>Establish action plan to accomplish the following:</p> <p>13.5 Determine updated training needs and training mechanism regarding revisions.</p> <p>13.6 Initiate revised Training Plan.</p> <p>13.7 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>CCDFS - 13.4: This is included in the Investigative Protocol training.</p> <p>CCDFS - 13.5: The CCDFS unit which conducts all such</p>	Action Plan QI Report	<p>13.1 7/31/06</p> <p>13.2 8/30/06</p> <p>13.3 9/30/06</p> <p>13.4 12/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>investigations is implementing this practice.</p> <p>CCDFS - 13.6: Additional update on statewide items is provided by DCFS.</p> <p>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.</p>		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>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.</p>	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	<p>PIP: Diligent Search Policy.</p> <p>14.1 Review new PIP policies for revision.</p> <p>14.2 Initiate revision process as determined necessary.</p> <p>14.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>14.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>14.5 Initiate revised Training Plan.</p> <p>14.6 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>CCDFS - 14.5 and 14.6: CCDFS will ensure that this is incorporated into all appropriate items of the intake and investigation</p>	Action Plan QI Report	<p>14.1 7/31/06</p> <p>14.2 14.2</p> <p>14.3 8/15/06</p> <p>14.4 14.3</p> <p>14.5 10/31/06</p> <p>14.6 14.4</p> <p>11/30/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>policies and procedures that are currently being revised. Training will follow. Additional update on statewide items is provided by DCFS.</p>		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>15. If one child dies, substantiate on all of the children due to emotional abuse of surviving siblings.</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDSS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Substantiation Guidelines.</p> <p>15.1 Review new PIP policies for revision.</p> <p>15.2 Initiate revision process as determined necessary.</p> <p>15.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>15.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>15.5 Initiate revised Training Plan.</p> <p>15.6 Establish QI monitoring process and feedback loop.</p>	<p>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.</p> <p>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</p>	Action Plan QI Report	<p>15.1 7/31/06</p> <p>15.2 8/15/06</p> <p>15.3 10/31/06</p> <p>15.4 12/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>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.</p> <p>CCDFS - 15.4 and 15.5: Update on statewide items is provided by DCFS.</p> <p>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 child fatalities due to abuse or neglect.</p>		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>16. Substantiated cases should all have a case plan unless it is determined unnecessary by a supervisor.</p>	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	<p>PIP: Case Planning Policy.</p> <p>16.1 Review new PIP policies for revision.</p> <p>16.2 Initiate revision process as determined necessary.</p> <p>16.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>16.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>16.5 Initiate revised Training Plan.</p> <p>16.6 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>16.1 7/31/06</p> <p>16.2 8/15/06</p> <p>16.3 10/31/06</p> <p>16.4 12/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>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.</p> <p>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 statewide items is provided by DCFS.</p> <p>CCDFS - 16.6: Supervisor approval and signature is required on all case plans.</p>		

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<p>K. HOWARD DAVIDSON, NATIONAL RESOURCE CENTER FOR LEGAL AND JUDICIAL ISSUES</p> <p>17. A child death must be entered into UNITY as a new report. This should be added to the intake policy.</p>	Legal/Law Policy and Procedure Action	State: Caroline Thomas and Marjorie Walker County: Nancy McLane and Thomas Morton	State: DCFS Policy Team, AG County: CCDSS Policy Team, WCDSS Policy Team, DA	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Intake Response Policy.</p> <p>17.1 Review new PIP policies for revision.</p> <p>17.2 Initiate revision process as determined necessary.</p> <p>17.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>17.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish action plan to accomplish the following:</p> <p>17.5 Initiate revised Training Plan.</p> <p>17.6 Establish QI monitoring process and feedback loop.</p>	<p>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</p>	Action Plan QI Report	<p>17.1 7/31/06</p> <p>17.2 8/15/06</p> <p>17.3 10/31/06</p> <p>17.4 12/1/06</p> <p>Action Plan completion date: 12/1/06</p>

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						<p>consist of the State's internal QI system reported in the State's PIP.</p> <p>CCDFS - 17.5: Additional update on statewide items is provided by DCFS.</p> <p>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 statewide policy regarding notification of child fatalities and case review of child fatalities due to abuse or neglect.</p>		

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ACTION PLAN FOR THE RURAL NEVADA CHILD DEATH REVIEW RECOMMENDATIONS

RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>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.</p>	Legal/Law Policy and Procedure Action	Counties: Elko, Humboldt, Lyon, Nye County Designees	County: Elko, Lyon, Nye County Coroners, Law Enforcement; Highway Patrol; School District Representatives (Counselors); EMTs; Hospital Employees (ER Docs; RNs); District Attorneys Rural Region Manager: Patricia Hedgecoth or designee State: Marji Walker Caroline Thomas Other: Administrative Team representative, Clark County, Washoe County, Rural Counties	Suggestion by Lyon County to ensure this training is eligible for POST credit. Lyon County recommends written materials and handouts be available on an ongoing basis as a teaching tool. Lyon County: All child deaths should be reported to CPS. Lyon County: Collaborative training between law enforcement and CPS will facilitate increased communication. Humboldt: Add highway patrol; written handouts would be helpful. Silver Springs: Add EMTs, health professionals such as RN's and ER physicians. Collaborative training is important and promotes face to face communication. Pahrump: Add CEUs for nursing and other fields as requested. White Pine: In our	1.1 Convene a statewide workgroup to research and analyze this recommendation for any needed changes to state law and policy. 1.2 If indicated, establish an action plan to develop strategies to facilitate law and policy changes.	Bill drafts have been forwarded for review and comment. Silver Springs: All child deaths should be reported to CPS.	Action Plan	1.1 03/31/07 1.2 5/31/07 Action Plan

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			representatives, as appropriate	county we work investigations together and have good information sharing. Nye: Include new participants in the child death review MDT.				

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<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>2. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting guidelines.</p>	Agency Technical Action	Counties: Elko, Humboldt, Lyon, Nye, County Designee Elko County Rep: Kathy Jones	County: Elko, Humboldt, Lyon, Nye, County Coroners, Law Enforcement; District Attorneys, Commissioners as appropriate Rural Region Manager: Patricia Hedgecoth or designee State: Marji Walker Caroline Thomas Other: Administrative Team representative, Clark County, Washoe County, Rural Counties representatives	Carson City: New officers forget to mark the appropriate check box that results in no notification to CPS. This can be resolved through supervisory oversight which is currently occurring and additional training. Humboldt: include a Commissioner as work group member. Pahrump: Could increase oversight to minimize errors by new officers.	Include this recommendation into the process noted in recommendation A.1 above.		Action Plan	5/31/07 Action Plan

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<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>3. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Child Advocacy Center model.</p>	Inter Agency Collaboration	County: White Pine County Designee	County: Elko, Humboldt, Lyon, Nye, County Coroners, Law Enforcement; Sheriff's Office; District Attorneys; Commissioners, School Districts; Head Starts; Mental Health Rep; UNR School of Medicine Outreach Program; Maxine Lana; Dr. Dinwiddie; Dr Krakaw; County Commissioners & Mayor (Humboldt) Rural Region Manager: Patricia Hedgecoth or designee	Carson City: New building opening soon with a room dedicated to child interviews. This room will have video capability to monitor interviews. Building opens in August. Carson city is interested in developing a forensic interviewing process and recruitment of a multidisciplinary team. Pahrump: Starting the sexual assault team up again. Interested in obtaining information on the Washoe County SART and CARES.	<p>3.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>3.2 Determine fiscal impact and budget capability.</p> <p>3.3 Determine staffing impact and budget capability.</p> <p>3.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>3.5 Submit budget request to all Counties Commissioners and other funding sources.</p>		<p>Feasibility Analysis</p> <p>Action Plan</p>	<p>5/31/07</p> <p>9/30/07 Action Plan</p>

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<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>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.</p>	Inter-Agency Collaboration	<p>Counties: Humboldt, Lyon County law enforcement designees</p> <p>Rural Region DCFS Representative</p>	<p>County: County Coroners, law enforcement investigators; DA; Dr. Krakaw</p> <p>State: Marji Walker, Caroline Thomas</p>	<p>Humboldt: Police Department has received training on the use of SUIDI, and will be using this tool with child fatalities.</p> <p>Carson City: Police Department participated in training in Las Vegas and the SUIDI was introduced at that time. The Department is reviewing the tool and considering its use in child fatality cases.</p> <p>White Pine: Interested in SUIDI information and training funds.</p>	<p>1.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, write analysis of determination.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>1.2 Determine fiscal impact and budget capability.</p> <p>1.3 Determine staffing impact and budget capability.</p> <p>1.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>1.6 Submit budget request to Counties Commissioners and other fund sources.</p>		<p>Feasibility analysis Action Plan</p>	<p>1.1 03/31/07</p> <p>1.2 6/30/07 Action Plan</p>

