State of Nevada
Department of Health and Human Services (DHHS)*
Division of Child and Family Services (DCFS)

Report of the Blue Ribbon Panel for the Review of Child Deaths

Introduction and Background

In 2006, DHHS Director Michael Willden called for the establishment of the Blue Ribbon Panel for the Review of Child Deaths. Chaired by former Nevada Supreme Court Justice Deborah Agosti, the Panel spent nine months reviewing state and county information regarding the extent to which officials responded to child death in a timely manner. In 2002, Nevada had reported three child fatalities due to maltreatment (Attachment 1: 2003 Maltreatment Report) to the federal child welfare oversight agency, the Administration for Children and Families (ACF). Several articles on child abuse and neglect and child fatalities appeared in Las Vegas newspapers and on television and came to the attention of DCFS as well as ACF. In an effort to understand the discrepancy between the reported data in 2002 and the actual information available publicly, the state initiated several actions:

1. All public child welfare agencies voluntarily began providing courtesy death notifications to DCFS.
2. Because the number of notifications received in a six month period exceeded the entire number reported in 2002, DCFS immediately initiated a data analysis project.
3. As a result of the data analysis project, DCFS identified additional required action, an independent, external case review process.
4. Upon receipt of the results of the external case review process, it became apparent that a Blue Ribbon Panel, consisting of Nevadans invested in improving the welfare of children, would be appointed to receive the report and monitor systemic action generated in response to the report.

While attempting to develop an accurate list of child fatalities, DCFS recognized that information currently available from Unified Nevada Information Technology for Youth (UNITY) did not accurately reflect the number of children who died with open child protective services cases. The State proceeded to manually analyze case records involving child deaths to determine the extent to which deaths were underreported. Initial results of the data analysis project confirmed that Nevada has been under-reporting child fatalities. The data analysis project also enabled DCFS to definitively identify children who have had

*(Attachment 14: Acronyms)

involvement with the child protective services/welfare system who have died and to develop specific recommendations aimed at decreasing the number of fatalities of child welfare system involved children (Attachment 2: Child Fatality Data Analysis and Improvement Project Reports).

DCFS then proceeded to develop a methodology which would involve the use of outside experts who would objectively review case files and make recommendations for improvement. An external formal case review of child fatalities in Clark County, Washoe County and rural Nevada was conducted by a multidisciplinary panel of experts who assessed and provided an objective analysis of selected cases. This panel consisted of national and state recognized and credentialed experts who were familiar with child fatalities and consisted of representatives from law enforcement, pediatrics, legal, children's advocacy, child welfare, and coroner/medical examiner (Attachment 3: National Expert Panel Members).

The experts identified systemic trends and areas needing improvement including recommendations to support the safety of children and prevention of child fatalities involving the offices of the county coroner, law enforcement, district attorney offices and child protective services across the state. The panel reviewed Clark County Department of Family Services (CCDFS) child fatality cases selected by DCFS that met the criteria for mandatory review as outlined in NRS 432B.405(1)(b). The panel analyzed the case reviews and developed a report of findings and recommendations (Attachment 4: Report of Findings and Recommendations Child Deaths 2001-2004 - Clark County; Report of Findings and Recommendations Child Deaths 2001-2004 - Washoe County and Rural Nevada).

The Blue Ribbon Panel (Panel) was convened to provide a forum to publicly accept and review the child fatality report prepared by the national experts as well as provide expertise in their areas such as mental health, legal, medical, advocacy, law enforcement, academic training and political thought. In addition, the Panel was convened to help the state move forward by providing assistance with new legislation, corrective action planning and interagency collaboration; development of recommendations from the national expert report; and help the state to address challenges in public perception about accountability and openness (Attachment 5: Blue Ribbon Panel Members). Finally, the Panel was convened to assist the state to build or regain the public's confidence in the State and County systems by conducting the entire process in a public forum. This report represents the deliberations and recommendations of the Blue Ribbon Panel.

