CITIZEN REVIEW PANEL

ANNUAL REPORT

for calendar year

2003

submitted by

The Nevada Citizen Review Panel

to

The Division of Child and Family Services

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EXECUTIVE SUMMARY

The State of Nevada Citizen Review Panel (CRP) was established in 1999 under Nevada Revised Statute (NRS) 432B.396 and has federally mandated responsibilities under Title I of the Child Abuse Prevention and Treatment Act (CAPTA). The Panel has the following primary mission:

> *To ensure the protection and safety of children through an evaluation of the Child Abuse Prevention and Treatment Act State Plan by examining State and local agencies' policies and procedures and specific cases where appropriate.*

The Panel consists of 12 members appointed by the Administrator of the Division of Child and Family Services (DCFS), who also serves on the Panel. The group includes representation from a variety of State and County agencies, community organizations, and professional backgrounds.

The Panel works toward fulfilling the following three primary goals:

1. Review the CAPTA State Plan and updates on an annual basis.
2. Review at least one policy area from the Governor's assurances.
3. Follow up on previous recommendations.

In essence, the Panel's work consists of the review of internal policies and procedures within the child protective services (CPS) system. Each year, the Panel's findings are summarized in an Annual Report submitted to the federal government as part of the CAPTA requirements.

During 2003, the Panel continued to narrow its focus as it worked to explore in more detail the topic areas set for review in 2002. The group maintained its examination of the policies and procedures surrounding the investigation of abuse in institutional settings.

Primary goals set by the Panel for 2003 included the following:

1. Develop a case record review process, initially focused on the investigation of abuse in institutional settings.
2. Complete pilot case record reviews focused on the investigation of abuse in institutional settings.
3. Create overlap between the case record review process and the federal Child and Family Services (CFS) Reviews.

The Panel achieved these goals through the development of its case record review process and the completion of pilot case record reviews in the northern and southern regions of the state.

A key component of the case record review process included finalizing the instrument used for case reviews. The review instrument was completed and approved by the Panel in the first half of the year and is based on applicable laws and regulations set forth in Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC). Through the use of the review instrument, the

pilot case record reviews enabled a comprehensive evaluation of investigative practices for abuse in institutional settings.

The Panel continued to receive updates on the federal Child and Family Services (CFS) Reviews and members were invited to take an active role in the statewide assessment process to prepare for the review. Nevada is scheduled for its onsite review in February, 2004. In order to create some overlap between the Panel's case record review process and the CFS Reviews, the Panel members agreed to include portions of the Safety Assessment section from the federal review instrument as part of the Panel's review instrument.

During 2004, the Panel plans to refine its case record review process and incorporate this activity as part of the regular work of the group.

OVERVIEW OF THE NEVADA CITIZEN REVIEW PANEL

Federal Requirements

As outlined in Public Law 104-235, Section 106 under Title I of the Child Abuse Prevention and Treatment Act (CAPTA) provides for a state grant program for the support and improvement of state CPS systems. This law sets forth a variety of eligibility requirements, including the establishment of citizen review panels. The purpose of the panels is "to provide new opportunities for citizens to play an integral role in ensuring that states are meeting their goals of protecting children from abuse and neglect."

The citizen review panel system within a given state must meet certain operational requirements and meet a scope of responsibilities within the function of the panel. These are outlined as follows.

Scope of Responsibilities

Each citizen review panel is required to review the compliance of State and local CPS agencies in the fulfillment of their responsibilities with respect to the following:

- Work in accordance with the CAPTA State Plan.
- Examine State and local policies and procedures.
- Review specific cases, when appropriate.
- Review other criteria the panel determines important to the protection of children, including the following:

    1. Review of the extent to which the State CPS system is coordinated with the Title IV-E foster care and adoption assistance programs.
    2. Review of child fatalities and near fatalities.

State Requirements

As part of the CAPTA requirements, states are required to codify citizen review panels through state law. In Nevada, this was completed with the passage of Assembly Bill (AB) 158 during the 1999 legislative session. The relevant text of AB 158 was incorporated into the Nevada Revised Statutes (NRS) under Chapter 432B.396. This law reads as follows:

The Division of Child and Family Services shall:

1. Establish a panel comprised of volunteer members to evaluate the extent to which agencies which provide protective services are effectively discharging their responsibilities for the protection of children.