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B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 2. One case of possible abuse and/or neglect should be submitted to a multidisciplinary team for possible neglect or abuse charges.	Legal/Law Policy and Procedure Action	County: Nye County designee	County: Nye County Coroners, Law Enforcement; District Attorney representatives; Multidisciplinary Team Rural Region Manager: Patricia Hedgecoth or designee		2.1 Obtain case name from the national expert panel. 2.2 Evaluate recommendation. 2.3 Review case 2.4 Develop plan of action in response to the recommendation.		2.1 2/28/07 2.2 4/30/07 2.3 6/30/07 2.4. 8/30/07	

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<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>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.</p>	Agency Technical Action	Counties: Storey, Churchill County designees State: Marji Walker, Caroline Thomas	Counties: Law enforcement representatives, District Attorney representatives; local CDR MDT; DPS; Law Enforcement training coordinators Rural Region Manager: Patricia Hedgecoth or designee		<p>3.1 Evaluate current training for mandatory reporters.</p> <p>3.2 Identify trainee group and training needs</p> <p>3.3 Convene curriculum development group</p> <p>3.4 Revise curriculum</p> <p>3.5 Establish training plan</p>	Pahrump: Interested in training with enough notice.	New curriculum Training Roster Evaluation Report	<p>3.1 4/30/07</p> <p>3.2 5/31/07</p> <p>3.3 6/15/07</p> <p>3.4 8/1/07</p> <p>3.5 10/1/07</p>

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	Inter Agency Collaboration	County: Carson City	<p>Counties: Elko, Humboldt, Lyon, Nye, Storey, Churchill, White Pine, Washoe County, Clark County and other counties as determined;</p> <p>Coroner; Medical Examiners; Nevada Sheriff and Chief's Association</p> <p>Rural Region Manager: Patricia Hedgecoth or designee</p>	A teleconference with the National Expert Panel is requested to further discuss this recommendation with Carson City.	<p>1.1 Determine the feasibility of the Recommendation for statewide implication.</p> <p>If not feasible, write feasibility analysis.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>1.2 Determine fiscal impact and budget capability.</p> <p>1.3 Determine staffing impact and budget capability.</p> <p>1.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>1.5 Submit budget request to Counties Commissioners.</p>	Silver Springs: It can be difficult coordinating and collaborating with a large group of professionals.	<p>Feasibility analysis</p> <p>Action Plan</p>	<p>1.1 3/31/07</p> <p>7/1/07 Action Plan</p>

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>2. Allot time and money to allow death investigators to attend local, regional, state and national meetings.</p>	Agency Technical Action	County: Nye County designee	<p>Counties: Elko, Humboldt, Lyon, Nye, Storey, Churchill, White Pine, Washoe County, Clark County law enforcement investigators and other counties as determined;</p> <p>Coroner; Medical Examiners; Nevada Sheriff's Association</p> <p>Rural Region Manager: Patricia Hedgecoth or designee</p>	<p>Carson City: Law Enforcement representatives indicate that they have adequate funding to send officers to training.</p> <p>Nye: The state fire marshal conducts investigations in cases of fire.</p> <p>Pahrump: Training money is available for law enforcement for attendance at training.</p> <p>White Pine: Interested in finding out about training funds available for Coroner/Sheriff offices.</p>	<p>2.1 Determine national meetings for attendance.</p> <p>2.2 Determine fiscal impact and budget capability.</p> <p>2.3 Determine availability of funds to support recommendation and submit requests.</p> <p>2.4 Submit additional budget request to County Commissioners, or other fund source, as appropriate.</p>			<p>2.1 6/30/07</p> <p>2.2 8/31/07</p> <p>2.3 10/31/07</p> <p>2.4 12/31/07</p>

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>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.</p>	Agency Technical Action	County: White Pine County	<p>Counties: Elko, Humboldt, Lyon, Nye, Storey, Churchill, White Pine, Washoe County, Clark County representatives and other counties as determined;</p> <p>Coroner; Medical Examiners</p> <p>Rural Region Manager: Patricia Hedgecoth or designee</p>	<p>Carson City: The Coroner/Sheriff indicates that they routinely order all necessary toxicology and metabolic tests as warranted.</p> <p>Pahrump: Dr. Warrell (contract medical examiner) orders appropriate tests and law enforcement and the DA defer to her medical expertise.</p> <p>White Pine: Washoe Co Coroner recommends testing.</p> <p>Teleconference with national expert panel member medical examiners.</p>	<p>3.1 Assess current practice</p> <p>3.2 Review existing policy and protocol.</p> <p>3.3 Modify or write new policy, as appropriate</p> <p>3.4 Determine fiscal impact and budget capability, as appropriate.</p> <p>3.5 Submit budget request to County Commissioners, as appropriate</p> <p>3.6 Implement policy, as appropriate</p>			<p>3.1 2/28/07</p> <p>3.2 3/31/07</p> <p>3.3 5/31/07</p> <p>3.4 6/30/07</p> <p>3.5 7/31/07</p> <p>3.6 9/1/07</p>

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>4. Re-open for investigation at least one case.</p>	Inter Agency Collaboration	County: Humboldt County designee	<p>County: District Attorney, Law Enforcement representatives; Coroner, Medical Examiners</p> <p>Rural Region Manager: Patricia Hedgecoth or designee</p>	Humboldt County requests teleconference with the National Expert Panel, particularly the medical examiners.	<p>2.5 Obtain case name from the national expert panel.</p> <p>2.6 Evaluate recommendation.</p> <p>2.7 Review case</p> <p>2.4 Develop plan of action in response to the recommendation.</p>		<p>2.1 2/28/07</p> <p>2.2 4/30/07</p> <p>2.3 6/30/07</p> <p>2.4. 8/30/07</p>	

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<p>D. CASE INTAKE, INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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:</p> <p style="margin-left: 20px;">a. CPS must investigate subsequent reports on cases where another child in the family had died.</p> <p style="margin-left: 20px;">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.</p> <p style="margin-left: 20px;">c. All deaths designated as</p>	Agency Technical Action	State: Marji Walker; Caroline Thomas	<p>Rural Region Manager: Patricia Hedgecoth or designee and representatives from DCFS covering the following counties: Carson City, Elko, Humboldt, Nye; other Rural Region staff as determined; law enforcement and DA</p> <p>Other: CCDFS policy team, WCDSS policy team, State: AG</p>	<p>DCFS has implemented a new statewide Program Improvement Plan (PIP) policy on this topic.</p> <p>Request teleconference with the national expert panel for discussion purposes.</p>	<p>PIP: Revise PIP Policy. Intake Response Policy.</p> <p>CFSP: Goals 1,2</p> <p>1.1 Assess legal capability.</p> <p>1.2 Establish statewide Policy Team.</p> <p>1.3 Develop statewide policy.</p> <p>Establish an action plan to accomplish the following:</p> <p>1.4 Complete policy approval process.</p> <p>1.5 Curriculum development.</p> <p>1.6 Training.</p> <p>1.7 Establish QI monitoring process and feedback loop.</p>		Action Plan QI Report	05/31/07

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<p>undetermined by the Coroner's Office.</p> <p>d. All deaths with prior CPS substantiations or at least three prior reports.</p>								
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.</p>	Agency Technical Action	County: Nye County designee	County: District Attorney representative; Coroner; Medical Examiner; County Health Department representative; Law Enforcement representatives Rural Region Manager: Patricia	Carson City: This is current protocol in Carson City. Nye: This is determined on a case by case basis. Why is this a "must"? Clarification from the national expert panel is requested. White Pine: Does not do this. Understanding the role of CPS is increasing with current collaboration.	<p>Establish an action plan to accomplish the following:</p> <p>2.1 Determine fiscal impact 2.2 Submit budget request, as appropriate 2.3 Establish statewide policy. 2.4 Complete policy approval process. 2.5 Curriculum development. 2.6 Training. 2.7 Establish QI monitoring process and feedback loop. 2.8 Establish reporting</p>		Action Plan QI Report	03/31/07 Action Plan

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			Hedgecoth or designee; AG;		requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team. (Blue Ribbon Panel Change to Action Steps)			
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	Other Action (Fiscal, training, etc.)	County: Churchill County designee State: Marji Walker, Caroline Thomas	Rural Region Manager: Patricia Hedgecoth or designee DCFS fiscal representative, training manager County: Policy teams representing all rural counties; Law Enforcement; Coroner; Medical Examiners Other county policy teams as identified. Local CDR MDT	CCDFS has initiated the training process and has advised the state that information is able to be shared with other jurisdictions. Carson City: CPS and law enforcement routinely collaborate and go out together or communicate timely for scene issues; Sheriff-Coroner also collaborates with CPS routinely. All three entities agree that the collaboration is effective and the protocol facilitates communication. Pahrump: After hours call outs are difficult.	Establish an action plan to accomplish the following: 3.1 Determine fiscal impact 3.2 Submit budget request, as appropriate 3.3 Establish statewide policy. 3.4 Complete policy approval process. 3.5 Curriculum development. 3.6 Training. 3.7 Establish QI monitoring process and feedback loop. 3.8 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.		QI Report	05/31/07 Action Plan