Because the DCFS agency is the entity responsible for child welfare in Nevada, ACF required DCFS to initiate a series of review processes and ongoing

oversight activities of CCDFS, and Washoe County Department of Social Services (WCDSS). These activities are delineated in the Program Improvement Plan (PIP), Child Abuse Prevention and Treatment Act (CAPTA) Corrective Action Plan (CAP) (Attachment 6: Program Improvement Plan (PIP) Summary).

The Blue Ribbon Panel held meetings from in April 2006 through January 2007. In addition to regularly scheduled panel meetings, the panel was also convened as a multidisciplinary team (MDT) to review the same child fatality cases analyzed by the national experts in Clark County. Seventeen cases were reviewed in June 2006 in order for the panel to fully comprehend the complexities of the child welfare system and confirm systemic barriers in order to develop appropriate recommendations for change. During this process, the Panel received on site technical assistance regarding the cases from the national experts. A second review was conducted by this MDT to review three additional cases outside the scope of the data analysis project. Recommendations related to this review are also incorporated into this report.

Panel Progress

The following information primarily summarizes the activities and actions of the Clark County Blue Ribbon Panel. The Northern Blue Ribbon Panel was convened on December 14, 2006 and had a compressed timeframe in which to assemble due to the forthcoming 2007 Legislative Session. This Panel met to receive the report from the national expert panel and review and accept the action plans for Washoe County and the state Rural Region.

The Panel reviewed and provided oversight to each county's action plan which followed the recommendations provided by the National Expert Panel. Various reports and data were examined which included the following: staffing and qualifications of Clark County child welfare workers; two separate case reviews conducted by Ed Cotton; reviewing national standards regarding caseload ratios; identifying issues and concerns regarding the UNITY information system; and County reports regarding problems associated with the agency Hotline.

While the Blue Ribbon Panel supports the recommendations of the National Expert Panel Review, it maintains the steadfast position that the State be diligent as to effective follow-up and implementation of these recommendations.

<u>Findings: Child Welfare/Child Protective Services</u>

During the time frame of its review, the Panel recognizes and applauds the efforts undertaken by Clark County DFS and County Government leaders to

begin to implement significant systemic changes within the agency. The Panel also recognizes the commitment by Washoe County DSS and County Government leaders to continue moving forward in addressing the recommendations by the National Expert Panel. The following findings were noted:

- Clark County DFS is still impeded by large caseloads, inadequate training, lack of supervision, poor data, dearth of community resources and services for children and their families, and a lack of accountability;
- Changes needed will take time and require ongoing commitment by Clark County leadership and DCFS;
- The Panel strongly encourages the Nevada Rural County Government leaders and DCFS to work together and implement their action plan;
- The entire system is in need of major overhaul including the need for an adequate management information system, the addition of more trained staff to lower caseloads, adequate emergency response systems in place (including the Clark County Hotline), and an effective system of oversight and accountability which serves to protect vulnerable children;
- Clark County needs to immediately proceed with implementing the recommendations articulated in Safe Futures, the plan articulated by CCDFS Director, Thomas Morton.
- The State needs to have in place a system of oversight and accountability.

<u>Findings: District Attorney</u>

- The report by the National Expert Panel identified many recommendations applicable to the District Attorney offices across the state. The Blue Ribbon Panel supports these recommendations and encourages each County to immediately proceed with the analysis and implementation of these recommendations.

<u>Findings: Law Enforcement</u>

- The report also identified many recommendations applicable to County and State law enforcement agencies across the state. The Blue Ribbon Panel supports these recommendations and encourages each County to immediately proceed with the analysis and implementation of these recommendations.

<u>Findings: Coroner</u>

- The report identified systemic recommendations applicable to Coroner and

Coroner/Sheriff offices across the state. The Blue Ribbon Panel supports these recommendations and encourages each County to immediately proceed with the analysis and implementation of these recommendations.

