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HENRY A. *et al.*

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

HENRY A., by his next friend M.J.; CHARLES AND CHARLOTTE B., by their next friend R.D.; LEO C.; VICTOR C.; DELIA, MAIZY, AND JONATHAN D. by their next friend S.W.; LINDA E.; CHRISTINE F., and OLIVIA G. by their next friend E.F., and MASON I., by his next friend M.J., individually and on behalf of others so situated,

Plaintiffs,

vs.

MICHAEL WILLDEN, Director of the Nevada Department of Health and Human Services; DIANE COMEAUX, former Administrator of Nevada Division of Child and Family Services; AMBER HOWELL, Administrator of Nevada Division of Child and Family Services; VIRGINIA VALENTINE, former Clark County Manager; DON BURNETTE, Clark County Manager; CLARK COUNTY; TOM MORTON, former Director of Clark County Department of Family Services; LISA RUIZ-LEE, Director of Clark County Department of Family Services; and DOES I-XX,

Defendants.

Case No. 2:10-CV-00528-RCJ-PAL

AMENDED COMPLAINT
(Class Action Alleged)
(Jury Trial Demanded)

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GLOSSARY OF TERMS

ADHD	Attention Deficit/Hyperactivity Disorder
Burnette	Don Burnette - Current Clark County Manager
CAP	Children's Attorneys Project of Legal Aid Center of Southern Nevada
CAPTA	Child Abuse Prevention and Treatment Act
Clark County DFS	Clark County Department of Family Services
Comeaux	Diane Comeaux - Administrator of Nevada Division of Children and Family Services from June 2008 until December 2011.
CPS	Child Protective Services
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
Howell	Amber Howell - Current Administrator of Nevada Division of Children and Family Services
ICPC	Interstate Compact on the Placement of Children
Morton	Tom Morton - Director of Clark County Department of Family Services from July 2006 - August 2011
NDA	National Deaf Academy
Nevada DHHS	Nevada Department of Health and Human Services
Ruiz-Lee	Lisa Ruiz-Lee- Current Director of Clark County Department of Family Services
State DCFS	Nevada Division of Children and Family Services
UNITY	Unified Nevada Information Technology for Youth
Valentine	Virginia Valentine - Clark County Manager from August 2006- January 2011.
Willden	Michael Willden - Director of the Nevada Department of Health and Human Services

INTRODUCTION

1. This action, consisting of individual claims for damages, declaratory, and injunctive relief, and class claims for declaratory and injunctive relief, is brought by twelve children who are or have been in the legal custody of the State of Nevada and/or Clark County and placed in foster care. Plaintiffs seek redress for the harms suffered while in Defendants' care and custody.

2. Plaintiffs were removed from the care of their parents, and their custody was transferred to Defendants, for the explicit purpose of keeping them safe from further harm and ensuring their well-being. But Defendants' child welfare system routinely fails in its legal obligations, duties and responsibilities to foster children. Although Defendants are and have long been aware of these failures, in many instances their proposed solutions have been ineffective, and in many cases they have taken no action at all. Defendants' policies, customs and omissions, as set forth in detail below, fail to comply with federal and state laws, depart substantially from professional judgment, standards, and/or practice, and reflect a deliberate indifference to the health and safety of the children Defendants are obligated to protect. As a result, Plaintiffs have sustained numerous injuries detailed below, including:

- abuse by a foster family that was so severe that the two very young Plaintiff children Defendants placed in that home had to be treated at a hospital;
- ignoring requests for authorization of urgently needed medical treatment until emergency surgery was required;
- destruction of a deaf Plaintiff's cochlear implant, which severely impaired his language development; and
- multiple placement disruptions, including a one-year-old child who was sent to *twelve* different foster care settings in a single year and two children who have been sent to more than *forty* different homes during their time in Defendants' custody.

3. Defendants operate a child welfare system that fails to comply with state and federal laws or professional standards. Although Nevada law grants explicit responsibility and authority to the state officials sued herein to develop and promulgate child welfare policy, these State

Defendants have abdicated that responsibility in large respects. As a result, Clark County Defendants have created many of their own policies. This mixture of state and county policies makes it virtually impossible to determine what policies apply and confounds the ability of even the most well-intentioned staff to determine what their responsibilities are to the children on their caseload. Defendant Tom Morton, the former director of the Clark County agency responsible for administering child welfare services, characterized the absence of clearly constructed policies and procedures, coupled with inadequate training of caseworkers, as "a recipe for disaster."

4. Nevada's foster care system is currently financed through a mix of federal, state, and county funds. The State provides funding to Clark County for operation of its foster care program, while Clark County is responsible for providing funding for child protective services within the county. The State also receives millions of dollars of federal funds for its child welfare system and allocates a portion of these funds to Clark County. Federal funds are the single greatest source of support for Nevada's child welfare system, ranging each year from 53% to 55% of all state spending on child welfare.

5. To become eligible for federal funding, Nevada agreed to administer its foster care program in accordance with federal statutes, regulations, and policies promulgated by the U.S. Department of Health and Human Services. The U.S. Department of Health and Human Services conducts periodic reviews to assess whether Nevada is in compliance with those federal mandates. These reviews assess the State's performance with regard to seven "child and family outcome categories" and seven "systemic factors" relating to key federal requirements. The 2004 review of Nevada's foster care program revealed that Nevada was not in substantial compliance with *any* of the seven child welfare outcomes designed to ensure children's "safety, permanency and well-being." U.S. DEP'T OF HEALTH AND HUM. SERVS., Final Report, Nevada Child And Family Services Review ("2004 Federal Review"), dated June 1, 2004. The outcomes included whether the State is protecting children from abuse and neglect; providing permanency and stability in children's living situations; and ensuring that children receive services to meet their physical and mental health needs.

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

- Unnecessary removal of children from their homes due to Clark County's failure to provide an adequate array of services to prevent placement in foster care in the first instance;
- Frequent changes in placement of children in foster care;
- Inadequate assessments of the safety of suspected victims of child abuse and neglect;
- Inadequate training of staff and insufficient recruitment of foster parents;
- Unanswered or lengthy delays in answering calls to the Child Abuse Hotline;
- The use of an invalid, ineffective risk assessment tool; and
- The failure to use data to provide effective oversight and supervision.

7. On August 11, 2006, Sharon M. Fujii, the then Regional Administrator for the Administration for Children and Families of Federal DHHS, informed Defendants Willden and Morton that "the manner in which the continuum of child welfare services is managed in Clark County should be a grave concern to the State." August 11, 2006 Letter from Sharon M. Fujii to Defendant Willden, copying Defendant Morton. She further notified the Defendants that the current Program Improvement Plan between the state and federal officials "is no longer adequate to address the serious deficiencies in the State's child welfare program, most specifically Clark County which accounts for the majority of the State's child welfare population." *Id*.

8. On August 30, 2006, following Ms. Fujii's letter, Defendant Willden wrote a letter to Defendant Morton warning him that:

> we continue to receive information indicating serious deficiencies with the [child welfare] system …; the existing level of effort to correct system deficiencies is not adequate; [and] that despite lists of corrective action plans … still we have major failures.

August 30, 2006 Letter from Fernando Serrano, the then Administrator of Child and Family services, and Defendant Willden to Defendant Morton.

9. Despite both the State and County Defendants' awareness of the serious deficiencies in the State's child welfare services, in general and specifically in Clark County, the State and County Defendants failed to implement the corrective actions necessary to address these defects.

10. In October 2008, the University of Nevada Las Vegas (UNLV) analyzed Clark County's foster care policies pursuant to a legislatively commissioned audit of child welfare services. The analysis determined the extent to which Clark County policies incorporated state and federal child welfare laws and regulations. The auditors concluded that Clark County policies included barely a third (37%) of federal and state laws and regulations. The audit also assessed the extent to which Clark County policies incorporated the recommendations provided in various independent reports of Nevada's child welfare system and the best practices identified by the researchers. When the recommendations and best practices were included in the inquiry, the percent of Clark County's compliance plummeted to a mere 13%.

11. In 2009, the U.S. Department of Health and Human Services again conducted a comprehensive review of Nevada's Child and Family Services to determine Nevada's compliance with federal mandates. The State's performance continued to fall far below national standards. U.S. DEP'T OF HEALTH AND HUMAN SERVS., Final Report Nevada Child and Family Services Review, dated January 2010 ("2009 Federal Review"). Nevada was only in substantial compliance with one of the seven child welfare outcomes designed to ensure children's "safety, permanency and well-being." In addition, Nevada was *not* in substantial compliance with four of the seven "systemic factors." The State failed to meet federal standards in broad categories, including safety-related outcomes, staff and care provider training, the case status review system, and the outcome for children's physical and mental health.

12. Most recently, a February 2012 letter from Federal DHHS's Administration for Children and Families to Defendant Howell confirms that Nevada still struggles to meet national foster care standards. Letter from Paul J. Kirisitz to Defendant Howell date-stamped February 14, 2012. The letter notes Nevada's failure to meet the standards in a number of outcomes on its

Program Improvement Plan and states, "[i]n addition, the State has not met the National Standard for the Safety Outcome of Absence of Maltreatment of Children in Foster Care." *Id*. The letter threatens a penalty of more than $1.6 million if State Defendants do not comply with the agreed upon goals. *Id*.

13. In addition to the federal reviews and audit referenced above, at least fifteen studies, reports, and audits commissioned or prepared by Defendants or other Nevada entities have documented Defendants' failure to protect the health, safety, and well-being of child abuse victims and children in foster care. Though Defendants have had full knowledge of these studies, reports, audits, and case reviews, they have nonetheless failed to remedy the long-standing and substantial deficiencies identified in them. These studies put Defendants on notice that, among other problems:

(a) *Defendants fail to adequately train and supervise caseworkers*. The 2008 legislative audit documented that few entry-level caseworkers have the rudimentary knowledge, skills, or training needed to perform their job of ensuring the health, safety, and well-being of foster children in Defendants' custody. Few Clark County caseworkers or their direct supervisors have a degree in social work or a license to practice social work in Nevada. Many caseworkers are assigned caseloads before completing even the most basic training. High caseloads and inadequate training of Clark County child protective services providers and foster care workers contribute to the crisis within the system. Many workers' caseloads far exceed those established by national standards. Poorly trained and unsupervised caseworkers with high caseloads fail to abide by law, regulations, and professional standards, and are incapable of or fail to exercise professional judgment, resulting in serious injury to children in foster care. Indeed, a recent assessment of Nevada's performance in managing its foster care system revealed that caseworkers failed to prepare a federally and state-mandated case plan for approximately 53% of the foster children in its care within the state-mandated 45-day time window following removal from the home. Further, the 2009 Federal Review found that Nevada failed to meet national standards for staff and provider training, noting that although Nevada requires licensed social workers to complete continuing education requirements, not all caseworkers are licensed social

workers. The State has no ongoing training or education requirements for caseworkers who are not licensed social workers.