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>4. Implement a policy that decisions to initiate an investigation when a child dies are made within 24 hours.</p>	Legal/Law Policy and Procedure	<p>County: White Pine County designee</p> <p>State: Marji Walker, Caroline Thomas</p>	<p>Rural Region Manager: Patricia Hedgecoth</p> <p>Other State: DCFS policy team, AG,</p> <p>County: Policy teams representing all rural counties; Law Enforcement; Coroner; Medical Examiners</p> <p>Other county policy teams as identified.</p>	DCFS has implemented a new statewide PIP policy on this topic and it is currently under review.	<p>PIP: Intake Response Policy.</p> <p>4.1 Review new PIP policies for revision with policy teams and other stakeholders, as identified.</p> <p>4.2 Initiate revision process as determined necessary.</p> <p>4.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>4.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>4.5 Initiate revised Training Plan.</p> <p>4.6 Establish QI monitoring process and feedback loop.</p>		QI Report	<p>4.1 - 4.3 In accordance with the revision schedule.</p> <p>4.4. - 4.6 In accordance with the completion of the revision schedule.</p>

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>5. Re-open a possible homicide case.</p>	Inter-Agency Collaboration	County: Humboldt County designee	County: District Attorney, Law Enforcement representatives; Coroner, Medical Examiners; DPS; NHP Rural Region Manager: Patricia Hedgecoth or designee	Humboldt: County requests a teleconference with the national Expert Panel to discuss this recommendation. Determine if this was miscoded through consultation with national expert panel. Possibly White Pine?	<p>5.1 Obtain case name from the national expert panel.</p> <p>5.2 Evaluate recommendation.</p> <p>5.3 Review case</p> <p>2.4 Develop plan of action in response to the recommendation.</p>		Action Plan	<p>5.1 2/28/07</p> <p>5.2 4/30/07</p> <p>5.3 6/30/07</p> <p>5.4. 8/30/07</p>

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>6. Review policies regarding contact with other states and develop a quality improvement plan to address out-of-state referrals and notification.</p>	Agency Technical Action	No County specified in report. State: QI Manager: Marji Walker, Caroline Thomas	Rural Region Manager: Patricia Hedgecoth State: DCFS policy team, AG, County: Policy teams representing all rural counties; Law Enforcement; Coroner; Medical Examiners Other county policy teams as identified.		<p>PIP: Diligent Search Policy.</p> <p>6.1 Review new PIP policies for revision.</p> <p>6.2 Initiate revision process as determined necessary.</p> <p>6.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>6.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>6.5 Initiate revised Training Plan.</p> <p>6.6 Establish QI monitoring process and feedback loop.</p>			6.1 - 6.3 In accordance with the revision schedule. 6.4. - 6.6 In accordance with the completion of the revision schedule.

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>7. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations.</p>	Agency Technical Action	<p>No County specified in report.</p> <p>State: QI Manager; Marji Walker, Caroline Thomas</p>	<p>Rural Region Manager: Patricia Hedgcoth or designee</p> <p>State: QI Manager; DCFS policy team, AG,</p> <p>County: Policy teams representing all rural counties; Law Enforcement; Coroner; Medical Examiners</p> <p>Other county policy teams as identified.</p>		<p>Establish an action plan to accomplish the following:</p> <p>7.1 Assess legal capability. 7.2 Establish statewide Policy Team. 7.3 Develop statewide policy. 7.4 Complete policy approval process . 7.5 Curriculum development. 7.6 Training. 7.7 Establish QI monitoring process and feedback loop.</p>		QI Report	4/30/07 Action Plan

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	Agency Technical Action	<p>No County specified in report.</p> <p>State: Marji Walker, Caroline Thomas</p>	<p>Rural Region Manager: Patricia Hedgecoth or designee</p> <p>State: DCFS policy team, AG,</p> <p>County: Policy teams representing all rural counties; Law Enforcement;</p> <p>Other county policy teams as identified.</p>	DCFS has implemented a new statewide PIP Policy on this topic and it is currently under review.	<p>PIP: Safety Assessment Policy.</p> <p>8.1 Review new PIP policies for revision.</p> <p>8.2 Initiate revision process as determined necessary.</p> <p>8.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>8.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>8.5 Initiate revised Training Plan.</p> <p>8.6 Establish QI monitoring process and feedback loop.</p>	Revision documents are currently in draft, having been presented to management on several occasions. Final re-writes are being completed.	Action Plan QI Report	2/28/07

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p>	Legal/Law Policy and Procedure Action	County: All County designees	<p>All County representatives: District Attorney representative; Coroner; Medical Examiner; Law Enforcement representatives</p> <p>Rural Region Manager: Patricia Hedgecoth or designee; AG;</p> <p>State: Marji Walker, Caroline Thomas</p>	Nye: Their SART Team has been re-established.	<p>Establish an action plan to accomplish the following:</p> <p>Forensic Interview Protocol:</p> <p>9.1 Determine fiscal impact</p> <p>9.2 Submit budget request, as appropriate</p> <p>9.3 Establish statewide policy.</p> <p>9.4 Complete policy approval process.</p> <p>9.5 Curriculum development.</p> <p>9.6 Training.</p> <p>9.7 Establish QI monitoring process and feedback loop.</p> <p>9.8 Establish reporting requirements and reporting responsibilities such as</p> <p>minutes for submission to the DCFS Administrative Team.</p> <p>Child Advocacy Center:</p> <p>3.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p>	Clarification is requested from the National expert Panel regarding this recommendation related but not limited to "separately from other siblings and away from parents and potential perpetrators".	Action Plan QI report	<p>9.1 03/31/07</p> <p>9.2 04/30/07</p> <p>9.3 05/31/07</p> <p>7/1/07 Action Plan</p>

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					If feasible, establish an action plan to accomplish the following: 3.2 Determine fiscal impact and budget capability. 3.3 Determine staffing impact and budget capability. 3.4 Determine availability of grants to support recommendation and submit proposal. 3.6 Submit budget request to all Counties Commissioners and other funding sources (Blue Ribbon Panel Change to action Step)			

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<p>E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT.</p> <p>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.</p>	Agency Technical Action	State: Statewide Training Manager & Coordinator;	<p>Rural Region Manager: Patricia Hedgecoth or designee and representatives from DCFS covering the following counties: Humboldt, Nye; other Rural Region staff as determined</p> <p>Other: CCDFS policy team, WCDSS policy team, DA, Law Enforcement; State: AG; Marji Walker; Caroline Thomas</p>	<p>DCFS has implemented a new statewide policy on this topic and it is currently under review.</p> <p>The state rural region child welfare agency requests a telephone conference with the national expert panel to discuss issues related to substantiation.</p>	<p>PIP: Substantiation Guidelines.</p> <p>1.1 Review new PIP policies for revision.</p> <p>1.2 Initiate revision process as determined necessary.</p> <p>1.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>1.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>1.5 Initiate revised Training Plan.</p> <p>1.6 Establish QI monitoring process and feedback loop.</p>		Action Plan QI report	<p>1.1 - 1.4 In accordance with revision schedule</p> <p>06/30/07 Action Plan</p>

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E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT. 2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.	Agency Technical Action	Rural Region Manager: Patricia Hedgecoth or designee		The state rural region child welfare agency requests a telephone conference with the national expert panel to discuss issues related to substantiation.	Obtain clarification from the national expert panel on this recommendation, which is actually a statement.			2/28/07

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>1. Specific recommendations that address children with disabilities:</p> <p style="padding-left: 20px;">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.)</p> <p style="padding-left: 20px;">b. Children with disabilities placed in foster care should be visited frequently to</p>	Agency Technical Action	State: Bridget Speer	<p>Rural Region Manager: Patricia Hedgecoth or designee</p> <p>Other State: Marji Walker; Caroline Thomas; Wanda Scott; Training Manager; Ellen Westphal;</p> <p>Representatives from DCFS covering the following counties: Elko, Humboldt, Lyon, Nye; other Rural Region staff as determined</p> <p>Other: CCDFS policy team; WCDSS policy team; training resources representatives; School representatives;</p>	Several counties (Carson, Nye, Silver Springs, White Pine, Humboldt, Pahrump) agreed that training on this topic should also include DA's, and Law Enforcement, not just CPS.	<p>1.1 Convene policy teams.</p> <p>1.2 Research existing policy in other states on this topic.</p> <p>1.3 Develop policy</p> <p>1.4 Complete the policy review and approval process.</p> <p>1.5 Analyze existing curriculum from other resources.</p> <p>1.6 Develop curriculum and complete the review and approval process.</p> <p>1.7 Determine updated training needs and training mechanism on new policy.</p> <p>Establish an action plan to accomplish the following:</p> <p>1.8 Initiate revised Training Plan.</p> <p>1.9 Establish QI monitoring process and feedback loop.</p>		<p>Policy Curriculum Training Plan</p>	<p>1.1 - 1-7 6/30/07</p> <p>8/1/07 Training Plan</p> <p>8/1/07 QI Monitoring</p>