Recommendations

The recommendations of both panels are noted below. Some recommendations listed are excerpted from analyses conducted for CCDFS by a private consultant, Edward E. Cotton and can be reviewed in their entirety in the attachment section of this report (Attachment 7, 8 and 9: Administrative Case Review Project Report of Data Analysis, Findings and Recommendations by Edward E. Cotton; Attachment 8: Administrative Review of Child Abuse and Neglect Investigations by Edward E. Cotton; Attachment 9: Administrative Review of Child Abuse and Neglect Investigations by Edward E. Cotton – Additional 8 pages).

I. Data: The State's UNITY data system is not supported by management, supervisory or field staff that use it, and it was repeatedly mentioned as a difficult system to maneuver through. Data "glitches" were noted, resulting in a child being documented as "safe", despite having died. There is a lack of use of the forms directory in UNITY and as a result, documentation is severely lacking. Case notes were missing, frequently unclear or inadequate, they did not include appropriate information to follow the direction of the case, inform the reader of the caseworker decision making process, and demonstrated no plan of action in most cases. Acronyms were used in case notes and are not standardized, which was confusing. There was little identification of supervisory oversight recorded in UNITY. Due to staff disuse, UNITY produces little, if any usable information or data that is at best, unreliable. Substantial additional funding will be needed by DCFS to improve this system.

- The state's UNITY data system must be examined by a team of internal and external experts to determine the necessary changes to ensure it is user - friendly, streamlined, produces adequate hard copy documents in order to analyze the flow of the case, and produces management reports that can be used effectively as a management tool.
- The Panel supports the data recommendations in the reports completed by Ed Cotton identified as Attachments 7, 8 and 9.
- Ensure correct child fatality information is obtained by CCDFS caseworkers or other identified staff and recorded into the statewide data system. Data comparisons revealed frequent discrepancies in child name spellings, dates of death, and causes of death.

- Increase internal data integrity by establishing a system of cross-checks between UNITY, Child Neglect Systems (CANS), the county courtesy notifications database, and Child Death Review (CDR) team data.
- Ensure complete case information and proper case closures. Many entries by CCDFS staff into the child welfare data system have incomplete or missing data elements, lack of detail in case notes, substantiation errors and improper case closure upon child death. Complete information is necessary to determine the cause of death, prior child protective services history, and substantiations of abuse or neglect. These data elements are critical to effectively understand and target leading causes of child death, implement appropriate prevention efforts and to develop correct data on total child deaths and related substantiations of abuse and neglect.
- Link child fatality data with other DCFS systems of care: Children may enter DCFS systems of care in three primary ways through receiving child protective services, juvenile justice services, and/or mental health services. It is important to cross-check with other internal DCFS data systems for a complete understanding of a child's individual history and factors related to the circumstances of death.

II. Action Plans: Action plans were compiled collaboratively with the state in meetings held with Clark County, Washoe County and rural Nevada. Representatives from the child welfare agencies, coroner's offices, district attorney's offices, county manager's offices, and law enforcement attended to address the recommendations by the national expert panel (Attachment 10: Action Plans).

The Blue Ribbon Panels met with county agencies to review and approve the action plans. Agency representatives provided status updates on action plan recommendations, goals and objectives in response to the reports both in writing and in person updating the panel on activities occurring over the previous four months. The panels expressed concern for the number of recommendations, appreciation for the Clark County, Washoe County and DCFS Rural Region responses and their commitment to act on the recommendations.

- The Clark County Panel and Washoe/Rural Panel support the recommendations developed by the national expert panel for all three jurisdictions and encourage all counties to fully evaluate and implement feasible recommendations.

- Both panels recommend close monitoring of ongoing activities in all jurisdictions, but particularly in Clark County due to the number of

systemic recommendations. All three action plans delineate, throughout the document, specific "report-to" entities for the monitoring of action steps. These entities must take the responsibility to scrutinize the progress made by the accountable agencies as determined in the action plan and take appropriate action if lack of follow through or failure is observed.

