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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

CLARK K.¹, by his next friend Sherry
Anderson; JALEN, SIA, ROSHAUN,
CALEB, and KING A., by their next friend
Tarrah Logan; TONI, SUMMER, and
FRANK B., by their next friend Marilyn
Paikai; and DONNA C., by her next friend
Jacquelyn Romero,

Plaintiffs,

vs.

KENNY C. GUINN, Governor of Nevada;
MICHAEL WILLDEN, Director of the
Nevada DHHS; FERNANDO SERRANO,
Administrator of the Nevada Division of
Child and Family Services; PAULA A.
HAWKINS, Bureau Chief of the Bureau of
Services for Child Care of the Division of
Child and Family Services; VIRGINIA
VALENTINE, Clark County Manager;
CLARK COUNTY DEPARTMENT OF
FAMILY SERVICES; TOM MORTON,
Director of Clark County Department of
Family Services; LOUIS PALMA, Manager
of Shelter Care for the Clark County
Department of Family Services; BRUCE L.
WOODBURY, TOM COLLINS, CHIP
MAXFIELD, YVONNE ATKINSON
GATES, MYRNA WILLIAMS,
LYNNETTE BOGGS MCDONALD, and
RORY REID, Clark County Commissioners;
and CLARK COUNTY,

Defendants.

CASE NO:
JUDGE:

**COMPLAINT
(CLASS ACTION ALLEGED)**

COMPLAINT (CLASS ACTION ALLEGED)

¹ Plaintiffs are proceeding under fictitious names and satisfy the requirements of Rule 10(a) of the Federal Rules of Civil Procedure. Pseudonym litigation should be permitted in this case because plaintiffs meet the following requirements laid out in Rule 10(a): plaintiffs are children; they are challenging governmental activity; and pressing the lawsuit using their real identities would compel plaintiffs to reveal highly intimate information.

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I.

JURISDICTION AND VENUE

1. This court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1343, and 1367. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 1343, 2201, 2202, and by Fed. R. Civ. P. 57 and 65.

2. Venue is proper pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims in this case arise in this district.

II.

THE PARTIES

3. Plaintiff Clark K. is a seventeen-year-old boy who has been in the legal custody of Clark County Department of Family Services ("Clark County DFS") since July 2003. He currently resides in Clark County, Nevada in the home of his grandparents who have been licensed foster parents for Clark County. Clark appears in this action by his next friends, Sherry Anderson who is his paternal grandmother.

4. Plaintiffs Jalen A., an eight-year-old boy; Sia A., a seven-year-old girl; Roshaun A., a five-year-old boy; Caleb A., a four-year-old boy; and King A., a one-year-old boy, are all siblings. They have been in the legal custody of Clark County DFS since December 2004. They currently reside in a foster home in Clark County, Nevada. Jalen, Sia, Roshaun, Caleb, and King appear in this action by their paternal aunt, Tarrah Logan, who is acting as their next friend. The children lived with Tarrah at various points in their lives, sometimes for as long as nine months, prior to their placement in foster care in December 2004. When they were taken into foster care, she visited them regularly. She is currently the legal guardian of the children's oldest and youngest siblings.

5. Plaintiffs Toni B., a four-year-old girl; Summer B., a seven-year-old girl; and Frank B., a five-year-old boy, are siblings. They have been in the legal custody of Clark

1 County DFS since October 3, 2002. They currently reside in a foster home located in Clark
2 County, Nevada. Toni, Summer, and Frank appear in this action by their next friend, Marilyn
3 Paikai. Mrs. Paikai has been a shelter/foster parent for Clark County since October 2001.
4 She was the foster parent for Toni for more than two years, and has provided care for and is
5 familiar with Toni's siblings, Summer and Frank.

6 6. Plaintiff Donna C. is a five-year-old girl who has been in the legal custody of
7 Clark County DFS since December 2004. She currently resides in a foster home in Clark
8 County, Nevada. Donna appears in this action by her next friend, Jacqueline Romero. Mrs.
9 Romero is a Clark County foster parent who previously cared for Donna.

11 7. Defendant Kenny C. Guinn is the Governor of Nevada, and is sued in his
12 official capacity. He is responsible for ensuring that all Nevada agencies comply with the
13 applicable federal and state laws, and oversees and directs the activities of Nevada
14 Department of Health and Human Services ("Nevada DHHS") and Nevada Division of Child
15 and Family Services ("State DCFS"), pursuant to Nev. Rev. Stat. § 232.310. His business
16 address is Capitol Building, 101 N Carson Street, Carson City, NV 89701.

18 8. Defendant Michael Willden is the Director of Nevada DHHS, and is sued
19 in his official capacity. He is the executive head of Nevada DHHS, and establishes
20 departmental goals, objectives, and priorities; approves divisional budgets; and delegates to
21 the division heads such authorities and responsibilities as he deems necessary for the efficient
22 conduct of the business of Nevada DHHS, pursuant to Nev. Rev. Stat. § 232.070. He is also
23 responsible for appointing divisional directors, pursuant to Nev. Rev. Stat. § 232.320,
24 including the Administrator of State DCFS, which has responsibility for ensuring the
25 provision of child welfare services throughout the state. His business address is 505 East
26 King Street, Room 600 Carson City, NV 89701-3708.

1 9. Defendant Fernando Serrano is the Administrator of State DCFS, and is sued in
2 his official capacity. He is responsible for the administration and oversight of all functions of
3 State DCFS. State DCFS administers all federal funds granted to the State for child welfare
4 services; it must adopt regulations establishing uniform standards for child welfare services
5 provided by the counties and is charged with monitoring the delivery of all child welfare
6 services by Clark and Washoe Counties. His business address is 711 East 5th Street, Carson
7 City, NV 89701.
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9 10. Defendant Paula A. Hawkins is the Bureau Chief of the Bureau of Services for
10 Child Care (“the Bureau”) of State DCFS, and is sued in her official capacity. She is
11 responsible for overseeing the functions of the Bureau, which are statewide and include the
12 incorporated areas of Clark County. The Bureau is responsible for licensing, monitoring, and
13 providing technical assistance to facilities caring for five or more children not licensed by
14 local entities to reduce the risk of harm to children in care outside of their own homes,
15 pursuant to Nev. Rev. Stat. § 424. Her business address is 400 W. King St, Suite 230, Carson
16 City, Nevada 89703.
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18 11. Defendants Bruce L. Woodbury, Tom Collins, Chip Maxfield, Yvonne
19 Atkinson Gates, Myrna Williams, Lynette Boggs McDonald, and Rory Reid are the seven
20 members of the Clark County Board of County Commissioners. The Board of County
21 Commissioners is responsible for running the County government, including hiring a County
22 Manager who is responsible for the day-to-day administrative operations of the County
23 government. Their business address is 500 Grand Central Parkway, Las Vegas, Nevada
24 89106.
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26 12. Defendant Clark County is subject to the jurisdiction of this court. With the
27 passage of Assembly Bill 1 in 2001, for counties with a population over 100,000,
28 responsibility for the funding and provision of child welfare and child protective services in

1 that county was transferred from State DCFS to the county agency. Clark County has a
2 population of over 100,000 and is responsible for providing funding in an amount set by the
3 County for the provision of child welfare services in the county.

4 13. Defendant Virginia Valentine is the Clark County Manager, and is sued in her
5 official capacity. She is responsible for managing the County's \$5 billion budget and
6 providing administrative oversight for all County departments, including the Department of
7 Family Services. Her business address is 500 S. Grand Central Parkway, Las Vegas, NV
8 89155.
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10 14. Defendant Clark County DFS has its principal place of business in Clark
11 County, Nevada. Clark County DFS is responsible for administering and providing all child
12 welfare services for abused and neglected children in Clark County, including child protective
13 services and shelter care, pursuant to Nev. Rev. Stat. § 432B.030.

14 15. Defendant Tom Morton is the Director of Clark County DFS, and is sued in his
15 official capacity. He is the executive officer of Clark County DFS and is responsible for
16 administering child welfare services in Clark County and for ensuring the safety and well-
17 being of children in or at risk of entering the child welfare system pursuant to Nev. Rev. Stat.
18 § 462B. His business address is 701 N. Pecos Rd, Bldng K, Las Vegas, Nevada 89101.
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20 16. Defendant Louis Palma is the Manager of Shelter Care for the Clark County
21 DFS, and is sued in his official capacity. He is responsible for oversight of all shelter care
22 facilities and programs in Clark County, which includes the day-to-day operations of Child
23 Haven. His business address is 701 N. Pecos Rd, Las Vegas, Nevada 89101.

24 **III.**

25 **INTRODUCTION**

26 17. This civil rights class action lawsuit is brought by ten children on behalf of all
27 abused and neglected children who are in, or at risk of entering, the Clark County foster care
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1 system. Plaintiffs seek declaratory and injunctive relief to compel Nevada and Clark County
2 officials to meet their legal duties under federal and state law to protect and care for abused
3 and neglected children.

4 18. During 2004, there were 8,979 investigations of child abuse or neglect reports
5 in Clark County. During the same year, 4,548 children entered foster care. There are
6 currently over 3,600 children in the legal custody of Clark County placed in foster family
7 homes, group homes, unlicensed and/or unpaid relative homes, and other settings.

8 19. Until 2004, Nevada operated a bifurcated child welfare system in which the
9 state's two counties with populations of over 100,000 – Clark and Washoe Counties – were
10 responsible for providing child protective services, while the State bore responsibility for
11 providing foster care services. As a result of AB 1, passed by the Nevada State Legislature in
12 2001, responsibility for both child protective services and foster care were vested with Clark
13 and Washoe Counties. The State retained responsibility for supervision and oversight of
14 Clark and Washoe Counties' programs to ensure, among other things, compliance with
15 federal and state laws, regulations, and standards. The transfer of foster care staff and
16 services from the State to Clark County was completed in October 2004.

17 20. Clark County's child welfare system is in crisis. Virtually every aspect of the
18 County's child protective services and foster care system is failing the children and youth it is
19 charged with protecting. The County's child welfare system denies children their rights under
20 the Federal and State Constitutions, laws, regulations, policies, and accepted professional
21 standards.

22 21. The County and State's failures have resulted in harm to an untold number of
23 children. A recent state report indicates that within the last four years at least 79 children
24 have died from abuse or neglect. These victims of fatal injuries or neglect include children in
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1 foster care and children left at home following a substantiated report of abuse. Many of their
2 deaths were preventable.

3 22. Within the past two and a half years, one study after another has documented
4 Clark County's failure to protect the health, safety, and well-being of child abuse victims and
5 children in foster care. These studies include:

- 6 □ A February 2004 federal Child and Family Services Review ("CFSR") of
7 Nevada's child welfare system that included an audit of Clark County's system
8 ("2004 Federal Review");
- 9 □ An April 2004 Audit of Child Haven and the Clark County Shelter Home
10 Program conducted by the Audit Department of Clark County ("2004 County
11 Audit");
- 12 □ An April 2005 Report to the Clark County Commissioners on the Status of
13 Child Welfare Services ("2005 County CWS Report");
- 14 □ A June 2005 report of a review of child abuse fatalities in Clark County
15 conducted by the Child Welfare Institute of which Defendant Morton was the
16 former director ("2005 CWI Review");
- 17 □ An October 2005 case review of Clark County child abuse and foster care
18 cases conducted by State DCFS ("2005 County Case Review"); and
- 19 □ An April 2006 Report of the Findings and Recommendations: Child Deaths
20 2001-2004 describing the results of an independent child death review panel
21 investigation of deaths related to child abuse or neglect in Clark County ("2006
22 Child Fatality Report").

23 23. During July 2006, representatives of the Administration for Children and
24 Families of the United States Department of Health and Human Services ("Federal DHHS")
25 conducted a site visit to reassess Clark County's child welfare program. Federal officials
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1 concluded that the situation for children and families served by Clark County's child welfare
2 system "has worsened" since officials' earlier on-site visit in February 2004. Some of the
3 specific deficiencies reported by federal officials include:

- 4 □ The State's acquiescence in Clark County's continued use of an unlicensed
5 congregate care facility – Child Haven;
- 6 □ Consistent overcrowding at Child Haven;
- 7 □ Unnecessary removal of children from their homes due to Clark County's
8 failure to provide an adequate array of services to prevent placement;
- 9 □ Frequent changes in placement of children in foster care;
- 10 □ Inadequate assessments of the safety of suspected victims of child abuse and
11 neglect;
- 12 □ Inadequate training of staff and insufficient recruitment of foster parents;
- 13 □ Unanswered or lengthy delays in answering calls to the Child Abuse Hotline;
- 14 □ The use of an invalid, ineffective risk assessment tool;
- 15 □ The failure to use data to provide effective management oversight and
16 supervision;
- 17 □ And the failure to provide a guardian *ad litem* for every child in foster care.

18 24. In a letter to Nevada child welfare officials on August 11, 2006, Sharon M.
19 Fujii, the Regional Administrator for the Administration for Children and Families of Federal
20 DHHS, informed Nevada that "the manner in which the continuum of child welfare services is
21 managed in Clark County should be a grave concern to the State." She notified state officials
22 that the current Program Improvement Plan between the State and federal officials "is no
23 longer adequate to address the serious deficiencies in the State's child welfare program, most
24 specifically Clark County which accounts for the majority of the State's child welfare
25 population."
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1 25. For years, Clark County has evaded scrutiny of its child protective services and
2 foster care programs. It has hidden behind a veil of confidentiality meant to protect children
3 and families, but which the County has used to shield itself from oversight and criticism.

4 26. Among other things, it has failed and continues to fail to comply with federal
5 law requiring that it provide the public with findings and information concerning child abuse
6 victims who have died or suffered near fatalities. The little information available to the public
7 about the child welfare system is incomplete and out of date. The most recent data on child
8 abuse and foster care is from 2004.