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<p>assess safety and well-being. Foster parents should be required to have a special care training before children with disabilities are placed with them.</p> <p>c. Any reports of child abuse, physical or sexual, should be thoroughly investigated with interviews that support the child's communication abilities.</p>			Nevada Sheriff and Chief's association; DA;					

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>2. Revise the Case Reporting System for CPS to clearly delineate intake, investigation, case plans, referrals and services.</p>	Agency Technical Action	State: Paul Bowen, IMS Manager or designee; Nancy O'Neill	<p>Rural Region Manager: Patricia Hedgcoth or designee</p> <p>Other State: Family Programs Office Staff; Representatives from DCFS covering the following counties: Lyon; other Rural Region staff as determined</p> <p>Other: CCDFS policy team; WCDFS policy team; training resources representatives</p>		<p>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.</p> <p>Establish an action plan to accomplish the following:</p> <p>2.1 Establish statewide Joint Application Design (JAD) /Policy Team.</p> <p>2.2 Review PIP requirements and modify as needed, to include enhancements to the UNITY system.</p> <p>2.3 As necessary, curriculum development on UNITY modifications.</p> <p>2.4 As necessary, training on UNITY modifications.</p> <p>2.5 Establish QI monitoring process and feedback loop.</p>		Action Plan QI Report	04/30/07

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>3. Require a written service plan for all cases that are substantiated.</p>	Agency Technical Action	State: Case Planning Policy Lead	<p>Rural Region Manager: Patricia Hedgecoth or designee</p> <p>Other State: Marji Walker; Caroline Thomas; Wanda Scott; Training Manager; Ellen Westphal; Representatives from DCFS covering the following counties: Nye; other Rural Region staff as determined;</p> <p>Other: CCDFS policy team; WCDSS policy team; training resources representatives</p>	DCFS has implemented a new statewide PIP Policy on this topic and it is currently under review.	<p>PIP: Substantiation Guidelines Case Planning Policy.</p> <p>3.1 Review new PIP policies for revision.</p> <p>3.2 Initiate revision process as determined necessary.</p> <p>3.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>3.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>3.5 Initiate revised Training Plan.</p> <p>3.6 Establish QI monitoring process and feedback loop.</p>		QI Report	<p>3.1-3.4 In accordance with the revision schedule.</p> <p>8.1.07 Training Plan</p> <p>8.1.08 8/1/07 QI Monitoring</p>

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F. PROVISION OF SERVICES BY CPS. 4. Create a way to more clearly log all CPS contacts with the families.	Agency Technical Action	State: Marji Walker; Caroline Thomas	County: Law Enforcement; District Attorney; Coroner; County representatives from all rural counties. Rural Region Manager: Patricia Hedgecoth or designee State: DCFS policy team, AG, 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. 3.1 Determine code changes 3.2 Modify code as necessary		QI Report	06/30/07 Action Plan

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>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.</p>	Inter-Agency Collaboration Action	State: QI Manager	<p>Rural Region Manager: Patricia Hedgecoth or designee</p> <p>State: DCFS Family Programs Office staff</p> <p>County: County representatives from all rural counties; DAG and DA representatives;</p> <p>Other: County representatives from all rural counties; CIP representatives; Judicial representatives</p> <p>Other: CJA Task Force representative</p>	<p>Lyon County: If there was a process of notification to law enforcement by CPS or the judicial system on orders, law enforcement would be able to intervene if judicial orders are being violated and law enforcement is involved in a case. Access to this information while checking background information would facilitate this type of intervention.</p> <p>Elko: Has established a CPS Alert System for law enforcement when attempting to locate family members.</p> <p>If law enforcement were to receive this type of information, a proactive approach may be achieved when stopping vehicles or performing other investigative functions and conducting background checks.</p>	<p>Program Improvement Plan (PIP): Case closure policy. Safety Assessment Policy. Risk Assessment Policy Case Planning Policy.</p> <p>5.1 Analyze the feasibility of the recommendation. If determined feasible, establish an action plan to accomplish the following:</p> <p>5.2 Assess legal capability.</p> <p>5.3 Establish statewide Policy Team</p> <p>5.4 Develop statewide policy</p> <p>5.5 Complete policy approval process</p> <p>5.6 Curriculum development</p> <p>5.7 Training</p> <p>5.8 Establish QI monitoring process and feedback loop</p> <p>5.9 Establish reporting requirements and reporting responsibilities minutes for submission to the DCFS CJA Task Force.</p>		Action Plan QI Report	

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>6. Require tracking and follow-up on all referrals for service.</p>	Agency Technical Action	<p>County: No County specified in report.</p> <p>State: Chris Lovass-Nagy;</p>	<p>State: DCFS Policy Team; IMS representative, QI Manager</p> <p>Rural Region Manager: Patricia Hedgcoth or designee</p> <p>County: County representatives from all rural counties;</p> <p>Other: Other county policy teams as identified.</p>	<p>DCFS has implemented a new statewide PIP Policy on this topic and it is currently under review.</p> <p>Silver Springs: SS#s could possibly be used to track cases in common.</p>	<p>PIP: Documentation Policy</p> <p>6.1 Review new PIP policies for revision.</p> <p>6.2 Initiate revision process as determined necessary.</p> <p>6.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>6.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>6.5 Initiate revised Training Plan.</p> <p>6.6 Establish QI monitoring process and feedback loop.</p>		QI Report	
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>7. Require that all cases being closed have complete documentation in the case record describing the justifications for closing the case.</p>	Agency Technical Action	<p>County: No County specified in report.</p> <p>State: Nancy O'Neill</p>	<p>County: County representatives from all rural counties;</p> <p>State: DCFS Policy Team;</p> <p>Rural Region Manager: Patricia Hedgcoth or designee</p>	<p>DCFS has implemented a new statewide PIP Policy on this topic and it is currently under review.</p>	<p>PIP: Case Closure Policy.</p> <p>7.1 Review new PIP policies for revision.</p> <p>7.2 Initiate revision process as determined necessary.</p> <p>7.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>7.4 Determine updated training needs and</p>		QI Report	

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			Other: Other county policy teams as identified.		training mechanism regarding revisions. 7.5 Initiate revised Training Plan. 7.6 Establish QI monitoring process and feedback loop.			
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.				No findings, therefore no action will be taken on this topic.				

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***ACTION PLAN FOR THE WASHOE COUNTY CHILD DEATH REVIEW
RECOMMENDATIONS**

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

RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>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.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	<p><u>County</u> <u>Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Dick Gammick (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);</p> <p>Kristen Erickson Ben Graham</p> <p>State: Marji Walker Caroline Thomas</p>	Bill draft language will be reviewed by Washoe County.	Refer To Clark County Action Plan	BDRs drafted	BDRs	n/a

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APPROVED: BRP 1/27/07

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*ACTION PLAN FOR THE WASHOE COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>2. Clarify and if necessary strengthen state law and policy to require mandatory reporting to CPS when a child dies due to part to neglect or abuse, even though there are no surviving siblings, and provide training on this to mandatory reporters.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	<p><u>County</u> <u>Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Dick Gammick (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);</p> <p>State: Marji Walker Caroline Thomas</p> <p>Kristen Erickson Ben Graham</p>	Bill draft language will be reviewed by Washoe County.	Refer To Clark County Action Plan	BDRs drafted	BDRs	n/a
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>3. Provide training to mandatory reporters on the broad range of definitions of abuse and neglect and appropriate reporting</p>	Interagency Collaboration Action	<p>State: Marji Walker Caroline Thomas</p> <p>District Attorney: Dick Gammick</p>	<p><u>County</u> <u>Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Dick Gammick (DA);</p>		<p>3.1 Evaluate current training for mandatory reporters.</p> <p>3.2 Identify trainee group and training needs</p> <p>3.3 Convene curriculum development group</p> <p>3.4 Revise curriculum</p> <p>3.5 Establish training plan</p>		<p>New curriculum Training Roster Evaluation Report</p>	<p>3.1 3/31/07 3.2 4/15/07 3.3 5/1/07 3.4 6/1/07 3.5 7/1/07</p>

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guidelines.			Sylvia Redmond (WC SO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);					
<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>4. Obtain funds for and develop a comprehensive assessment center for abuse and neglect, modeled after the Child Advocacy Center model.</p>	Inter-Agency Collaboration	John Berkich (WC Manager's Office); WCDSS: Mike Capello or designee	<u>County Workgroup:</u> Vern Mc Carty (Coroner); Dick Gammick (DA); Sylvia Redmond (WC SO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);	Washoe County received a HUD appropriation and has broken ground to build a comprehensive center to respond to both adult and child sexual assault cases. The adult program is known as SART and the children's program is known as CARES. Washoe County has a strong partnership with the Northern Nevada Medical Center who donated the land to build the facility.	<p>4.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>4.2 Determine fiscal impact and budget capability.</p> <p>4.3 Determine staffing impact and budget capability.</p> <p>4.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>4.5 Submit budget request to County Commissioners.</p>	Washoe County has an interest in exploring future expansion of the facility/program to form a child advocacy center. A physician currently working with the existing program has extensive experience and is interested in pursuing a fellowship as a forensic pediatrician.		<p>4.1 3/31/07</p> <p>4.2 6/30/07</p> <p>Action plan</p>