2. Adopt regulations to carry out the provisions of subsection 1 which must include, without limitation, the imposition of appropriate restrictions on the disclosure of information obtained by the panel and civil sanctions for the violation of those restrictions.

During 2001, NRS 432B.396 was amended as a result of AB 248 to establish civil sanctions for violations of confidentiality on the part of review panel members. This amendment includes additional language highlighted in subsection two as follows:

1. Establish a panel comprised of volunteer members to evaluate the extent to which agencies which provide protective services are effectively discharging their responsibilities for the protection of children.

2. Adopt regulations to carry out the provisions of subsection 1 which must include, without limitation, the imposition of appropriate restrictions on the disclosure of information obtained by the panel and civil sanctions for the violation of those restrictions. **The civil sanctions may provide for the imposition in appropriate cases of a civil penalty of not more than $500. The Division may bring an action to recover any civil penalty imposed and shall deposit any money recovered with the State Treasurer for credit to the State General Fund.**

Nevada Citizen Review Panel

The State of Nevada Citizen Review Panel (CRP) operates with the following mission:

> *To ensure the protection and safety of children through an evaluation of the Child Abuse Prevention and Treatment Act State Plan by examining State and local agencies' policies and procedures and specific cases where appropriate.*

The Panel consists of 12 members appointed by the Administrator of the Division of Child and Family Services (DCFS), who also serves on the Panel. The group includes representation from a variety of State and County agencies, community organizations, and professional backgrounds. Membership categories for the Panel are not federally mandated. However, they were originally based on the membership categories mandated under CAPTA for the Children's Justice Act (CJA) Task Force. The CJA Task Force functions in a complementary manner with the CRP, and therefore the membership was mirrored accordingly. Recently, both the Panel and DCFS Administration have placed more emphasis on recruiting community members who are not directly affiliated with the child welfare service system, but still have a professional interest in the wellbeing of children. This includes recruitment from sectors including school districts, child care providers, nonprofit advocacy and service organizations, and professional medicine.

The Panel works toward fulfilling the following three primary goals:

1. Review the CAPTA State Plan and updates on an annual basis.
2. Review at least one policy area from the Governor's assurances.
3. Follow up on previous recommendations.

In essence, the Panel's work consists of the review of internal policies and procedures within the CPS system. Each year, the Panel's findings are summarized in an Annual Report submitted to the federal government as part of the CAPTA requirements.

Appendix A of this report includes a detailed overview of the State child welfare system, which describes the key components of the system of care reviewed by the Panel. Appendix B of this report includes a list of the current members along with their respective affiliations and areas of representation.

Meeting Dates and Activities

During 2003, the Panel met six times to work on specific activities related to its primary area of review for the year:

Meeting Date	*Topics*
February 25, 2003 *Panel Meeting*	• Officer election. • Update on Child and Family Services (CFS) Reviews. • Continue development of case record review instrument, including review of alternate recommended instrument. • Plan for mock case review training. • Update on related CJA Task Force projects and staff reports.
July 9, 2003 *Panel Meeting*	• Finalize and approve case record review instrument, including review of alternate recommended instrument. • Complete mock case review training. • Finalize plans for pilot case record reviews. • Update on related CJA Task Force projects and staff reports.
October 21, 2003 *Southern Region Case Record Review*	• Southern team review of cases involving abuse in institutional settings. • CPS investigative staff interview.
October 27, 2003 *Northern Region Case Record Review*	• Northern team review of cases involving abuse in institutional settings.
November 12, 2003 *Panel Meeting*	• Debriefing on pilot case record reviews. • Discussion of cases, review process, review instrument, and staff interviews. • Development of recommendations for Annual Report. • Update on Child and Family Services (CFS) Reviews. • Update on related CJA Task Force projects and staff reports.
December 17, 2003 *Panel Meeting*	• Review and finalize 2003 Annual Report. • Update on related CJA Task Force projects and staff reports.

PANEL ACTIVITIES AND RECOMMENDATIONS

Introduction

During 2003, the Panel continued to narrow its focus as it worked to explore in more detail the topic areas set for review in 2002. The group maintained its examination of the policies and procedures surrounding the investigation of abuse in institutional settings. The Panel members continued to collaborate with staff to tighten its focus on this topic area and to build stronger recommendations that include clear ideas about how policies and procedures can change to help improve service delivery within the State system.

