

# **GUIDELINES FOR INVESTIGATING SUSPICIOUS CHILD DEATHS\***



*Photograph Courtesy Jennifer Childress Photography\*\**

## **Southern Nevada Child Fatality Taskforce (SNCFT)**

# Introduction

In 2006, the Nevada Department of Health and Human Resources (DHHS) contracted with a panel of national experts to review a select number of child deaths that occurred in Clark County from 2001 to 2004. This independent Child Death Review Panel made findings and recommendations to enhance child safety and prevent child deaths in Clark County. That same year, the DHHS convened the Clark County Blue Ribbon Panel for the Review of Child Deaths, which consisted of child welfare experts in Nevada, to review the report of Recommendations by the independent Child Death Review Panel and provide oversight to the Action Plan for the Clark County Death Review. *(See Appendix)*

One recommendation of the Blue Ribbon Panel was to establish a county based, multidisciplinary committee (coroner, district attorney, law enforcement, Child Protective Services (CPS), meeting 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 district attorney disposition of cases.

The goal of the Southern Nevada Child Fatality Taskforce (SNCFT) in creating the guidelines\* is to create a more uniform, consistent community response to Child Death in Clark County. These guidelines are intended to provide direction to public entities responsible for responding to suspicious child death in Clark County. These guidelines are created as the result of a collaborative effort of all participants in, and community consultants to, the Southern Nevada Child Fatality Task Force. Recognizing that each child death will be unique as to facts and circumstances, these guidelines have been created to provide guidelines for response to Child Death, but are created with the recognition that deviation from these recommended guidelines may occasionally be prudent and necessary depending on the facts and circumstances presented, in the professional discretion of the responding entities.

*\*All provisions of these guidelines are intended to implement relevant statutory requirements and remain subject to applicable provisions of Federal, State and local laws, as well as individual entity policy regarding investigation of, and response to, child abuse, neglect and death.*

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# **Southern Nevada Child Fatality Taskforce**

## **Guidelines for Investigating Suspicious Child Fatalities**

### **I. Law Enforcement Response**

- A.** Law Enforcement will normally be the first responders at any reported potential or suspicious child death scene.
- B.** Law Enforcement will respond and evaluate the situation in accordance with Department policy, including but not limited to the following as the circumstances dictate as determined by the officers:
  - 1.** Assess if there are child injuries and/or circumstances that are suspicious and/or if there is a child fatality;
  - 2.** Summon medical assistance, if not already done;
  - 3.** Secure the scene(s) and protect the evidence;
  - 4.** Conduct the preliminary Investigation, including,
    - i. locating and separating witnesses;
    - ii. documenting information on all individuals present and compiling background information and vital statistics.
  - 5.** Maintain a scene log of all individuals who come and go from the scene, including the names of all emergency response team members (paramedic and fire responders).
  - 6.** Contact the designated Investigative Detail for call-out to the scene.
  - 7.** Prepare an officer report.

## **II. Multiagency Response Team Notification**

- A.** The Investigative Detail will contact Multiagency Response Team member:
  - 1.** Coroner's Office
- B.** The assigned Lead Investigator/Detective(s) (*hereafter Lead Investigator*) will respond to the scene when contacted by Patrol or other law enforcement responder:
  - 1.** After evaluating the circumstances surrounding the death, if the Lead Investigator determines the circumstances are suspicious for abuse and/or neglect, the Lead Investigator will make a report to the CPS Hotline.
  - 2.** In the absence of a report to CPS, the Lead Investigator will request a CPS history check on all children and caregivers in the household.

## **III. Scene Investigation/Initial Safety Assessment**

### **A. Law Enforcement Role**

The Lead Investigator will investigate the scene in accordance with his/her Department policy as the circumstances dictate based on the sound discretion of the Lead Investigator including, but not limited to, the following:

- 1.** Contacting the patrol unit for a briefing at the scene.
- 2.** Obtaining pertinent documents from the patrol officers, if any.
- 3.** Assessing the scene and ensure it is contained.
- 4.** Verifying the location of all parties and ensuring they are separated.
- 5.** Obtaining all basic preliminary information and preparing an Investigative Checklist.
- 6.** Verifying information on all parties and witnesses involved in the scene.
- 7.** Determining if any siblings or other children in the household are witnesses and can be interviewed, and assigning responsibilities for those interviews.

