Citizen Review Panel Purpose and Responsibilities

Public Law 104-234, Title I, Section 106, the Child Abuse Prevention and Treatment Act (CAPTA) provides for a state grant program for the support and improvement of state Child Protective Systems (CPS). CAPTA requires that Nevada have at least three (3) Citizen Review Panels (CRP) to receive funding for child protection efforts. Citizen Review Panels are to review various aspects of the child protection system at the state and local levels and make recommendations for improvements.

Nevada has designated three (3) standing committees to serve as CRP's. All Nevada CRP's meet at least quarterly, and meetings adhere to Open Meeting Law. Panels may make recommendations for training, policy, or system improvements.

Nevada CRPs include the:

- **Child Death Review Executive Committee (CDR),** which provides coordination and oversight of local child death review teams;
- **Children's Justice Act Task Force (CJA),** which is charged with developing, establishing, and operating programs designed to improve the assessment, investigation, and prosecution of suspected child abuse and neglect;
- **Clark County Department of Family Services Citizens Advisory Committee (CAC),** which identifies and communicates perspectives on services provided and how to best meet the needs of families that utilize the Clark County Department of Family Services

Panels include members with expertise in the prevention and treatment of child abuse and neglect and have diverse membership, including but not limited to, representatives from:

- Community Advocacy and Non-Profit Organizations
- Public Child Serving Agencies
- Law Enforcement
- Parent and Youth Leaders
- Court Systems including Attorneys and Judges
- Mental and Physical Health
- Education
- Public Health

Historical Citizen Review Panel Recommendations

Below are previous recommendations made to the Department of Health and Human Services, Division of Child and Family Services (DCFS) by the Executive Committee to Review the Death of the Children and the DCFS responses to the recommendations.

2024

CRP Recommendation: It is recommended that DCFS via the Executive Committee to Review the Death of Children, partner with community agencies as appropriate to increase evidence based public awareness around child deaths to include asphyxia, motor vehicle accidents, drowning, poisoning overdoes or acute intoxication, and suicide. The efforts will include education and collaboration to prevent future child fatalities in Nevada.

DCFS response:

The Division accepts this recommendation. The Executive Committee to Review the Death of Children will continue to focus on increasing evidence based public awareness and preventative efforts to address child fatalities and near fatalities that are due to asphyxia, motor vehicle accidents, drowning, poisoning, overdoses or acute intoxication, and suicide through discussion during the Executive Committee to Review the Death of Children meetings and through a Notice of Funding Opportunity (NOFO) where community partners are able to apply for funding aimed at preventing child fatalities.

2023

CRP Recommendation 1: It is recommended that DCFS, via the Executive Committee to Review the Death of Children, continue to collaborate with statewide organizations, including but not limited to, DPBH, Hospital Association, and the Statewide Overdose Data to Action Team, to address the ongoing concerns of fentanyl related overdoses & accidental ingestions by:

- Providing education to the families we serve about the dangers of fentanyl;
- Staying informed about the resources provided by the Statewide Overdose Data to Action Team.

DCFS response:

DCFS accepts this recommendation. The Executive Committee to Review the Death of Children will continue to discuss this recommendation and further discover ways to promote the dangers of fentanyl. The Executive Committee to Review the Death of Children has encouraged DPBH, via a letter, to put forth legislation in the 2025 session regarding the addition of fentanyl to standard drug testing panels at all hospitals in Nevada.

CRP Recommendation 2: It is recommended that DCFS, via the Executive Committee to Review the Death of Children, continue to collaborate with statewide organizations, to include but not limited to, DPBH, and Nevada Off-Road Association, to address the ongoing concerns of off-road vehicle accidents involving minors by:

- Providing education to the families we serve about the Importance of proper off-road vehicle safety;
- Partnering with the Nevada Outdoor School to facilitate safety training.

DCFS response:

DCFS accepts this recommendation. The Executive Committee to Review the Death of Children will continue to discuss this recommendation and further discover ways to promote the off-road vehicle safety for minors. By collaborating with SAFEKIDS Renown and Nevada Outdoor School it is hopeful that enough support will be to encourage future legislation of proper off-road vehicle safety for minors.

CRP Recommendation 3: It is recommended that DCFS provide training to the child welfare workforce and partner agencies, including, but not limited to, CASA, CAP Attorneys, and other court professionals on:

- Understanding the impacts of childhood trauma and adverse childhood experiences (ACEs) on parental behavior; and
- Understanding how childhood trauma and ACEs may negatively affect parent's ability to safely care for their child(ren).
- Incorporate conversations about protective factors as ways to mitigate risk and safety concerns.

DCFS response:

DCFS accepts this recommendation. DCFS Administrator, Dr. Cindy Pitlock, emailed all DCFS employees for training regarding ACEs and impact on youth and families. The Executive Committee to Review the Death of Children will distribute these trainings to its members and encourage them to distribute the trainings through their network. The Regional Child Death Review Team will begin to identify common trends of protective factors. Nevada is updating Statewide Policies used by child welfare staff regarding safety assessments and developing policy around family first prevention services.

2022

CRP Recommendation 1: It is recommended that DCFS partner with sister agencies and other community providers as appropriate to enhance the Choose Your Partner Carefully campaign to ensure the language used in the brochure uses the appropriate, inclusive language and is on par with the current research, to help people identify when they may be in an unhealthy relationship that may impact their children, including placing the children in an unsafe situation.

