

State of Nevada
Findings on Clark County Child Deaths

- A high percentage of children who die each year in Clark County are known to county DFS, meaning they have a history of open or closed child abuse reports at the time of their deaths. Sixty-nine of the 292 children who died in 2004 – 23.6 percent – were known to the system. Seventy-five of the 260 children who died in 2003 – 28.8 percent – were known to the system.
- Substantially more children who died in 2004 had a history of involvement with DFS – including an open case – at the time of their death, than children who died in 2003. In 2004, a total of 52 children who died were known to DFS – 18 children had an open case and were supposedly receiving services from DFS when they died. Another 34 had one or more closed cases at the time of their death. In contrast, in 2003, seven children who died had open cases and 15 had closed cases.
- The number of deaths due to child abuse in Clark County is very likely far beyond what has been reported previously. In 2004, Clark County ruled only five deaths due to abuse or neglect. However, 69 of the 292 children who died from all causes during 2004 were known to the system before their death. The state’s report recommended that another 22 of the 69 cases needed further review because abuse was the suspected cause of death.
- The underreporting of child abuse deaths and the secrecy in Clark County has gone on for many years. Seventy-nine additional children are suspected of having died from abuse or neglect during the four-year period covered by the report – 22 in 2003 and 2004, 20 in 2002, and 15 in 2001.
- The 79 cases identified as needing further review because these children may have died from abuse do not include all cases for which a closer analysis is needed. For example, in eight of the 13 homicides in 2004, the child was known to the system at the time of death, yet none of those cases are identified as “needing further review.” In five of eight suicides, the child was also known to the system, yet not a single one of those cases is categorized as needing further review.
- Data released by the state in its December 1, 2005 report on child fatalities referenced earlier gives a better sense of the magnitude of the problem, but provides little detail. For example, the report fails to answer critical questions, including the age, ethnicity and sex of the child; and what, if any, services were being provided at the time of death?
- A panel of experts assembled in early 2006 to review the 79 cases identified as needing further review issued the following findings regarding Clark County DFS:

- Mandatory safety assessments forms were almost all incomplete, incorrect, or dated long after the incident of abuse.
- DFS accepts parents' explanations and information without verification and consequently fails to make good decisions about the risks to children.
- DFS fails to visit, interview, and assess the safety of surviving siblings promptly even when a child's death occurred in a family with a prior CPS history.
- DFS records do not contain coroner or law enforcement reports, suggesting workers have not included them as part of their investigation.
- DFS investigations are often incomplete.
- Caseworkers fail to have monthly contact with families to ensure the child's continued safety, and often substitute phone contacts for home visits.
- Cases are closed even though problems in the family and risks to the child's safety and well-being are not resolved.
- Mandatory case and safety plans are not in the files.
- Children are returned to parents who have failed to complete required substance abuse treatment.
- Mandated child abuse reporters, including local hospitals, are put on hold for lengthy periods of time when calling to report child deaths or suspected abuse.
- DFS investigators fail to make contact with families quickly after receiving a report of suspected abuse.