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<p>A. IDENTIFICATION OF AND THE REPORTING TO CPS, OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>5. Identify funding for and recruit a trained forensic pediatrician.</p>	Inter-Agency Collaboration	District Attorney: Dick Gammick; WCDSS: Mike Capello or designee	John Berkich (WC Manager's Office); State: Chris Lovass-Nagy	Washoe County successfully recruited a pediatrician to Nevada, specializing in child abuse and neglect, working in Clark County. The pediatrician, Dr. Neha Mehta, voiced support in consulting with northern Nevada on child abuse and neglect cases as requested.	<p>5.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>5.2 Determine fiscal impact and budget capability.</p> <p>5.3 Determine availability of grants to support recommendation and submit proposal.</p> <p>5.4 Submit budget request to County Commissioners.</p>	Northern Nevada Medical Center has been an active partner in recruitment of physicians. Dr. Kathy Wagner currently is involved with the CARES program. Dr. Wagner has experience and is willing to participate in a fellowship to become a forensic pediatrician.		<p>5.1 3/31/07</p> <p>5.2 6/30/07</p> <p>Action Plan</p>
<p>B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS.</p> <p>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</p>	Inter Agency Collaboration	Coroner: Vern Mc Carty	<u>County Workgroup:</u> Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Dick Gammick (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D.	The Coroner's Office has initiated a daily reporting process to CPS of all deaths of children. In addition a reporting form has been developed to transmit detailed information on suspicious cases.	<p>1.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>1.2 Determine fiscal impact and budget capability.</p> <p>1.3 Determine staffing impact and budget capability.</p> <p>1.4 Determine availability of grants to support recommendation and</p>	Coroner's investigators currently have said protocols as a guide to report preparation. Further discussion with law enforcement is needed to determine how such protocols impact local investigative protocols.		<p>1.1 3/31/07</p> <p>1.2 6/30/07</p> <p>Action Plan</p>

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investigators. These guidelines include reenactment of the death event using dolls.			(Corner's Office); Other Medical Examiners		submit proposal. 1.6 Submit budget request to County Commissioners.			
B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 2. Two cases of possible abuse and/or neglect should be submitted to the district attorney's office for review and further investigation conducted.	Legal/Law/Policy and Procedure Action	District Attorney: Dick Gammick	Law Enforcement: representation to be determined depending upon jurisdiction upon receipt of individual case names.		2.1 Obtain case names from the national expert panel. 2.2 Evaluate recommendation. 2.3 Review cases 2.4 Develop plan of action in response to the recommendation.	Washoe County received the cross-walk document that identifies cases with respect to the findings for each section but does not identify the cases in the recommendation sections. Further identification of those cases is needed.		2.1 2/28/07 2.2 4/30/07 2.3 6/30/07 2.4 8/30/07
B. INVESTIGATION BY LAW ENFORCEMENT OF SUSPECTED CHILD ABUSE AND CHILD DEATHS. 3. Law enforcement should establish a policy to notify CPS on every child death they investigate, regardless of cause and manner.	Inter Agency Collaboration	District Attorney: Dick Gammick	WCDSS: Mike Capello or designee Law Enforcement: Reno Police Department (RPD); Sparks Police Department (SPD); Washoe County Sheriff Office	Through Child Protection Enforcement Team (CPET) all law enforcement agencies were provided with pocket cards to guide field officers in decision-making. In addition CPET provided training on child abuse and neglect to all LEA officers last	3.1 Clarification is needed regarding "notify" versus "report" from the national expert panel. 3.2 Designate multidisciplinary policy team members to develop policy. 3.3 Convene policy team 3.4 Analyze existing policy 3.5 Develop new or modified policy 3.6 Develop a training plan			3.1 2/28/07 3.2 3/31/07 3.3 4/30/07 3.4 5/30/07 3.5 6/30/07 3.6 7/13/07

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			(WCSO);	year.				
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 1. Establish a state level study group and consult with experts from the national Association of Medical Examiners and the U.S. Centers for Disease Control to explore the feasibility of abolishing the state's county-based coroner system and replacing it with a state medical examiner system. This would allow for oversight on death investigation and certification to physicians rather than lay appointees.	Agency Technical	District Attorney: Dick Gammick	Washoe County will reconvene the Coroner/Medical Examiner Transition Panel	Analysis of this recommendation was initiated prior to the national expert panel review process. Key considerations include issues and differences faced by large counties and rural counties with this type of system and the type of funding and personnel support necessary. Statutory language will require review and modification, as appropriate.	1.1 Determine the feasibility of the Recommendation for statewide implication. If feasible, establish an action plan to accomplish the following: 1.2 Determine fiscal impact and budget capability. 1.3 Determine staffing impact and budget capability. 1.4 Determine availability of grants to support recommendation and submit proposal. 1.5 Submit budget request to County Commissioners.	Washoe County is in the process of establishing a Medical Examiner Model. The estimated date of implementation is July 1, 2007.		1.1 3/31/07 7/1/07 Action Plan

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>2. All Children in state custody should have full death investigations through the coroner's office, regardless of suspected cause and manner.</p>	Agency Technical	Coroner: Vern Mc Carty District Attorney: Dick Gammick	County Workgroup: Mike Capello or designee (WCDSS); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Coroner's Office); Other Medical Examiners State: Marji Walker	Clarification is made to this recommendation in interpreting the phrase "state custody" in the recommendation to mean "governmental agency" custody. Further discussion about the need for "automatic" full death scene investigation is under discussion. With the implementation of the Medical Examiner model further discussion about the feasibility will need to occur.	<p>2.1 Obtain individual case names in order to determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>2.2 Determine fiscal impact and budget capability.</p> <p>2.3 Determine staffing impact and budget capability.</p> <p>2.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>2.5 Submit budget request to County Commissioners.</p> <p>2.6 Develop policy</p> <p>2.7 Implement policy</p>			<p>2.1 3/31/07</p> <p>7/1/07 Action Plan</p>
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>3. Cause of death statements should always be listed by forensic pathologist on autopsy reports, prior to review by the coroner's office.</p>	Agency Technical	Washoe County will reconvene the Coroner/Medical Examiner Transition Panel District Attorney: Dick Gammick		The Sheriff/Coroner system in rural counties present several concerns in reference to this recommendation and will be addressed in the rural region action plan.	<p>3.1 Assess current practice</p> <p>3.2 Review existing policy and protocol.</p> <p>3.3 Modify or write new policy</p> <p>3.4 Implement policy</p>	The transition to the Medical Examiner model will resolve this issue.	New Policy	<p>3.1 3/1/07</p> <p>3.2 6/30/07</p> <p>3.3 9/28/07</p> <p>3.4 12/13/07</p>

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C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 4. Coroner should not change cause and/or manner statements from forensic pathologists without first meeting with pathologists to address scene circumstances and autopsy together prior to certification and consider a mechanism to also have a deputy coroner available to "sign off" on all cases.	Agency Technical	Coroner: Vern Mc Carty District Attorney: Dick Gammick	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners	Review of this issue involved a single case in which transitional language was subsequently developed.	4.1 Assess current practice 4.2 Review existing policy and protocol. 4.3 Modify or write new policy 4.4 Implement policy	Completed.	New Policy	4.1 3/31/07 4.2 6/30/07 4.3 9/28/07 4.4 12/31/07
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 5. Establish improved communication and collaboration between the coroner and pathologists, and between coroner and CPS and law enforcement. Recommend that all deputy coroner investigative reports to the pathologists include mention of CPS and law enforcement involvement, as this information must be provided to the pathologist prior to death certification. The pathologist should not be	Inter Agency Collaboration	Coroner: Vern Mc Carty District Attorney: Dick Gammick or designee. Ellen Clark, M.D. (Corner's Office); Other Medical Examiners Mike Capello or designee (WCDSS);	<u>County Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Dick Gammick (DA); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);	The transition to the Medical Examiner model will resolve this issue. In addition the Corners office and the Pathologists have implemented an expanded and timely case staffing process to insure information is shared.	5.1 County Management to convene multidisciplinary workgroup to review issues of this recommendation and conduct assessment to determine validity of the recommendation. 5.2 County Management to facilitate development of a plan of action to address recommendation. 5.3 Determine need to establish MOU. 5.4 Develop MOU, as determined 5.5 Implement MOU		Workgroup convened MOU	5.1 3/31/07 5.2 4/30/07 5.3 6/15/07 5.4 As determined 5.5 As determined