9 27. Nevada and its counties receive millions of dollars in federal funds for the
10 provision of child welfare services and are therefore required to comply with federal
11 mandates, including those set forth in the Adoption and Safe Families Act of 1997, the Child
12 Abuse Prevention and Treatment Act, and the Early Periodic Screening, Diagnosis and
13 Treatment provisions of Medicaid law. In state fiscal year 2004, Nevada spent over \$79
14 million on child welfare services, of which \$44 million was federal funds.

15 28. This lawsuit also challenges the placement of children, and the conditions in
16 which they are forced to live, at Child Haven – an unlicensed child care institution operated
17 by Clark County. For years, Child Haven has not been a safe “haven” for the children and
18 youth placed there. Upon entering foster care in Clark County, children are placed at Child
19 Haven and remain there for as little as a few hours or as long as a year or more. For years,
20 unlike other facilities providing care to foster children in Nevada, Child Haven has been
21 allowed to operate without meeting the minimum licensing standards required by state law.
22 The Child Haven facility houses infants and young children alongside teenagers, some of
23 whom have significant behavioral problems and pose a risk of serious harm to the younger,
24 more vulnerable children in the facility. Child Haven is frequently extremely overcrowded
25 resulting in children sleeping on the floors and in gymnasiums, separated from their siblings
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1 and in conditions that have contributed to the spread of infectious disease at Child Haven.
2 Children's needs, particularly their need for mental health care, are not being met.

3 29. High caseloads and inadequate training of Clark County child protective
4 services and foster care workers contribute to the crisis within the system. Many workers'
5 caseloads exceed those established by national standards. Workers are ill prepared and
6 supervised to perform a job in which failure to abide by law, regulations, and professional
7 standards, and failure to exercise professional judgment results in serious injury to or death of
8 a child.
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10 30. Investigations of child abuse reports – both those involving children in foster
11 care and those left at home – routinely fail to comply with state law and professional
12 standards. As a direct result, children who could and should have been protected suffer
13 unnecessarily.

14 31. Clark County DFS has failed to recruit and retain a sufficient number of foster
15 homes, resulting in harm to children whose needs are mismatched with the foster parents'
16 experience and abilities. Placements are often made based solely upon whether or not there is
17 an available bed in the foster home. As a result, placements often break down, and children
18 are shuttled from one house, group home, and institution to another. Caseworkers fail to visit
19 children in these placements, and, as a result, are unaware of the quality of care the child is
20 receiving, the harm befalling the child, the risk to which the child is exposed, and the lack of
21 needed services.
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23 32. Children in foster homes recruited, licensed, and supervised by Defendants are
24 subjected to abuse and neglect in those homes. When there are complaints about foster
25 homes, Clark County DFS often turns a deaf ear, allowing children to remain in dangerous
26 homes that either should not have been licensed in the first place or should have had their
27 license revoked. At the same time, Clark County DFS retaliates against foster parents who
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1 advocate for services for a child placed in their homes or who disagree with the department's
2 plan for the child, driving out the very foster parents the system needs. Clark County DFS
3 also fails to provide foster parents with even the most basic background information about
4 children they place in their homes and the supportive services needed.

5 33. Children entering foster care have many special needs – for medical and
6 mental health care as well as educational and special educational services. Clark County DFS
7 fails to act as a responsible parent to children in its custody. As a result, foster children's
8 needs are not met and services are delayed or not provided at all, causing substantial harm to
9 these children.
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11 34. Children in foster care have no voice in the court proceedings where decisions
12 are made that affect their basic safety, their temporary and permanent placement, and their
13 general well-being. Even though state and federal law mandate appointment of a
14 representative to look out for the interests of the child in all cases, Clark County falls woefully
15 short of meeting this requirement.

16 35. If Defendants' unconstitutional and unlawful actions and omissions are not
17 halted, many more children will be harmed. Another generation of children entrusted to the
18 County and State will suffer untold misery, some will die, and others will leave the foster care
19 system ill prepared to live healthy, independent, and productive lives.
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21 IV.

22 CLASS ACTION ALLEGATIONS

23 36. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(a)
24 and 23(b)(2). Plaintiffs represent a countywide class of children who have been, are, or will
25 be victims of child abuse and neglect and have been, are, or will be in the legal custody of
26 Clark County DFS.
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1 37. The requirements of Fed. R. Civ. P. 23 are met in that the class is so numerous
2 that joinder of all members is impracticable. Furthermore, the class is fluid in that new
3 members are regularly created. There are over 3,600 children in foster care in Clark County.
4 Throughout the year, many more children enter care than is reflected in any single day census.
5 During 2004, for example, a total of 4,548 were removed from their homes and placed in
6 foster care.

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8 38. All the members share common issues of law and fact. All of the plaintiffs and
9 class members are in need of adequate child welfare services, must rely on Clark County DFS
10 and State DCFS Defendants for those services, and are harmed by Defendants' systemic
11 failure to fulfill their legal obligations to provide safe care, adequate treatment, and necessary
12 services. Questions of law and fact common to the class of plaintiffs predominate over any
13 individual issues of law and fact.

14 39. Specific common questions of fact include, but are not limited to,

- 15 a) Whether class members are placed at an overcrowded, unlicensed
16 congregate facility that fails to meet their needs;
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18 b) Whether class members are left in dangerous situations due to
19 Defendants' failure to conduct timely investigations of reports of abuse and
20 neglect;
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22 c) Whether Defendants fail to recruit and support an adequate array of
23 foster placements to meet the needs of class members;
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25 d) Whether class members are placed in homes and other facilities in
26 which they have been harmed or are at risk of harm;
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28 e) Whether class members are deprived of needed medical, mental health,
and dental care services;

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- f) Whether class members are provided with appropriate educational services;
- g) Whether class members are represented by a guardian *ad litem* in abuse and neglect proceedings in the Clark County District Court;

40. Specific common questions of law include, but are not limited to,

- a) Whether upon entry into foster care class members' placement in Child Haven, an unlicensed child care facility, violates Nevada and federal laws;
- b) Whether the failure to conduct timely investigations of complaints of child abuse or neglect involving class members violates their rights under Nevada and federal law;
- c) Whether the failure to properly screen, license, support and supervise foster homes in which class members are placed is a denial of their rights under Nevada and federal law;
- d) Whether the failure to provide class members with timely necessary medical and mental health screenings, assessments, and treatment denies their rights under Nevada and federal law; and
- e) Whether the failure to appoint a guardian *ad litem* for class members is a denial of their rights under Nevada and federal law;

41. The claims of the named plaintiffs are typical of the claims of the class they represent.

42. The named plaintiffs will fairly and adequately protect the interests of the class they represent. Plaintiffs know of no conflict of interest among the class members.

43. Each named plaintiff appears by a next friend, and each next friend is sufficiently familiar with the facts and circumstances surrounding the child's situation to fairly and adequately represent the child's interests in this litigation.

1 initiate an investigation within three days of completing the evaluation. Nev. Rev. Stat. Ann.
2 § 432B.260(4).

3 49. All child protective services investigations must include certain actions. In all
4 cases there must be a prompt face-to-face meeting with the child Nev. Admin. Code Ann. §
5 432B.155. If there are other children in the household, the caseworker must also assess the
6 protective needs of each of those children even though they may not be the subject of the
7 report. Nev. Admin. Code Ann. § 432B.150(3)(c).

8 50. The child protective service investigation must be completed within 30 days of
9 receipt of the report, at which time Clark County DFS must determine if the report is
10 substantiated or unsubstantiated. Nev. Admin. Code Ann. § 432B.170 (a). Upon completion
11 of the investigation, the department may file a petition with the juvenile court, provide
12 services to the family to ensure the safety of the child or children, or close the case.

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15 2. Protective custody and filing of petition

16 51. While conducting or upon completion of an investigation Clark County DFS
17 may decide to remove the child from the home and place the child in protective custody. Nev.
18 Rev. Stat. Ann. § 432B.390.

19 52. If the child is placed in protective custody, a juvenile court hearing must take
20 place within 72 hours to determine whether the child should remain in protective custody or
21 be returned home pending further action by the Court. Nev. Rev. Stat. Ann. § 432B.470(a).

22 53. Within ten days of the hearing on protective custody, Clark County DFS must
23 file a petition to initiate further child welfare proceedings or recommend against further court
24 action. Nev. Rev. Stat. Ann. § 432B.490(1)(a).

25 54. If the child is released from protective custody, Clark County DFS must
26 provide a range of services to help preserve the family and prevent further placement outside
27 the home, including, but not limited to: social work and counseling, psychological and
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1 medical services, parental education and services for treatment of substance abuse. Nev.
2 Admin. Code Ann. § 432B.240.

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4 3. Adjudicatory and dispositional hearings

5 55. An adjudicatory hearing must be held within 30 days of filing the petition.
6 Nev. Rev. Stat. Ann. § 432B.530(1)-(2). If the court finds that the allegations in the petition
7 are unsupported, the petition is dismissed and the child ordered released if he is in protective
8 custody. Nev. Rev. Stat. Ann. § 432B.530(5). If the court determines that the allegations in
9 the petition are true and that the child is in need of protection, Clark County DFS is required
10 to submit a report and recommendations for the disposition of the case. If the department
11 recommends that the child be removed from the custody of her parents, it must submit a plan
12 for ensuring that the child will receive safe, proper, and appropriate care in the placement, and
13 describe the services that will be provided to the child and her parents to facilitate the
14 reunification of the family. Nev. Rev. Stat. Ann. § 432B.540(2).

15
16 56. Upon receipt of the report and recommendation of Clark County DFS, the
17 court may order the child to remain in the custody of his parents with or without supervision
18 by Clark County DFS, place the child in the custody of a relative, or place him in the custody
19 of the department. Nev. Rev. Stat. Ann. § 432B.550.

20
21 4. Appointment of guardian ad litem

22 57. Upon the filing of a petition, the court must appoint a guardian *ad litem* for the
23 child. Nev. Rev. Stat. Ann. § 432B.500. The guardian *ad litem* must “represent and protect
24 the best interests of the child until excused by the court” and “inform the court of the desires
25 of the child, but exercise his independent judgment regarding the best interests of the child.”
26 Nev. Rev. Stat. Ann. § 432B.500(3)(a)&(g). Among other responsibilities, the guardian *ad*
27 *litem* is required to research the facts of the child’s case and ensure that the court receives an
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1 independent, objective account of the facts; meet with the child at the child's placement as
2 often as necessary to determine whether the child is safe and to ascertain that the placement is
3 in the child's best interests; participate in the development and negotiation of any plans or
4 orders regarding the child; monitor whether the plans are being implemented and appropriate
5 services are being provided; appear at all proceedings regarding the child; and present
6 recommendations to the court. Nev. Rev. Stat. Ann. § 432B.500(3).
7

8 5. Placement in and supervision of foster family homes

9 58. State DCFS is required to establish and ensure the counties' compliance with
10 minimum standards for foster family homes, group homes, and other child care facilities in
11 which foster children are placed. Nev. Rev. Stat. Ann. §424.020. In carrying out this
12 obligation, State DCFS is required to promulgate regulations establishing uniform standards
13 for the licensing of foster family homes, group homes, and child care institutions. Nev. Rev.
14 Stat. Ann. § 432B.190(1).
15

16 59. Clark County DFS is responsible for licensing foster and group homes in
17 which it places foster children in its custody and ensuring that those homes meet state
18 standards. Nev. Rev. Stat. Ann. §424.030; Nev. Rev. Stat. Ann. §424.016(1). Licensing is
19 required in order to protect children from abuse or neglect and ensure that the foster parent
20 can properly care for children. Nev. Rev. Stat. Ann. §§424.016; 424.030; Nev. Admin. Code
21 Ann. § 424.100.
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23 60. Upon being granted protective or legal custody of a child in foster care, Clark
24 County DFS selects the foster home or other setting in which the child is placed.

25 61. Any child care institution used for the placement of foster children must be
26 licensed by either the city, county, or state, depending on its location. Nev. Rev. Stat. Ann. §§
27 432A.131; 432A.220. Child care institutions located within Las Vegas must be licensed by
28

1 the city. Nev. Rev. Stat. Ann. § 432A.131. It is a misdemeanor offense to operate a child
2 care institution without a license. Nev. Rev. Stat. Ann. § 432A.220.

3 62. No family foster home can be licensed to care for more than six children,
4 excluding any children residing in the home who are related to the foster parent or who are
5 not foster children. The number of children for whom a home may be licensed must factor in
6 the foster parents' own children under the age of 16, as well as the characteristics of the
7 children in need of placement. No more than two children under the age of eighteen months
8 or four children under the age of five may be placed in the same home. Nev. Admin. Code
9 Ann. § 424.160.
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11 63. Before placing a child in a foster home, Clark County DFS must provide the
12 foster parent with information necessary to ensure the health and safety of the child and other
13 persons in the foster home. That information must include the medical history and behavior
14 of the child. Nev. Rev. Stat. Ann. § 424.038

15 64. Clark County DFS must supervise and monitor the child's care in a foster
16 home. At any time during the child's placement that it appears that a child lacks proper care
17 and management, the child must be removed from the home. Nev. Rev. Stat. Ann. § 424.060.
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19 65. Clark County caseworkers must have at least monthly face-to face contact with
20 children in foster care. At least bi-monthly, caseworkers must visit children in their foster
21 care placements. Nev. Admin. Code Ann. § 432B.405(a)&(b).

22 66. Clark County DFS must also provide support and services to the foster parent
23 including responding in a timely manner to requests for assistance and establishing a program
24 of respite care for foster parents to temporarily relieve them of the stresses and responsibilities
25 of caring for children. Nev. Rev. Stat. Ann. § 424.077; Nev. Admin. Code Ann. § 424.805.