- 8.** Coordinating the preliminary interviews of witnesses and/or suspects.
- 9.** Evaluating if drug screening is warranted for the caregivers, children in the home and/or anyone who had access to the child during this period. (Also See CPS Role)
- 10.** Obtaining a valid consent or applying for a search warrant before processing the scene, barring any exigent circumstances; if any questions arise concerning the search warrant, consulting with the Child Homicide DA.
- 11.** After obtaining a valid consent or a search warrant, processing the scene by CSI/CSA in conjunction with other investigative agencies.
- 12.** Briefing with CSI/CSA to ensure booking of evidence and adequate processing of the scene.
- 13.** Based on circumstances found at the scene and the cooperation of the necessary parties, conducting with the Coroner Investigator a re-enactment (i.e. with a doll in infant death cases) detailing events as obtained in the statement(s); ensuring the entire re-enactment is videotaped.
- 14.** Ensuring that the Medical Examiner is provided with a copy of the videotaped re-enactment, if obtained, for his/her review, preferably on the day of the autopsy.
- 15.** Photographing body positions as described and all injuries on the child.
- 16.** Directing the photo documentation of siblings and other children in the household or at the scene if abuse or neglect is suspected. If there is apparent bruising, requesting serial photos for the subsequent 2-3 days.
- 17.** Taking measurements of heights fallen, objects that were in the way, etc.
- 18.** Photographing/diagraming/video-taping of entire house/video walk through.
- 19.** Obtaining the emergency medical services reports for all emergency responders; obtaining statements that may have been made to the emergency responders.

20. Contacting the hospital for a medical update regarding the victim's status, discuss additional evaluations if warranted, and obtain information about injuries. *(See Section V regarding Hospital Information.)*
21. Ensuring that all written reports from the law enforcement unit responding to the scene, including a roster of all persons at the scene, have been obtained.
22. Observing the CSI/CSA conduct a preliminary examination of the decedent with the Coroner Investigator for visible injuries on the child if the child is at the scene.
23. Directing the CSI/CSA in the documentation and impounding of all evidence samples and/or formula, food, medications, bottles, and bedding as determined necessary by the Investigative Detail. The investigative report must include the party impounding the evidence or taking the samples. Any of this evidence must be made available to the Coroner's Office if requested.
24. Gathering detailed information on the circumstances of the incident and all events for a minimum of 72 hours preceding the incident, or longer as dictated by the injuries. The detailed information should include the actions of any caregivers, children in the home and/or anyone who had access to the child during this period.
25. As the Multiagency Response Team members arrive, the Lead Investigator(s) will meet with all responders for an initial briefing pertaining to the status of the investigation including any of the information above obtained, in the best interest of the investigation.
26. If the Lead Investigator has reasonable cause to believe that siblings or other children in the household are or may be at risk of abuse and neglect, the Lead Investigator will ensure that CPS is notified.
27. The Investigative Detail will conclude with the processing of the scene and, if there is a secondary scene at a hospital, CSI/CSA will respond to hospital for photos of the victim.

***\* If the death is delayed and the scene is no longer available for processing, the Lead Investigator will confer with the Coroner Investigator and share investigative findings, scene photos and any other information related to the death.***

## **B. Coroner Investigator Role**

- 1.** The Coroner Investigator will meet with law enforcement and coordinate the investigation.
- 2.** The Coroner Investigator will conduct the walkthrough and assessment at the scene(s) in conjunction with law enforcement.
- 3.** The Coroner Investigator and law enforcement will hold joint interviews when it is in the best interest of the investigation.
- 4.** The Coroner Investigator will confer with CPS as needed.
- 5.** The Coroner Investigator will conduct the body examination and complete the Coroner's Child Death Checklist.
- 6.** The Coroner Investigator will participate in the re-enactment (using a doll if an infant death is involved).
- 7.** The Coroner Investigator will notify the appropriate funeral home.
- 8.** The Coroner Investigator should impound, as necessary, formula/food/medications/bottles or samples thereof if law enforcement does not.
- 9.** If the death is delayed and the scene is no longer available for processing, the Lead Investigator will confer with the Coroner Investigator and share investigative findings, scene photos and any other information related to the death.