DCFS response:

The DCFS accepts the first recommendation. DCFS will partner with Prevent Child Abuse Nevada, as they are the agency who releases the Choose Your Partner Carefully brochure to ensure appropriate and inclusive language is used in the brochure. Furthermore, DCFS will ensure that each child welfare jurisdiction has the updated pamphlet to distribute as appropriate.

CRP Recommendation 2: It is recommended that DCFS perform a statewide analysis of current programs that are working with children that may provide prevention around the top four causes/manners of

death to identify where any systematic gaps may be so that preventative funding can be more precisely targeted.

DCFS Response:

The DCFS accepts the second recommendation. DCFS will partner with each child welfare agency to gather information about their community service providers who provide prevention services around the top four causes/manners of child death to identify any found systemic gaps so that preventative funding can be more precisely targeted during the annual notice of funding process.

2021

CRP: Recommendation 1: It is recommended that the DCFS identify ways in which wraparound services can be provided to families who have a youth that may have suicidal ideation. Additionally, best practice would be to refer a family, and the services started as soon as possible to prevent more youth from dying by suicide.

DCFS response:

- DCFS accepts this recommendation and will partner with other agencies, develop a list of providers, and
- recommend the local child welfare jurisdictions establish procedures when a youth may have suicidal ideation to ensure the youth's safety and that the youth is referred to services in a timely manner. DCFS child welfare will:
- Partner with DCFS Mobile Crisis Response Team {MCRT) to learn about their process for referring families to service providers.
- Partner with Wraparound In Nevada to learn more about what the program offers and if they can be a service provider for families with youth with suicidal ideation.
- Develop a list of providers who are able to provide services to families on an emergency basis; and
- Request the child welfare agencies develop procedures for child welfare staff to follow when a youth may have suicidal ideation.

CRP Recommendation 2: It is recommended that DCFS partners with sister agencies to provide education to parents/caregivers on how to look for signs of suicidal ideation and keep their child safe once suicidal ideation/signs have been identified. This includes, but is not limited to, appropriate firearm safety/storage, medication safety/storage, and other potential means.

DCFS response:

- DCFS accepts this recommendation. DCFS will continue to partner with sister agencies to provide education for parents/caregivers. DCFS has

already partnered with the Office of Suicide Prevention and Children's Behavioral Health who have produced a packet of resources to distribute to local agencies. DCFS will continue this partnership which will allow any new and/or relevant information to be distributed when appropriate. Clark County's Child Death Review Team has previously reached out to gun shop owners within Clark County to provide brochures about proper gun storage and training. Through the Executive Committee to review the death of children, DCFS will monitor the progress of this activity and consider implementation statewide. DCFS will explore the ability for child welfare agencies to provide gun safety locks, gun safes, and/or medication lockboxes to distribute to families that may need them.

CRP Recommendation 3: It is recommended that the DCFS partner with sister agencies and other community providers as appropriate to increase evidence based public awareness around Safe Sleep and Water Safety in an effort to prevent unsafe sleep and drowning deaths.

DCFS response:

DCFS accepts this recommendation. DCFS will continue to partner with sister agencies. DCFS intends to explore development of public service announcements to increase the education around Safe Sleep environments and Water Safety. DCFS through Executive Committee to review the death of children will:

- Award funding to agencies that prioritize Safe Sleep;
- Partner with the Division of Public and Behavioral Health (DPBH)'s Maternal, Child and Adolescent Health to promote the National Safe Sleep Awareness in October which could include public awareness campaigns and educational resources;
- Partner with Cribs for Kids to ensure all hospitals in the state have a Safe Sleep educational program; and
- Explore how to increase public awareness regarding water safety and water competency and/or form partnerships with relevant agencies that can assist with this goal.

CRP Recommendation 4: It is recommended that the DCFS continue to prioritize training that will improve the investigative process of handling of cases of child abuse and neglect, including, but not limited to child protection model assessments, domestic violence, mandatory reporting, and trauma-informed practices.

DCFS response:

DCFS accepts this recommendation. The Children's Justice Act (CJA) Task Force continues to prioritize funding for various trainings. The CJA recently approved funding for child welfare staff and stakeholders to attend the following trainings:

- The Child Welfare League of America Conference;

- Child Abuse and Family Summit;
- Forensic Interview training provided by the National Children's Advocacy Center (NCAC); and
- Domestic violence training that will address the risk and protective factors for families.
    - Additionally, the Child Welfare/ Human Services Training workgroup on domestic violence recommended trauma-informed training, instruction on proper completion or interpretation of intimate partner violence and domestic violence assessments and understanding model protocols for identifying and responding to high lethality risk domestic violence situations for child welfare staff. Nevada recognizes the need for further training and education about domestic violence. Child Welfare agencies need a program or model that can be integrated with Nevada's current child welfare practice model. Nevada is going to send out a Request for Proposals {RFP) for a domestic violence model that can be integrated with Nevada's current child welfare practices. DCFS is also exploring the establishment of a mandatory reporter training platform that would standardize mandated reporting in Nevada, improve reporting of and prevent child abuse and neglect.