Primary goals set by the Panel for 2003 included the following:

1. Develop a case record review process, initially focused on the investigation of abuse in institutional settings.
2. Complete pilot case record reviews focused on the investigation of abuse in institutional settings.
3. Create overlap between the case record review process and the federal Child and Family Services (CFS) Reviews.

The Panel achieved these goals through the development of its case record review process and the completion of pilot case record reviews in the northern and southern regions of the state.

A key component of the case record review process included finalizing the instrument used for case reviews. The review instrument was completed and approved by the Panel in the first half of the year and is based on applicable laws and regulations set forth in Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC). Through the use of the review instrument, the pilot case record reviews enabled a comprehensive evaluation of investigative practices for abuse cases in institutional settings, including the following:

- Case intake
- Screening and assessment
- Assignment to staff
- Response timelines
- Notification of CPS by law enforcement
- Notification of licensing agency
- Notification of parents and institution
- Investigation protocols
- Safety assessment
- Risk assessment
- Use of multi-disciplinary teams
- Case file documentation
- Corrective action plans
- Follow-up by licensing agency
- Staff training
- Tracking of multiple referrals

The Panel continued to receive updates on the federal Child and Family Services (CFS) Reviews and members were invited to take an active role in the statewide assessment process to prepare for the review. Nevada is scheduled for its onsite review in February, 2004. In order to create some overlap between the Panel's case record review process and the CFS Reviews, the Panel

members agreed to include portions of the Safety Assessment section from the federal review instrument as part of the Panel's review instrument.

As part of the review of policies and procedures surrounding investigations of abuse in institutional settings, the Panel continued working with a contractor, Candace Young-Richey, employed by DCFS to assess agency response to these types of cases. The contractor interfaces with both the CRP and the CJA Task Force to help tie the work of the two groups together. The goal of the project is to help create stronger recommendations on the part of the CRP and the CJA Task Force, as well as to develop concrete information in the form of an assessment of the State's current capacity to address institutional abuse. Together, these efforts will enable DCFS, the Panel, and the Task Force to present a strong case for change to the State Legislature.

Based on this, the Panel's recommendations for 2003 were made in two primary areas:

1. Policies and procedures surrounding the investigation of abuse in institutional settings.
2. The case record review process undertaken by the Panel.

These recommendations are presented in detail below, along with brief summaries of the other activities undertaken by the Panel during the year.

Recommendations: Investigation of Abuse in Institutional Settings

Recommendation 1: Agencies should establish specialized units for the investigation of abuse in institutional settings and adopt policies to require that cases are assigned to appropriately trained staff within these units.

Discussion: The Panel members recognize that the investigation of abuse in institutional settings requires a different set of skills and knowledge, and therefore should be assigned to staff members who are trained in institutional abuse and can effectively complete the investigations. Specialized units established within the primary State and County CPS agencies would ensure that a core group of CPS workers are appropriately trained and available to conduct these investigations. Specialization provides consistency and focused staff with strengthened protocols and knowledge.

Recommendation 2: Agencies should adopt specific policies to provide ongoing training to staff members designated to conduct the investigation of abuse in institutional settings.

Discussion: The quality of training for individuals who conduct the investigation of abuse in institutional settings needs to be given priority. The Panel members recognize that caseworkers are often put in an environment where they have not been trained. Therefore, specialized training is critical in order to equip staff with the skills and abilities needed to effectively conduct institutional abuse investigations. Staff supervisors also need to understand skills needed by staff, legal issues, and special requirements of the institutional abuse investigation process.

Training should be periodically updated and additional opportunities should be provided to staff across the long-term. Staff members cannot be expected to rely on single training events, and should have regular training in order to develop expertise and improved investigative procedures.

Recommendation 3: Agencies should establish investigative procedures that include a review of the needs of the child or children involved in cases of alleged abuse or neglect.

Discussion: The Panel is concerned that in some cases there appears to be a bias such that the children involved are seen as the source of the problem, while the institutional caretakers are seen to be doing the best they can. In addition to focusing on the children and their behaviors, investigators need to take a more balanced approach wherein the actions of the caretakers are considered equally. Outside of the traditional scope of an investigation, CPS workers should go beyond an incident driven approach and explore coexisting risk factors and conditions that may have contributed to the alleged abuse. In particular, staff should ensure that children are placed in a level of care appropriate for their needs.

Recommendation 4: CPS workers who investigate abuse in institutional settings should use a standardized checklist for key actions taken as part of the investigation, and also use standardized safety and risk assessment tools.