26 67. Clark County DFS must complete an assessment for each child in DFS custody
27 at least semiannually. The assessment must include the current level of functioning of the
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1 family, the current risk to the child if he were returned to the custody of his parent, and the
2 services required to meet the child's needs as set out in his case plan. Nev. Admin. Code
3 Ann. § 432B.420(1). These assessments must be based, in part, on direct interviews with
4 family members of the child, personal observations of interaction at home and in the
5 community between the child and family members, case histories, and medical records. Nev.
6 Admin. Code Ann. § 432B.420(2).

8 6. Interstate placements of children

9 68. If a child is placed with any person who resides outside of the state, the
10 placement must follow the procedures and criteria set forth in the Interstate Compact on
11 Placement of Children ("ICPC"). Nev. Rev. Stat. Ann. § 127.330.

12 69. In adopting and enacting the ICPC, the Nevada Legislature sought to ensure
13 that: (a) each child requiring placement receives the maximum opportunity to be placed in a
14 suitable environment and with persons or institutions having appropriate qualifications and
15 facilities to provide a necessary and desirable degree and type of care; (b) the appropriate
16 authorities in a state where a child is to be placed may have full opportunity to ascertain the
17 circumstances of the proposed placement, thereby promoting full compliance with applicable
18 requirements for the protection of the child; (c) the proper authorities of the state from which
19 the placement is made may obtain the most complete information on the basis of which to
20 evaluate a projected placement before it is made; and (d) appropriate jurisdictional
21 arrangements for the care of children are promoted. Nev. Rev. Stat. Ann. §127.330.

22 70. The ICPC requires, among other things, that a child must not be sent to the
23 receiving state until the appropriate public authorities in the receiving state notify the sending
24 agency, in writing, that the proposed placement does not appear to be contrary to the interests
25 of the child.
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B. Federal statutory framework

1. The Adoption Assistance and Child Welfare Act of 1980, as amended by the Adoption and Safe Families Act of 1997: Titles IV-B and IV-E of the Social Security Act. 42 U.S.C. §§ 622 et seq.; 671 et seq.

71. States that meet federally established child welfare standards in the day-to-day operation of their child welfare programs are eligible for federal child welfare funding under Titles IV-B and IV-E of the Social Security Act. 42 U.S.C. §§ 622 et seq.; 671 et seq. Nevada has submitted a mandated State Plan describing how the State will assure compliance with federal child welfare requirements under these titles and receives federal child welfare funds.

72. Federal child welfare mandates with which Nevada must comply include the following: to place children only in settings that conform to national professional standards and are subject to a uniformly applied set of standards; to provide quality services that protect foster children’s safety and health; to provide each child with a written case plan containing specified elements, and a case review system with specified elements; to place each child in a safe setting that is the least restrictive and most family like setting; to provide updated health and education records to foster parents or foster care providers at the time of placement; and to provide notice and a right to be heard to foster parents and any preadoptive parent or relative providing care in any proceeding concerning the child. 42 U.S.C. §§ 671(10); 671(16); 671(22); 675(1); 675(5); 675(5)(A); 675(5)(B); 675(5)(D); 675(5)(G); 622(b)(10)(B)(ii).

2. The Child Abuse Prevention and Treatment and Adoption Reform Act (“CAPTA”), 42 U.S.C. § 5101 et seq.

73. The Child Abuse Prevention and Treatment and Adoption Reform Act (“CAPTA”), as codified at 42 U.S.C. §5101 et seq., provides federal grants to states to assist them in supporting their programs for abused and neglected children. To receive federal

1 money under CAPTA, each state must submit a State Plan outlining the areas of child
2 protective services the state intends to address with the funding, and it must ensure that it is
3 complying with the statutory provision. 42 U.S.C. § 5106a(b)(1)(A); 42 U.S.C. §
4 5106a(b)(2)(A)(ix). CAPTA specifically requires that every abused or neglected child who is
5 the subject of a judicial proceeding must be represented by a properly trained guardian *ad*
6 *litem*. 42 U.S.C. §5106a(b)(2)(A)(xiii).

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8 74. The guardian *ad litem* may be an attorney or a court-appointed special
9 advocate, or both. Since the original enactment of this federal mandate, Congress has
10 amended the provision several times to describe explicitly and amplify the duties of the
11 guardian *ad litem*. For example, the guardian *ad litem* must obtain a first-hand, clear
12 understanding of the situation and needs of the child and make recommendations to the court
13 concerning the best interests of the child. 42 U.S.C. §5106a(b)(2)(A)(xiii).

14 75. Nevada receives federal funding pursuant to CAPTA. State DCFS is
15 responsible for administering any federal funds, including CAPTA funds, for child welfare
16 services and ensuring county compliance with federal mandates. Nev. Rev. Stat. §
17 432B.180(1). It is required to plan, coordinate and monitor the delivery of child welfare
18 services provided throughout the state, as well as evaluate all child welfare services and
19 withhold money from any agency that is not complying with its regulations. Nev. Rev. Stat. §
20 432B.180(2); Nev. Rev. Stat. § 432B.180(6). State DCFS is also required to promulgate
21 regulations establishing uniform standards for child welfare services provided in the state.
22 Nev. Rev. Stat. § 432B.190(1).

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25 3. The Medicaid Act, Early and Periodic Screening, Diagnostic and Treatment
26 (EPSDT) Services, 42 U.S.C. § 1396 et seq.

27 76. Medicaid is a cooperative federal and state funded program designed to
28 provide medical and remedial services to low income people under Title XIX of the Social

1 Security Act, 42 U.S.C § 1396 et seq. States that choose to participate in the Medicaid
2 program receive federal matching funds for their own programs. To receive those funds,
3 states must adhere to the minimum federal requirements according to the Social Security Act,
4 its implementing regulations, C.F.R. §§ 430 et seq., and the Supremacy Clause of the United
5 States Constitution.

6 77. Federal law requires states to cover certain mandatory services, including Early
7 and Periodic Screening, Diagnostic and Treatment (“EPSDT”) services, for Medicaid-eligible
8 children under the age of 21. 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. §1396d(a)(4)(B).
9 Under EPSDT, states are required to provide screening services to identify defects,
10 conditions, and illness. States must then provide the necessary diagnostic and treatment
11 services to correct or ameliorate those conditions, whether or not such services are covered
12 under the state plan. 42 U.S.C. § 1396d(r); 42 C.F.R. § 441.56(b).

14 78. Nevada has chosen to participate in the Medicaid program. Under its Medicaid
15 program, Nevada must provide EPSDT services to eligible children under the age of 21.
16 Children under the age of 21 who are in foster care are eligible for Medicaid. Accordingly,
17 Nevada is mandated to provide EPSDT services to these children.

19 VI.

20 **FACTUAL ALLEGATIONS FOR NAMED PLAINTIFFS**

21 **Clark K.**

22 79. Clark is a seventeen-year-old youth who came into the legal custody of Clark
23 County DFS in July 2003. Prior to that time, the department had received ten reports of abuse
24 or neglect involving Clark and/or his siblings.

25 80. While in DFS custody, Clark has been placed in inappropriate and dangerous
26 placements, which have been harmful to his physical, mental, and emotional well-being. He
27 has been denied adequate food, clothing and shelter; subjected to frequent changes in
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1 placement; denied necessary medical and mental health care; denied an education and special
2 education services; separated from his siblings; denied other necessary services to meet his
3 needs; and denied access to any sort of representation by an attorney or guardian *ad litem*.

4 81. In September 1999, Clark's mother moved from Las Vegas to Texas, and took
5 Clark with her. Clark and his mother lived with approximately ten other relatives in a two-
6 bedroom trailer. Most of their food came out of dumpsters behind grocery stores because
7 Clark's mother spent her money on drugs. About a year later, Clark's mother took him with
8 her to live in Virginia. In Virginia, he was often left with strangers while his mother was off
9 buying, dealing, and taking illegal drugs. Clark missed many days of school due to his
10 mother's absence, neglect, and instability. As a result of these absences, Clark was held back
11 at least one grade.
12

13 82. In December 2001, Clark and his mother returned to Texas. Subsequently,
14 Clark contacted his grandparents in Las Vegas and pleaded with them to rescue him from the
15 unsafe and unhealthy living arrangement in Texas. His grandmother drove to Texas, and
16 brought Clark back to live with her and his grandfather in Las Vegas.
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18 83. Following Clark's arrival at their home, his grandparents contacted Clark
19 County DFS and shared information about the unsafe living environment Clark had endured
20 in Texas. At the advice of DFS, Clark's grandparents first became his legal guardians and
21 later became licensed foster parents. During the entire time that Clark lived with his
22 grandparents, he attended school regularly, got good grades, and was in good health. Clark's
23 younger brother also lived with him and his grandparents for much of the time.

24 84. On August 29, 2003, Clark was adjudicated a neglected child and placed in the
25 legal custody of Clark County DFS. DFS continued his placement in the home of his
26 grandparents. Clark did not receive notice of the adjudication hearing on August 29, nor was
27 he represented by an attorney or guardian *ad litem*. Although Clark's grandparents had
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1 discussed Clark's need for a Court Appointed Special Advocate (CASA) with his caseworker,
2 he was never provided one.

3 85. On September 17, 2003, a dispositional hearing was held on Clark's Petition
4 for Neglect. Clark's grandparents went to the courthouse to attend the hearing, but were
5 refused entry into the courtroom. Clark's caseworker knew that Clark's grandparents were at
6 the courthouse and that they wished to attend the hearing and provide input, but they were
7 denied an opportunity to express Clark's wishes or explain their concerns for his safety should
8 he be returned to his mother in Texas. Clark's caseworker did not notify Clark about the
9 hearing, tell him the purpose of the hearing, or ask him whether he wanted to go back to
10 Texas. Clark was given no opportunity to speak to the court or have anyone else represent his
11 interests. Had he been asked about his wishes, or allowed to speak at the hearing, he would
12 have told the court that he absolutely did not want to go back and live with his mother in
13 Texas and would have explained the reasons he was afraid to be placed with her.

14 86. Subsequently, Clark's caseworker told his grandparents and Clark that the
15 court had decided that he should be placed back with his mother in Texas. Clark's
16 grandparents were strongly opposed to this decision and expressed their concerns to Clark
17 County DFS. They sent letters to DFS caseworkers and administrators describing their
18 concerns regarding Clark's safety and health should he be returned to Texas. Clark County
19 DFS never responded to their letters or addressed their concerns.

20 87. Throughout October 2003, Clark County DFS attempted to get Clark's
21 grandparents to disenroll him from school and take him to the airport to go to Texas. They
22 refused.

23 88. On October 21, 2003, a Clark County DFS caseworker spoke to Clark for the
24 first time about his impending placement back with his mother in Texas. The caseworker told
25 Clark that he had spoken to Clark's mother and that she reported that she had a job, was not
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1 using drugs, and could take care of him. Clark responded: “It’s horrible down there... I know
2 my mom... she can’t keep a steady job ... she has been on drugs since I was little... I know
3 what it’s like down there. I don’t want to go.”

4 89. Despite Clark’s strong desire to remain with his grandparents, his articulated
5 concerns about going to live with his mother in Texas, and his history of neglect in Texas,
6 Clark County DFS nonetheless forced him to return to Texas. In late October 2003, Clark’s
7 caseworker picked Clark up at his house, drove him to the airport, walked him to security, and
8 put him on a flight to Houston, Texas.

9 90. Clark’s caseworker failed to complete an assessment of his safety before
10 returning him to his mother’s custody. The caseworker made no attempt to confirm what
11 Clark’s mother had told him during their brief phone conversations. He did not contact her
12 alleged employer, her alleged landlord, or the local Texas child protective services. Despite
13 her years of drug abuse, he did not require that she submit verification of successfully
14 completing treatment or that she submit to a drug screen. He also did not conduct any
15 criminal background check with Texas authorities. In addition, Clark County DFS failed to
16 comply with the requirements of the Interstate Compact on the Placement of Children, to
17 which both Texas and Nevada are signators. Nev. Rev. Stat. Ann. §§127.320-350; Tex. Fam.
18 Code § 162.101 *et seq.*

19 91. Had the caseworker conducted a reasonable investigation, he would have
20 learned that Clark’s mother was on probation for burglary, had been without a job for a very
21 long time, and had no suitable housing. She was sharing an overcrowded trailer with her
22 alcoholic parents, and was continuing to abuse drugs and alcohol.

23 92. After sending Clark to Texas, Clark County DFS essentially washed their
24 hands of him altogether. They made no efforts to determine whether he was safe with his
25 mother, nor did they follow up with anyone in Texas to ensure that his needs were being met.
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1 93. Once again, Clark led a miserable life in Texas. He initially lived with his
2 mother, maternal grandmother, and many others in a filthy trailer. At any given time, there
3 were at least eight people sharing the trailer with five or six dogs. Animal feces were littered
4 throughout. Clark slept on a filthy mattress on a bunk bed that he shared with his
5 grandmother, or he slept on the floor. Clark was surrounded by drug use and drug dealing.
6 His mother used and sold everything from marijuana to crack in Clark's presence. His
7 relatives stole his possessions (including clothes, shoes, socks, hats, CDs, a CD player, a
8 guitar, a backpack, and a bike), and sold them for drug money.

10 94. Clark often went several days without food. Although his mother was
11 receiving food stamps for him, she traded them for drugs. She and her parents frequently dug
12 food out of dumpsters for themselves and Clark to eat. At other times he would only have a
13 few crackers and applesauce. Much of the time, his only meal of the day was the free lunch
14 he received at school.

15 95. For the year and a half he was left in Texas, Clark was moved around among
16 various family members, moving about twelve times. Most of the time they moved from one
17 trailer park to another. At one point they were all living out of a truck with a camper shell on
18 the back. During most of his time in Texas, Clark was virtually abandoned by his mother.
19 She would frequently disappear on drug binges; she never held down a job; and she never
20 provided for his basic needs.