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working in a vacuum.								
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 6. Allot time and money to allow death investigators to attend local, regional, state and national trainings and meetings.	Agency Technical	Coroner: Vern Mc Carty District Attorney: Dick Gammick	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners	Seven out of ten investigators have national credentials; some training is self funded; funds were provided from past legislative efforts for training. Training and funding is needed in the rural counties.	6.1 Determine training needs 6.2 Determine fiscal impact and budget capability. 6.3 Determine availability of grants to support recommendation and submit proposal. 6.4 Submit budget request to County Commissioners, as appropriate.	The Coroner's office disagrees with the finding as it pertains to Washoe County. Efforts will continue to insure future training opportunities for the staff.		6.1 6/30/07 6.2 8/31/07 6.3 10/31/07 6.4 12/31/07
C. INVESTIGATION BY CORONER/MEDICAL EXAMINER 7. Comprehensive toxicology testing and metabolic studies (e.g., Pediatrix) should be conducted rather than the basic panel tests currently being conducted, on most infants and children under the age of 18 years.	Agency Technical	Coroner: Vern Mc Carty District Attorney: Dick Gammick	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners John Berkich (WC Manager's Office);	This is viewed as a policy issue and in reviewing most of the cases in this review had full toxicology testing, but some did not. Under the Medical Examiner model there are plans to expand the pool of cases that would receive such testing.	7.1 Assess current practice 7.2 Review existing policy and protocol. 7.3 Modify or write new policy 7.4 Determine fiscal impact and budget capability. 7.5 Submit budget request to County Commissioners 7.6 Implement policy			7.1 2/28/07 7.2 3/31/07 7.3 5/31/07 7.4 6/30/07 7.5 7/31/07 7.6 9/1/07

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<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>8. Neuropathology consultation on formalin fixed brains should be obtained especially on potential abusive head injury deaths and for instances of hypoxic/ischemic encephalopathy.</p> <p>C.8.</p>	Agency Technical Action	Coroner: Vern Mc Carty District Attorney: Dick Gammick	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners	This decision will be evaluated by the Medical Examiner on a case-by-case basis. However, one of the Medical Examiners will be trained in neuropathology.	<p>8.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>8.2 Determine fiscal impact and budget capability.</p> <p>8.3 Determine staffing impact and budget capability.</p> <p>8.4 Submit budget request.</p> <p>8.5 Establish Policy Team</p> <p>8.6 Develop county policy.</p> <p>8.7 Complete policy approval process.</p> <p>8.8 Complete the training delivery process.</p> <p>8.9 Establish QI monitoring process and feedback loop.</p> <p>8.10 Establish reporting requirements and reporting responsibilities</p>		Action Plan QI Report	8.1 3/31/07 07/31/07 Action Plan
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>9. Consider using terms on death certificate other than SIDS, such as "sudden unexplained death in infancy/undetermined" when intense petechiae, CPS</p>	Agency Technical	Coroner: Vern Mc Carty District Attorney: Dick Gammick	Ellen Clark, M.D. (Corner's Office); Other Medical Examiners	The transition to the Medical Examiner model will resolve this issue as there will be a standardization of death certification processes in Washoe County. Note this seems to	<p>9.1 Assess current practice</p> <p>9.2 Review existing policy and protocol.</p> <p>9.3 Modify or write new policy</p> <p>9.4 Develop a training plan</p>			9.1 3/31/07 9.2 4/31/07 9.3 5/31/07 9.4 6/30/07

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issues, co-sleeping or other unsafe sleep environment issues are present.				relate to a single case in 2002.				
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>10. Re-open for investigation at least one case.</p>	Agency Technical	<p>Coroner: Vern Mc Carty</p> <p>District Attorney: Dick Gammick</p>	<p>Ellen Clark, M.D. (Corner's Office); Other Medical Examiners</p> <p>Law Enforcement: representation to be determined depending upon jurisdiction upon receipt of individual case names.</p>		<p>10.1 Obtain case names from the national expert panel.</p> <p>10.2 Evaluate recommendation.</p> <p>10.3 Review cases</p> <p>10.4 Develop plan of action in response to the recommendation.</p>	<p>Washoe County received the cross-walk document that identifies cases with respect to the findings for each section but does not identify the cases in the recommendation sections. Further identification of those cases is needed.</p>		<p>10.1 2/28/07</p> <p>10.2 4/30/07</p> <p>10.3 6/30/07</p> <p>10.4 7/31/07</p> <p>Action Plan</p>
<p>C. INVESTIGATION BY CORONER/MEDICAL EXAMINER</p> <p>11. Establish a policy and procedure with reference to organ procurement, and involve law enforcement and the district attorney.</p>	Agency Technical	<p>Coroner: Vern Mc Carty</p> <p>District Attorney: Dick Gammick</p>	<p>Law Enforcement: RPD; SPD; WCSO;</p>	<p>Policy currently exists. Most offices currently have the appropriate forms for tracking and identification of harvesting restrictions. An additional one page form has been developed to enhance the existing process.</p> <p>Note there is a pending</p>	<p>11.1 Assess current practice</p> <p>11.2 Review existing policy and protocol.</p> <p>11.3 Modify or write new policy</p> <p>11.4 Develop a training plan</p>			<p>11.1 3/31/07</p> <p>11.2 4/31/07</p> <p>11.3 5/31/07</p> <p>11.4 6/30/07</p>

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

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APPROVED: BRP 1/27/07

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				BDR on this issue.				
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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:</p> <ul style="list-style-type: none"> 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. 	Agency Technical Action	WCDSS: Mike Capello	<p>State: DCFS Policy team, AG, County: CCDFS policy team, WCDSS policy team, DA</p> <p>State Lead: Marji Walker; Caroline Thomas</p>	<p>DCFS has implemented a new statewide Program Improvement Plan (PIP) policy on this topic.</p>	<p>PIP: Revise PIP Policy. Intake Response Policy. CFSP: Goals 1,2</p> <ul style="list-style-type: none"> 1.1 Assess legal capability. 1.2 Establish statewide Policy Team. 1.3 Develop statewide policy. <p>Establish an action plan to accomplish the following:</p> <ul style="list-style-type: none"> 1.4 Complete policy approval process. 1.5 Curriculum development. 1.6 Training. 1.7 Establish QI monitoring process and feedback loop. 		Action Plan QI Report	03/31/07

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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. D.1.								
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 2. When a baby dies and manner or cause is "undetermined" death, siblings must be interviewed privately and have a full physical exam.	Agency Technical	District Attorney: Civil Division WCDSS: Mike Capello	WCDSS: Mike Capello or designee; Civil D.A.; AG Office; Ellen Clark, M.D. (Coroner's Office); Other Medical Examiners; Washoe County Health	Funding was previously provided through the Washoe County Health Department to support this type of recommendation through the provision of nursing staff. Funding was ceased.	2.1 Determine the feasibility of the recommendation. If feasible, establish an action plan to accomplish the following: 2.2 Determine fiscal impact and budget capability. 2.3 Determine staffing impact and budget capability. 2.4 Submit budget request.		Action Plan QI Report	03/31/07 Action Plan

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			Department		2.5 Establish Policy Team 2.6 Develop county policy. 2.7 Complete policy approval process. 2.8 Complete the training delivery process. 2.9 Establish QI monitoring process and feedback loop. 2.10 Establish reporting requirements and reporting responsibilities			
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 3. CPS should not defer their investigations to law enforcement and should immediately assess safety of surviving siblings. Train all CPS investigators so that they understand that a law enforcement and/or coroner investigation does not abrogate CPS responsibility for its own investigation.	Other Action (Fiscal, training, etc.)	District Attorney: Civil Division WCDSS: Mike Capello or designee;	State: DCFS representative, County: WCDSS: Mike Capello or designee; WCDSS policy team members; CCDFS reps Other: Law enforcement representatives, Executive Team representatives	CCDFS has initiated this process and has advised the state that information is able to be shared with other jurisdictions. WCDSS implemented new policy following CCDFS review. Historically CPS only deferred in homicide cases but now CPS actively involved in reported cases from the onset.	Establish an action plan to accomplish the following: 3.1 Establish statewide policy. 3.2 Complete policy approval process. 3.3 Curriculum development. 3.4 Training. 3.5 Establish QI monitoring process and feedback loop. 3.6 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.		Action Plan QI Report	06/30/07 Action Plan
D.7.								