Discussion: The Panel members believe that best practices can be both implemented and maintained through the use of standardized forms and tools used statewide. CPS workers should not feel constrained by the use of standardized checklists and assessments, but rather incorporate necessary and legally required actions as part of every investigation, and utilize a consistent approach when assessing safety and risk for children in care.

Recommendation 5: CPS workers should use a standardized checklist to ensure that the contents of case files are consistent and complete.

Discussion: Related to recommendation four, the Panel members believe that consistent documentation is necessary across cases statewide. This not only helps to ensure that required steps are taken in investigations, but also helps to ensure that outside reviewers understand the actions that have been taken for quality assurance and case compliance reviews.

When conducting their own case reviews, the Panel found in particular that it was often not clear that the notification requirement for caregivers and parents involved in an investigation was met based on NAC 432B.360(5). Additional documentation such as interaction with law enforcement and licensing agencies was also not present in some of the files reviewed. The Panel members believe it is likely that a better investigation process is taking place than is initially evident, but there is not enough documentation in the case files to demonstrate this to reviewers.

Recommendation 6: The search capability of the UNITY data system needs to be improved so that varying data elements can be cross referenced to ensure that contacts are not missed when investigations are conducted. Data entry in to the system needs to be checked for accuracy.

Discussion: The Panel members understand that currently the UNITY data system will not accept institutional entries, such that institutions must be entered as individual "clients" and cannot be tied to a group of related records. This limits how institutional cases can be referenced and searched within the data system, and may prevent CPS workers from finding relevant case records or recognizing multiple referrals for a given institution. The Panel believes there should be multiple ways to conduct a case search and cross reference files within UNITY, including by institution name, child's name, foster parent's name, etc.

When conducting their own case reviews, Panel members also found that names were misspelled across the documents in the case files reviewed. Because the UNITY data system searches are often done by client or foster family name, records may be missed because of data entry errors. Data entry needs to be checked for accuracy to prevent this.

Recommendation 7: DCFS needs to address the issue of how statewide institutional abuse data is gathered and how the UNITY data system will enable this.

Discussion: The Panel understands that currently a comprehensive, statewide report of institutional abuse cases from all DCFS licensed facilities is not available through the UNITY data system. The Panel believes that institutional abuse cases should be tracked statewide in order to accurately assess the prevalence and rates of such abuse in Nevada.

Recommendation 8: Agencies should establish a formalized tracking mechanism to determine whether multiple referrals are made at a given institution. From this, a trigger point should be established to conduct a supervisory review of institutions with multiple referrals.

Discussion: The Panel believes that agencies need to monitor repeat referrals from institutional settings, assess patterns within the cases, and initiate a broader review of institutions with repeat problems. A best practice for documentation is implemented by Washoe County, which uses an Institutional Face Sheet that summarizes multiple referrals against a given institution that is placed at the front of relevant case files.

Agencies need to determine a point at which the quantity or type of referrals will trigger an investigation of institutions from a supervisory level in terms of their policies, procedures, and practices. From a quality of care standpoint, institutions should not only have an interest in what laws and regulations apply to the operation of facilities, but also an interest in outcomes for children in their care. Related criteria for review of cases with children who have a series of problems or are high risk should also be established.

Recommendation 9: CPS and licensing agency staff members need to establish protocols for sharing information about investigations. Coordination between CPS and licensing would make everyone involved in an investigation equally aware of the status of a case, as well as promote follow through for appropriate licensing reviews and corrective action plans.

Discussion: The Panel recognizes that the involvement of licensing agency staff in the investigation of abuse in institutional settings is critical. In particular, licensing staff is responsible for reviewing institutional policies to determine if they are abusive or not. Also, CPS workers frequently contribute to recommendations for corrective actions plans, but often are not provided copies of these plans or made aware of the follow up completed by licensing agencies.

Additionally, as noted in recommendation eight above, a succession of unsubstantiated reports should be tracked and licensing agencies should be involved in the supervisory review of institutions where multiple referrals occur. Support services should be provided in conjunction with licensing agencies as necessary to help prevent future abuse in institutional settings.

Recommendations: Case Record Review Process

Recommendation 10: The Panel should include the review of CPS cases as part of its annual workplan.