## C. Child Protective Services (CPS) Role

In the event of a suspicious child death, CPS has a duty to perform child safety/risk assessments for other children in the household. CPS's role in scene investigation and initial safety/risk assessment is intended to implement that duty.

1. CPS will assign the report for investigation and if a child death is suspicious, CPS will respond to the scene. *(See definition of suspicious)*
2. CPS will check in with the Lead Investigator when arriving at the scene. CPS will coordinate with the Lead Investigator so as to perform child safety/risk assessments without interfering with the crime scene.
3. CPS will obtain demographic information regarding involved parties at the scene pursuant to CPS investigation requirements.
4. CPS will coordinate with the Lead Investigator in scene interviews of witnesses and suspects. *(See Law Enforcement Role)*
5. CPS may view the reenactment, video reenactment (with a doll in infant death cases) and/or video as the scene supports.
6. CPS may conduct or participate in interviews of siblings and other children in the household. *(The Child Advocacy Center is the preferred location for the interviews of children.)*
7. CPS may provide for medical assessment of any siblings or other children in the household as the CPS investigation reasonably warrants.
8. If the investigation so requires, the Lead Investigator may request that CPS provide information on any prior CPS history for persons in or frequenting the household. If the child and/or siblings and/or other children in the household have resided in another state(s), then CPS will request a case history check from the identified state(s).
9. CPS may participate in a scene walkthrough and assessment in conjunction with the Lead Investigator.
10. CPS will assess the safety of surviving siblings and other children in the household and take safety actions as warranted.

- a) CPS will confer with the Lead Investigator regarding interview strategies and the availability of any needed child(ren) for interviewing.
- b) In consultation with the Lead Investigator, CPS may interview collaterals (i.e. family members, persons known to the family)
- c) CPS will advise the Lead Investigator regarding the proposed placement plan.
- d) CPS may determine if drug screening is warranted for the caregivers, children in the home and/or anyone who had access to the child during this period.
- e) Pursuant to a determination by CPS that any child in the household requires removal, CPS will facilitate an alternative placement.

#### **D. District Attorney Role**

1. The Clark County Deputy District Attorney assigned to prosecute child homicides within the District Attorney's Special Victim's Unit, or its equivalent, (hereinafter the Child Homicide DDA) may receive notice of potentially criminal child deaths as determined by Lead Investigator and be briefed on preliminary findings for the purpose of providing legal advice concerning prospective prosecution.
2. The Child Homicide DDA may provide legal advice to the Lead Investigator on legal issues that may include probable cause, search warrants, consent to search and sufficiency of evidence.

## **IV. Scene Debriefing**

- A.** The Lead Investigator will debrief with the other agencies at the scene, including the Coroner's Office, and CPS, and may seek legal advice from the Child Homicide DDA as necessary.
- B.** If the Child Homicide DDA is not present, the Lead Investigator will determine if the Child Homicide DDA should be called for a debriefing.
- C.** CPS will address the safety of other children in the household and request input from other agencies. The Multiagency Response Team will discuss the practical aspects of making the children available for interviews.
- D.** If CPS determines that safety is an issue and/or that there will be an alternate placement, the Lead Investigator will be notified before CPS removes any children from the scene. CPS will brief the investigative agencies on where the children are being placed, including the name, address, and contact information for secondary interviews if warranted.
- E.** The Lead Investigator will advise the Coroner Investigator who to contact in law enforcement with the date and time of the autopsy.
- F.** All responding parties determine any further investigative work needed.
- G.** If it is necessary for law enforcement to return to the home scene after consulting with medical staff, then the Lead Investigator will either obtain legal consent to return to the home or obtain a search warrant. At that time, the Lead Investigator will have impounded any necessary items based on medical findings.
- H.** The Lead Investigator will tentatively schedule the 72-hour debriefing.

## **V. Hospital Information *(in case of a victim's hospitalization)***

- A.** The Lead Investigator or his/her designee will obtain an initial verbal report on the child's condition and follow-up with the acquisition of all medical records.
- B.** The Lead Investigator will make every effort to contact CPS and the Child Homicide DDA to provide a medical update.