22 96. Although Clark was getting A's and B's in school when he lived with his
23 grandparents in Las Vegas, upon placement with his mother in Texas, his grades plummeted.
24 In some of the places he was taken to live, he had no transportation to school. He also never
25 received the special education services to which he was entitled based on previous
26 assessments and an IEP adopted while attending Clark County School District. In addition,
27 during the entire time he was in Texas, his mother never provided him with medication to
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1 address his attention deficit hyperactivity disorder, which made it even more difficult for him
2 to concentrate in school

3 97. Finally, in the spring of 2005, Clark managed to get in touch with his
4 grandmother in Las Vegas. With help from his sister, Clark took a Greyhound bus back to his
5 grandparents in Las Vegas.

6 98. Shortly after returning to Las Vegas, Clark's family contacted Clark County
7 DFS to tell them Clark had returned to live with his grandparents. Subsequently, DFS
8 attempted to locate Clark's mother, but was not successful. Despite the traumatic events
9 Clark experienced in Texas, DFS made no efforts to provide him with counseling or other
10 services. Clark County DFS also failed to provide him with any educational services to make
11 up for the significant time he was not in school. In the absence of any services or assistance
12 from DFS, Clark and his grandparents researched various training programs and decided that
13 Clark should attend Job Corps.

14 99. Clark was accepted at the Job Corps in Reno, and began living there and
15 attending classes and vocational training. However, on or around March 15, 2006, Clark went
16 missing. Although Job Corps officials notified Clark County DFS of Clark's disappearance,
17 little or no attempts were made to locate him. Even after the court directed DFS to do
18 everything in their power to find Clark, DFS took few, if any, steps to determine Clark's
19 whereabouts. At one point, Clark called the DFS hotline and told them he was ready to go
20 home to his grandparents, but DFS failed to take timely action to help bring him back to a safe
21 placement.

22 100. Clark lived on the streets in Reno for about three months, until he eventually
23 learned about a program called "Home Free" sponsored by the National Runaway
24 Switchboard. He was provided with a free one-way Greyhound ticket back to his
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1 grandparents in Las Vegas. He returned to their care on May 19, 2006, and has been living
2 with them ever since.

3 101. Since returning to Las Vegas, Clark has received almost no independent living
4 services, or any other kind of services from Clark County DFS. His caseworker has been
5 unresponsive to multiple calls from Clark's grandparents to follow up on securing needed
6 services. Clark is afraid to go back to school because he is now so far behind. He still has
7 significant unmet mental health needs, and lives with the fear that DFS could again take him
8 from his grandparents and send him to an unsafe placement against his will. He has difficulty
9 trusting adults or believing that anyone cares about him. He worries that people are like his
10 relatives in Texas – just waiting to do him in.
11

12 **A. Children**

13 102. Jalen, Sia, Roshaun, Caleb, and King A. are siblings - four boys and one girl,
14 ages eight, seven, five, four, and one, respectively. They have been in the custody of Clark
15 County DFS since December 2004. Their baby brother, Jerome, died in a DFS-licensed foster
16 home on April 3, 2005, at the age of 14 months.

17 103. While in DFS custody, these five children have been placed in multiple
18 inappropriate and dangerous placements that have been harmful to their physical, mental, and
19 emotional well-being. They have been placed in a restrictive, overcrowded, and dangerous
20 child care facility (Child Haven) for almost a year; subjected to further emotional and
21 physical abuse and neglect while in foster and shelter homes; placed in shelter and foster
22 homes that lacked the information and services to care adequately for their basic needs;
23 denied treatment and care to address their history of abuse and neglect; denied visitation and
24 contact with relatives; denied representation by either a guardian *ad litem* or an attorney
25 during their first year in foster care; and separated from each other for long periods of time.
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1 104. The A. children first came into foster care after the youngest sibling, King,
2 tested positive for drugs when he was born in December 2004. The children were initially
3 taken to Child Haven for a day, and then were split up and placed in three different DFS-
4 licensed foster and shelter homes. The three oldest children were placed in the foster home of
5 Joan Smith. About a month later, Caleb and Jerome were moved into the Smith home with
6 their siblings. King was placed in a different foster home, separated from his siblings.
7 While in the Smith home, the children were physically and emotionally abused as a result of
8 Clark County DFS's failure to provide adequate training, supervision, and support to foster
9 parents; failure to investigate reports of abuse and neglect; and failure to remove children
10 from dangerous placements.
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12 105. Within their first month of placement, Ms. Smith had difficulty caring for the
13 five children who at the time ranged in age from one year to six years of age. During this
14 time, Ms. Smith was also having problems with her troubled adopted daughter, who was
15 regularly running away from home. In February or March 2005, Ms. Smith began making
16 repeated requests to Clark County DFS, both verbally and in writing, to remove the children
17 from her home. Upon information and belief, DFS failed to respond to these requests and
18 failed to provide Ms. Smith with any supportive services to help her care for the A. children.
19

20 106. Clark County DFS also failed to investigate multiple reports of abuse and
21 neglect while the children were living at the Smith home. While visiting Jerome in the
22 hospital in February 2005, the children's biological father observed bruises on Jerome.
23 During another visit with all of the children, they told their father that they were being
24 mistreated at the Smith home by both the foster mother and her adopted daughter, and that
25 Ms. Smith would hit infant Jerome. Although the children's father made multiple reports to
26 DFS of the abuse occurring in the Smith home, DFS did not investigate the reports, and let all
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1 five children remain in the home until Jerome was tragically scalded to death on April 3,
2 2005.

3 107. Despite the reports of abuse in the home and Ms. Smith's requests to have the
4 A. children removed, Clark County DFS placed another infant in Ms. Smith's home in
5 February or March 2005. At this time, Ms. Smith had seven children in her home: the five A.
6 children, her adopted twelve-year-old daughter, and the new infant.

7 108. When she was originally licensed for foster care in August 2002, Ms. Smith
8 was granted a license for only three female children, ages 11-18 years. On April 16, 2004,
9 Ms. Smith was issued a Group Foster Home license for four male or female children, ages 0-
10 17 years. On its face, this license noted "there is only one bedroom allocated to foster
11 children in this home." Effective September 20, 2004, her capacity was increased to five
12 beds, and effective January 4, 2005, her capacity was increased to six beds. On April 1, 2005,
13 just two days before Jerome's death, her shelter care license for six beds was renewed.
14

15 109. Clark County DFS's increases in the licensed capacity of Ms. Smith's home
16 did not take into consideration her training, abilities, or demonstrated record of caring for
17 such a large number of foster children. Rather, it was based solely on the need for more
18 shelter care beds in the county.
19

20 110. On April 3, 2005, Ms. Smith left the A. children at home alone with her
21 teenage adoptive daughter. While Ms. Smith was at the hospital with her other foster infant,
22 fourteen-month-old Jerome was scalded to death in the bathtub at the Smith home. At least
23 two of Jerome's siblings witnessed his death.

24 111. On November 8, 2005, the City of North Las Vegas filed criminal charges
25 against Ms. Smith related to Jerome's death. Smith ultimately pled guilty and is currently
26 serving her sentence of a few months in a Clark County facility. Her foster care license was
27 revoked.
28

1 112. The day after Jerome’s death, his five surviving siblings were placed at Child
2 Haven. A few days later, all of the siblings except for King, who remained at Child Haven,
3 were placed in another foster home. During their first week at this home, the children were
4 left home alone at night multiple times. They were subsequently removed from this
5 placement after less than two weeks and returned to Child Haven where they remained from
6 April 2005 through May 2006 – over a year and a month.

7
8 113. For the thirteen months the A. children were in Child Haven, they were subject
9 to restrictive, overcrowded, oppressive conditions, and denied necessary services, resulting in
10 deterioration of their mental and physical health and well-being. At the time when they most
11 needed a caring environment, they were forced to give up their personal clothes and
12 belongings; were required to wear communal clothing; were not allowed to attend school in
13 the community for at least ten months; were given only limited visiting time with parents and
14 relatives; and were subjected to a point-based discipline system inappropriate for children of
15 their young ages — conditions that have lead Child Haven to be described as a “junior
16 prison.”

17
18 114. After King was moved back to the infant building at Child Haven, he
19 developed serious respiratory problems. His condition was so severe that he was not allowed
20 to go outside, and had to have breathing treatments twice a day. His condition persisted for
21 over nine months before he was taken outside Child Haven to see a specialist.

22 115. At Child Haven the A. children were denied needed mental health services to
23 help them cope with witnessing the death of their infant brother, as well as the abuse and
24 neglect they have experienced in their short lives. Jalen is the only child who has received
25 any mental health services, and the little counseling he was provided at Child Haven was on
26 an “as needed” basis and was inadequate to meet his needs. When the children’s aunt Tarrah
27 asked Child Haven staff why the children were not receiving mental health services following
28

1 the death of their infant brother, she was told by staff that Child Haven is “not a placement,”
2 and because of this DFS does not have to provide them with any services while they are there.

3 116. The children received inadequate educational services while at Child Haven.
4 Jalen and Sia, the two older children, never attended school in the community during the
5 entire year and a month they were placed at Child Haven; they were only allowed to attend
6 the on-site school with other children living at Child Haven. Caleb and Roshaun were finally
7 able to attend a school in the community for a half-day after they had been in Child Haven for
8 over ten months.

9
10 117. Tarrah visited the children at Child Haven about every other weekend from
11 April 2005 through March 2006. However, in the Spring of 2006, a County DFS caseworker
12 informed Tarrah that she could no longer visit with her nieces and nephews because it would
13 give them “false hope.” The caseworker did not allow Tarrah a goodbye visit with the
14 children nor did she allow Tarrah to explain to the children that she was not abandoning them,
15 but rather it was the department’s decision to terminate her visits. The children now have no
16 stable adult figure in their lives.

17
18 118. In May 2006, the children were moved from Child Haven to another foster
19 home. This is the fifth placement change for Jalen, Sia, and Roshaun since they entered Clark
20 County DFS custody in December 2004. It is Caleb’s fourth placement change, and King’s
21 third placement change since entering foster care in December 2004, and they are all at risk of
22 future placement changes, including being returned once again to Child Haven.

23 **B. Children**

24 119. Seven-year-old Summer, five-year-old Frank, and four-year-old Toni B. are
25 siblings. They have been in the legal custody of Clark County DFS since October 2002.

26 120. While in foster care, the B. children have been placed with a series of foster
27 parents who were given little background information about the children and were not trained
28

1 or supported to meet the children's special needs. As a direct and foreseeable result, the
2 children changed placements many times, with Frank and Summer experiencing between five
3 and seven placements within three months. The children were also physically and
4 emotionally abused in at least one foster home, and have been placed at Child Haven several
5 times. In addition, Clark County DFS failed to conduct a proper investigation of reports of
6 abuse of Summer and Frank, and failed to provide the children with needed health and
7 educational services. For the first year that the children were in DFS custody, they were not
8 represented by a guardian *ad litem*.
9

10 121. On October 3, 2002, Clark County DFS assumed legal custody of then eleven-
11 month-old Toni, three-and-a-half-year-old Summer, and two-year-old Frank when the
12 children were brought to Child Haven by a baby sitter who reported that the mother had
13 abandoned them. DFS petitioned the juvenile court to find the children abused and neglected
14 based upon the mother's history of substance abuse, including having taken
15 methamphetamine during her pregnancy with Toni, and the father's incarceration. The
16 children were placed in the DFS licensed shelter home of Marilyn Paikai, where they lived for
17 the next six months.
18

19 122. Upon their entry into foster care, all three children demonstrated multiple
20 special needs. Frank suffered anxiety attacks and night terrors, and often banged his head
21 from one side of the crib to the other in the middle of the night. His language skills were not
22 developmentally appropriate for a child his age. Summer was physically aggressive toward
23 her younger siblings, and her other behaviors suggested that she had been the victim of sexual
24 abuse. One of Summer's foster parents took her to the doctor after she complained of
25 "burning" on her "bottom," and the examination revealed that she had genital warts.
26 Although her therapist subsequently reported to Clark County DFS that she suspected
27 Summer had been sexually abused, DFS never investigated these concerns or reports. Toni
28

1 was underweight and emotionally disturbed. Her behavior was self-abusive - pulling her hair
2 out, banging her head on the walls and floor, and biting her arms. One mental health therapist
3 described little Toni as “a bundle of raw nerves.” Others suspected she suffered from Down
4 Syndrome. She was hypertonic and was very difficult to console and relax.

5 123. On April 9, 2003, all three children were removed from Mrs. Paikai’s
6 shelter home, supposedly to be placed in a permanent placement. However, they stayed at
7 their next foster care placement with the Jackson family for less than seven weeks before
8 being moved again. At the time the children came to live with them, the Jacksons were newly
9 licensed and had recently completed the foster parent training program. They had never cared
10 for any other foster children, and had no experience or training in caring for children with the
11 extent of special needs of Toni, Summer, and Frank. The Jacksons also had two young
12 children of their own - ages three and six.

14 124. Almost from the first day the children were placed in the Jackson foster home,
15 the foster parents began calling the caseworker asking for help with their care of the children.
16 They did not know how to respond to the children’s behaviors. Summer, for example, threw
17 temper tantrums, forced herself to vomit, and attacked her younger brother.

19 125. Clark County DFS did not return the foster parents’ calls nor did they provide
20 any supportive services that might have enabled the Jacksons to continue caring for the
21 children and prevented another disruption in the children’s placement.

22 126. On May 26, 2003, the Jackson foster father called and asked Mrs. Paikai, the
23 former shelter care mother, to provide them with respite by taking the children for the day.
24 She agreed and the foster father dropped off the children at her home. When the time came
25 for the foster father to pick up the children later that day, he refused to do so.