Discussion: The Panel believes that completing case record reviews helps orient members as to what areas of the child welfare system they are supposed to examine as part of the CRP federal mandate. It is a good way to educate members on how to be effective in their review of the CPS system and in making recommendations for improvement. The members found the pilot review process to be educational and thought provoking, and felt it made the Panel's CPS review work both focused and meaningful.

When future case record reviews are conducted, the members would like to have access to both paper-based files and electronic database information.

Recommendation 11: The Panel should engage in a multi-agency review approach so that the steps taken by licensing agencies can be understood and reviewed as part of the CPS case record review process.

Discussion: Related to recommendation nine above, the Panel not only recognizes the value of coordination between CPS and licensing agencies for investigations, but also the value of understanding actions and outcomes from both areas of the system as part of case reviews. Specific to the investigation of abuse in institutional settings, there are questions about where and to whom reports go in licensing agencies, how follow-up is conducted, and what corrective action plans result for the institutions investigated.

Recommendation 12: The current case record review instrument should be simplified further into a checklist format.

Discussion: Based on the pilot case record reviews, some Panel members found the current review instrument somewhat complex and lengthy. It is suggested that the instrument be reworked into a simpler checklist format, so that case file contents and key investigative actions can be marked off in a bullet-point format.

Summary: Case Record Review Process Development

The Panel members began development of the case record review process during 2002, at which time they had agreed to establish the primary area of review as CPS policies and procedures focused on the investigation of abuse in institutional settings. In particular, the members were interested in looking at the intake and assessment of institutional abuse cases. It was agreed to complete the following action items:

1. Develop and approve a case record review instrument.
2. Take part in a mock case review for initial training.
3. Establish regional teams for case record reviews.
4. Conduct pilot case record reviews and staff interviews.

Development of the case record review instrument took considerable time because a variety of source materials were considered. Initially, staff relied on the State's CPS Case Compliance Record Review Sheet as a source format to develop a draft instrument for the Panel to consider. This is a detailed document used to ensure compliance with Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) specific to abuse investigations. This was narrowed and customized into a simplified format in order to fit the Panel's focus on policies and procedures surrounding the investigation of abuse in institutional settings.

During 2003, the Panel was presented with alternate source materials to consider, including the federal review instrument used for the Child and Family Services (CFS) Reviews, as well as an instrument developed by Hornby Zeller and Associates (HZA). HZA contracts with the State for program evaluation and data services, along with support for the CFS Reviews process. The Panel received presentations on both instruments during its first two meetings of the year. It was decided by the members that the original draft instrument based on the State's CPS Case Compliance Record Review Sheet would be used, with some additional material from the federal instrument for the CFS Reviews.

A mock case review was conducted to provide initial training to the members in order to understand what an 'ideal' case looks like. Walking through a mock case that demonstrates best practices prepared the members to better understand the information and documentation they should encounter when conducting actual on site reviews.

The Panel then established regional teams to examine case records in the northern and southern regions of the state for its pilot process. The members had previously agreed it was important to conduct onsite reviews at field offices, versus inviting staff to make presentations at meetings. The Panel members believe this onsite review structure will lend more authority to and create better recommendations within the Annual Report. The pilot reviews were conducted in October, 2003, and served as the primary source of the Panel's recommendations for the year. The Panel plans to further develop and refine the case record review process and make it part of its annual workplan.

Summary: Panel Involvement in CFS Reviews

The Panel was provided an overview of the Child and Family Services (CFS) Reviews in late 2002, and the members took part in a detailed review of the process at the first meeting in 2003. The Panel recognizes that the purpose of the reviews is to determine how well the State system is operating and identify areas where improvement is needed in order to promote system change.

The detailed review included discussion of the seven systemic factors that are examined as part of the CFS Reviews as follows:

1. Statewide information system
2. Service array
3. Case review system
4. Staff training
5. Quality assurance system
6. Agency responsiveness to the community
7. Foster and adoptive parent licensing, recruitment, and retention

Development of the Panel's case record review process for the year, described above, included consideration of the federal review instrument used for the CFS Reviews. The Panel members were asked to review a copy of the statewide assessment due by December, 2003, and provide comments. Additionally, members were asked to consider participating as reviewers during the on site review scheduled for February, 2004.