III. Legislation: Legislation is needed to provide the state with statutory oversight responsibility, establish accountability measures and bring about improvements in the operation and function of the statewide child welfare system, including state responsibility to license all institutions providing care for children. The bill drafts reviewed and revised by the panel provide the recommended legislative changes to support these improvements. The panel approved support of all of the bill drafts and agreed to testify at the 2007 Legislative Session in support of the proposed legislation. Additional funding for DCFS will be required in order for the Division to provide the oversight needed (Attachment 11: Bill Drafts and Concept Paper).

- Recommended bill drafts must be supported and funded.

IV. Hotline: The panel was concerned about the wait time and apparent ineffectiveness in the functioning of the hotline. Thomas Morton, Director, CCDFS, provided the Hotline Audit Report to the panelists for review and discussion. The conclusion of the Hotline assessment indicates that it is not a Hotline but rather a reception center that, almost as an aside, screens referrals of child abuse and neglect. Fewer than 10% of the calls received were actually related to current maltreatment and the assessment showed that the Hotline failed to make sound decisions in about one in four referrals. The panel recognizes that the county took action to analyze the problems but also recognizes the need for continued improvements in this area (Attachment 12: Assessment of Clark County Department of Family Services' Child Abuse Hotline).

- The recommendations of the Assessment of Clark /County Department of Family Services child abuse Hotline must be adhered to and monitored for compliance.

V. Safe Futures: The Safe Futures document outlines a number of steps that CCDFS can implement to improve child welfare services in Clark County. The panel recognizes the action delineated in the document as a significant commitment on behalf of the county to improve child welfare service, but also recognizes that additional work must by completed to

continue to resolve the child protective system problems (Attachment 13: Safe Futures).

- The Safe Futures plan must be adhered to and monitored for compliance.

VI. Recruitment, Staffing, Caseload Levels And Training: Thomas Morton, Director CCDFS, presented organizational charts to the panel for discussion. Panelists were provided with information on the supervisor-to-caseworker ratio which was reported to be 1 to 7, consistent with national standards. The role of supervisors was explained, with their primary function to be provision of quality assurance and back up activities to support caseworkers. Concern was expressed by panelists regarding a lack of documented supervisory oversight discovered during the case review process.

Further discussion occurred and the panel concluded that CCDFS does not have adequate supervisory oversight to guide caseworkers and problem solve casework issues. With a current supervisory ratio of 1:7 and a recommended ratio of 1:5 by the Child Welfare League of America (CWLA), best practice ratios are not attainable. It was noted that CWLA recommended ratios applied to experienced social workers. In reviewing the Cotton report, it is noted that supervisory reviews of case files occurred at one case per worker per month. The panel asked for clarification regarding best practice recommendations related to supervisory review and additional discussion occurred. The panel concluded that if CCDFS workers are not seasoned social workers then the appropriate ratio should be less than 1:5 due to the need for additional supervisory oversight.

Mr. Morton also provided the panel with information on caseload studies in response to a panelist question on the caseload size at CCDFS and its impact on worker productivity. Mr. Morton provided information from the National Association of Social Workers, California Chapter related to the child welfare workload study. The panel supports this source of information to establish baseline information for analysis and planning purposes.

Panelists received a variety of additional information from Clark County DFS staff and held several discussions on these topic areas. The following findings related to CCDFS were determined:

- Child welfare is a demanding field, requiring advanced skills in working effectively with families and children with multiple problems;

- Most of child welfare work is performed by individuals with limited professional education, oftentimes with degrees in fields unrelated to the human services;
- Very little training is provided in advanced practice, and supervision;
- Child welfare workers are not adequately compensated for the at-risk work they perform;
- Schools of social work cannot meet the workforce needs in child welfare; and
- Child protection requires advanced practice skills, suggesting that minimally, a master's degree in social work or other related discipline is required.

Additional panel recommendations are grouped by topic area as follows:

State Standards Recommendations

- State standards must be set regarding the recruitment, staffing, caseload levels and training required for child welfare workers. Funding must be provided.

Recruitment Recommendations

- CCDFS should recruit and hire staff with degrees in social work.