26 127. Mrs. Paikai then called Child Haven and reported that she had the children
27 back in her home but had bed space only for one. Child Haven staff told Mrs. Paikai to keep
28

1 the children and call back on Tuesday after the holiday weekend. The children remained in
2 Mrs. Paikai's home until the following Friday when the caseworker picked up Summer and
3 Frank, and decided that Toni would remain with Mrs. Paikai.

4 128. Toni remained in Mrs. Paikai's shelter home for more than two years – until
5 August 2005 - when she was returned to her mother on a trial basis. During the entire time
6 Toni was placed with Mrs. Paikai, her Clark County DFS caseworker made only one visit to
7 the foster home to check on the well-being of Toni.
8

9 129. For the next three months, between June and August 2003, Summer and Frank
10 were moved every two weeks from one foster home to another. Altogether they were moved
11 five or six times in less than three months. After being moved five or six times, they went
12 back to Child Haven for six weeks.

13 130. In each home selected by Clark County DFS, the foster parents were not
14 adequately trained nor did they have the experience and skills to provide the type of intensive
15 care that Summer and Frank required.
16

17 131. Frank was physically abused by the foster mother in one of the foster homes
18 through which County DFS shuttled Summer and Frank between June and August 2003. In
19 July 2003, during a visit with their biological mother, the children told her that the foster
20 mother was hitting them. Frank pulled down his pants and showed his mother a black and
21 blue bruise on his left hip the size of a baseball. The mother called the caseworker in and told
22 her about the bruise and what the children had said.

23 132. Following the mother's report of abuse in the foster home, the caseworker
24 failed to take pictures of Frank's injury. The caseworker did not refer the report of abuse to
25 an investigator, but instead took Summer and Frank out one at a time to talk to them. After
26 these conversations with the children and without conducting any investigation, the
27 caseworker took the children back to the same foster home the children had complained
28

1 about. Upon returning the children to this foster home, the caseworker merely reminded the
2 foster parent not to hit kids.

3 133. Several days after the children reported abuse in the foster home, the foster
4 mother called and admitted to Mrs. Paikai that she had hit Summer; she insisted that Summer
5 needed to be on medication to deal with her out of control behaviors. She also admitted that
6 she punished Summer by making her lay in her bed for four or five hours during the day.
7

8 134. The very next morning after the phone call from the foster mother, Mrs. Paikai
9 called the children's caseworker. She told her about the conversation she had with the foster
10 mother and expressed her concerns for the safety of the children. Following this call, the
11 caseworker removed Summer and Frank from the foster home - seven days after Frank
12 showed the bruise to his mother and she reported it to the caseworker.

13 135. Upon removing the children from the abusive foster home, the caseworker
14 asked Mrs. Paikai to keep them. However, Mrs. Paikai had no bed space available and was at
15 her licensed capacity. Nonetheless, with the plea of the caseworker that there was nowhere
16 else for the children to go, she agreed to keep them until the worker could find another home.
17 While they were back with Mrs. Paikai, Summer and Frank told her that the foster mother
18 threatened them with being sent back to Child Haven and told Summer that if she did not stop
19 crying, staff there would pull her eyes out.
20

21 136. Subsequently, Frank and Summer were placed with Mrs. Paikai's sister who
22 was a licensed foster parent. In the new foster home, the children demonstrated much of the
23 same behaviors and special needs that they had shown in the previous homes. Their new
24 foster mother repeatedly called the caseworker for support with the care of the children but
25 her calls, too, were never returned. For the entire two weeks the children were in this foster
26 home no one from Clark County DFS came to check on the children or responded to the foster
27 mother's pleas for help.
28

1 137. With no support, assistance, or response to her pleas for help, the foster mother
2 took the children to a therapist’s office in search of some assistance. When the therapist
3 called the caseworker, she told her to take the children back to Child Haven. Following these
4 instructions, the therapist transported the children back to Child Haven, where they remained
5 for another five weeks.

6 138. In August 2003, Summer and Frank were placed in the therapeutic foster home
7 of Rosie and Robert Beck. They lived in this home for two years.

8 139. At the end of August 2005, Clark County DFS returned all three children to
9 their mother — while maintaining legal custody. DFS did not perform the requisite safety
10 assessment prior to placing the children with their mother. Indeed, at the time the decision
11 was made, the caseworker stated that she was “95% certain that placement back with the
12 mother will fail.”

13 140. During the “trial” time with their mother, the children’s educational, mental
14 health, and medical needs went unmet. For the entire time that Toni lived with her mother she
15 was not enrolled in, nor did she attend one day of, school. She had previously been enrolled
16 at the early Program for Delayed Children of Clark County, and was receiving special
17 education services, weekly speech therapy, and occupational therapy. While living with her
18 mother, she did not receive any of the special education or related services she had been
19 receiving. As a result, Toni’s speech, behavior, and educational progress deteriorated
20 significantly. Her speech became unintelligible. Her medical needs also went unmet.

21 141. In October 2005, while back with her mother, Clark County DFS received a
22 report that Summer had a suspicious burn on her thigh. Upon information and belief, this
23 report was not properly investigated. School authorities also reported concerns about
24 Summer, and that she was missing many days of school. On several occasions during this
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1 “trial visit” with their mother, the children were caught in the middle of domestic violence
2 between their mother and her boyfriend.

3 142. On January 6, 2006, the trial placement with the children’s mother was
4 abruptly ended, and Toni, Summer, and Frank were returned to foster care. Upon information
5 and belief, the removal of the children was prompted by the mother’s failing a drug test and
6 calls from Summer’s school reporting that the children were being left alone.

7
8 143. The return of the children to foster care was handled in a manner inconsistent
9 with the safety, needs, and well-being of the children and in violation of professional
10 standards and common sense. After a loud and disturbing argument and struggle with their
11 mother in front of the B. children, the caseworker put the children in her car. She then called
12 Summer and Frank’s former foster parent, Rosie Beck, and asked her to meet her at major
13 intersection in Las Vegas. The caseworker then drove into a parking lot and handed off the
14 children to Mrs. Beck. Summer refused to get out of the car until the caseworker told her that
15 she would be taken to Child Haven if she did not go with Mrs. Beck. The caseworker
16 provided the foster mother with no paperwork or authorization to care for the children.

17
18 144. Upon the children’s return to foster care in January 2006, the Clark County
19 DFS caseworker did not contact Mrs. Paikai to ask if she would resume care of Toni and her
20 siblings. DFS refused to place Toni in the foster home in which she had spent most of her
21 life, despite the repeated requests of Mrs. Paikai. Instead, the agency placed the children with
22 foster parents who are in their sixties and have three other special needs children. Despite the
23 advice of Toni’s physician that it was in Toni’s best interest to continue contact with Mrs.
24 Paikai and her husband, DFS has cut off all contact between Toni and the Paikais.

25 **Donna C.**

26 145. Five-year-old Donna C. has been in the legal custody of Clark County DFS
27 since December 2004. She is currently placed in a DFS licensed foster home.
28

1 146. Since Clark County DFS assumed custody of Donna, she has been denied
2 necessary and appropriate medical, dental, and mental health care; removed from a foster
3 home in which she was receiving exemplary care; and subjected to mental and emotional
4 harm. In addition, she has at no time been represented by a guardian *ad litem* or attorney.
5 She has had no legal representation at court hearings, staffings, Child and Family Team
6 meetings, or in any other decision-making meetings held by DFS at which decisions were
7 made about her placement, treatment, and/or permanent plan.
8

9 147. Donna was removed from the custody of her mother and placed in foster care
10 due to her mother's addiction to drugs, multiple child molestation allegations her mother had
11 made against multiple partners, lack of stable living accommodations, her mother's criminal
12 history (which included serving four years in federal penitentiary for the sale and possession
13 of cocaine), and a Florida juvenile court's removal of Donna's older sister from her mother's
14 care and custody.

15 148. In 2005, Donna was returned to her mother on a trial visit with Clark County
16 DFS retaining legal custody. Upon information and belief, before Donna was reunited with
17 her mother, DFS failed to complete a safety and risk assessment. After Donna's placement
18 back with her mother, DFS failed to make regular visits to the home and monitor her care,
19 safety, and well-being. Upon information and belief, DFS also failed to provide services to
20 Donna and failed to continually assess whether her mother had achieved the goals and
21 objectives of the case plan. Shortly after Donna was placed back with the mother, her
22 assigned caseworker left or was reassigned and no other DFS caseworker was assigned to
23 Donna's case for several months.
24

25 149. While Donna was living with her mother, her mother stole a car, left Nevada
26 with Donna, and began traveling throughout the United States and Canada. For three or more
27 months, Donna lived in the stolen car with her mother and was subjected to a series of
28

1 traumatizing events. Her mother drove from one state to another, evading authorities and
2 engaging in illegal conduct including the purchase of illegal drugs. Donna was often forced
3 to accompany her mother into truck stop bathrooms in which she witnessed her mother buy,
4 sell, smoke, snort, and inject drugs. Donna also endured mental torment and torture. She was
5 terrorized by her mother's paranoia and began herself to believe and participate in it. For
6 example, she was not permitted to drink water because her mother was convinced that all
7 water was poisoned by the "cult." She frequently had Donna crawl under the car to look for a
8 global tracking device she believed the "cult" had put there.
9

10 150. During the months Donna was with her mother, she went without food and
11 water for long periods of time. She developed an eating disorder characterized by excessive
12 chewing of her food, failing to swallow it, and then gagging. She was confined to the car for
13 long periods of time and denied exercise and play.

14 151. While in the care of her mother, Donna was repeatedly exposed to domestic
15 violence in which she was often caught in the middle of physical fights between her mother
16 and her mother's boyfriend. From a very early age, Donna's mother told her that she had
17 been sexually molested by members of the "cult."
18

19 152. As a result of her months of living with a severely emotionally disturbed and
20 drug-addicted mother, Donna suffered long-lasting harm the full impact of which is not yet
21 known.

22 153. In December 2005, Donna's mother was arrested in New Mexico and charged
23 with auto theft. Law enforcement authorities in New Mexico discovered that Donna was in
24 the custody of Clark County DFS and made arrangements to have her returned to Las Vegas.

25 154. On December 12, 2005, Donna was returned to Las Vegas. She was taken by a
26 DFS caseworker from the airport directly to the foster home of Ernest and Jacquelyn Romero.
27 When she arrived at the Romero home, she had nothing but a small bag of severely worn
28

1 clothing stained with cat urine and feces. She had no toys, and not even an extra pair of clean
2 underwear.

3 155. Since County DFS was not visiting Donna while she was placed with her
4 mother or otherwise monitoring her care, several months went by before DFS discovered that
5 Donna had been abducted. Indeed, DFS first learned that Donna was no longer in Las Vegas
6 when they were contacted by New Mexico authorities in December 2005.

7
8 156. Three days before her placement in the Romero's home, a Clark County DFS
9 caseworker contacted them to ask if they would accept Donna. Although Donna had been in
10 foster care before her abduction by her mother, DFS provided almost no information about
11 Donna, other than her age, to the prospective foster parents. They were told that Donna had
12 no known behavioral problems or sexual abuse history.

13 157. Upon her return to foster care, Donna weighed approximately thirty pounds.
14 Her bones were sticking out; she appeared anorexic. Her muscles were atrophied as a result
15 of sitting in the car for days at a time.

16 158. Despite her physical condition and the trauma she experienced, Clark County
17 DFS failed to conduct a comprehensive health or mental health assessment of Donna when
18 she returned to foster care. Donna's caseworker told the foster parents a few days after Donna
19 was placed with them that she needed counseling, but made no arrangements for an
20 assessment to gauge the severity of her physical and mental health problems. The Romeros
21 did not even receive a Medicaid card for Donna until several months after she was placed in
22 their home.

23
24 159. Donna did not receive prompt, appropriate treatment to help her cope with the
25 harm caused by months of living with her severely mentally ill mother. She was placed on a
26 waiting list for several months. Almost four months elapsed before she was seen by any
27 mental health professional.
28

1 160. While in the Romero home, Donna flourished and began to recover from the
2 harms she had suffered while on the road with her mother. When she came to the Romero
3 home, Donna did not know her ABCs, or numbers. With the daily help of the foster mother,
4 Donna made great strides.

5 161. The Romero home is the type of foster home Clark County DFS should retain
6 and try to replicate, if possible. The Romeros possess the attributes foster families need to
7 help children brought into foster care. The Romeros are licensed as a flex family, meaning
8 they are dually licensed as an adoptive and foster home. The Romeros wanted to adopt
9 Donna, and conveyed this to DFS. However, they were also prepared to provide her with a
10 stable foster care home even if adoption was not the placement goal.
11

12 162. On or about April 25, 2006, a hearing was scheduled in the Clark County
13 District Court to review Donna's case and to determine, among other things, if a petition to
14 terminate parental rights should be filed. Prior to this hearing, Donna's foster parent sent a
15 letter to the juvenile court judge presiding over Donna's case. In her letter, Mrs. Romero
16 described Donna's condition when she arrived at the foster home, their concerns for her safety
17 and well-being, and the progress she had made since she came to live with them. She
18 expressed her concerns about Donna's safety if returned to her mother, based on Donna's
19 statements and information that her mother herself had shared about her drug abuse history.
20 Finally, she asked the court to consider revising Donna's visitation plan to ensure that her
21 mother could not leave town with her again.
22

23 163. On May 4, 2006, Mrs. Romero was summoned to a meeting at Clark County
24 DFS where for two hours she was confronted and criticized by five members of the DFS staff
25 for having written a letter to the juvenile court judge in Donna's case. Donna's caseworker
26 was upset that she wrote the letter without asking DFS for permission. The caseworker
27
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1 retaliated against them by beginning to plan for Donna's removal from their home despite the
2 fact that she was receiving exemplary care.