## **VI. Autopsy**

- A.** The Lead Investigator may attend the autopsy and brief the Medical Examiner on investigative findings. Additional members of the Multiagency Response Team may attend the autopsy when it is in the best interest of the investigation.
- B.** The Lead Investigator will inform the Medical Examiner if a videotaped doll re-enactment is available and provide the tape to the Medical Examiner for review as soon as possible, preferably on the day of the autopsy.
- C.** At the conclusion of the autopsy, a preliminary verbal summary of findings will be provided by the Medical Examiner to law enforcement.
- D.** Following the autopsy, the Lead Investigator will contact the assigned CPS Investigator regarding the medical findings.

## **VII. 72 Hour Debriefing/Ongoing Investigation**

- A.** Based on the investigative/medical findings, the Lead Investigator and the Child Homicide DDA will determine if a 72-hour case staffing is warranted in the case.
- B.** The Multiagency Response Team at the 72-hour case staffing may include the appropriate law enforcement agency, the Child Homicide DDA, CPS, the Medical Examiner, as well as any appropriate medical experts, and any other individuals deemed necessary to the case.
- C.** The Lead Investigator will give prior notice to all Multiagency Response Team members attending the 72-hour case staffing. The Team will meet at a location designated by the Lead Investigator.
- D.** All attending agencies and medical personnel will conduct a review of relevant findings for the case.
- E.** Participants in the 72-hour debriefing will compile a list of any further investigative issues and reports to be obtained after consideration of legal advice provided by the participating Child Homicide DDA.
- F.** The appropriate Multiagency Response Team members will participate in a case assessment with the Child Homicide DDA.
- G.** Participants will determine if drug testing of the parents or other adults in the home will need to be done.
- H.** The Lead Investigator will continue to identify potential witnesses, obtain copies of the 911 tape, interview collateral witnesses, verify

information contained in initial statements, meet with medical professionals to discuss case, obtain all medical records and pursue any other warranted investigative leads.

- I. When appropriate, the Lead Investigator will contact CSI/CSA to photograph injuries 72 hours after the initial response for comparisons.
- J. If there are surviving siblings or other children in the household CPS will notify the Juvenile DDA assigned to the unit.
- K. The Juvenile DDA will report to law enforcement on the status of any Protective Custody hearing involving siblings or other children in the household.

## **VIII. Internal Information and/or Document**

### **Sharing/Exchange** *(among the members of the Multiagency Response Team assigned to each case).*

#### **A. Law Enforcement**

- 1. An investigative summary will be forwarded to the Medical Examiner to assist in determining Cause and Manner of Death.
- 2. An investigative summary will be forwarded to the CPS Caseworker, the Juvenile DDA and the Child Homicide DDA for court purposes.
- 3. Law enforcement specific information transcribed interviews, arrest reports, incident reports, prior arrest/incident reports, call-out info, polygraphs, voice stress test results will be shared with all participating agencies as permitted by law.
- 4. The Lead Investigator will distribute to relevant Multiagency Response Team Members any follow-up evidence or reports as they are received, including 911 tapes, EMS reports, medical records (present event, any previous hospitalizations and birth records), transcribed witness statements, police reports, the autopsy report, and photos as permitted by law and if such disclosure does not compromise the investigation.

#### **B. Child Protective Services**

- 1. As necessary to the investigation and at the request of the District Attorney's Office and/or law enforcement, CPS will provide the Child Homicide DDA and the Juvenile DDA and the appropriate law enforcement agency with the following reports and documents if available:

- a) Any prior CPS history – in and out of state – for all family members living in the household
  - b) Case notes
  - c) Polygraph results
  - d) Drug test results received
  - e) Clinical evaluation results
  - f) Clark County foster licensing files for the homes or persons that are the subject of an investigation of child death.
2. As necessary to the investigation, the caseworker will provide all further documentation as it is requested by the District Attorney's Office and the appropriate law enforcement agency.

### **c. Coroner's Office**

1. The Coroner's office will provide the Criminal and Juvenile Divisions of the District Attorney's Office, CPS and the appropriate law enforcement agency with the following documents:
  - a) Autopsy Report
  - b) Toxicology Report
  - c) The Coroner's Investigative Report
2. The Coroner's office will share information revealed in the preliminary findings of the autopsy with the Lead Investigator, CPS and the District Attorney's Office.