Caseload Recommendations

- Caseload ratios must be examined by a team of internal and external experts to determine the appropriate "mix" between a caseworker's workload and the actual numbers of families/children. The team should apply best practices in accordance with local needs and national standards published by the Child Welfare league of America (CWLA). Whenever actual caseloads exceed established standards by 10% for over six months, the funding must be increased to meet the caseload demands.

Service/Caseload Type	**CWLA Recommended Caseload/ Workload** (New and active cases per month)
Initial Assessment/ Investigation	12 active cases per month, per 1 social worker
Ongoing Cases	17 active families per 1 social worker and no more than 1 new case assigned for every six open cases
Combined Assessment/ Investigation and Ongoing Cases	10 active on-going cases and 4 active investigations per 1 social worker
Supervision	1 supervisor per 5 social workers

(Attachment # 15 - CWLA Standards of Excellence for Services to Abused or

Neglected Children and their Families, Revised 1999)

Service/Caseload Type	CWLA Recommended Caseload/ Workload
Foster Family Care	12-15 children per 1 social worker
Supervision	1 supervisor per 5 social workers

(Attachment # 16 - CWLA Standards of Excellence for Family Foster Care Services, Revised 1995)

Training Recommendations

- The opportunity for specialization within child welfare (i.e. expertise in forensics, domestic violence, in home preservation, parenting skills, etc.) must be developed.
- Ongoing extensive staff development/training programs at the County level that are responsive to local needs must be available;
- The state must ensure that all child welfare workers successfully complete core child welfare training (i.e. new worker orientation) followed by ongoing advanced practice skills development such as the establishment of a statewide certificate of completion in Child Welfare Core Training.

Best Practice Recommendations

- An extensive analysis needs to be conducted to determine the actual amount of activity and intensity of work required to engage families that is fueled by best practice expectations. From determining such standards for practice, a workload study must be completed to determine the actual number of workers needed to provide quality intensive services rather than meeting minimal standards which are superficial at best.

VII. Personnel, Administration, Management, Supervision: The Clark County Panel reviewed child fatality cases that were alarming. Personnel issues were identified. Specifically:

- Management to supervisor to caseworker ratios must be evaluated by a team of internal and external experts to determine the appropriate "mix" of managers and supervisors needed to support caseworker activity and provide adequate supervisory oversight and management functions.
- Recommend DCFS review all file data from the CCDFS file review to identify trends, including personnel observations and make recommendations for additional corrective action not already identified in the national expert panel report.

VIII. Foster Parent Licensing and Recruitment: The Clark County panel cited concern about foster parent licensing and recruitment delays.

- Clark County must improve and streamline the licensing and recruitment processes and provide ongoing support for foster parents, in accordance with the Safe Futures document.

IX. Edward Cotton Reports: The Panel supports all recommendations noted in the reports written in reports by Edward Cotton (Attachment # 7, 8 and 9).

Summary of State Action

The state review, consisting of the data analysis process, consultation with the national expert panel to conduct case reviews, and appointment of the Blue Ribbon Panel resulted in the initiation of the change process. Additionally, state oversight related to the achievement of Program Improvement Plan and CAPTA Corrective Action Plan goals, the implementation and strengthening of the statewide quality improvement process including child fatality analysis, have all contributed to a substantial increase in ongoing oversight activities by the state.

Conclusion

While County government has initiated action, much work still remains to be done with all partners including law enforcement, the Coroner's office, District Attorney's office, and child protective services. The development of a collaborative partnership between all entities will facilitate ongoing analysis of systemic issues and resolution development and implementation.

Although the Blue Ribbon Panels on Child Death will end in January 2007, ongoing, statewide corrective action and jurisdictional action plans support continuous oversight and follow through. Passage of the proposed legislation,

ongoing, independent monitoring and return of some iteration of the national expert panel to conduct additional reviews prior to convening of the 2009 legislative session will support continued forward momentum. A report of these activities should be made to a newly constituted Blue Ribbon Panel convened to advise the Director of Department of Health and Human Services. With this combined oversight activity established, systemic change is possible.

INDEX OF ATTACHMENTS

Attachment Number and Name