APPENDIX A: OVERVIEW OF THE STATE CHILD WELFARE SYSTEM

Prior to 2001, the child welfare system in Nevada was bifurcated between State and County agencies as a result of State law. Under Nevada Revised Statute (NRS) 432B.352, the law required that counties in which the "population is 100,000 or more shall provide protective services for the children in that county and pay the cost of all those services." In Nevada there are two counties that meet this criterion: Washoe County in northern Nevada and Clark County in southern Nevada. As a result, there are three separate agencies that provide child welfare and child protective services (CPS):

1. State of Nevada Division of Child and Family Services (DCFS)
2. Washoe County Department of Social Services (WCDSS)
3. Clark County Department of Family Services (CCDFS)

These agencies work together through the CPS Statewide Managers Team, also known as the Nevada Child Protection and Permanency Planning Team. This team collaborates on pertinent law, regulation, and policy issues necessary to maintain statewide consistency for investigative and casework practices. The CPS Statewide Managers Team assists with the development and oversight of the Child Abuse Prevention and Treatment Act (CAPTA) Basic State Grant.

The child protection agencies conduct child abuse investigations and may take children into protective custody and place them in licensed foster homes. Bifurcation occurred when the County child protection agencies transferred long term or other foster care or potential adoption cases to the State via DCFS. Children were transferred from their initial CPS placement in the County to the State agency's licensed foster care home. The transfer included changes in social workers, court process, and service delivery systems.

However, during 2001, the Nevada State Legislature passed Assembly Bill (AB) 1 of the 17th Special Session, which provides for the integration of State and local child welfare services. This bill is intended to end the practice of transferring cases from the Counties to the State, thereby reducing the number of changes in placement for a child in protective custody. Integration means that the two larger Counties will incorporate the previously separate child welfare functions of foster care and adoptions into one continuous system of child protection. The following are directives of AB 1:

- Transfers certain duties of the Division of Child and Family Services (DCFS), under the Department of Human Resources (DHR), to agencies of Washoe and Clark Counties.
- Establishes a Legislative Committee on Children, Youth, and Families to oversee the system transition.
- Makes appropriations to fund the transition between State and County agencies.

The implementation of this transition is projected to occur through 2005. WCDSS began implementation in April, 2002, and CCDFS began implementation in October, 2003. The integration of child welfare services is intended to accomplish the following:

- Begin to eliminate the inefficiencies of the current system by reducing the number of placements of children in foster homes.
- Decrease the length of time that children remain in out-of-home care and ensure that children are placed in permanent homes as soon as possible.
- Establish rates for foster care reimbursement at a level that enables a provider of foster care to care for a child adequately. Rates should be standardized within each county and structured in a manner that avoids any unnecessary interruptions in foster home placements because of changing levels of reimbursements.
- Establish as a priority the fairness to employees affected by the integration of the child welfare system.
- Establish that DCFS and counties whose population is 100,000 or more have a shared fiscal responsibility for the costs of providing child welfare services, must be committed to ensuring through negotiation in good faith future maintenance of their efforts in providing these services, and must equitably share future costs for providing these services.
- Establish that integration of the child welfare system in Nevada will allow the placement of children in a child welfare system that is adequately funded and structured to avoid unnecessary interruptions in placement and will ensure that permanency is achieved for children in accordance with federal and state laws.

Child Death Review Teams

Child Death Review Teams, required by CAPTA, have been organized throughout Nevada since 1993. Technical assistance has been provided with CAPTA funds to assist with child fatality issues through presentation of a forum for discussion and through the establishment of a workplan to address these issues in Nevada. Some issues that were identified include varying definitions of child abuse and neglect and the use of various forms. Participants included representatives from the following entities:

- Coroner's office
- State of Nevada Health Division
- Law enforcement
- District attorneys
- Child protective services (CPS)
- Medical professionals including pathologists and representatives from laboratories, hospitals, and clinics
- Court Appointed Special Advocates (CASA)
- Family Resource Centers (FRCs)
- School districts

Child Death Review Teams are now organized and active throughout the State. There are five regional teams and a Statewide Team housed in social service agencies. Regional teams consist of the following:

1. Washoe County Department of Social Services (WCDSS)
2. Clark County Department of Family Services (CCDFS)
3. Rural Northeastern Nevada (Elko area)
4. Fallon
5. Carson (Carson, Douglas, Storey, and Lyon Counties)

During 2000, the Statewide Team was successful in developing common terminology and definitions for statewide application. A standardized data collection instrument developed by the statewide team, with input from coroners and the Bureau of Health Planning and Statistics, has been implemented along with appropriate protocols.