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<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>4. Implement a policy that decisions to initiate an investigation when a child dies is made within 24 hours.</p> <p>D.2.</p>	Legal/Law Policy and Procedure Action	WCDSS: Mike Capello	State: DCFS policy team, AG, County: WCDSS: Mike Capello or designee CCDFS policy team, WCDSS policy team members and agency technical action work group, DA	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Intake Response Policy.</p> <p>4.1 Review new PIP policies for revision.</p> <p>4.2 Initiate revision process as determined necessary.</p> <p>4.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>4.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>4.5 Initiate revised Training Plan.</p> <p>4.6 Establish QI monitoring process and feedback loop.</p>	Completed this policy is now in place.	QI Report	n/a
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p> <p>D.3.</p>	Legal/Law Policy and Procedure Action	State: DCFS policy team, AG WCDSS: Mike Capello or designee	State: DCFS policy team, AG County: WCDSS: Mike Capello or designee WCDSS policy team, CCDFS policy team, DA; Vern Mc Carty (*Coroner); ElleIn Clark, M.D. (Coroner's Office) and other Medical Examiners	Requirements must adhere to CAPTA Section 106 (b) (2) (A) (ii) which states: policies and procedures (including appropriate referral to child protection service system and for other appropriate services) to address the needs of infants born and identified as being affected by illegal substance abuse or	<p>PIP: Plan of Safe Care Policy</p> <p>5.1 Review new PIP policy for revision.</p> <p>5.2 Initiate revision process as determined necessary.</p> <p>5.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>5.4 Determine updated training needs and training mechanism regarding revisions.</p>		Action Plan QI Report	n/a

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				<p>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-</p> <p>(I) establish a definition under Federal law of what constitutes child abuse; or</p> <p>(II) require prosecution for any illegal action.</p>	<p>Establish action plan to accomplish the following:</p> <p>5.5 Initiate revised Training Plan.</p> <p>5.6 Establish QI monitoring process and feedback loop.</p>			

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				<p>NRS 432B.310 (2) states: An agency which provides child welfare services shall not report to the Central Registry any information concerning a child identified as being affected by prenatal illegal substance abuse or as having withdrawal symptoms resulting from prenatal drug exposure unless the agency determines that a person has abused or neglected the child.</p> <p>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.</p> <p>In order to address this issue, the Plan of Safe Care Policy has recently been implemented</p>				

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D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 6. Develop a quality improvement plan to require supervisor oversight and written approval of actions on all child death investigations. D.8.	Agency Technical Action	WCDSS: Mike Capello or designee	State: State Leads: Marji Walker; Caroline Thomas; DCFS policy team; AG; County: WCDSS policy team, CCDFS policy team, DA	WCDSS has completed an Agency Improvement Plan in 08/2005 that was submitted to the DMG for approval and ongoing monitoring	Establish an action plan to accomplish the following: 6.1 Assess legal capability. 6.2 Establish statewide Policy Team. 6.3 Develop statewide policy. 6.4 Complete policy approval process . 6.5 Curriculum development. 6.6 Training. 6.7 Establish QI monitoring process and feedback loop.		QI Report	03/31/07 Action Plan
D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS 7. Utilize research based safety assessment tools and ensure that in child deaths, assessments are completed on all surviving siblings within 24 hours. Current policy requires three days D.9.	Agency Technical Action	State: Marji Walker Caroline Thomas WCDSS: Mike Capello or designee	State: DCFS policy team County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic	PIP: Safety Assessment Policy. 7.1 Review new PIP policies for revision. 7.2 Initiate revision process as determined necessary. 7.3 Analyze existing curriculum for revision and revise as determined necessary. 7.4 Determine updated training needs and training mechanism regarding revisions. Establish an action plan to accomplish the following: 7.5 Initiate revised Training Plan. 7.6 Establish QI monitoring process and	Revision documents are currently in draft, having been presented to management on several occasions. Final re-writes are being completed.	Action Plan QI Report	2/28/07

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					feedback loop.			
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>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.</p> <p>D.10.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	State: DCFS policy team, AG County: WCDSS: Mike Capello or designee WCDSS policy team, CCDFS policy team, RPD; SPD; WCSO; DA, CAC representative	<p>Washoe County received a HUD appropriation and has broken ground to build a comprehensive center to respond to both adult and child sexual assault cases. The adult program is known as SART and the children's program is known as CARES. Washoe County has a strong partnership with the Northern Nevada Medical Center who donated the land to build the facility. Of concern is the establishment of a protocol that is the least intrusive to the victim and family, avoiding duplication of</p>	<p>8.1 Determine fiscal impact and budget building capability. 8.2 Explore all funding sources. 8.3 Determine feasibility of recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p> <p>If feasible, establish action plan to accomplish the following: 8.4 Submit budget requests. 8.5 If appropriate, facilitate CAC expansion statewide.</p>		Action Plan QI Report	<p>8.1 4/31/07</p> <p>6/30/07 Action plan</p>

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				interviews or creation of prosecutory issues.				
<p>D. CASE INTAKE AND INVESTIGATION AND ASSESSMENT BY CPS OF SUSPECTED CHILD ABUSE AND OF CHILD DEATHS</p> <p>9. Supervisors should ensure that due diligence is followed in locating out of state CPS records at least five years prior to the death in suspicious cases, including identifying prior addresses, contacting state, and reviewing and incorporating out of state information into the case file.</p> <p>D.13.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	<p>State: DCFS policy team, AG County: WCDSS policy team, CCDFS policy team, DA</p> <p>State Lead: Marji Walker</p>	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Diligent Search Policy.</p> <p>9.1 Review new PIP policies for revision.</p> <p>9.2 Initiate revision process as determined necessary.</p> <p>9.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>9.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>9.5 Initiate revised Training Plan.</p> <p>9.6 Establish QI monitoring process and feedback loop.</p>	Revision process has been initiated.	Action Plan QI Report	In accordance with revision schedule

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<p>E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT.</p> <p>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.</p> <p>E.1.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	State: DCFS policy team, AG; State Lead: Marji Walker; County: WCDSS policy team, CCDFS policy team, DA	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Substantiation Guidelines.</p> <p>1.1 Review new PIP policies for revision.</p> <p>1.2 Initiate revision process as determined necessary.</p> <p>1.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>1.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>Establish an action plan to accomplish the following:</p> <p>1.5 Initiate revised Training Plan.</p> <p>1.6 Establish QI monitoring process and feedback loop.</p>	Revision process has been initiated.	Action Plan QI Report	In accordance with revision schedule.
<p>E. CPS SUBSTANTIATION OF CHILD ABUSE OR NEGLECT.</p> <p>2. As described in the previous section, efforts to improve investigations will provide more information to make appropriate decisions.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	State: Marji Walker		Obtain clarification from the national expert panel on this recommendation, which is actually a statement.			2/28/07

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LAST UPDATED: 1/25/2007WCDSS

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*ACTION PLAN FOR THE WASHOE COUNTY CHILD DEATH REVIEW RECOMMENDATIONS

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RECOMMENDATION	WORKGROUP NAME	ACCOUNTABLE PERSONS	WORKGROUP MEMBERS	UPDATED INFORMATION	ACTION STEPS	INTERIM STATUS UPDATES	VERIFICATION DOCUMENTS	*DUE DATES
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>1. Revise the CPS Case Reporting System including the Unity System so that intake, investigation, case plans, referrals and services are clearly delineated and can be catalogued on a time scale.</p> <p>F.1.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	<p>State: DCFS policy team, IMS;</p> <p>County: WCDSS policy team, CCDFS policy team, IMS</p> <p>State Lead: IMS Chief or designee</p>		<p>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.</p> <p>Establish an action plan to accomplish the following:</p> <p>1.1 Establish statewide Joint Application Design (JAD) /Policy Team.</p> <p>1.2 Review PIP requirements and modify as needed, to include enhancements to the UNITY system.</p> <p>1.3 As necessary, curriculum development on UNITY modifications.</p> <p>1.4 As necessary, training on UNITY modifications.</p> <p>1.5 Establish QI monitoring process and feedback loop.</p>		Action Plan QI Report	03/31/07 Action Plan
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>2. Require a written service plan for all cases that are substantiated.</p> <p>F.2.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	<p>State: DCFS policy team, AG; State Lead: Marji Walker;</p> <p>County: WCDSS policy team, CCDFS policy team, DA</p>	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Substantiation Guidelines Case Planning Policy.</p> <p>2.1 Review new PIP policies for revision.</p> <p>2.2 Initiate revision process as determined necessary.</p> <p>2.3 Analyze existing curriculum</p>	Revision process has been initiated.	QI Report	In accordance with revision schedule.