## **IX. External Communication and Information Sharing**

The public release of information regarding the case under review should be the responsibility of a designated department or agency represented on the Multiagency Response Team. In most instances, the official spokesperson will be the public information officer for law enforcement or the Child Homicide DDA. While the release of public information is governed by the policy of a Multiagency Response Team member's department or agency subject to NRS 432B.175, in all instances the release of information to the public should be coordinated with the departments or agencies that are represented on the Team and information received from some other agency of the Multiagency Response Team shall be presumed confidential.

These communication guidelines are intended to coordinate the communication process between all agencies involved with a child fatality as it relates to the release of information. All agencies must adhere to the confidentiality restrictions of NRS 432B.175. Each agency should coordinate the release of information to ensure

consistency and accuracy of the information released concerning a child death, and maintaining confidentiality of information as required by law.

### **Public Communication Rapid Response Team Notification**

DFS Public Information Officer on behalf of DFS, the PIO for the responding law enforcement jurisdiction, the County Office of Public Communications on behalf of the County Manager, and the PIO from the Coroner's Office should be notified whenever a child fatality occurs. Each key member on the initial Public Communication Rapid Response Team will be responsible for notifying their chain of command about the incident. Depending on the location of the incident and the situation, the following agencies may be contacted:

- *Clark County Manager's Office*
- *Clark County Department of Family Services*
- *Clark County Office of the Coroner/Medical Examiner*
- *Clark County District Attorney's Office*
- *Clark County Juvenile Justice Services*
- *Boulder City Police Department*
- *Henderson Police Department*
- *Las Vegas Metro Police Department*
- *Mesquite Police Department*
- *North Las Vegas Police Department*
- *Nevada Highway Patrol*
- *City of Las Vegas City Manager's Office*

### **Law Enforcement Serves as Lead Agency**

Since information released by any other agency could inadvertently compromise components of the department's investigation, the police department of jurisdiction in the area where the death occurred will take the lead in responding to media requests for child death information. Law enforcement may restrict information that would otherwise be public pursuant to NRS 432B.175 where necessary to avoid compromise of an ongoing investigation. To the extent feasible, the dissemination of information will be coordinated with DFS, the Coroner's Office and all other involved parties to ensure continuity.

In the event coordination efforts are not possible, each agency shall endeavor to release only that information which was directly generated by the speaking agency, and will not disclose information acquired from any other investigating agency, but will instead refer the media inquiry to the agency that originally generated or acquired the requested information.

## Public and Media Information

Noted below is information that can and cannot be released once coordinated efforts have been established between agencies, and law enforcement has advised the release will not compromise its investigation:

- **Law Enforcement:**
  - (a) **To the professional media:** Law enforcement agencies can release the following information: child's sex; date of birth and date of death (providing it does not compromise the investigation); the parent's/guardian's arrest information and criminal history; nature of the crime; and approximate location of the crime. The following information is not released: child's name, cause of death, **identity of the parent and a picture pursuant to NRS 432B.175**, witness or suspect statements and any other investigative documents, information, evidence, etc.
  - (b) **To the general public:** Law enforcement agencies can release the following information: child's sex; date of birth and date of death; nature of the crime; and approximate location of the crime (providing it does not compromise the investigation).
  
- **Coroner/Medical Examiner's Office:** The Coroner/Medical Examiner's Office releases to the public the name of the decedent, age, race, gender, date of birth, time of death, cause and manner of death, and the location of death. Autopsy reports, medical records and documents containing medical information are not released to the public. However, upon request, autopsy reports and Coroner/Medical Examiner generated documents containing medical information may be released to decedent's next of kin.
  
- **Clark County Department of Family Services:** DFS may release information **only** as allowed by **NRS 432B.175**, specifically:
  - (a) A summary of the report of abuse or neglect and a factual description of the contents of the report;
  - (b) The date of birth and gender of the child;
  - (c) The date that the child suffered the fatality or near fatality;
  - (d) The cause of the fatality or near fatality, if such information has been determined;
  - (e) *Whether* the agency which provides child welfare services had any contact with the child or a member of the child's family or household before the fatality or near fatality and, if so:
    - (1) The *frequency* of any contact or communication with the child or a member of the child's family or household before the fatality or near fatality and the date on which the last contact or communication occurred before the fatality or near fatality;
    - (2) *Whether* the agency which provides child welfare services provided any child welfare services to the child or to a member of the child's family or household before or at the time of the fatality or near fatality;