(b) *Defendants fail to meet the needs of children under their care.* Despite legally mandated obligations to these children, Defendants fail to identify and meet foster children's needs, causing them substantial harm. Defendants routinely fail to ensure that children in foster care are provided with the mental health and medical services that they need and to which they are legally entitled. For example, in many instances, Defendants address the mental health needs of foster children solely by prescribing psychotropic drugs. Moreover, Defendants fail to monitor the children's health and well-being after these drugs have been administered. Even after discovering abuse or neglect in a foster home, Defendants often fail to obtain needed services for the foster children who were victimized. This problem has been exacerbated by Defendants' failure to fulfill their legal obligation to provide prospective foster parents with critical information about the foster child's background and history of abuse, medical history and needs, family history, behaviors, and educational records.

(c) *Defendants fail to ensure that caseworkers conduct legally required visits with foster children.* Caseworkers regularly fail to visit children in their placements and are therefore unaware of the quality of care the child is receiving, the harm befalling the child, the risk to which the child is exposed, and the lack of needed medical, mental health, education, and other services.

(d) *Defendants fail to take reasonable and legally mandated steps to protect children from harm.* Investigations of child abuse reports involving children in foster care routinely fail to comply with state law and professional standards. As a direct result, children who could and should have been protected suffer unnecessarily. County Defendants often turn a deaf ear to reports of abuse and neglect in foster care settings, allowing children to remain in dangerous homes that either should not have been licensed in the first place or should have had their licenses revoked.

14. As alleged herein, Defendants are further victimizing foster children rather than discharging their duty to provide for their safety, care, and well-being. Because of their

pervasive, long-standing, and well-documented deficiencies in providing suitable out-of-home placements, mental health services and monitoring, and other basic needs, Defendants have harmed and continue to harm Plaintiff children physically, emotionally, and psychologically. Defendants' policies, customs and omissions described in this Complaint threaten the ability of foster children to grow, develop, and live safe and healthy childhoods. Plaintiffs have been harmed by Defendants' policies, customs, omissions and failures to fulfill their legal obligations to foster children, and without court action, they will continue to suffer injury as a result of Defendants' unconstitutional deprivations and statutory violations. Many other children entrusted to the care and protection of Defendants will also suffer unless Defendants' violations are redressed.

15. This action seeks compensatory and punitive damages for the past harms that Plaintiffs have suffered while in the custody of Defendants. This action also seeks declaratory and injunctive relief to stop continuing violations of Plaintiffs' legal rights and to prevent Defendants, through their policies, customs and omissions, from continuing to harm the very children whom Defendants have a responsibility to protect.

16. In addition, this action also seeks declaratory and injunctive relief on behalf of a class of children in the Clark County foster care system for whom Defendants have failed to fulfill mandatory obligations to develop case plans with the requisite information within the requisite time period under Nevada and federal law.

JURISDICTION AND VENUE

17. This Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3) & (4). Plaintiffs' action for declaratory relief is authorized by 28 U.S.C. §§ 1343(a)(4), 2201, 2202 and by Fed. R. Civ. P. 57. Plaintiffs further invoke the supplemental jurisdiction of this Court pursuant to 28 U.S.C. § 1367 to hear and decide claims arising under state law.

18. Venue is proper in this Court 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.

THE PLAINTIFFS

19. During the time that Plaintiffs have been, or were, in Defendants' custody, Plaintiffs resided in Clark County, Nevada, with the exception of Plaintiff Mason I., who resided in Clark County, Nevada, at all times relevant herein, except from May 2008 to December 2009, when the State sent him to a treatment center in Florida. During the time that Plaintiffs have been in Defendants' custody, Plaintiffs' next friends[1] resided in Clark County, Nevada, with the exception of next friend R.D., who resides in Kingman, Arizona, and next friend M.J., who is temporarily residing out of state.

20. Plaintiff **Henry A.** is a fourteen-year-old boy who has been in the legal custody of, and placed in foster care with, Clark County Department of Family Services ("Clark County DFS") and/or Nevada Division of Children and Family Services ("State DCFS") since he was four years old. Henry appears in this action by his former foster parent, M.J., who is acting as his next friend. Henry entered foster care at the age of four after being physically abused by his mother, including being locked in the trunk of her car. Despite knowledge of extreme physical abuse, Clark County DFS placed Henry back with his mother, only to later return him to foster care. Henry suffers from severe mental health problems, but any treatment he received was repeatedly discontinued and disrupted because Defendants moved him to more than forty different placements, and assigned him six or seven different caseworkers (including one who had not completed basic training), in the first seven years that he was in their care. He has had to change mental health providers more than ten times, and Defendants have often failed to provide any information regarding his mental health assessments and treatment history to his new providers. Defendants have also caused Henry to be administered multiple psychotropic

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[1] Plaintiffs and their next friends are proceeding under fictitious names and satisfy the requirements of Rule 10(a) of the Federal Rules of Civil Procedure. Plaintiffs are, or were, minors in government custody who are challenging governmental action. Revealing their true identities would cause them to disclose highly intimate information, including details of abuse and neglect. Disclosure of the next friends, many of whom are currently caring for the children, would result in identification of the Plaintiffs. In addition, the use of next friends should be permitted in this case, as Plaintiffs and their next friends satisfy the requirements of Rule 17(c) of the Federal Rules of Civil Procedure and the criteria set forth in *Whitmore v. Ark.*, 495 U.S. 149, 163-64 (1989). The next friends are all either family members or current or former foster parents. These individuals have the intention to act in the children's best interest.

medications without adequate care and monitoring and without periodic reassessments of his psychological condition. In July 2009, for example, Henry suffered drug poisoning as a result of the multiple medications he was administered, spent several weeks in the intensive care unit (ICU) of a hospital, and suffered near organ failure. Henry has suffered and continues to suffer injury as a result of Defendants' policies, customs and omissions.

21. Plaintiffs **Charles B.**, age eleven, and **Charlotte B.**, age three, are siblings. They were in the legal custody of, and placed in foster care with, Clark County DFS from March 2009 until the fall 2010 when Charles and Charlotte were returned to their mother's care. Charles and Charlotte appear in this action by their grandfather, R.D., who is acting as their next friend. Upon removing Charles and Charlotte from their home, Defendants refused to place them with their grandmother, despite an obligation to place foster children with relatives when safe and appropriate placements are available, despite a court order requiring that these children be placed with their grandmother, and despite their grandmother being ready, willing, and able to provide them a safe and appropriate placement. Instead, Defendants placed Charles and Charlotte in a foster home in which the foster mother and her teenaged son abused them, including by locking Charlotte in a closet without food and water for long periods of time in a soiled diaper and beating Charles when he tried to help Charlotte. The Las Vegas police ultimately removed the children from that foster home and brought them to a hospital for treatment. At the hospital, Charlotte was found to be suffering from dehydration, bruises on her forehead, cuts on both legs, and diaper rash so severe that her buttocks were ulcerated and bleeding. The foster mother has been charged with child abuse, and her son has pleaded guilty to assault. During the time in which they remained in Defendants' custody, Charles and Charlotte were put in at least seventeen placements, including multiple single-night placements at Child Haven, a shelter for abused and neglected children. Charles and Charlotte have suffered and continue to suffer injury as a result of Defendants' policies, customs and omissions.

22. Plaintiff **Linda E.** is a nineteen-year-old woman who was in the legal custody of, and placed in foster care with, Clark County DFS and/or State DCFS for over fifteen years. As Linda is no longer a minor, Linda now appears in this action for herself. Defendants placed Linda

in more than forty different foster care settings, including many inappropriate and dangerous placements in which she suffered abuse and neglect. For example, Defendants placed Linda in the home of an aunt where she had previously suffered abuse. Linda reported this abuse to her caseworker, but her circumstances did not improve. She was also left at a psychiatric facility for six months because Defendants failed to identify an appropriate placement for her. Linda's placement history with Defendants is so riddled with failures that it was not until the 2008–2009 school year—her junior year in high school and her fourteenth year in Defendants' custody—that she was able to complete an entire grade in the same school. Defendants failed to provide Linda with the medical and mental health care she needed and instead caused her to be administered multiple psychotropic drugs without adequate care and monitoring and without periodic reassessments of her psychological condition. Linda has suffered and continues to suffer injury as a result of Defendants' policies, customs and omissions.

23. Plaintiffs **Leo** and **Victor C.** are nineteen-year-old twins who were in the legal custody of, and placed in foster care with, Clark County DFS beginning in November 2006. Leo exited the system when he reached the age of majority in December 2010. Victor elected to remain in the child welfare system and now receives foster care benefits under the A.B. 350 program that the State legislature enacted in 2011. As Leo and Victor are no longer minors, they now appear in this action for themselves. Defendants at first repeatedly refused to place the brothers in the care of their grandmother, who was ready, willing, and able to provide a safe and appropriate placement for them. Instead, Defendants shuttled the brothers between their father's house and the home of their mother and her boyfriend, where they were repeatedly abused. The boys were eventually abandoned at Child Haven. While in the custody of Defendants, Leo and Victor did not receive the urgently needed psychiatric care to which they were entitled. Defendants took no steps to arrange psychiatric treatment in response to repeated suicidal threats made by Victor. Additionally, after Victor's needs and symptoms escalated to the point where he had to be hospitalized twice, Defendants failed to arrange for Victor to receive follow-up treatment by a psychiatrist. Leo and Victor have suffered and continue to suffer injury as a result of Defendants' policies, customs and omissions.