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					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.			
F. PROVISION OF SERVICES BY CPS. 3. Create a way to more clearly log all CPS contacts with the families. F.3.	Agency Technical Action	County: Mike Capello or designee	State: DCFS policy team, AG, IMS County: WCDSS policy team, CCDFS policy team, DA, IMS; RPD; SPD; WCSO State Lead: IMS Chief or designee	Difficulty arose with the Clark County analysis in identifying common cases across jurisdictions since all use different identification numbers. The UNITY System does not have the capacity to log all contacts. The extensive paper files reviewed by the panel made the process difficult.	Establish an action plan to accomplish the following: 3.1 Establish statewide JAD/Policy Team to assess and modify UNITY. 3.2 Develop statewide policy to include enhancements to the UNITY system. 3.3 Complete policy approval process. 3.4 Curriculum development. 3.5 Training. 3.6 Establish QI monitoring process and feedback loop. 3.7 Determine code changes 3.8 Modify code as necessary		QI Report	06/30/07 Action Plan

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F. PROVISION OF SERVICES BY CPS. 4. Require supervisor and or judicial approval prior to allowing reunification of parents who do not complete required substance abuse treatment, mental health treatment, or domestic violence services. F.5.	Inter-Agency Collaboration Action	County: Mike Capello or designee	State Lead: DCFS staff Marji Walker Caroline Thomas County: WCDSS and CCDFS 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. 4.1 Analyze the feasibility of the recommendation. If determined feasible, establish an action plan to accomplish the following: 4.2 Assess legal capability. 4.3 Establish statewide Policy Team 4.4 Develop statewide policy 4.5 Complete policy approval process 4.6 Curriculum development 4.7 Training 4.8 Establish QI monitoring process and feedback loop 4.9 Establish reporting requirements and reporting responsibilities minutes for submission to the DCFS CJA Task Force.		Action Plan QI Report	06/30/07 Action Plan

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<p>F. PROVISION OF SERVICES BY CPS.</p> <p>5. Require tracking and follow-up on all referrals for service.</p> <p>F.6.</p>	Agency Technical Action	WCDSS: Mike Capello or designee	<p>State: DCFS policy team, IMS; State Lead: Chris Lovass-Nagy</p> <p>County: WCDSS policy team; IMS; CCDFS policy team; IMS</p>	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Documentation Policy</p> <p>5.1 Review new PIP policies for revision.</p> <p>5.2 Initiate revision process as determined necessary.</p> <p>5.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>5.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>5.5 Initiate revised Training Plan.</p> <p>5.6 Establish QI monitoring process and feedback loop.</p>	Revision process has been initiated.	QI Report	In accordance with revision schedule
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>6. Require that when a death occurs on open cases, a new investigation/ case records be created.</p> <p>F.7.</p>	Agency Technical Action	County: Mike Capello or designee	<p>State: DCFS policy team, State Leads: Marji Walker Caroline Thomas; AG;</p> <p>County: WCDSS policy team, CCDFS policy team, DA</p>	DCFS has implemented a new statewide PIP policy on this topic	<p>PIP: Intake Response Policy.</p> <p>6.1 Review new PIP policies for revision.</p> <p>6.2 Initiate revision process as determined necessary.</p> <p>6.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>6.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>6.5 Initiate revised Training Plan.</p>		QI Report	n/a

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					6.6 Establish QI monitoring process and feedback loop.			
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>7. Require that all cases being closed have complete documentation in the case file describing the justifications for closing the case.</p> <p>F.8.</p>	Agency Technical Action	County: Mike Capello or designee	<p>State: DCFS policy team, AG</p> <p>County: WCDSS policy team, CCDFS policy team, WCDA Civil</p> <p>State Lead: Marji Walker; Caroline Thomas</p>	<p>The WCDSS Agency Improvement Plan (AIP) will address this.</p> <p>DCFS has implemented a new statewide PIP policy on this topic</p>	<p>PIP: Case Closure Policy.</p> <p>7.1 Review new PIP policies for revision.</p> <p>7.2 Initiate revision process as determined necessary.</p> <p>7.3 Analyze existing curriculum for revision and revise as determined necessary.</p> <p>7.4 Determine updated training needs and training mechanism regarding revisions.</p> <p>7.5 Initiate revised Training Plan.</p> <p>7.6 Establish QI monitoring process and feedback loop.</p>	Revision process has been initiated	QI Report	In accordance with revision schedule
<p>F. PROVISION OF SERVICES BY CPS.</p> <p>8. Establish a high level, independent review (separate from licensing and CPS) of all deaths and serious injuries occurring in any</p>	Inter Agency Collaboration	WCDSS: Mike Capello or designee	<p>County Management:</p> <p>Executive Team: Administrative Team: CCDFS</p> <p>State: Marji</p>	A charter has been developed to initiate the review process.	<p>8.1 Establish statewide Policy Team.</p> <p>8.2 Develop statewide policy.</p> <p>8.3 Complete policy approval process.</p> <p>8.4 Establish QI monitoring process and feedback loop.</p> <p>8.5 Establish reporting</p>		Policy implemented	<p>8.1 3/31/07</p> <p>8.2 6/30/07</p> <p>8.3 9/30/07</p> <p>8.4 11/30/07</p> <p>8.5 12/15/07</p>

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licensed foster home and/or in adoptive home that have more than one special needs and/or medically fragile child. N/A			Walker; Caroline Thomas		requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.			
G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS. 1. Institute a policy that all child death cases investigated by law enforcement, the coroner and CPS are brought to the DA for their review. G.2.	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	<u>County Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office); Other: Administrative team representative	The Washoe County DA currently reviews all child deaths, except those that occur under a physician's care.	1.1 Determine feasibility of recommendation. If not feasible, provide written analysis of the lack of feasibility. If feasible, establish action plan to accomplish the following: 1.2 Assess legal capability. 1.3 Establish countywide Policy Team. 1.4 Develop countywide policy. 1.5 Complete policy approval process. 1.6 Establish QI monitoring process and feedback loop. 1.7 Establish reporting requirements and reporting responsibilities such as minutes for submission to the DCFS Administrative Team.		QI Report	1.1 5/1/07 6/30/07 Action Plan

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.</p> <p>2. Reinstate the position of a dedicated DA for child abuse and neglect cases on a 24/7 basis.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	County Workgroup: John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);	Discussions are currently occurring and in the process of evaluation regarding additional training for the current on call district attorney to address this recommendation. There is also a plan to provide additional training to the existing on-call.	<p>2.1 Determine the feasibility of the recommendation.</p> <p>If not feasible, provide written analysis of the lack of feasibility.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>2.2 Determine fiscal impact and budget capability.</p> <p>2.3 Determine staffing impact and budget capability.</p> <p>2.4 Submit budget request.</p>			<p>2.1 2/28/07</p> <p>6/30/07 Action Plan</p>
<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.</p> <p>3. Reinvestigate cases described above and consider for prosecution.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	Law Enforcement: RPD; SPD; WCSO		Obtain clarification from the national expert panel in order to respond to this recommendation.	Washoe County received the cross-walk document that identifies cases with respect to the findings for each section but does not identify the cases in the recommendation sections. Further identification of those cases is needed.		2/28/07

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.</p> <p>4. Require mandatory training on domestic violence laws and polices for attorneys.</p> <p>N/A</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	Court Improvement Project; Administrative Office of the Courts; WCDSS; CCDFS; AG; State Lead: Pete Galanowicz;	<p>A multitude of training is currently provided in this area.</p> <p>The Washoe working group is unclear about the role of AOC in providing training of this type and suggests that the DA'S association or the Nevada Prosecutor's advisory panel be consulted.</p>	<p>4.1 Collaborate with the courts to determine feasibility of recommendation.</p> <p>4.2 Assess training needs</p> <p>4.3 Develop action plan with CIP/AOC to establish a training plan, as appropriate.</p>	Training grants have been received by CIP and a training coordinator is currently working with DCFS to establish such training.		<p>4.1 4/31/07</p> <p>4.2 9/30/07</p> <p>4.3 12/31/07</p> <p>Action Plan</p>
<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.</p> <p>5. Review and utilize Nevada Evidence Code Section that allow for prosecution in corpus delicti cases.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick			Consult with the national expert panel to obtain additional information on this recommendation.			4/30/07

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<p>G. ACTIONS TAKEN BY THE CIVIL AND CRIMINAL DIVISIONS OF THE DISTRICT ATTORNEY'S OFFICE AND THE COURTS.</p> <p>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.</p>	Legal/Law Policy and Procedure Action	District Attorney: Dick Gammick	<p><u>County Workgroup:</u> John Berkich (WC Manager's Office); Mike Capello or designee (WCDSS); Vern Mc Carty (Coroner); Sylvia Redmond (WCSO Detectives); Rocky Treplett (Sparks PD); Ellen Clark, M.D. (Corner's Office);</p>	<p>This is a duplicate recommendation.</p> <p>Washoe County received a HUD appropriation and has broken ground to build a comprehensive center to respond to both adult and child sexual assault cases. The adult program is known as SART and the children's program is known as CARES. Washoe County successfully recruited a pediatrician to Nevada, specializing in child abuse and neglect, working now in Clark County. The pediatrician, Dr. Neha Mehta, voiced support in consulting with northern Nevada on child abuse and neglect cases as requested.</p>	<p>6.1 Determine the feasibility of the recommendation.</p> <p>If feasible, establish an action plan to accomplish the following:</p> <p>6.2 Determine fiscal impact and budget capability.</p> <p>6.3 Determine staffing impact and budget capability.</p> <p>6.4 Determine availability of grants to support recommendation and submit proposal.</p> <p>6.5 Submit budget request to County Commissioners.</p>	<p>Northern Nevada Medical Center has been an active partner in recruitment of physicians. Dr. Kathy Wagner currently is involved with the CARES program and is interested in participating in fellowship for to be designated as a forensic pediatrician.</p>		<p>6.1 3/31/07 6.2 6/30/07 Action Plan</p>

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