The Statewide Team has also narrowed the field of categories relating to deaths down to six and developed a single review form for data entry. The statewide report captures global data in these six categories and the system has the capacity to search for detailed information. CCDFS maintains the database for the teams and generates the statewide report.

The system operates in the following manner:

- All autopsy reports sent for review from the coroner's office in the north are sent to WCDSS where they are disseminated to the appropriate Child Death Review Team. Likewise in the south, all autopsy reports sent for review from the coroner's office are sent to CCDFS where they are disseminated to the appropriate Child Death Review Team.
- Each Child Death Review Team meets to discuss these reports and each has a set of review forms that they keep for determinations by the team.
- At the end of the calendar year, the forms are sent to CCDFS for processing and generation of the annual report.

Although there are some variations, the death review process is similar within each county. The general model tends to follow a six-step process, outlined as follows:

1. The coroner identifies the modes of death prior to any analysis or involvement by a Child Death Review Team. The coroner lists one of four modes of death on the death certificate: 1) accidental, 2) homicidal, 3) natural, or 4) undetermined.
2. The health district or a county health office forwards all child death information to the coroner, who then forwards it to the Child Death Review Team Coordinator. This is done the first of every month in counties where a death has occurred. In other counties, it occurs only on an as-needed basis.
3. The Coordinator sends out notification to all Team members listing the children who will be reviewed at the next meeting.
4. Team members review each case from the perspective of their representative agencies or professional backgrounds to determine the necessity of further review.

5. The Team meets on a monthly basis, or as needed, to discuss the facts surrounding the death and the involvement of various agencies. It then draws conclusions from these facts to assist responsible parties to take necessary actions. Verbal exchange of information at team meetings is informal and confidential. No minutes are kept. Data on number, type of cases, and recommendations are logged. Notes on protocol and policy issues are also recorded.
6. The Team's review may be cursory or in-depth, depending upon the available information and the perceived need and basis of several risk factors including drug ingestion, undetermined cause of death, head trauma, malnutrition, bathtub drowning, suffocation, fractures, sudden infant death syndrome (SIDS), blunt force trauma, homicide, child abuse, neglect, burns, sexual abuse, gunshot wounds, stillborn or fetal death that may be drug related, and poisoning.

During 2003, the Nevada State Legislature passed Assembly Bill (AB) 381. This legislation revises the purpose, membership, and procedures of the teams established to review child deaths in Nevada. Additionally, it increases the fee for death certificates in the state to support the reviews conducted by the teams. A broader, multidisciplinary membership within Child Death Review Teams will include representatives from law enforcement, professional medicine, the district attorney's office, schools, and the coroner's office. Limitations on disclosure will increase the confidentiality of case records reviewed by the teams and prevent the subpoena of information in civil and criminal proceedings.

The Statewide Team will take on the functions of an Executive Committee, with the following key duties:

- Adopt statewide protocols for the review of child deaths.
- Oversee training and development of multidisciplinary teams to review child deaths.
- Compile and distribute a statewide annual report including statistics and recommendations for regulatory and policy changes.

Additionally, the Executive Committee will be responsible for establishing and Administrative Team, comprised of administrators of agencies who provide child welfare services. This Administrative Team will receive the Executive Committee's annual report and be required to respond to recommendations within 90 days.

Substitute Care – Foster Care

The authority for the substitute care program is delegated to the Division of Child and Family Services (DCFS) by Nevada Revised Statutes (NRS) 432.020, which establishes the Division's responsibility to support and maintain children placed in its custody, and NRS 432.032, which provides authority to adopt program regulations. NRS 432B.190 requires the Division to provide for the protection of the legal rights of parents and children, to evaluate the development and contents of plans submitted for approval regarding efforts to avoid removal of children from their homes, and to facilitate return where removal is necessary.

Substitute care is a family-focused service that provides for the temporary care of children in need of protection. Its services are aimed at changing behaviors in parents that have resulted in child maltreatment leading to out-of-home placement. The Division returns children who have been removed and may be safely restored to their families through the provision of services to the child and family. When reunification is not possible, the Division seeks alternative permanency options which best suit the child's needs. Specifically, the Division provides assessment and comprehensive case management services that support the child, the parents, and the caregivers.