24. Plaintiffs **Delia**, **Maizy**, and **Jonathan D**. are siblings. Four-year-old Delia was in the legal custody of, and placed in foster care with, Clark County DFS from March 2008 until October 2010. Maizy, age seven, and Jonathan, age six, were in the legal custody of, and placed in foster care with, Clark County DFS from late 2005 until August 2009. Delia, Maizy, and Jonathan appear in this action by S.W., who has adopted all three children and is acting as their next friend. Delia, Maizy, and Jonathan have multiple medical problems and developmental delays. Defendants placed the children in Child Haven as infants, where they did not receive even basic care to meet their medical and nutritional needs. Instead of feeding the children age-appropriate food, the staff at Child Haven kept the children on an inadequate formula diet and failed to adjust the feeding techniques after observing the children regurgitate their food on numerous occasions. Both Maizy and Jonathan were left in their cribs for the majority of their days at Child Haven with limited interaction with adults and other children and few opportunities for exercise or physical development. As a result of this neglect, both children were diagnosed with failure to thrive, a diagnosis made when children are consistently underweight due to environmental and social factors. At the time of the children's placement with her, S.W. was given little information about their history, background, or special needs. Defendants also failed to provide S.W. with the training, support, or assistance DFS knew she needed in order to meet the medical, developmental, and emotional needs of the children.

25. Defendants have actively impeded S.W. from obtaining urgently needed medical treatment for Jonathan and Delia, including neglecting to return calls and failing to provide authorization for at least three necessary procedures. Left untreated, these conditions became so severe that doctors determined they could proceed with the procedures on an emergency basis without Defendants' authorization. As a result of Defendants' failure to provide medical treatment when it was urgently needed, Jonathan and Delia have ongoing complications. Jonathan's colon is now misshapen and needs to be surgically corrected as a result of Defendants' delay in authorizing treatment to remove a calcified stool from his impacted colon. Delia has also had to undergo emergency surgery to remove a tumor located behind her eye. This surgery was delayed because of Defendants' failure to provide her with necessary and timely medical care,

and Delia had to undergo chemotherapy as a follow-up to the surgery. Delia, Maizy, and Jonathan have suffered and continue to suffer injury as a result of Defendants' policies, customs and omissions.

26. Plaintiff **Olivia G.**, age eleven, was in the legal custody of, and placed in foster care with, Clark County DFS from January 2006 until 2011. Olivia appears in this action by E.F., who has adopted Olivia and is acting as her next friend. During 2005, Defendants received multiple reports that Olivia and her siblings were being abused, but they did not remove Olivia and her siblings from their parents' care until almost a year after the initial report. Olivia was placed with a series of relatives, but Defendants made no effort to determine whether those relatives were able to provide appropriate care for her or to monitor the care she received in the relative homes. Olivia suffered abuse in those homes, including multiple incidents where she was beaten with a belt. She has been diagnosed as suffering from severely impaired neuropsychological functioning and a range of cognitive and behavioral impairments. Defendants caused Olivia to be administered powerful multiple psychotropic medications without adequate care and monitoring and without periodic reassessments of her psychological condition—Olivia sometimes went for up to eighteen months without a neuropsychological exam or reassessment while in Defendants' care. In April 2009, Defendants placed Olivia with E.F. but failed to provide E.F. with all the information and authorizations required to obtain Olivia's prescriptions. As a result, Olivia was forced to go through an abrupt, medically contraindicated withdrawal from powerful psychotropic medications. Olivia has suffered and continues to suffer injury as a result of Defendants' policies, customs and omissions.

27. Plaintiff **Christine F**. is a five-year-old girl who was in the legal custody of, and placed in foster care with, Clark County DFS from May 2008 until June 2010. Christine appears in this action by E.F., who adopted Christine in June 2010 and is acting as her next friend. Christine is a medically fragile child who is severely developmentally delayed and who suffers from permanent disabilities and a seizure disorder. Christine was hospitalized at University Medical Center after falling out of a second-story window at the home of her mother, grandmother, and two uncles. Despite suspicious marks around her ankles, suggesting that

someone had held her out the window by her ankles before dropping her, or had swung her by her legs into a wall, DFS did not investigate the incident and did not take custody of Christine until her parents refused to authorize medically necessary treatments to remedy Christine's injuries. Approximately six weeks after Christine was medically ready for discharge from the hospital, Defendants finally placed her in the custody of E.F. Defendants failed to provide E.F. with Christine's seizure medications and offered almost no support or training on how to care for Christine's extensive special needs. Defendants failed to provide Christine with regular medical care or therapeutic services, such as physical, occupational, and speech therapy. Clark County DFS also allowed Christine's grandmother, who Clark County DFS knew to have a history of child abuse allegations made against her and who was watching over Christine when she fell from the window, to have unsupervised visits with Christine in her own home, greatly increasing the danger to Christine's health and safety. Christine has suffered and continues to suffer injury as a result of Defendants' policies, customs and omissions.

28. Plaintiff **Mason I.** is a fourteen-year-old boy who has been in the legal custody of, and placed in foster care with, Clark County DFS since July 2003. Mason appears in this action by his former foster parent, M.J., who is acting as his next friend. Mason lived with M.J. for nearly 1.5 years, beginning in September of 2008. Deaf since birth, Mason entered foster care at the age of six after enduring sexual, physical, and emotional abuse by his parents and grandparents. He suffers from posttraumatic stress disorder and reactive attachment disorder, among other serious mental health diagnoses. During the first six years he was in Defendants' custody, Mason had been in more than twenty-five placements, including a treatment center in Florida, the National Deaf Academy ("NDA"), to which Defendants transferred Mason for approximately nineteen months. Mason's only means of communication with others is via American Sign Language. Despite knowing of his impairments, Defendants have failed to place Mason in homes able to meet his special needs. Defendants have not provided Mason with a qualified American Sign Language Interpreter on a consistent basis, thereby depriving him of the ability to effectively communicate with others and participate in and benefit from evaluations and medical treatment. Defendants have routinely failed to fully disclose Mason's relevant medical,

mental health, family, social or educational backgrounds to Mason's foster parents, or health and mental health professionals, or to provide him with the medical, mental health, and educational services he needs and to which he is entitled. For example, Defendants failed to provide Mason with proper and medically necessary treatment, including speech therapy, following his receipt of a cochlear implant. Against Mason's wishes, the NDA staff with whom Defendants placed him rendered Mason's implant permanently inoperative. Defendants also routinely administered, had administered by caregivers they selected and supervised, or acquiesced in others' administrating, multiple psychotropic drugs to Mason with little to no information about the individual drugs or their possible interaction. Further, Defendants placed Mason at NDA without ensuring that it was safe and capable of meeting Mason's needs. Defendants then ignored Mason's complaints of sexual abuse at NDA, took no steps to investigate or verify his safety or well-being, and never once visited the facility or had a face-to-face interview with Mason while he was there. Mason has suffered and continues to suffer injury as a result of Defendants' policies, customs and omissions.

29. Each Plaintiff appears for themselves or by a next friend, and each next friend is sufficiently familiar with the facts and circumstances surrounding the child's situation to represent the child's best interests in this litigation fairly and adequately.

THE DEFENDANTS

30. Defendant Michael Willden ("Willden") has been the Director of the Nevada Department of Health and Human Services ("Nevada DHHS") since July 2001 and is sued in his official and individual capacities. As Director of Nevada DHHS, Defendant Willden is responsible for carrying out the administration of the Nevada Division of Children and Family Services ("State DCFS"), which has responsibility for ensuring the provision of child welfare services throughout the state. NEV. REV. STAT. §§ 232.300, 232.320. Defendant Willden is also responsible for appointing divisional directors, including the Administrator of State DCFS. NEV. REV. STAT. § 232.320. Nevada DHHS, through its Division of Health Care Financing and Policy, is also the single state agency responsible for administering Nevada's Medicaid program. NEV. REV. STAT. §§ 422.270, 422.271. Defendant Willden is responsible for administering federal

funds and ensuring county compliance with all federal mandates of the Medicaid program. NEV. REV. STAT. § 232.070.

31. Defendant Diane Comeaux ("Comeaux") was the Administrator of State DCFS from June 2008 until December 2011 and is sued in her individual capacity. She was responsible for the administration and oversight of all functions of State DCFS. State DCFS has broad responsibilities to Plaintiffs and other foster children. Among its responsibilities, the Division must administer all federal funds provided to the State by the United States Department of Health and Human Services, as well as plan, coordinate, and monitor the delivery of child welfare services throughout the State. NEV. REV. STAT. § 432B.180. State DCFS is required to promulgate regulations "establishing reasonable and uniform standards for child welfare services." NEV. REV. STAT. § 432 B.190. Notably, federal law precludes State DCFS from "delegat[ing] to other than its own officials its authority for exercising administrative discretion in the administration or supervision of the plan including the issuance of policies, rules, and regulations on program matters." 45 C.F.R. §205.100(b)(2). Thus, State DCFS must evaluate all child welfare services provided throughout the State and take corrective action against any agency providing child welfare services which is not complying with any applicable laws, regulations or policies. NEV. REV. STAT. § 432B.180(8). Defendant Comeaux, as Administrator of State DCFS, was also responsible for administering any money granted to the State by the Federal Government with respect to children in the child welfare system. NEV. REV. STAT. § 432B.180(1).

32. Defendant Amber Howell ("Howell") is the current Administrator of State DCFS and has held that position since March 2012. Howell is sued in her official capacity. As the current Administrator of State DCFS, Defendant Howell has taken over the responsibilities of Defendant Comeaux, some of which are listed in paragraph 31.

33. Defendants Willden, Comeaux, and Howell are referred to collectively as the "State Defendants."

34. Defendant Clark County is a public entity established and maintained by the laws and Constitution of the State of Nevada. Clark County operates, manages, directs, and controls Clark County DFS and employs and/or is responsible for the other County Defendants in this

action including, but not limited to, caseworkers, supervisors, foster home licensors, and administrators. Clark County has created the Clark County DFS to provide and administer child welfare services in the County.

35. Defendant Virginia Valentine ("Valentine") was the Clark County Manager from August 2006 until January 2011 and is sued in her individual capacity. She was responsible for managing the County's budget and providing administrative oversight for all County departments, including Clark County DFS.

36. Defendant Don Burnette ("Burnette") is the current Clark County Manager and has held that position since January 2011. Burnette is sued in his official capacity.