3 164. For Donna's birthday, her foster parents were planning a party. It would have
4 been the first birthday party Donna had ever had. They told the caseworker about the party,
5 and asked that any placement changes of Donna be postponed until at least after her birthday
6 party. The worker refused. She removed Donna from the Romeros' home ten days after the
7 meeting at DFS and just before her birthday.
8

9 165. Donna's therapist advised the County DFS caseworker that removing Donna
10 from the Romero home would be harmful and detrimental to Donna's well-being. During the
11 almost six months Donna was living with the Romeros, she developed an attachment not only
12 to the foster parents, but also to their seven- year-old daughter. As a direct and foreseeable
13 result of the abrupt, unplanned, and wholly unjustified removal of Donna from the Romero
14 home, she suffered significant mental distress and emotional harm.
15

16 VII.

17 CLARK COUNTY'S CHILD WELFARE SYSTEM IS DESPERATELY 18 IN NEED OF REFORM

19 166. Defendants have long known of the urgent need for systemic reform of
20 Nevada's child welfare system. Numerous reports have demonstrated that the system fails to
21 protect and actually affirmatively harms many of Nevada's abused and neglected children.
22 The failures of Clark County's child protection and foster care system have been open and
23 notorious for years.

24 167. Between February 2004 and August 2006, local newspapers and television
25 stations in Las Vegas reported on the child abuse or neglect deaths of more than twenty-four
26 children in Clark County. A substantial number of these children were in foster care with
27 Clark County DFS; had an open child protective services case with DFS at the time of their
28

1 death; or had a history of involvement with child protective services and a case that had been
2 closed by DFS despite strong indications that the child was at risk.

3 168. In 2004, the Administration of Children and Families of the United States
4 Department of Health and Human Services (“Federal DHHS”) conducted a performance
5 review of Nevada’s child welfare system. The review, referred to as a Child and Family
6 Service Review (“CFSR”), was designed to determine whether Nevada’s child welfare system
7 substantially complies with the requirements of the “State’s Plan for Title IV-E of the Social
8 Security Act Foster Care” and was meeting children’s needs for safety, well-being, and
9 permanency. All states are required to have a State Plan in order to access Title IV-E foster
10 care funds. During the CFSR review process, Federal DHHS identified numerous concerns
11 related to Clark County’s child welfare system, as discussed below.
12

13 169. In October 2005, State DCFS conducted a review of a sample of child welfare
14 cases from Clark County DFS. The 2005 County Case Review assessed DFS performance in
15 protecting child abuse victims and foster children from harm, achieving permanent
16 placements for them, and promoting their physical and emotional well-being. The children
17 whose cases were reviewed included children in foster care and children left in their home
18 after a report of suspected abuse/neglect. The case review instrument used was adapted from
19 the tool used by federal reviewers who conducted the CFSR of the State’s child welfare
20 program in 2004.
21

22 170. In six of the seven outcome measures used to assess Clark County DFS’s
23 protection and care of children, reviewers found that DFS failed to achieve a minimally
24 acceptable level of performance. More specifically, the 2005 County Case Review found that
25 DFS failed to conduct appropriate assessments prior to removing children from their homes or
26 returning them to their homes; failed to conduct legally required visits with foster children;
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1 failed to address the educational needs of children in foster care; and failed to ensure that
2 foster children received needed health care and mental health services.

3 171. Many of the findings of the 2005 County Case Review were corroborated by a
4 more recent review of child abuse cases in Clark County. In December 2005, after several
5 meetings with plaintiffs' counsel, the Nevada DHHS began an analysis of Clark County's
6 alarming child fatality data. Based on concerns relating to child welfare practices raised by
7 this preliminary analysis of fatality data, State DCFS contracted with the National Center for
8 Child Death Review to conduct an in-depth study of 79 suspected child abuse/neglect deaths
9 that occurred between 2001 and 2004. A panel of child welfare experts from outside Nevada
10 was hired to manage the review process.

12 172. The panel made numerous findings regarding systemic problems, including:
13 failure to respond to hotline calls promptly; failure to conduct appropriate safety assessments;
14 and failure to substantiate reports of abuse and neglect that should have been substantiated.
15 The panel also identified significant deficiencies relating to case practices, including; failure
16 to make monthly visits with foster children; failure to provide children and families with
17 needed services; and failure to prepare service or safety plans for children and families. In
18 addition, the panel noted that there was inadequate training for caseworkers and that the
19 system did not have adequate resources and staffing to meet children's needs.

21 173. On August 11, 2006, Federal DHHS took the unusual step of informing the
22 State of Nevada that it intended to renegotiate the State's Program Improvement Plan due to
23 worsening conditions for abused and neglected children in Clark County. Federal DHHS's
24 rationale for taking this step included that there were "[s]erious deficiencies in the State's
25 child welfare program, most specifically Clark County"; and that there was "[c]onsistent
26 overcrowding at Child Haven and recent tragedies involving children in foster care." Federal
27 DHHS further stated that "the manner in which the continuum of child welfare services is
28

1 managed in Clark County should be a grave concern to the State and should be addressed by
2 the State in its administration and supervision of the program.”

3 **A. Abused and neglected children in Clark County are placed in an unlicensed,**
4 **overcrowded, and unsafe facility for extended periods of time**

5 174. Defendants’ failure to recruit, train, support, and retain a sufficient number of
6 foster homes has resulted in over reliance on Child Have, a large, unlicensed congregate care
7 facility in Las Vegas. Nearly all children who have been removed from the homes of their
8 parents because of suspected abuse or neglect are first taken to Child Haven. Children
9 frequently are forced to stay at Child Haven for long periods of time because there are no
10 available beds at foster family shelter homes.

11 175. Upon admission to Child Haven, children are stripped of their clothes and all
12 personal belongings. Throughout their stay at Child Haven, children are not permitted to
13 wear their own clothes - not even their own underwear - but are periodically issued clothes
14 and shoes from a communal pile of clothing. Oftentimes the clothes and shoes do not fit, and
15 may not even match the child’s gender.

16 176. Children placed at Child Haven are forced to live in overcrowded buildings
17 where they sometimes sleep on the floor, are not provided with the health, educational or
18 therapeutic services they need, and often act out their justifiable rage at being treated
19 neglectfully. Their basic emotional needs are not met and they are not given even basic
20 information about the plans the agency has for them.

21 177. Child Haven is an unsafe place for children. A growing number of children
22 with significant behavioral and emotional/mental health problems are placed at Child Haven.
23 Youth with a history of admissions to psychiatric hospitals, on psychotropic medication, and
24 with behaviors requiring the use of physical restraints by staff, present a frequent danger to
25 other children and staff. Older teens, some with a history of delinquent behavior, reside on
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1 the same campus, in close proximity to and sharing some common areas with toddlers and
2 elementary school age children.

3 178. For years, Defendants have failed to address the problem of runaways from
4 Child Haven. Some youth are allowed to “walk away” from the facility when behaviors
5 escalate to a point that staff determine that it is in the best interests of other children at Child
6 Haven that they be allowed to run away. While on runaway, these youth have engaged in
7 dangerous, sometimes life-threatening behaviors. During August 2006, a youth who had run
8 away seven times from Child Haven was murdered on the streets of Las Vegas. County DFS
9 has done little to address the chronic problem of runaways from Child Haven thus placing
10 children and youth at substantial risk of harm.

12 179. In 2004, federal reviewers found that “there is no monitoring or oversight
13 process for Child Haven.” This finding and the continued operation of Child Haven without a
14 license, they concluded, was a violation of federal mandates that the state develop and
15 implement standards to ensure that children in foster care are provided with quality services
16 that protect the safety and health of children.

18 180. Following another site visit by federal officials to Child Haven in the summer
19 of 2006, federal officials notified Defendants that “the situation (at Child Haven and within
20 other parts of Clark County’s child welfare system) had worsened since the on-site visit” in
21 February 2004. Federal officials concluded that “immediate and ongoing attention” was
22 needed to ensure the safety, permanency, and well-being of children placed at Child Haven.

24 181. During the last couple of years, a number of factors have compounded the
25 inevitable risk and harm to children admitted to Child Haven. The problems resulting from
26 chronic, increasingly severe overcrowding are exacerbated by the admission of children and
27 youth with ever more serious and challenging behaviors, the agency practice of compelling
28 staff from other sections of the agency to work overtime at the buildings, the use of untrained

1 volunteers, and the failure to provide children with the necessary assessments and therapeutic
2 interventions to meet their needs.

3 182. Federal law forbids the use of federal funds for institutions caring for more
4 than twenty-five children. As a result, Clark County does not receive any federal funds to
5 defray the \$9 million per year that it costs to support the 6,000 children that pass through or
6 reside at Child Haven in a year. Despite this fact, federal officials notified Nevada that
7 “[w]hile Child Haven placements are not eligible for Title IV-E reimbursement, the children
8 placed in this unlicensed congregate facility are the responsibility of the State of Nevada not
9 just Clark County.”

11 183. Current social science research provides substantial evidence that the care
12 children and youth receive in group care and shelters like Child Haven is far more expensive
13 and less beneficial than care provided in foster family homes. As Richard Barth, the current
14 Dean of the School of Social Work at the University of Maryland wrote recently, “[c]ounties
15 across the United States have been closing child welfare shelters - at times, as a result of court
16 orders – but mostly because it is humane and cost effective...The money [spent to operate
17 large shelters like Child Haven] could be more effectively spent in recruiting and providing
18 training and support for foster caregivers.”

20 **B. Child Haven has been chronically overcrowded for years**

21 184. Child Haven was designed to be a temporary shelter while children await
22 placement with their relatives or in a more family-like setting. Child Haven’s campus
23 consists of eight buildings and an on-grounds school. One building is used for visits between
24 parents and children and/or administrative purposes; it is not used to house children. Each of
25 the seven buildings used to house children has a capacity for 12 children except for the
26 infants’ building, which has a capacity for 20 infants. Accordingly, Child Haven currently
27 has a total capacity for 92 infants, children, and youth.
28

1 185. Despite its large size, Child Haven is chronically overcrowded, with many of
2 the buildings housing more than twelve children. Overcrowding has been tolerated for years.
3 For all but a few months since January 2003, the number of children housed at Child Haven
4 has exceeded capacity. The average daily population has been as high as 160 children or
5 higher, and has frequently been 146 or higher.

6 186. The overcrowding at Child Haven has worsened since October 2005, most
7 recently reaching more than 220 infants, children, and youth. Overcrowding in the Agassi
8 building – reserved for a maximum of twenty newborns and infants – is endemic. During the
9 first week of April 2006, there were 56 infants in several buildings at Child Haven.
10

11 187. In recent months the situation has become so dire that the staff lunch room was
12 converted into an annex for infants. Cribs are stacked one against the other in a room not
13 intended or designed for the care of infants.

14 188. Overcrowding at Child Haven is not limited to the infant and toddler buildings.
15 On December 9, during a “special evening inspection” of Child Haven by the Clark County
16 Health Department, the inspector noted overcrowding in the Bigelow building. The Bigelow
17 building is for boys between the ages of five and ten. Instead of the usual 18 children, on that
18 evening there were 26 children being housed in the building. Several children had no
19 bedroom, and were forced to sleep on the floors of the common areas of the building. These
20 children slept on mats placed on the floor.
21

22 189. Most recently, the federal government weighed in on the chronic overcrowding
23 at Child Haven. As of June 30, 2006, there were 205 children living at Child Haven, over half
24 of whom were between the ages of 0-4. Federal DHHS stressed the need to develop
25 immediate strategies to address this and other problems at Child Haven.
26

27 **C. Conditions at Child Haven endanger children and do not promote their well-**
28 **being**

1 190. Overcrowding at Child Haven has contributed to and exacerbated the
2 frequency and severity of outbreaks of infectious and communicable diseases among the
3 children placed there. On August 1, 2005, the Clark County Health Department reported an
4 outbreak of hand-foot-mouth disease. A September 30, 2005 Health Department survey
5 reported a concern of possible Methicillin-resistant Staphylococcus aureus (MRSA) among
6 children in Child Haven. On that occasion, a two-year-old boy was found to have an MRSA
7 infection of the eye and a 10-month-old girl suffered an infection on her buttocks. The boy
8 was taken to Sunrise Hospital for a culture to determine if the suspected infection was MRSA,
9 but was returned to the Child Haven building before the culture results were obtained thus
10 exposing other children to the risk of infection.

12 191. In addition to these health concerns, there are also no standards in place to
13 ensure that children's health, mental health, and educational needs are met. No individual
14 assessments of children's needs are conducted while they are placed at Child Haven, and as a
15 result, their treatment needs go unidentified and neglected and informed decision-making to
16 select the child's next placement does not occur.

18 192. Clark County DFS considers Child Haven to be a temporary placement even
19 though many children stay for weeks, months, and years at a time. Because of the purported
20 short-term nature of the placement, DFS does not arrange for or provide services for many of
21 the children in need of special treatment and services.

22 193. Children who are discharged from Child Haven are not prepared for what is
23 ahead. A child is given little or no explanation of where they are being placed and who will
24 be their next caregiver. They are given no opportunity to meet the caregiver before being
25 abruptly transferred to the next placement. They have no voice in the selection of the
26 placement.

1 **D. Placement of infants and toddlers at Child Haven is harmful, contrary to the**
2 **overwhelming opinion of mental health, child development and child welfare**
3 **experts, and contrary to federal and state mandates**

4 194. Infants entering foster care have very high rates of risk factors for
5 psychopathology, medical illnesses, and developmental delays, and consequently have
6 extensive service needs. Sixty to eighty percent of young children entering care have at least
7 one medical illness and twenty-five percent have three or more chronic conditions. As many
8 as three-quarters of young children in placement need further developmental evaluation or
9 have a developmental delay.

10 195. Infants and toddlers, in particular, are most susceptible to long-term
11 detrimental effects as a result of placement, even for relatively short periods of time, in
12 institutions. The first three years of a child's life are the most critical period for brain
13 development, as this is the time when the brain is in an unparalleled time of developmental
14 change.