The continuum of out-of-home care services includes emergency shelter care, foster family care (including placements with relatives), group home care, therapeutic foster care, respite care, residential treatment care both in and out of state, and independent living services. The Division emphasizes the safety and wellbeing of children, recognizes the family as the fundamental foundation of child rearing, and acknowledges the importance of a comprehensive, community-based, child-centered, family-focused, and culturally competent teamwork approach.

The Division believes families offer children and young adults opportunities for permanency and family relationships that are intended to last a lifetime. Permanency affords the stability and security that children must have for building competency and self-reliance and for maximizing their cultural and spiritual growth. The Division supports collaborative efforts in every community to help assure permanence in the lives of all children.

DCFS began major child welfare reform in 1992 with the commitment to move from a protective authority to a family-centered approach in casework. The first phase was the adoption of a training series for social workers that incorporates the philosophy and principles of family-centered practice in the four major casework areas:

1. Child protective services (CPS)
2. Adoption
3. Foster care
4. Child welfare

In 1994, the second phase of this initiative included the creation of the Foster Care Statewide Steering Committee to address professionalization, training, and retention of foster caregivers. The goal was to improve the quality of foster care by means of a family-centered approach with foster caregivers. The yearlong efforts of this task force and its three subcommittees resulted in a number of improvements within foster care. These included the following:

- Implementation of a 36-hour pre-service foster parent training curriculum
- Involvement of foster care providers in case planning
- Promotion of the development of a Foster Parent Bill of Rights

To continue the efforts of this initiative and to address the quality of care standards required by the Adoption and Safe Families Act (ASFA), DCFS formed a Quality of Care Standards (QCS) Statewide Task Force. The Task Force reviewed current standards and suggested additional

standards to improve services and practices. The QCS Task Force was composed of child welfare managers, supervisors, social workers, specialists, foster care providers, and representatives from County social services. The Task Force represented Nevada's three geographic regions: north, south, and rural. Five areas were addressed by the Task Force:

1. Foster care licensing
2. Training
3. Retention and support
4. Quality of care for foster children
5. Professionalization of foster caregivers

After an initial review and recommendation report was developed, the QCS Task Force membership was dissolved into other groups that continue to evaluate the five areas outlined above and to recommend ways to improve the delivery of services and quality of care for children in foster care.

Specific to the training implemented by the Task Force, Nevada adopted a 36-hour pre-service training curriculum in 1997, which is required of all potential foster and adoptive families. The training is designed to provide families with knowledge and skills that can greatly contribute to their success. Some families will decide that foster care and/or adoption is not for them, while others will begin to gain an understanding of the role of their family and how additional children can enhance their family life.

The northern and southern regions have trainers on staff who provide the 36-hour pre-service training. The rural region contracts out to a local provider to recruit and train foster homes, using the same pre-service curriculum. This is an established curriculum developed by the Institute for Human Services in Columbus, Ohio, which is widely considered to be state-of-the-art training.

Beginning in 2002, since the implementation of the integration of child welfare services in Washoe and Clark Counties, the training now varies by region in terms of hours required and curriculum content, ranging from approximately 22 to 36 hours. However, since only eight hours are required by law, the regional training requirements significantly exceed the minimum established requirements.

APPENDIX B: PANEL MEMBERS

Current Members

Member	*Affiliation*	*Representation*
Appell, Annette	University of Nevada, Las Vegas – School of Law	Children's Attorney – southern region
Bosworth, Jone	Division of Child and Family Services (DCFS)	Division Administrator – northern region
Herzik, Mary	Court Appointed Special Advocates (CASA) of Washoe County	CASA – northern region
Moorehead, Larry	Foster Parent	Foster Parent – northern region
Swetnam, Laurel	DCFS – Southern Regional Early Childhood Services	Mental Health – southern region
Walker, Marcia Rose	Economic Opportunity Board (EOB)	Community Representative – southern region

Advisory Staff

Member	*Affiliation*	*Representation*
Capello, Michael Durand, Jim	Washoe County Department of Social Services (WCDSS)	Child Protective Services – northern region
Stillian, Carol	Clark County Department of Family Services (CCDFS)	Child Protective Services – southern region
Walker, Marji	DCFS – Family Programs Office	Social Services – northern region

Proposed New Members

Member	*Affiliation*	*Representation*
Borders, Bob	Clark County School District	School District – southern region
Rosenberg, TJ	Nevada P.E.P.	Nonprofit Advocacy and Service Organizations – southern region
Waugh, Sherry	University of Nevada, Reno – Child & Family Research Center	Child Care Providers – northern region