37. Defendant Tom Morton ("Morton") was the Director of Clark County DFS from July 2006 until August 2011 and is sued in his individual capacity. He was the Executive Officer of Clark County DFS and was responsible for administering child welfare services in Clark County and for ensuring the safety and well-being of children in or at risk of entering the child welfare system, pursuant to Nevada Revised Statute section 432B.

38. Defendant Lisa Ruiz-Lee ("Ruiz-Lee") is the current Director of Clark County DFS. Ruiz-Lee was first named Interim Director in August 2011 and was named Director in May 2012. Ruiz-Lee is being sued in her official capacity.

39. Defendants Clark County, Valentine, Morton, Burnette, and Ruiz-Lee are collectively referred to herein as the "County Defendants."

40. Doe Defendants I through X are, and at all times relevant hereto were, caseworkers for Clark County and Clark County DFS responsible for overseeing the safety, placement, health care, education, and/or well-being of Plaintiffs while in the custody of Clark County DFS, and are sued in their official and individual capacities.

41. Doe Defendants XI through XX are, and at all times relevant hereto were, supervisors for Clark County and DFS directly responsible for the supervision of Doe Defendants I through X, and are sued in their official and individual capacities.

42. The true names and capacities of Defendants named herein as Does I through XX are presently unknown to Plaintiffs who therefore sue Defendants by fictitious names. When the

true names and positions of these Does are discovered, Plaintiffs will seek leave to amend this complaint and substitute the true names of Defendants. Plaintiffs or their next friends are informed, believe, and therefore allege that Defendants so designated herein are responsible in some manner and legally accountable for the events, occurrences, and harms suffered by Plaintiffs as set forth in this action.

43. At all material times, each Defendant acted under the color of the laws of the State of Nevada.

44. The acts and omissions of the Clark County Defendants, caseworkers, supervisors, and other employees described herein were pursuant to the actual policies and customs of Clark County.

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITIES OF DEFENDANTS

Responsibilities and Knowledge of State Defendants

45. Until October 2004, Nevada operated a bifurcated child welfare system in which the State's two counties with populations of over 100,000—Clark and Washoe counties—were responsible for providing child protective services, while the State bore responsibility for providing foster care services. Under this system, abused and/or neglected children removed from their parents or guardians were first placed in the legal and protective custody of Clark County DFS pending the juvenile court's findings and disposition of the case. Children not returned from protective custody were placed in the legal custody and foster care of State DCFS. Consequently, many foster care children, including plaintiffs Henry and Linda, have been in the legal custody of both the Clark County DFS and the State DCFS.

46. As of October 2004, as a result of AB 1 (2001), responsibility for foster care was transferred from State DCFS to Clark and Washoe counties. The State retained responsibility for supervision and oversight of Clark and Washoe counties' child protective services and foster care programs to ensure, among other things, compliance with federal and state laws, regulations, and standards. The transfer of foster care staff and services from the State to Clark County was completed in October 2004.

47. When the State transferred child welfare services from the State to Clark and Washoe counties, "that did not relieve the State of its oversight and management responsibility for child protection and child welfare services." August 11, 2006 Letter from Sharon M. Fujii to Defendant Willden. Instead, "[t]he integration of child welfare services affirmed the State's accountability, supervision and management of the child welfare program Statewide." *Id.*

48. Furthermore, the duties of Nevada DHHS and State DCFS exceed merely documenting and reviewing documentation of Clark County's failures to provide safe and proper care. In their own words,

> The Division of Child and Family Services (DCFS) **is responsible** for Children's Mental Health (in Clark and Washoe, the two largest populated counties), Youth Corrections, Child Welfare Services and Child Care Licensing. As such, the implementation and administration of Child and Family Services Plan is the responsibility of DCFS. This includes: Title IV-E, Title IV-B, Subpart I (Child Welfare Services) and Subpart 2 (Promoting Safe and Stable Families), Child Abuse and Treatment Act (CAPTA), and the Chafee Foster Care Independence Program (CFCIP).

Annual Progress & Services Report (APSR) state fiscal year (SFY) 2011, at 6 (emphasis added).

49. Accordingly, State Defendants Willden, Howell and Comeaux are, or were, responsible for the statewide implementation and administration of federal child welfare programs including Titles IV-B and IV-E of the Social Security Act. *See* NEV. REV. STAT. § 232.300; § 232.320; § 432B.180. In testimony before the state legislature in 2009, Defendant Comeaux acknowledged "DCFS has state oversight for county-administered child protective and child welfare services." *State of Nev. Div. of Child & Family Servs.: Testimony Before the Assemb. Comm. on Health & Human Servs.*, 75th Sess. (Nev. Feb. 6, 2009) (PowerPoint Presentation accompanying statement of Diane Comeaux), http://www.leg.state.nv.us/Session/75th2009/Exhibits/Assembly/HH/AHH230C.pdf at 7.

50. State Defendants receive millions of dollars in federal funds to meet the needs of children in the child welfare system and are therefore required to comply with federal mandates, including those set forth in 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*. ("Adoption and Safe Families Act").

51. Between 1996 and 2006 federal financial contribution to Nevada's child welfare system increased from $31 million per year to over $54 million per year. Federal funds comprise over 50% of all State spending on child welfare.

52. Nevada DHHS, through its Division of Health Care Financing and Policy, is also the single state agency responsible for administering Nevada's Medicaid program. NEV. REV. STAT. §§ 422.270, 422.271. Defendant Willden is responsible for administering federal funds and ensuring county compliance with all federal mandates of the Medicaid program. NEV. REV. STAT. § 232.070.

53. State Defendants also are responsible for the management and day to-day operation of Children's Mental Health Services in Clark and Washoe counties. Children's Mental Health Services is the Nevada program created to address the needs of children (and their families) with significant emotional and behavioral challenges.

54. Children committed to the legal custody of State or County Defendants may be placed in one of several different types of out-of-home placements. These placements include, among others, foster family homes, treatment foster homes, and group homes.

55. State DCFS is required to establish and ensure that Clark and Washoe counties comply with minimum standards for licensure of foster family homes, group homes, and other child care facilities in which foster children are placed. NEV. REV. STAT. § 424.020. In carrying out this obligation, State DCFS is required to promulgate regulations establishing uniform standards for the licensing of foster family homes, group homes, and child care institutions. *Id.*; NEV. REV. STAT. § 432B.190(1).

56. For many years, the State Defendants have had knowledge that their failure to train, supervise and adequately monitor DCFS, Clark County, and Clark County caseworkers was seriously harming the foster children in Clark County. These are the same failures that caused Plaintiffs' injuries. As discussed in Sections I.A.2, I.B.2, and I.C.1-2 herein, Defendants' failures have been documented extensively in reports and correspondence provided to the State Defendants.

57. Evaluations and analyses generated from State Defendants' own data system, the Unified Nevada Information Technology for Youth (UNITY) System, have also documented the Defendants' failures. State Defendants are required by federal law to operate such a database, which is called a Statewide Automated Child Welfare Information System (SACWIS). The State Defendants received numerous reports based on the UNITY database that placed them on notice of the problems that caused Plaintiffs' injuries.

58. State Defendants have responsibility to train the Clark County caseworkers who provide foster care services. For example, they must "operate a staff development and training program that supports the goals and objectives in the CFSP [Child and Family Services Plan], addresses services provided under titles IV-B and IV-E, and provides initial training for all staff who deliver these services." Annual Progress & Services Report (APSR) SFY 2011, at 57. State Defendants are also responsible for providing "ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties." *Id*. at 58.

59. State Defendants' responsibility to provide training to Clark County child welfare workers is also clearly documented in the Intrastate Interlocal Contract first entered into by the State and County in 2005. This contract expressly states that State Defendants are responsible for providing training and technical assistance to Clark County. However, the inadequacy of the training provided has been repeatedly documented for many years. *See, e.g.*, February 7, 2006 Letter from Sharon M. Fujii to Fernando Serrano (identifying Clark County's "need for an on-going supervisory training program"); Report to U.S. Representative Shelley Berkley on the State of Clark County DFS (2007) (hereinafter "Berkley Report") at 9-10 (noting that the state training program for caseworkers was "grossly inadequate" and that "the state has been unsuccessful in developing and delivering training that adequately prepares caseworkers for the job"); Missouri Alliance for Children and Families, Report to Clark County, Nevada DFS, Out of Home Care Resources and Practices (August 2007) at 4 (noting that comprehensive training is not offered to new staff); Final Report: Nevada Child and Family Services Review, U.S. Department of Health and Human Services Administration for Children and Families (2010) at 15 (finding that Nevada was not in substantial conformity with the "Staff and Provider Training" systemic factor and that

the State's new worker training was "not adequate to provide caseworkers with the skills" to do their jobs). State Defendants' failure to train caseworkers adequately has led to many of the injuries suffered by Plaintiffs, as discussed in more detail below in Sections I.A.3, I.B.3, and I.C.1-2.

60. In 2007, the Nevada legislature enacted A.B. 263. A.B. 263 confirmed not only that the State was required to establish standards for child welfare services, but that it was also required to enforce those standards. NEV. REV. STAT. § 432.0155. If an agency which provides child welfare services was "not complying with any state or federal law relating to the provision of child welfare services, regulations adopted pursuant to those laws or statewide plans or policies relating to the provision of child welfare services," the State had a duty to require corrective action from that agency. NEV. REV. STAT. § 432B.180(6).

61. State Defendants have the duty and responsibility to take action, including providing supervision, oversight and guidance; instituting policies and procedures; training workers; and withholding funds for the failure of the County to comply with its own duties. The failure to take this action has caused the violations of Plaintiffs' constitutional and statutory rights. State Defendants have failed to fulfill those duties thereby allowing those violations to continue unabated for years, increasing the number of foster children harmed and causing and/or exacerbating the harm suffered by Plaintiffs and class members.

Responsibilities and Knowledge of County Defendants

62. As noted above, Clark County has been responsible for running the day-to-day operations of both child protective services and the foster care system in Clark County since 2004.

63. Clark County is responsible for providing funding in an amount set by the County for the provision of child protective services. NEV. REV. STAT. § 432B.325. State DCFS provides the funding to Clark County for the operation of its foster care program. The legislative appropriation for foster care services and all federal funds for child welfare services go to State DCFS. State and County Defendants negotiate a contract—the Intrastate Interlocal Contract with

the State of Nevada for Operation of Child Welfare, Eligibility and Foster Care Licensing Programs—detailing the County's responsibilities and specifying how the funds will be allocated.