- (3) *Whether* the agency which provides child welfare services made any referrals for child welfare services for the child or for a member of the child's family or household before or at the time of the fatality or near fatality;
  - (4) *Whether* the agency which provides child welfare services took any other actions concerning the welfare of the child before or at the time of the fatality or near fatality; and
  - (5) A summary of the *status* of the child's case at the time of the fatality or near fatality, including, without limitation, whether the child's case was closed by the agency which provides child welfare services before the fatality or near fatality and, if so, the reasons that the case was closed; and
- (f) *Whether* the agency which provides child welfare services, in response to the fatality or near fatality:
- (1) Has provided or intends to provide child welfare services to the child or to a member of the child's family or household;
  - (2) Has made or intends to make a referral for child welfare services for the child or for a member of the child's family or household; and
  - (3) Has taken or intends to take any other action concerning the welfare and safety of the child or any member of the child's family or household.

**Note:** Where DFS is only allowed to state **whether** an action occurred, it is **not** allowed to provide specific information regarding **what** that action may have been. Any information not specified in the statute specifically, is not public and may not be released by DFS or by any multiagency team member where DFS is the sole source of the information.

## **X. Case Submission and Prosecution**

### **A. District Attorney's Office - Criminal**

1. The appropriate law enforcement agency will determine if probable cause exists. If so, the Lead Investigator will prepare the case for submission to the Criminal Division of the District Attorney's Office.
2. Pursuant to NRS 432B.290, the Criminal Division of the District Attorney's Office will be provided access to all law enforcement and Department of Family Services data and information regarding the case submittal and all follow-up reports as they are obtained by law enforcement.
3. The case will be submitted to the District Attorney's Criminal Division for criminal prosecution.
4. A screening process will be established by the District Attorney, to include participation by the Child Homicide DDA, and/or the Chief of

the Special Victim's Unit or its equivalent, for the approval of prosecution of cases involving the death of a child under suspicious circumstances.

5. In the event prosecution is denied by a deputy in the District Attorney's Case Assessment Team, there will be a process for review that will ultimately involve the District Attorney.
6. The District Attorney will endeavor to have a child death prosecution handled by the same Deputy District Attorney from beginning to end, where practicable and where in the best interest of the prosecution, at the District Attorney's sole discretion.

## **B. District Attorney's Office - Juvenile**

1. The Juvenile Division of the District Attorney's Office will receive notification from DFS of all suspicious child fatalities when there are surviving siblings or any other children in the household.
2. The Juvenile DDA will staff cases with the DFS Investigator and Supervisor for the purpose of providing legal advice for prosecution or other appropriate legal action.
3. The Juvenile DDA will obtain all related reports from DFS, law enforcement, medical and coroner.
4. The Juvenile DDA will review the case for appropriate legal action, including but not limited to the filing of a NRS 432B petition; the case will be reviewed for both issues of abuse and neglect, as well as failure to protect by the non-offending parent.
5. If the Juvenile DDA determines that the filing of a petition is not warranted, DFS may submit the case to the Attorney General's Office for the filing of a petition. In that event the Juvenile DDA will provide a copy of all relevant discovery to the Attorney General's Office for their review.
6. The District Attorney will endeavor to have a child death prosecution handled by the same Deputy District Attorney from beginning to end, where practicable and where in the best interest of the prosecution, at the District Attorney's sole discretion.
7. Juvenile DDA will provide DFS a copy of all relevant reports and discovery after the adjudicatory hearing (trial) and before the Dispositional Hearing.
8. If a criminal prosecution is approved, the Child Homicide DDA and the Juvenile DDA will endeavor to keep one another informed regarding

the status of their respective cases as related to the child death, including but not limited to consultation with one another and provision of information that may be pertinent to either case, along with videos and/or transcripts of the Juvenile proceedings or the criminal proceedings as they become public.

9. If a criminal prosecution is not approved or is not submitted for prosecution regarding a suspicious child death, and the Juvenile DDA later learns of facts or other information that may not have been communicated to the Child Homicide DDA, the Juvenile DDA will endeavor to communicate with the Child Homicide DDA regarding any newly discovered or additional information that may be pertinent to the evaluation of a suspicious child death for criminal prosecution.