15 196. Infants and toddlers need the presence of a primary caregiver to form an
16 attachment to in order to develop normal emotional bonds and socialization skills. Having
17 already suffered the trauma of abuse and neglect by a primary caregiver, they have an even
18 greater need for a stable, nurturing, individual caregiver.

19 197. Children in Child Haven end up interacting with a multiple shift-work staff.
20 At Child Haven, infants and young children receive care from an ever-changing and large
21 number of different caretakers, which is contrary to their well-being and harmful to their
22 development. There is no one person who provides consistent care for each infant. It is
23 estimated that in a week, an infant may have as many as twenty different caregivers. Staff,
24 though well-meaning, are simply unable to respond to each child's individual cues and unable
25 to attend to each child's individual needs. Shelter care institutions like Child Haven tend to
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1 be more concerned with the children’s physical care and establishment of routine, rather than
2 the development of appropriate social interaction, language development, and autonomy.

3 198. The placement of infants and toddlers in Child Haven is at odds with the
4 mandate of federal law that children in foster care must be placed in the least restrictive, most
5 family like setting consistent with the best interest and special needs of the child.

6 199. Placement of infants and toddlers in Child Haven runs counter to the
7 overwhelming opinion of experts in the field of child welfare, infant mental health, and child
8 development. It is also against the overwhelming weight of current social science and infant
9 mental health research. That research confirms that children living in institutions like Child
10 Haven tend to suffer from motor and language delays and display a lack of attachment and
11 sense of trust, a restricted range of emotion expressions, and an absence of social play. In
12 comparison to children placed in foster family homes, these children show poorer
13 development and social emotional functioning.

14 200. Clark County DFS’s practice of placing infants at Child Haven also is
15 inconsistent with its own determination, as stated in a 2004 Clark County Audit Department
16 report, that “based on research ... infants and small toddlers under 3 years of age ... have
17 been shown to do better in a home with consistency in their caregivers versus those placed in
18 an institution.”
19
20

21 **E. Children remain housed at Child Haven for months and sometimes years**

22
23 201. Child Haven is intended to be a short-term placement for children taken into
24 custody. Clark County DFS policy specifies that children are not to be placed in the shelter
25 for longer than two weeks. Despite this policy, many children, including infants and toddlers,
26 remain in Child Haven for long periods of time.
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1 202. In 2004, community stakeholders interviewed as part of the federal CFSR
2 expressed concerns about the number of infants and very young children who are placed in
3 Child Haven and who remain in the shelter for long periods of time.

4 203. As of June 2006, the average length of stay was 45 days, with many children
5 remaining at Child Haven for three to six months, and sometimes a year or longer. According
6 to Federal DHHS, one child had been living in Child Haven for over two years.

7
8 **F. Child Haven operates without the required license**

9 204. Although Nevada law requires all child care facilities operating in the state to
10 obtain a license from the appropriate government agency before accepting children, Child
11 Haven has operated for years without a license. Child Haven, which is subject to licensure by
12 the City of Las Vegas Child Care Licensing Board, has also never complied with the licensing
13 standards established by state law.

14 205. More than two years ago, as part of a federal CFSR, reviewers noted that Child
15 Haven operated without the necessary license. County and State Defendants were directed as
16 part of their Program Improvement Plan to ensure that Child Haven met all applicable
17 licensing requirements. A deadline of January 31, 2006 was established for compliance with
18 this provision of the PIP. Child Haven was not licensed as of January 31, 2006, and continues
19 to operate in violation of the applicable licensing statutes, regulations, and standards
20

21
22 **G. Staffing and training at Child Haven are woefully inadequate**

23 206. Buildings at Child Haven are staffed by a combination of full-time employees,
24 part-time staff, temporary employees, and volunteers. Child Development Specialists staff
25 each of the buildings working in three shifts around the clock.

26 207. Direct care staff receives a mere two days of training in what the agency calls
27 the Child Haven Active Teaching Treatment Approach (CHATTA). During what amounts to
28

1 no more than twelve hours of actual training, staff receive half-hour segments on such
2 subjects as principles of behavior, relationship building, youth rights, and working with the
3 school. Furthermore, the CHATTA model has little or no empirical basis and its use with all
4 age groups of children is inappropriate.

5 208. The number and qualifications of staff at Child Haven are inadequate to ensure
6 the care, protection, and well-being of children at the facility. Overcrowding at Child Haven
7 has led to requests and/or demands from the DFS director that other DFS staff not employed
8 at Child Haven volunteer for duty at Child Haven. County DFS caseworkers who are
9 encouraged or coerced into volunteering to staff Child Haven are not trained in the care or
10 supervision of the infants, children, and youth at the facility, thus placing those children at
11 risk.
12

13 **H. Defendants' failure to conduct proper child abuse and neglect investigations and**
14 **make reasonable efforts to keep children safely at home is harmful to children**

15 209. Multiple studies of casework practices in Clark County have indicated that
16 DFS is failing to conduct adequate investigations of allegations of child abuse and neglect.
17

18 210. In the October 2005 County Case Review conducted by State DCFS, the
19 reviewers found that children were removed from home without conducting a safety
20 assessment to determine whether they could remain safely at home with provision of
21 supervision and services to the family. The review also found that Clark County DFS failed
22 to conduct ongoing safety and risk assessments to monitor children left in their homes.

23 211. These findings were reinforced in the study conducted by the National Center
24 for Child Death Review. The panel concluded that Clark County DFS has failed to
25 investigate numerous child deaths despite evidence of substance abuse, prior substantiations,
26 significant neglect, and lack of supervision; failed to perform timely safety assessments
27 relating to other children living in the home following a child death; and failed to substantiate
28

1 numerous reports of abuse and neglect that should have been substantiated. The panel also
2 found that DFS failed to respond to hotline calls promptly, leaving some callers on hold for
3 over 55 minutes and resulting in 27% dropped calls.

4 212. Based on the federal Program Improvement Plan review and a recent on-site
5 visit to Clark County, Federal DHHS again echoed findings in previous reports of severe
6 problems with CPS investigations in Clark County. Federal DHHS concluded that Clark
7 County does not have a 24 hour, seven day a week Child Protective Services Response team,
8 which results in many children being unnecessarily removed by law enforcement and taken
9 directly to Child Haven. Children who are removed from their homes by law enforcement are
10 not provided with a safety or family risk assessment. Moreover, Federal DHHS noted that
11 employees staffing the child abuse hotline have been deployed by the shelters to handle
12 shelter intake, resulting in even longer waits and hotline calls going unanswered.

14 213. Child abuse investigations often are not completed within a reasonable time
15 thus placing children who are the subject of such reports and their siblings at tremendous risk.
16 In recent months, there have been more than 340 investigations that are still pending and
17 unresolved more than 45 days after the initial report of suspected abuse or neglect was
18 received by Clark County DFS.

20 214. In addition to inadequate investigations, Clark County DFS has also failed to
21 make reasonable efforts to ensure that families receive services that would allow children to
22 remain safely in their homes. Federal DHHS has found that “there is an inadequate array of
23 services to prevent placement by providing in-home family support services that are
24 integrated and facilitate the ability of children to remain in their own homes or return home in
25 a timely manner.”

26 215. Nevada’s Court Improvement Program workgroups have also identified the
27 overall lack of services as a significant problem, and identified three areas in which services
28

1 are particularly needed: substance abuse, mental health, and developmental delays. Courts in
2 Nevada have begun levying fines on State and county agencies for failing to provide children
3 and families with needed court-ordered services.

4 **I. Defendants fail to place children in safe, appropriate, stable foster home**
5 **placements and supervise and support those placements**

6 216. Defendants' over-reliance on Child Haven is fueled, in part, by their failure to
7 recruit an array of suitable foster homes to meet the needs of Nevada's abused and neglected
8 children.
9

10 217. Clark County DFS also fails to follow up on foster and adoptive parent
11 inquiries from its own recruitment campaigns. A recent recruitment campaign received 1,340
12 inquiries, but only resulted in 24 new foster homes. Many inquiries from prospective foster
13 parents were not pursued in a timely manner.

14 218. Clark County DFS has failed to devote the staff and other resources necessary
15 to recruit, train, and retain an adequate number of foster parents to meet the needs of children
16 in foster care. Clark County has only one full-time foster parent recruiter and one foster
17 parent trainer. Washoe County, with one-fourth the number of children in foster care, has
18 three full-time recruiters and three full-time trainers. Clark County DFS continues to employ
19 the same recruitment strategies from year to year with the same poor results.
20

21 219. Due to the shortage of foster homes, children are often placed wherever an
22 open bed exists, rather than in homes that meet their needs. Little effort is made to assess
23 children's needs before placing them in a foster home or to match them with a foster parent
24 who has the appropriate skills or training. To make matters worse, caseworkers often fail to
25 provide foster parents with information that is crucial to ensuring foster children's safety,
26 health, and well-being.
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1 220. Some children have been placed with foster families that are taking care of
2 more children than allowed by their license permits. Clark County DFS frequently grants
3 waivers in order to place more children in the foster home than the foster parents' license
4 permits.

5 221. Once children are placed in foster homes, they are often all but forgotten.
6 Foster parents are not provided adequate support or training, and are frequently left to fend for
7 themselves under challenging circumstances. This lack of support results in failed foster
8 placements and increased instability for foster children. Worsening the effects of the
9 traumatic experiences they encountered prior to entering foster care, foster children are re-
10 traumatized by frequent placement disruptions.

11 222. Caseworkers fail to make the requisite visits with children to ensure that their
12 needs are being met. Clark County DFS's own study found that in almost two-thirds of cases,
13 case workers failed to visit their clients as required by law. Federal reviewers found that in
14 more than 40% of Clark County cases, the frequency of visits between caseworker and
15 children was insufficient to ensure adequate monitoring of the child's safety and well-being.
16

17 223. The federal performance review of Nevada's child welfare system found that
18 only 31 percent of foster children in the Clark County had stable placements. Many of the
19 children experiencing multiple placements in Clark County were under five years of age.
20 Frequent changes in placement led to a lack of continuity in services, changes in schools, and
21 an overall negative impact on children's well-being.
22

23 224. Federal reviewers found that chronic widespread disruptions in foster
24 children's placements are due to a lack of supports for foster families, failure to provide foster
25 parents with sufficient information about a child prior to placement to ensure that the family is
26 able to meet the child's needs, insufficient mental health resources for children, and a lack of
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1 an array of placements to permit the matching of a child’s needs with the skills, knowledge,
2 and abilities of the foster caregiver.

3 **J. Defendants fail to provide abused and neglected children with timely medical**
4 **care, mental health care, and educational services necessary to meet their needs**

5 225. Federal and State law require Defendants to provide foster children with
6 medical, dental, and mental health services to meet their needs. Given the neglectful and
7 chaotic environments foster youth often grow up in, it is crucial that they receive prompt
8 assessments and medically necessary services.
9

10 226. Moreover, studies have shown that a high percentage of foster children have
11 significant mental health problems. Mental health experts agree that children with serious
12 mental health problems require an array of individualized services tailored to address their
13 needs. Such services should include professionally acceptable assessments, behavioral
14 support and case management services, family support, crisis support, wraparound services,
15 therapeutic foster care and other mental health services, in a home-like setting.
16

17 227. Federal law requires states to cover certain mandatory services, including Early
18 and Periodic Screening, Diagnosis, and Treatment (“EPSDT”) services, for Medicaid-eligible
19 children under the age of 21. 42 U.S.C. § 1396a(a)(10)(A), 42 U.S.C. § 1396d(a)(4)(B).
20 Under EPSDT, states are required to provide screening services to identify defects,
21 conditions, and illness. States must provide the necessary services to correct or ameliorate
22 those conditions or illness.

23 228. Despite these requirements, foster children are often deprived of needed health
24 and mental health care. The 2005 County Case Review found that Clark County DFS fails
25 even to assess the mental health and health needs of 50% of the children in care. For those
26 children who do receive some sort of assessment, DFS fails to ensure that physical and mental
27 health services are being provided.
28

1 229. The 2006 Child Fatality Report also found that DFS fails to provide children
2 and families with services needed to resolve identified issues. DFS fails to complete service
3 plans for children or to document or follow-up on referrals for services.

4 230. Moreover, DFS does not ensure that children with mental health needs receive
5 an individualized treatment that addresses their needs. There is a severe lack of mental health
6 services such as behavioral support, psychiatric and other clinical services, case management
7 services, therapeutic foster care services provided in a home-like setting, and wraparound
8 services.

9
10 231. Nevada law also requires foster placements to ensure that foster children attend
11 school full-time; are provided with appropriate educational assessments and services; receive
12 an appropriate education, including special education services or training programs, as
13 needed; and are afforded an opportunity to complete schooling or training in accordance with
14 their aptitude.

15 232. Despite these requirements, the Federal DHHS has found that foster children's
16 educational needs were being woefully neglected. DFS fails to obtain copies of school
17 records for children in foster care; fails to obtain copies of the Individualized Education Plan
18 (IEP) for children receiving special education services and to provide such information to
19 foster parents; and fails to advocate for children's educational needs in the school system.

20
21 **K. Caseworkers' high caseloads, inadequate training, and poor supervision threaten**
22 **the safety and well-being of Nevada's abused and neglected children**

23 233. A well-trained, experienced, and adequately staffed workforce is a vital
24 component of any child welfare system. When caseworkers are overwhelmed, untrained, and
25 poorly supervised, the child welfare system inevitably breaks down, resulting in reasonably
26 foreseeable harm to foster children. Unfortunately, Clark County's system is lacking in each
27 of these important workforce areas.
28

1 234. High caseloads are prevalent among Clark County DFS caseworkers and are
2 among the highest in the state. In February 2005, the average caseload for DFS caseworkers
3 was 1:35.