64. Clark County DFS is also responsible for licensing foster and group homes in which it places foster children in its custody and for ensuring that those homes meet state standards. NEV. REV. STAT. §§ 424.016(1), 424.020, and 424.030. This responsibility includes monitoring foster and group homes to ensure that they continue to meet licensing standards, removing foster children from homes where necessary, and providing support to those homes. NEV. REV. STAT. §§ 424.040, 424.060, 424.077. Licenses must be renewed every two years. NEV. REV. STAT. § 424.030. Licensing is required to protect children from abuse or neglect and ensure that the foster parent can properly care for children. NEV. ADMIN. CODE § 424.100.

65. Clark County is also required to "provide to the provider of family foster care such information relating to the child as necessary to ensure the health and safety of the child and other residents of the family foster home." NEV. REV. STAT. § 424.038.

66. In addition, Clark County is responsible for "visit[ing] every licensed family foster home and group foster home as often as necessary to ensure that proper care is given to its children." NEV. REV. STAT. § 424.040. If Clark County at any time finds that a child in a foster home is "subject to undesirable influences or lacks proper or wise care and management," Clark County is required to remove the child if that child is in its custody, or if the child is not in Clark County custody, notify the applicable agency. NEV. REV. STAT. § 424.60.

67. Upon receipt of a report of child abuse, Clark County is obligated to promptly investigate the claim. NEV. REV. STAT. § 432B.260. As part of that investigation, Clark County is required to determine the composition of the family, household, or facility including the name, sex, and age of any children in the report and their siblings, the person(s) responsible for their care, and any other adults living in the household. NEV. REV. STAT. § 432B.300. Clark County is also required to determine whether there is reasonable cause to believe any child is being abused or neglected. If there is a reasonable cause to believe a child is being abused or neglected, it is the County's duty to determine the immediate and long-term risks to the child if the child was to remain in the same environment and evaluate what treatment and services appear necessary to

prevent the abuse or neglect. *Id.* If the County determines that the child is in need of further protection it may refer the case for criminal prosecution and/or take the child into protective custody. NEV. REV. STAT. § 432B.380-390.

68. On its website, Clark County Department of Family Services acknowledges that its "role is to help keep children safe." Clark County Department of Family Services (DFS), http://www.clarkcountynv.gov/Depts/family_services/Pages/default.aspx (last visited July 18, 2012). However, numerous studies and reports have found that Clark County is, and has been for years, failing in that role.

69. County Defendants are well aware of these failures. County Defendants have failed to adequately train, monitor, and supervise their employees and as result the foster children in Clark County have continued to suffer grave injuries. As discussed in Sections I.A.2, I.B.2, and I.C.1-2 herein, these failures have been documented extensively in reports and correspondence provided to the County Defendants.

70. County Defendants' actions, and failures to act, have caused many of the injuries suffered by Plaintiffs, as discussed in more detail below in Sections I.A.3, I.B.3, and I.C.1-2. As discussed above and in Sections I.A.2, I.B.2, and I.C.1-2 herein, County Defendants have known about these problems for years.

71. County Defendants also have been on notice of the above problems as a result of multiple lawsuits brought against them by other foster youth who have been injured while in Clark County's custody.

I. ALLEGATIONS REGARDING DEFENDANTS' POLICIES, CUSTOMS AND OMISSIONS

A. Defendants Fail to Inform Foster Parents and Other Caregivers of Essential Information Necessary for Stable and Successful Placements

1. Federal and State Laws Require Caseworkers to Provide Foster Parents Specific Information About a Child's Health and Behavioral Background Before Placing the Child

72. When Defendants remove a child from his home and take him into protective custody, they assume an obligation to place him into a safe and appropriate living situation with foster parents or other caregivers to take care of him. *See*, *e.g.*, 42 U.S.C. § 671(a)(22).

73. To fulfill that obligation, federal law mandates, among other things, that "before a child in foster care under the responsibility of the State is placed with prospective foster parents, the prospective foster parents will be prepared adequately with the appropriate knowledge and skills to provide for the needs of the child, and that such preparation will be continued, as necessary, after the placement of the child." 42 U.S.C. § 671(a)(24).

74. The Federal Foster Care and Adoption Assistance Act also requires that within 60 days of removal from the home, caseworkers must develop a case plan for each foster child that includes the child's health and education records, known medical problems and prescribed medications, and other relevant related information. 42 U.S.C. §§ 671(a)(16), 675(1), 45 C.F.R. §1356.21(g)(2). This Act also expressly requires that the caseworker provide an updated copy of the child's record to the foster parent or provider *at the same time the caseworker places the child with that parent or provider*. 42 U.S.C. § 675(5)(D).

75. Nevada law also requires County DFS and/or State DCFS to provide prospective foster parents with specific information about the child, including information about the child's family, medical, and behavioral history, *before* placing that child with the foster parents. NEV. REV. STAT. § 424.038. The purpose of sharing such information is to identify and provide for the most appropriately matched foster home. NEV. REV. STAT. § 424.038(1), NEV. ADMIN. CODE § 424.465. State regulations further require that information about the child's situation and needs be continually shared by the child welfare agency and the foster care providers in a timely manner, thereby ensuring that the child's needs are continuously addressed with appropriate services, including respite for foster care providers. NEV. ADMIN. CODE §§ 424.805, 424.810.

76. State DCFS acknowledges these obligations. Its Substitute Care Manual expressly requires that its social workers inform a child's foster care providers about that child's known history, including the child's current and previous behavior and any "acting out" behavior. Substitute Care Manual, Chap. 201. As required by law, the Manual requires the social workers to provide this information to the foster parents *before* placing the child. The Manual cautions: "[C]are providers need as much information as possible . . . to decide if they are capable of caring for the child." *Id.*

77. Both federal and state laws require caseworkers to provide this information before or during placement to ensure that the prospective foster parent, relative, or other caregiver has sufficient information to make an informed judgment about his ability to provide the child with safe and appropriate care and to ensure that the placement selected for the child will remain stable, thereby avoiding another move for a child already traumatized by his removal from home. Further, placing a child with severe psychological and/or behavioral problems in a home that is not equipped to handle him puts both the child and the foster family members at risk of harm.

78. Defendants acknowledged that once they place a child into a foster home, keeping his placement as stable as possible is crucial to that child's well-being. Clark County Placement in Substitute Care Policies and Procedures § 3000. Conversely, removing a child from his foster home and sending him to yet another placement is a serious disruption in the child's life that can have devastating effects. Removal causes the child to lose any sense of stability he developed in the home and can prevent him from receiving vital medication, counseling, educational or therapeutic services. Moving a child repeatedly can prevent the child from developing attachments, cause severe emotional trauma, and exacerbate existing mental health and behavioral problems. It is therefore critical that Defendants' caseworkers fulfill the agency's obligation to provide the requisite information to the foster parents to ensure the success of each foster child's placement.

79. In addition, failure to disclose information about the child's health care needs and history can also result in delays in getting appropriate assessments and treatment. Foster parents unaware of the child's past providers, diagnoses, and treatments cannot provide crucial history information to the child's healthcare providers. It is therefore critical for the provision of necessary medical and mental health treatment that Defendants fulfill their information-gathering and sharing obligations.

2. Defendants' Policies, Customs and Omissions Violate Federal and State Law Regarding the Provision of Information to Foster Parents

80. Defendants' policies, customs and omissions, including, but not limited to the State and County Defendants' failure to properly train and supervise caseworkers, result in their routine failure to provide the required information about foster children to foster parents.

81. The most recent Federal Review based on data from UNITY indicated that only approximately 53% of children had case plans within 45 days of removal from the home. This data confirms that a specifically identified deficiency noted in the 2004 Federal Review continues to be a serious problem. State and County Defendants were aware of the 2004 review and subsequent reviews. *See* August 11, 2006 Letter from Sharon M. Fujii to Defendant Willden; Berkley Report at 3-4. Thus, Defendants are well aware of their routine failure to collect necessary information in the first place.

82. Even when State Defendants have collected highly relevant medical and mental health information about foster children, they routinely fail to share that information with County actors to whom the State Defendants have delegated such critical responsibilities in the foster care arena, making it impossible for caseworkers to pass the information on to foster parents. On information and belief, because most children entering foster care are enrolled in Medicaid, information about their medical history should be readily available in databases maintained by Nevada DHHS. This is also the case with information maintained by State Defendants' Children's Mental Health Services program, which is responsible for providing mental health services to Plaintiffs and other children in Clark County who are in need of mental health screenings, assessments, and treatment. On information and belief, State Defendants do not provide critical information within their possession and control to County Defendants to ensure that foster parents receive accurate and complete health histories of the foster children.

83. The failure of Defendants' caseworkers to fulfill the obligation to share required information about the children in their custody and care with foster parents is foreseeable. Defendants employ many caseworkers who are not adequately educated or trained regarding how to collect the necessary and required information about foster children or what information they

must share with prospective foster parents. In fact, Defendant Comeaux herself had no background education in this area. A large majority of County Defendants' caseworkers do not have degrees in social work, even at the bachelor's level, and approximately one-third of the caseworkers have been at their jobs for less than one year. Compounding these caseworkers' lack of education and experience, upon information and belief, Defendants allow new caseworkers to proceed in the field for months before providing them with even the initial, basic training. Nor are caseworkers who fail to provide the requisite information to foster parents in violation of federal and state law held accountable through supervision.

84. State Defendants have long had knowledge of this failure to share required information and failure to train caseworkers to do the same. Multiple reports and surveys conducted by State Defendants' own task forces as far back as 2005 have noted that 40% or more of foster parents surveyed reported that they had not received sufficient background information about foster children placed in their homes. *See, e.g.*, State of Nevada DHHS, State Child Welfare Multidisciplinary Team, Monthly Report, December 2006 at 18; State of Nevada DHHS, State Child Welfare Multidisciplinary Team, Quarterly Report, January-March 2007 at 23-24; State DCFS—which State Defendants now or once did oversee—authored these reports and worked to review their findings with County Defendants' staff. *See also* UNLV School of Social Work, "A Survey of Foster Parents' Satisfaction Toward Nevada's System of Child Welfare," February 15, 2006, at 11 (finding that over 40% of foster parents surveyed as part of a study commissioned by State Defendants felt their caseworker had not informed them of their foster child's behavioral or emotional needs prior to placement). In one such report, State Defendants noted that foster parents reported a failure to receive sufficient background information in 67% of cases reviewed; that same month, 72% of foster parents reported having to request a child's removal due to placement challenges related to lack of medical or behavioral information. State of Nevada DHHS, State Child Welfare Multidisciplinary Team, Quarterly Report, January-March 2007 at 24.