## Glossary

**CAC:** Clark County Child Advocacy Center

**Child Homicide DDA:** Child Homicide Deputy District Attorney

**CPS:** Clark County Department of Family Services, Child Protection Services

**CSI/CSA:** Crime Scene Investigator and Crime Scene Analyst

**DFS:** Clark County Department of Family Services

**DHHS:** State of Nevada Department of Health and Human Services

**Exigent Circumstances:** “[T]hose circumstances that would cause a reasonable person to believe that entry (or other relevant prompt action) was necessary to prevent physical harm to the officers and other persons, the destruction of relevant evidence, the escape of the suspect, or some other consequence improperly frustrating legitimate law enforcement efforts. *Howe v. State*, 112 Nev. 458, 466, 916 P.2d 153, 159 (1996) (quoting *Doleman v. State*, 107 Nev. 409, 414, 812 P.2d 1287, 1290 (1991) (quoting *United States v. McConney*, 728 F.2d 1195, 1199 (9th Cir.1984)).” *Camacho v. State*, 119 Nev. 395, 400, 75 P.3d 370, 374 (Nev, 2003)

**Juvenile DDA:** Deputy District Attorney assigned to handle child abuse and neglect cases in Family Court pursuant to NRS 432B

**Investigative Detail:** Section(s) within a law enforcement agency responsible for investigations.

**Lead Investigator:** Law enforcement officer or detective in charge of an investigation or his/her designee

**LRMS:** Law Records Management System

**Multiagency Response Team:** Representatives from agencies who deal with child fatalities, work together to improve the investigation and prosecution of child homicides, and ensure the continued safety of surviving children when there is a suspicious child death. The Multiagency Response Team may consist of the appropriate law enforcement agency, the Child Homicide DDA, CPS, the Medical Examiner if the child is deceased at the time of the debriefing

**NRS432b:** Nevada Revised Statutes governing the Protection of Children from Abuse and Neglect

**Protective Custody Hearing:** NRS 432B.470 requires that a child taken into protective custody pursuant to NRS 432B.390 must be given a hearing, conducted by a judge, master or special master appointed by the judge for that particular hearing, within 72 hours, excluding Saturdays, Sundays and holidays, after being taken into custody, to determine whether the child should remain in protective custody pending further action by the court

**Serial Photos:** Photos taken in succession to document the healing process of identified injury

**SNCFT:** Southern Nevada Child Fatality Taskforce reporting to the Clark County District Attorney and the Clark County Manager's Office with membership made up from representatives from the following agencies: Clark County Manager's Office, Clark County Family Services, Clark County Office of the Coroner/Medical Examiner, Clark County District Attorney's Office, Clark County Juvenile Justice Services, Las Vegas Metro Police Department, North Las Vegas Police Department, Henderson Police Department, Boulder City Police Department, Mesquite Police Department, and the Nevada Highway Patrol. The Team's membership also includes a pediatrician

**Suspicious Child Death:** The death of a person under 18 years of age where the circumstances surrounding the death are suspicious for abuse and/or neglect

# **Southern Nevada Child Fatality Taskforce**

## **SNCFT Sponsors**

- Darryl Martin, Clark County Manager's Office
- David Roger, Clark County District Attorney's Office

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- Teresa Lowry, Clark County District Attorney, Vice Chair
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- Paula Hammack, Clark County Department of Family Services
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- Tom Morton, Clark County Department of Family Services
- Peggy Rowe, Clark County Department of Family Services
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- Frank Sullivan, Eighth Judicial District Court
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- Troy Hatch, Henderson Police Department
- Vincent Cannito, Las Vegas Metropolitan Police Department
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- Various members of the National Independent CDR Panel

## Appendix

- NRS 432B: access from <http://www.leg.state.nv.us/nrs/NRS-432B.html>
- Independent Child Death Review Panel Report: access from <http://www.dcfs.state.nv.us/ChildFatalities/BlueRibbon/Attachment04a.pdf>

\*These guidelines are subject to change based on changes to the Nevada Revised Statutes; changes in local agency policies, procedures, codes, and/or ordinances; and to new national best practices, and/or research.

### \*\*Front Cover Photograph

Front cover photograph courtesy of Jennifer Childress Photography [www.jennchildress.com](http://www.jennchildress.com). This photograph is of Ms. Childress' sister in-law and her son Ian. Ian was 3 months at the time of the picture. Both were killed in a car accident one year after this photograph was taken.