4 235. DFS staff caseloads are significantly higher than the caseload ratio required for
5 accreditation by the Council on Accreditation, which is no greater than 1:18. They also far
6 exceed the caseload ratios established by Child Welfare League of America Standards, which
7 are between 1:12 and 1:15.

8 236. As a direct result of the high caseloads of workers within Clark County DFS,
9 investigations of reports of abuse are not initiated promptly nor completed within 30 days,
10 investigations fail to comply with minimum standards required of such investigations,
11 monthly visits to foster homes are not conducted, and children are harmed or at grave risk of
12 harm.

13 237. Caseworkers receive only minimal training prior to working with children and
14 families. As a result, they are ill-prepared to perform the duties and responsibilities assigned
15 to them and fail to exercise professional judgment when making life and death decisions for
16 children.

17 238. During the 2004 federal CFSR, federal reviewers found that many caseworkers
18 do not complete required ongoing in-service training. Although Washoe County and the rural
19 areas of the state require that workers must be licensed, Clark County does not. Even staff
20 assigned to investigate abuse reports are not licensed.

21 239. The Child Fatality Study found that DFS fails to make monthly contact with
22 children and family who have open cases and follow-up appropriately; fails to resolve
23 problems or concerns prior to closing cases; fails to complete service or safety plans for
24 children and families; and fails to provide case workers with appropriate training.
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1 240. The 2006 Child Fatality Report found that County DFS caseworkers
2 consistently fail to document critical information. Case files lacked documentation of
3 investigative contacts, family background checks, progress toward case goals, the basis for
4 safety decisions, the nature and purpose of service referrals, and contact with service
5 providers to ascertain progress. The study found that such poor documentation practices
6 serve as a major barrier to future quality assurance efforts, and could represent a critical
7 weakness in the overall safety net.
8

9 **L. Defendants fail to ensure that abused and neglected children have a voice in**
10 **court proceedings**

11 241. Approximately half of all children and youth who are the subject of abuse and
12 neglect proceedings in Clark County are unrepresented by a guardian *ad litem* in those
13 proceedings.
14

15 242. Children who are the subject of abuse and neglect proceedings in Clark County
16 are, if provided with any representation at all, represented either by the Children's Advocacy
17 Project (CAP) of Clark County Legal Services or Las Vegas Court Appointed Special
18 Advocates (CASA). On occasion a child may have both an attorney and CASA.

19 243. CAP employs six attorneys, each of whom represents 40 to 50 children.
20 Consequently, on average, no more than 300 out of the 3,000 children in foster care in Clark
21 County are represented by an attorney. Upon information and belief, CAP attorneys do not
22 act as guardians *ad litem* for the children or youth they are appointed to represent.

23 244. There are about 200 CASAs in Clark County. In 2005, they represented 480
24 children, and they reported that they had to turn away 89 children who were referred by the
25 court.
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1 Assistance and Child Welfare Act of 1980, as amended by the Adoption and Safe Families
2 Act of 1997, as codified at 42 U.S.C. §670 *et seq.*

3 **XI.**

4 **FOURTH CAUSE OF ACTION-**
5 **FEDERAL ADOPTION ASSISTANCE ACT (ASSERTED PURSUANT TO 42 U.S.C. §**
6 **1983)**

7 260. Each and every allegation is incorporated herein as if fully set forth.

8 261. The foregoing actions and omissions of Defendants in their official capacities,
9 amount to a policy, pattern, and/or practice of depriving all plaintiffs of rights conferred on
10 them by the federal Adoption Assistance and Child Welfare Act of 1980, as amended by the
11 Adoption and Safe Families Act of 1997 (collectively the “Adoption Assistance Act”) and the
12 regulations promulgated under the Act, 45 C.F.R. Parts 1355-1357, as asserted pursuant to 42
13 U.S.C. § 1983. These rights granted to individual foster children include, but are not limited
14 to:
15

- 16 a) The right to placement in foster homes or other settings that conform to national
17 professional standards and are subject to a uniformly applied set of standards. 42
18 U.S.C. § 671(a)(10).
- 19 b) The right to quality services that protect foster children’s safety and health. 42
20 U.S.C. § 671(a)(22).
- 21 c) The right of each child to have a written case plan, containing specified elements,
22 the right to have services provided in accordance with that plan, and the right to
23 have the status of her case reviewed no less than every six months in order to
24 determine, among other things, the safety of the child and the extent of compliance
25 with the case plan. 42 U.S.C. §§ 671(a)(16); 675(1); 675(5)(B).

- 1 d) The right to placement in a safe setting that is the least restrictive and most family
2 like setting, consistent with the best interest and special needs of the child. 42
3 U.S.C. §§ 622(b)(10)(B)(ii); 675(5)(A).
- 4 e) The right to have health and educational records reviewed, updated, and a copy
5 supplied to foster parents or foster care providers with whom the child is placed at
6 the time of placement. 42 U.S.C. §§ 622(b)(10)(B)(ii), 675(5)(D).
- 7 f) The right to have the foster parents and any pre-adoptive parent or relative
8 providing care to the child present at any proceeding held with respect to the child
9 as a matter of right. 42 U.S.C. §§ 622(b)(10)(B)(ii), 675(5)(G).
- 10 g) All other rights created by 42 U.S.C. §§ 622(b)(10)(B)(ii) and 675(5).

11
12 **XII.**

13 **FIFTH CAUSE OF ACTION–**
14 **VIOLATION OF RIGHT TO GUARDIAN AD LITEM PURSUANT TO CHILD**
15 **ABUSE PREVENTION AND TREATMENT ACT (ASSERTED PURSUANT TO 42**
16 **U.S.C. § 1983)**

16 262. Each and every allegation is incorporated herein as if fully set forth.

17 263. As a result of the foregoing actions and inactions of Defendants, plaintiffs have
18 been deprived of their right to a guardian *ad litem* in all proceedings before the juvenile court
19 in violation of 42 U.S.C. § 5106a(b)(2)(A)(xiii), as asserted pursuant to 42 U.S.C. § 1983,
20 causing serious injury and harm.
21

22 **XIII.**

23 **SIXTH CAUSE OF ACTION–**
24 **EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM**
25 **(“EPSDT”) OF THE MEDICAID ACT (42 U.S.C. 1396 ET SEQ.) (ASSERTED**
26 **PURSUANT TO 42 U.S.C. § 1983)**

26 264. Each and every allegation is incorporated herein as if fully set forth.
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- 1 b. The entitlements arising from Nev. Rev. Stat. Ann. § 432B.260, requiring Clark County
2 DFS to initiate child welfare investigations promptly upon receipt of a report of possible
3 abuse or neglect of a child;
- 4 c. The entitlements arising from Nev. Admin. Code Ann. §§ 424.160 and 424.805, requiring
5 Clark County DFS to ensure that the number of children placed in a particular foster home
6 does not exceed established levels; to respond in a timely manner to foster parents' requests
7 for assistance in meeting their foster child's needs; to assist foster parents in developing their
8 capabilities to meet their foster child's needs; and to provide a program of respite care to
9 foster parents;
- 10 d. The entitlements arising from Nev. Admin. Code Ann. § 432B.405 and Nev. Admin. Code
11 Ann. § 424.565, requiring Clark County DFS to ensure that foster children receive necessary
12 care and services for their mental and emotional health, and receive visits no less than once a
13 month from a caseworker;
- 14 e. The entitlements arising from Nev. Admin. Code. Ann. §§ 432B.185 and 432B.405,
15 requiring Clark County DFS to assess plaintiffs' safety before returning them to the custody
16 of their parents, using input from persons directly involved with the case;
- 17 f. The entitlements arising from Nev. Rev. Stat. Ann. § 432A.131 and Las Vegas Mun. Code
18 § 6.24.050, requiring that child care facilities must be licensed prior to placement of plaintiffs
19 in such facilities;
- 20 g. The entitlements arising from Nev. Admin. Code Ann. § 432B.340, requiring residential
21 institutions to provide the resources needed to prevent foreseeable harm to children;
- 22 h. The entitlements arising from Nev. Admin. Code Ann. § 424.530 to be free from physical
23 and emotional abuse while in a foster home; and
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1 i. The entitlements arising from Nev. Rev. Stat. Ann. § 127.330, requiring that placements of
2 plaintiffs with a person who resides outside of the State must follow certain procedures and
3 criteria.

4 **XV.**

5 **EIGHTH CAUSE OF ACTION–**
6 **SUBSTANTIVE DUE PROCESS CLAIM UNDER THE NEVADA CONSTITUTION**

7 269. Each and every allegation is incorporated herein as if fully set forth.

8 270. The foregoing actions and inactions of Defendants constitute a failure to
9 exercise an affirmative duty to protect the welfare of all plaintiffs, which is a substantial
10 factor leading to, and proximate cause of the violation of the constitutionally protected liberty
11 and privacy interests of plaintiffs. The foregoing actions and inactions of Defendants
12 constitute a policy, pattern, practice and/or custom that is inconsistent with the exercise of
13 reasonable professional judgment and violates the constitutionally protected rights and liberty
14 and privacy interests of all plaintiffs. As a result, plaintiffs have been and are being deprived
15 of the substantive due process rights conferred upon them by Art. 1, §8(5) of the Nevada
16 Constitution.

17
18 271. These substantive due process rights include, but are not limited to: the right to
19 protection of their person from unnecessary harm while in government custody; the right to a
20 living environment that protects foster children’s physical, mental, and emotional safety, and
21 well-being; the right to services necessary to prevent foster children from deteriorating or
22 being harmed physically, psychologically, otherwise while in government custody; the right
23 not to be deprived of liberty by retention in government custody or locked detention facilities
24 beyond necessity; the right to treatment and care consistent with the purpose of the
25 assumption of custody by Defendants; the right not to be retained in custody longer than
26 necessary to accomplish the purposes to be served by taking the child into custody; and the
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1 right to receive care, treatment, and services determined and provided through the exercise of
2 accepted, reasonable professional judgment.

3 **XVI.**

4 **NINTH CAUSE OF ACTION-**
5 **NEGLIGENCE**

6 272. Each and every allegation is incorporated herein as if fully set forth.

7 273. The foregoing actions and inactions of Defendants amounts to a pattern,
8 practice, and custom of failure to exercise reasonable professional judgment in violation of
9 Nevada child welfare statutes, as follows:

10 a. Nev. Rev. Stat. Ann. §§ 432B.500 and 432B.505, requiring that plaintiffs be appointed
11 a guardian *ad litem* who must appear at all proceedings before the court and perform specific
12 duties, including representing and protecting the best interests of the child;

13 b. Nev. Rev. Stat. Ann. § 432B.260, requiring Clark County DFS to initiate child welfare
14 investigations promptly upon receipt of a report of possible abuse or neglect of a child;

15 c. Nev. Admin. Code Ann. §§ 424.160 and 424.805, requiring Clark County DFS to
16 ensure that the number of children placed in a particular foster home does not exceed
17 established levels; to respond in a timely manner to foster parents' requests for assistance in
18 meeting their foster child's needs; to assist foster parents in developing their capabilities to
19 meet their foster child's needs; and to provide a program of respite care to foster parents;

20 d. Nev. Admin. Code Ann. § 432B.405 and Nev. Admin. Code Ann. § 424.565, requiring
21 Clark County DFS to ensure that foster children receive necessary care and services for their
22 mental and emotional health, and receive visits no less than once a month from a caseworker;

23 e. Nev. Admin. Code. Ann. §§ 432B.185 and 432B.405, requiring Clark County DFS to
24 assess plaintiffs' safety before returning them to the custody of their parents, using input from
25 persons directly involved with the case; and
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1 f. Nev. Rev. Stat. Ann. § 432A.131 and Las Vegas Mun. Code § 6.24.050, requiring that
2 child care facilities must be licensed prior to placement of plaintiffs in such facilities;

3 g. Nev. Admin. Code Ann. § 432B.340, requiring residential institutions to provide the
4 resources needed to prevent foreseeable harm to children; and

5 h. Nev. Rev. Stat. Ann. § 127.330, requiring defendants to follow established procedures
6 and criteria when placing plaintiffs with a person who resides outside of the state.
7

8 274. As evidenced by their failure to comply with these laws, Defendants have
9 breached their legal duties to plaintiffs. Plaintiffs belong to the class of persons that the
10 provisions were intended to protect, and the injuries plaintiffs suffered are of the type the
11 provisions were intended to prevent. Defendants' negligence has caused damage to plaintiffs.

12 **XVII.**

13 **PRAYER FOR RELIEF**

14 WHEREFORE, Plaintiffs respectfully request that this Court:

15 a) Assert jurisdiction over this action;

16 b) Order that plaintiffs may maintain this action as a class action pursuant to Rule 23(a)
17 and 23(b)(2) of the Federal Rules of Civil Procedure;

18 c) Declare unconstitutional and unlawful pursuant to Rule 57 of the Federal Rules of
19 Civil Procedure Defendants' violations of plaintiffs' rights.

20 d) Preliminarily and permanently enjoin Defendants from subjecting plaintiffs to
21 practices that violate their rights.

22 e) Order appropriate remedial relief to ensure Defendants' future compliance with their
23 legal obligations to plaintiffs and retain jurisdiction of this matter to ensure full, adequate, and
24 effective implementation of the relief ordered by this Court;
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1 f) Award to the plaintiffs the reasonable costs and expenses incurred in the prosecution
2 of this action, including but not limited to reasonable fees and costs pursuant to 42 U.S.C. §§
3 1988 and 1920 and Fed. R. Civ. P. 23(h); and

4 g) Grant such other and further equitable relief as the court deems just, necessary, and
5 proper to protect the plaintiffs from further harm by Defendants.

6 DATED this 30th day of August, 2006.

7 WOLFENZON SCHULMAN

NATIONAL CENTER FOR YOUTH
LAW

8 /s/ Bruno Wolfenzon, Esq.

/s/ William Grimm, Esq.

9
10
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