85. County Defendants have also had knowledge of the failure to share required information and failure to train caseworkers to do the same. In addition to their involvement with

and/or knowledge of the reports noted above, Defendant Morton himself has linked this shortcoming to State Defendants' failure to properly train County caseworkers. According to Defendant Morton, "Staff have never been comprehensively trained in what information to seek and how to seek it. Consequently, the majority of case contact notes reflect little or no information about the functioning of children and caretakers or their progress toward case goals. Safety and risk factors are often missed or misinterpreted. Many caretaker and child needs are never identified." Berkley Report at 10. An independent report contracted by Clark County also indicates that "the system does not exist that facilitates … sharing of information" with foster parents regarding the needs of foster children prior to placement. Missouri Alliance for Children and Families, Report to Clark County, Nevada DFS, Out of Home Care Resources and Practices (August, 2007) at 8. Defendant Clark County, which Defendant Valentine oversaw, contracted for the creation of this report, and its authors interviewed staff from Clark County DFS, which Defendant Morton oversaw. *See id.* at 2, 3.

3. Plaintiffs Have Been Injured as a Result of Defendants' Failure to Provide Required Information

86. Defendants' policies, customs and omissions regarding withholding critical and required information about children caused injury to children in Defendants' custody, including Plaintiffs, by causing frequent and avoidable movements from one failed placement to another, and by causing the disruption, delay and/or withholding of services needed by Plaintiffs. For example:

(a) Defendants had significant and extensive information about Henry's history, including that Henry had (1) suffered severe physical abuse from his mother before entering foster care; (2) received numerous diagnoses of serious and often conflicting mental health disorders from a variety of mental health providers; (3) been administered psychotropic medications, including multiple medications at the same time; and (4) was prone to extremely erratic behavior. Defendants failed to provide this information to prospective foster parents. In May 2009, when M.J. met with Defendants' caseworkers to decide whether to take Henry into her home upon his discharge from a treatment facility, M.J. was told only that Henry "might" have

ADHD, and that he no longer needed a higher level of care. Defendants did not provide any information or written record of Henry's medications, other diagnoses, or significant mental health and behavioral issues, and they failed to discuss Henry's discharge plan with M.J. or to put her in contact with any psychiatrist who had treated Henry to discuss continuation of his care or how to administer his many medications. In fact, M.J. learned for the first time that Henry was on multiple psychotropic medications when she picked him up from treatment and was given a plastic bag containing Adderall, Abilify, Trileptal, and other prescription drugs. When he arrived in M.J.'s home, Henry was aggressive and threatening toward M.J. and her other children. It was only after M.J. brought Henry to meet with a psychiatrist that M.J. learned from Henry's caseworker of Henry's extensive history of psychiatric problems and erratic behaviors. Henry's aggressive behavior continued, and he was eventually admitted to two psychiatric facilities. Since being admitted, Henry has not been returned to M.J.'s care. Henry's multiple placements have disrupted his medical and mental health care and deprived Henry of the consistent assessment and treatment needed to address his multiple physical and mental health needs. Defendants' failure to provide M.J. with the information described here prevented M.J. from assessing her ability to handle a child with his high level of special needs, placed his safety and the safety of M.J. and her other children at risk, and ultimately caused the placement to fail. In addition, Defendants have shuttled Henry among more than ten different mental health providers. Upon information and belief, Clark County DFS did not provide many of these mental health providers with information about Henry's health history, previous providers, assessments, and treatment. Defendants' failures also impaired the continuity and effectiveness of Henry's mental health care. Henry has suffered injuries to his health, safety and well-being as a result of Defendants' policies, customs and omissions.

(b) In 2007, when Olivia was seven years old and in Defendants' custody, a neuro-psychological evaluation found that she had "severely impaired neuropsychological functioning" and a range of cognitive and behavioral impairments. Olivia was placed on multiple psychotropic medications, including an antipsychotic and medications for bipolar disorder and ADHD. In March 2009, Defendants moved Olivia to a treatment foster home. Upon information and belief,

Defendants did not provide the foster parents with an accurate and complete description of Olivia's mental and behavior health and other special needs prior to placing her in their home. Within two weeks of her arrival, Olivia was admitted to Monte Vista, and the treatment foster parents refused to accept her back into their home. While Olivia was a patient at Monte Vista, she was administered at least three different medications, including an antipsychotic. Upon Olivia's discharge from Monte Vista, Defendants placed her with E.F. Defendants failed to provide E.F. with information about Olivia's medications and failed to grant her the authorization necessary to obtain them through Medicaid. As a result, E.F. was unable to fill Olivia's prescriptions for the drugs she was then taking. Defendants' failure to secure Olivia's medications forced Olivia to go through an abrupt and painful withdrawal from powerful psychotropic drugs. Upon information and belief, the abrupt withdrawal of a child from such medications is medically contraindicated and posed a grave risk to her health and safety. Defendants' failure to provide full and accurate information regarding Olivia's history and mental health and behavioral needs caused her March 2009 placement to fail. Olivia suffered injury to her health, safety and well-being as a result of Defendants' policies, customs and omissions.

(c) Before entering Defendants' custody, Leo and Victor suffered physical, emotional, and sexual abuse at the hands of their parents and other adults with whom they lived at various times. In April of 2007, while the brothers were living at Child Haven, Victor became severely depressed and threatened to hang himself. He exhibited harmful and destructive behaviors toward himself and other children in the group home. In May and June 2007, Victor was hospitalized at two different psychiatric institutions. In June 2007, Defendants placed Leo and Victor with a foster parent who had a developmentally delayed teenaged granddaughter living in the home. Upon information and belief, Defendants failed to provide the foster parent with sufficient information about Leo's and Victor's history of physical and sexual abuse, multiple placements, and psychiatric problems for her to make an informed decision about accepting placement of the children, and determine the level of care and supervision they would need upon joining her home. Just weeks after accepting Leo and Victor into her home, and with no knowledge of the boys' history of abuse, the foster mother left the children unsupervised, and

Victor and the teenaged granddaughter had sexual intercourse. The placement was terminated immediately. Victor was given three years probation, and experienced multiple additional placements before he was eventually sent to a youth prison in Elko. Leo was eventually placed with his grandmother. Defendants' policies, customs and omissions resulted in the failed placement and injured Victor's and Leo's health, safety and well-being.

(d) In March 2009, Defendants removed Charles and Charlotte from their parents' home and placed them in a foster home. In the next twelve months, Charles and Charlotte lived in at least twelve different placements, including multiple stays at Child Haven for only a day at a time. Upon information and belief, when Defendants placed Charles and Charlotte with foster parents, Defendants failed to provide the foster parents with sufficient information about the children's background and needs to enable them to make informed decisions about their ability to care for the children, and as a result, multiple placements failed. Charles and Charlotte suffered injury to their health, safety and well-being as a result of Defendants' policies, customs and omissions.

(e) In the fifteen years that Linda was in Defendants' custody, she was in more than forty placements, including foster homes, shelters, group homes, and psychiatric hospitals. She has suffered abuse and neglect throughout her time in foster care and has been placed on psychotropic drugs, including multiple drugs at the same time. Upon information and belief, Defendants failed to provide multiple foster parents with whom they placed Linda with required information about her background, special needs, medication history, prior placement history, and other information necessary for the foster parents to make informed decisions about their ability to provide adequate care for Linda. Defendants' failures caused multiple foster families to terminate her placements. As a result of Defendants' policies, customs and omissions, Linda suffered injury to her health, safety and well-being.

(f) Upon information and belief, Defendants failed to disclose to prospective foster parents Mason's history of maltreatment, his behaviors, the results of his mental health evaluations and treatment, and other information critical to making an informed decision about their capacity and willingness to provide safe and adequate care for Mason, and how their

acceptance of Mason might affect the other children in their foster home. Some of the foster homes in which Defendants placed Mason were incapable of meeting his needs. For example, Defendants placed him with newly licensed, completely inexperienced foster parents who were not properly equipped to care for Mason. As a result of Defendants' policies, customs and omissions, Mason was injured.

87. As the direct and proximate result of Defendants' policies, customs and omissions regarding the failure to collect, and/or the withholding of, critical and required information, as alleged herein, Plaintiffs have endured repeated failed placements, lack of access to continuous and/or effective mental health care, abuse, and neglect, and have been forced to take numerous psychotropic drugs. As a result of these experiences, Plaintiffs have suffered bodily harm, substantial physical and emotional pain and suffering, humiliation, extreme and severe mental anguish, acute anxiety, emotional and physical distress, and fear and depression, all to their damage and detriment.

4. It Is Likely that Plaintiffs and Others Will Continue to Suffer Harm as a Result of Defendants' Policies, Customs and Omissions

88. Defendants' policies, customs and omissions regarding the collection and sharing of critical information about foster children make it likely that the Plaintiffs still in Defendants' custody, and others, will continue to suffer harm in Defendants' custody.

89. A federal audit of a sample of Defendants' data from 2007 and 2008 indicates that during these years, almost a quarter of the children who were in foster care for less than a year moved to three or more placements. Similarly, almost half of children who remained in foster care between one and two years moved to three or more placements. A 2008 UNLV Performance Audit showed that almost one-third of children in foster care had been in multiple school placements since coming into care. Nevada Institute for Children's Research and Policy, Performance Audit of Nevada's Child Welfare System, Final Report for the Legislative Counsel Bureau Audit Division (2008) (hereinafter "UNLV Performance Audit") at 46. Staff at State DCFS, which Defendant Comeaux supervised in mid-2008, were interviewed as part of the audit.

90. This data comes as no surprise to Defendants. Defendants have been on notice for years that children in their custody are frequently shuttled from one temporary placement to another. The 2004 federal performance review of Nevada's child welfare system found that only 31% of foster children in Clark County had stable placements. Many of the children who experienced multiple placements were under five years of age.

91. Defendants' policies, customs and omissions regarding their withholding of information from foster parents reflect a deliberate indifference to the health and safety of those children, constitute a substantial departure from professional standards, and evidence a lack of professional judgment.

92. Unless Defendants change their policies and customs to ensure that foster parents receive the required information about foster children before accepting them into their care, the Plaintiffs still in custody, and other foster children, likely face future injury from the failure of those placements, and from the disruption, delay, and/or withholding of services that results when Defendants fail to share critical information.

B. Defendants Fail to Provide Foster Children with Necessary Medical and Mental Health Treatment to Which They Are Entitled

1. Federal and State Laws Require Defendants to Provide Timely Medical and Mental Health Services to Meet the Needs of Children in Their Custody

93. The Fourteenth Amendment to the U.S. Constitution provides foster children in government custody with substantive due process rights to services necessary to prevent foster children from deteriorating or being harmed physically, developmentally, psychologically, or otherwise while in government custody, including adequate mental, dental, psychiatric, and psychological services and the right to receive care, treatment, and services determined and provided through the exercise of accepted, reasonable professional judgment.

94. Federal laws require Defendants to provide foster children with medical and dental care and mental health treatment when needed. Federal law grants foster children the right to services to protect their safety and health. 42 U.S.C. § 671(a)(22). Similarly, state law requires that Defendants provide services to foster children to address their needs while in foster care.

NEV. ADMIN. CODE 432B.400, NEV. ADMIN. CODE § 432B.405. Those services include, but are not limited to, medical, hospital, psychiatric, surgical or dental services, or any combination thereof. NEV. REV. STAT. 432B.044, NEV. REV. STAT. § 432.010(8). It is State DCFS policy to "ensure that physical, developmental and mental health needs of custodial children are identified and diagnosed through the use of standardized, periodic screenings." State Child Welfare Policies and Procedures, Nevada Division of Child and Family Services Policy Manual § 0207.2.1. It is also State DCFS policy to "identify and respond to the needs of children under the age of three with developmental delay(s)." *Id*. § 0502.2.1.

95. Defendants provide medical services to foster children in their custody primarily, if not exclusively, through the Medicaid program. As broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are even more expansive. When Congress amended the Medicaid statute in 1989, it made the provision of Early and Periodic Screening, Diagnostic, and Treatment services ("EPSDT") to Medicaid eligible children mandatory for participating states. 42 U.S.C. §§ 1396d(r), 1396d(a)(4)(B). When medically necessary, states are required to make available to Medicaid eligible children all of the twenty-eight types of care and services included as part of the definition of "medical assistance" in the Medicaid Act, including "necessary health care, diagnostic services, treatment and other measures . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services[.]" 42 U.S.C. §§ 1396d(r)(5).

96. The breadth of Medicaid's EPDST requirements is underscored by the statute's definition of "medical services." Section 1396d(a)(13) defines as covered medical services any "diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services . . . for the *maximum reduction of physical or mental disability* and restoration of an individual to the *best possible functional level.*" 42 U.S.C. § 1396d(a)(13) (emphasis added). The Medicaid Act further requires that medical assistance "shall be furnished with *reasonable promptness* to all eligible individuals." 42 U.S.C. §1396a(a)(8) (emphasis added).

97. Federal laws also require that State DCFS provide methods to (a) inform foster children or their caretakers about EPSDT programs, (b) provide foster children on request with

"screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status," and (c) provide foster children diagnostic and treatment services. 42 C.F.R. § 441.56(a)-(c).

98. State DCFS policy, most recently revised in November 2011 and sent from Defendant Howell to Defendant Ruiz-Lee, requires that children in the custody of a child welfare agency "will receive a Nevada Medicaid Healthy Kids screening exam (EPSDT)." Nevada Division of Child and Family Services, Statewide Policy Manual: Health Services, § 0207.5. Screenings must include, but are not limited to, comprehensive health and development/behavior history; developmental/behavioral assessment; and comprehensive unclothed physical exam. *Id*. State DCFS policy also determines the frequency of such screenings: children under 1 year are to receive 6 screenings; children from 1-2 years are to receive a total of 4; and the frequency lessens as children age. *Id*. § 0207.5.5. State DCFS policy requires Clark County DFS to develop internal policies to comply with these requirements, to document referrals in a state database within five days of the referral, and to ensure that supervisors verify that screening exams take place on all children who enter foster care within the designated time frame and per the designated periodic screening schedule and "that any other health exams, assessments/evaluations diagnosis, prescription medications, treatments, and /or referrals" are documented by the caseworker. *Id*. § 0207.6. Overall, the policies aim "[t]o facilitate that children in custodial care receive all necessary health care services." *Id*. § 0207.2.2.

99. It is County DFS policy to "assure[] the safety of each child in its care and custody by providing a pre-placement health screening for initial placement or any placement movement" and "ensure[e] that foster children participate in Nevada's EPSDT program." County DFS Medical Case Management Unit Policies and Procedures § 9130, discussion draft, dated December 19, 2008. On information and belief, these policies and procedures are now in place. County DFS also has undertaken the responsibility to "[e]nsure completion of Early Periodic Screening, Diagnostic and Treatment (EPSDT) examination and any required medical follow-up care within fourteen (14) days for *all* children who enter substitute care." *Id*. § 9120.

100. In addition to the required screenings and treatments, caseworkers are required to visit foster children at their placements on a monthly basis. NEV. ADMIN. CODE § 432B.405. Such visits provide opportunities for the caseworker to observe whether a child has unmet medical and mental health needs or is in need of additional screening and treatment.

2. Defendants' Policies, Customs and Omissions Cause Defendants Regularly and Routinely to Fail to Provide Required Screenings and Treatment to Which Foster Children in Their Custody Are Entitled

101. State and County Defendants have long had knowledge of their failure to provide services and the periodic screenings required by law. The 2008 UNLV Performance Audit found that in 60% of the cases reviewed, foster children had not received the mandatory EPSDT screening/wellness check when they entered foster care. UNLV Performance Audit at 45. This audit also found that only 46.2% of children with identified mental health needs received mental health screenings. *Id.* at 45. Staff at State DCFS, which Defendant Comeaux supervised in mid-2008, were interviewed as part of the audit. As the recommendations were given to both Clark County and the State Department of Child and Family Services, County and State Defendants were well aware of their failure to meet the mental health needs of the children. *See id.* at 11. The 2009 Federal Review found that caseworkers had made no concerted effort to address children's mental health needs in 33% of the cases sampled. Final Report: Nevada Child and Family Services Review, U.S. Department of Health and Human Services Administration for Children and Families (2009) at 58. The County Defendants were also clearly aware of the findings of the Federal Review, as it is referenced on their website. *See* Clark County website, available at http://www.clarkcountynv.gov/Depts/family_services/Pages/CFSRReport.aspx. (citing performance audit).

102. State and County Defendants' own evaluations and commissioned reports document that even when Defendants do assess children to determine what services they need, Defendants routinely fail to provide them with the necessary services. A 2007 County Case Review found that Clark County DFS met the health and mental health needs of only 50% of the children whose cases were reviewed in 2006 and only 57% of the cases reviewed in 2007. 2007 DCFS County Case Review, at 8. The January 2010 CFSR documented that only 54% of Clark

County foster children receive adequate services to meet their physical and mental health needs. 2010 CFSR at 55. The UNLV Performance Audit found that, of the children referred for mental health services, 45.5%—nearly half—did not receive the recommended services. UNLV Performance Audit at 45. Furthermore, Defendants do not ensure that children with mental health needs receive individualized treatment that addresses their particular needs. *See, e.g.*, Berkley Report at 10 (Defendant Morton himself has admitted that "regardless of what [needs are] identified, the same limited array of services is offered rather than individualizing services around the unique needs of the child and family"). Instead, as detailed below, many children with serious mental health needs receive only medication to control their behavior, rather than therapeutic services to treat their underlying mental health issues.

103. State and County Defendants have also known about the particular problem of medicating foster children rather than providing them with therapeutic services. In September 2008, the Children's Attorneys Project (CAP) of the Legal Aid Center of Southern Nevada, which represents several hundred foster children in Clark County, sent a letter to Defendants Willden and Morton addressing the inadequate mental health services their clients were receiving, including that: medication is often the only mental health treatment foster children receive; children are sent from one psychiatric facility to another, typically with new diagnosis and treatment regimes at each facility, with no consultation between providers at the different facilities; and children who could be treated in outpatient facilities are instead confined in hospital settings. The letter was signed by Barbara Buckley, the Executive Director of the Legal Aid Center of Southern Nevada, who also was the Speaker of the Nevada Assembly at that time. The letter described these inadequacies as "both systemic and of such magnitude as to actually put our clients at risk." *See also* Berkley Report at 12 (Defendant Morton asserts that "[o]ften, when a child is stabilized in an in-patient facility and ready for release, there is no lower level of care provider willing or able to accept the child").

104. Defendant Comeaux acknowledged in testimony before the Nevada legislature during its 2009 session that the state's UNITY system was not accurately tracking foster children who were being administered psychotropic medications and that caseworkers were not aware of

the medications a child was receiving and not monitoring and overseeing those medications. *Assembly Bill 364: Makes Various Changes Concerning the Protection of Children: Hearing on A.B. 364 Before the Assemb. Comm. on Health & Human Servs.*, 75th Sess. (Nev. Apr. 8, 2009) (statement of Diane Comeaux), http://leg.state.nv.us/Session/75th2009/Minutes/Assembly/HH/Final/870.pdf at 83.

105. In 2011 and 2012, the Nevada Legislative Auditor also noted serious problems in the provision of medication to Clark County foster children. A 2011 Legislative Auditor Report concluded that medication management processes and procedures in six facilities were inadequate. Nevada Legislative Auditor, Review of Governmental and Private Facilities for Children (October 2011), at 7. As both State and County facilities were examined, both State and County Defendants were well aware of this audit. *See id*. at 4 (thanking the management and staff of the audited facilities for their assistance during the reviews)*; see also* http://www.lasvegassun.com/news/2011/oct/17/state-inspectors-find-foster-children-living-unhea (discussing the results of this audit and the notification of Clark County of substandard conditions of at least one foster home). For example, the report noted that at one location, eight of ten medication files were missing important documentation, including doctors' orders for medication and medication logs. *Id.* at 18. The reviewers also found an empty syringe on the floor and medications stored in areas accessible to youth. *Id.* at 14. A 2012 Legislative Auditor Report found that eight of ten files reviewed in a foster home were missing important documentation about the medications being administered in the home. Nevada Legislative Auditor, Review of Governmental and Private Facilities for Children (April 2012), at 38. The auditors also found evidence that a youth was given the incorrect dosage of a prescription for more than two months and physician orders to change medications and begin new medications were not followed. *Id.* As both State and County facilities were examined, both State and County Defendants were well aware of this audit. *See id.* at 3 (thanking the management and staff of the audited facilities for their assistance during the reviews).

106. Defendants' policies and customs with respect to psychotropic drugs are a key aspect of their failure to provide required screenings and treatment. Psychotropic medications,

including antidepressants, antipsychotics, mood stabilizers, and tranquilizers, are powerful drugs that affect the central nervous system. Some of these medications can cause users to become addicted. Many of these drugs carry potentially serious side effects, such as diabetes, obesity, and liver failure, and have the potential to adversely affect children's brain chemistry later in life. The FDA has not approved such drugs for the widespread uses for which they are being prescribed to the foster children in Defendants' custody. Administering a combination of two or more psychotropic drugs can cause adverse reactions that endanger the patient's health. Little to no data exists to support the prescribing of multiple psychotropic medications in the pediatric population.

107. Rather than provide mental health services with necessary psychiatric treatment, such as individual therapy, group counseling, or other types of care that meet their mental health needs, Defendants have elected to respond to many foster children's issues by allowing widespread administration of powerful psychotropic medications, often in combination. Defendants' policies, customs, and omissions permit the routine administration of these drugs to subdue a child's misbehavior and make the child easier to control, without regard to the side effects and potential dangers of these medications and whether the drugs are medically necessary. Defendants fail to ensure that psychiatrists who prescribe psychotropic drugs comply with professional standards for doing so, including ensuring that such psychiatrists have a specialization in child and adolescent psychiatry and have received training in the use of these medications in the child's age group. Further, Defendants fail to ensure psychiatrists are provided with child-specific information, including the child's health history, physical exam, psychosocial assessment, and mental health, co-morbid conditions, family history, and school records, required to conduct a thorough examination in accordance with professional standards, before prescribing psychotropic medications. Defendants have failed to control and monitor the administration of these drugs to foster children, jeopardizing their health and safety.

108. Once a child begins taking a psychotropic medication, it is critical that the child receive proper monitoring to ensure that the drug is having its intended effect and is not causing harm. Such monitoring requires sufficient time to assess clinical response and side effects.

Professional standards therefore require that the doctor monitor, among other things, the child's height, weight, blood pressure, blood test results, and other laboratory findings and make any adjustments to the dosage or type of medication that may become necessary. Psychosocial interventions, including psychotherapy, are frequently required along with the medication. Defendants fail to ensure that the necessary monitoring takes place or that other psychosocial interventions are provided to foster children, including Plaintiffs.

109. As a direct and foreseeable result of Defendants' policies, customs and omissions, including but not limited to the State and County Defendants' failure to properly train and supervise caseworkers, foster children who are administered psychotropic medication do not receive proper monitoring, including psychotherapy, to ensure that the drug is having its intended effect and is not causing harm. This problem is exacerbated when foster children change placements, because in those instances, the children are often forced to change health care providers, including psychiatrists. As a result of Defendants' policies, customs and omissions, Defendants often fail to transmit a child's assessments, diagnoses, medication history, and treatment records to the new treating physician. Defendants do not require a child's current and former mental health providers to consult on the treatment plan. As a direct and foreseeable result, children routinely receive new and often conflicting diagnoses from their new doctors and may begin taking different or additional medications, increasing the risk of harm to the child.

3. Plaintiffs Have Been Injured as a Result of Defendants' Failure to Provide Necessary Medical and Mental Health Services to Which They Are Entitled

110. Plaintiffs have been injured by Defendants' policies, customs and omissions that result in foster children not receiving the necessary medical and mental health services to which they are entitled. For example:

(a) Although Delia was noticeably underweight when she entered Defendants' custody, Defendants failed to assess her developmental and medical needs. In July 2009, Delia's then current foster parent, S.W., brought Delia to the hospital to seek care for a severely swollen eyelid. The examining physician determined that Delia needed an MRI to determine whether she had a potentially life-threatening tumor, but S.W. lacked authority to authorize the diagnostic

procedure. S.W. immediately attempted to contact Delia's caseworker and supervisor. Despite multiple calls about this emergency situation, however, neither the caseworker nor the supervisor returned S.W.'s calls. Ultimately, Delia received the necessary procedures either because the doctor deemed the situation to be emergency or, in the case of the MRI, because S.W. was able to obtain consent from Delia's biological mother. The MRI revealed that Delia had a tumor that needed to be removed immediately. Delia had surgery and then had to undergo chemotherapy. Defendants' conduct delayed Delia's access to the MRI screening that diagnosed her malignant tumor and delayed her surgery and chemotherapy. During Delia's time in Defendants' custody, Defendants' caseworkers rarely visited her at her placement and did not monitor Delia's health to verify that she was receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address her physical and mental health needs has injured Delia.

(b) While Jonathan was placed at Child Haven as an infant, the staff failed so completely to provide for his medical and nutritional needs that he was diagnosed with failure to thrive and was developmentally delayed. Although he often regurgitated his food after eating, staff took no steps to ensure he received adequate nutrition. At five months, Jonathan was unable to turn his head. Defendants also deprived Jonathan of urgently needed medical care. After coming to live with S.W., Jonathan became seriously ill with an impacted colon. When his doctor recommended a colonoscopy, S.W. and Jonathan's doctor repeatedly sought authorization from Defendants, but Defendants refused to consent and failed to approve medical procedures that would assist in diagnosing his medical condition and developing a treatment plan to alleviate his symptoms. Jonathan suffered constant physical pain from his condition for several months, until it became so severe that he required emergency surgery to remove the calcified stool. Further, DFS never authorized the surgery. Rather, because the doctor determined that it had become a life-threatening situation, the doctor apparently determined that Nevada law authorized him to conduct the surgery without obtaining DFS consent or a court order. This emergency surgery was a direct result of Defendants' deliberate indifference to Jonathan's medical needs.

During Jonathan's time in Defendants' custody, Defendants' caseworkers rarely visited Jonathan and did not monitor his health to verify that he was receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address his physical and mental health needs has injured Jonathan.

(c) While Maizy was placed at Child Haven as an infant, she also suffered from lack of attention and care. She too was diagnosed with failure to thrive and became developmentally delayed. At fifteen months, Maizy weighed only thirteen pounds and was unable to crawl. During Maizy's time in Defendants' custody, Defendants' caseworkers rarely visited her and did not monitor her health to verify that she was receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and all necessary screening, assessments, and treatment services to address her physical and mental health needs have injured Maizy.

(d) Defendants have caused Henry to change medical and mental health providers more than ten times during his time in their custody. Upon information and belief, Defendants failed to transfer Henry's records to each doctor in the chain. Accordingly, Henry's treating doctors were often unaware of his health history, previous providers, assessments, diagnoses, medications, and treatment. This has led to inconsistent diagnoses and the administration of multiple and inconsistent medications. Henry has experienced long periods during which no assessment of his mental and behavioral health needs was completed or updated and during which he did not receive necessary periodic assessments and reassessments of the various medications that he had been prescribed. For many years while in Defendants' custody, Henry has been administered various psychotropic medications, including multiple medications at the same time. Defendants failed to monitor Henry's reactions to the medications. In June 2009, Henry fell gravely ill after being poisoned by the combination of psychotropic medications he was then taking. Henry was hospitalized in an ICU for two weeks and nearly suffered organ failure. Upon his discharge from the ICU to Monte Vista, and while still in Defendants' custody, Henry was again administered the same or similar psychotropic medications that had led to his emergency

hospitalization. Henry again fell gravely ill and again spent two weeks in treatment in the ICU. During Henry's time in Defendants' custody, Defendants' caseworkers rarely visited him and did not monitor his health to verify that he was receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address his physical and mental health needs has injured Henry.

(e) Upon information and belief, when Linda was seven years old and in Defendants' custody, she was confined at a psychiatric facility for a six-month period that was longer than medically necessary because Defendants did not have another placement for her. Linda was placed on psychotropic drugs at various points from the time she was seven until she was thirteen. Linda was often compelled to take a variety of such drugs, at times taking as many as five or six different medications at once. These medications often made Linda lethargic and unable to focus. Upon information and belief, Linda was at times prescribed these medications simply because a caregiver requested a "fix" for her behavior, without proper consent and without an appropriate, comprehensive assessment by a qualified health professional. During Linda's time in Defendants' custody, Defendants' caseworkers rarely visited her and did not monitor her health to verify that she was receiving all necessary medical screenings, assessments, and treatment services. Although Defendants caused Linda to take powerful psychiatric medications, Defendants failed to provide her with psychiatric care to consistently monitor her medication. Defendants also failed to provide Linda with a mental health assessment and medically necessary medical and dental care. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address her physical and mental health needs has injured Linda.

(f) Defendants did not provide Victor with a mental health assessment or services to address his severe depression, suicidal threats, and other needs for many months. The staff at one of Victor's group homes did not allow him to attend medical and psychiatric appointments. In the spring of 2007, due to continued suicide threats, Victor was hospitalized twice in quick succession at two different mental health facilities, without consultation between the facilities.

Defendants also failed to provide Victor with follow-up psychiatric services and did not ensure that he received prescribed medications upon release from the second facility. Further, although they knew both Leo and Victor had suffered abuse, Defendants failed to provide care to address those traumas. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address their physical and mental health needs caused injury to Victor and Leo.

(g) Defendants failed to provide necessary medical care to Charles and Charlotte. In 2009, while in foster care and in Defendants' custody, Charles was placed on Adderall and Ritalin. Upon information and belief, Charles's psychiatrist prescribed these drugs for ADHD, instead of treating Charles with behavioral approaches, based on nothing more than the request of a foster mother who had only known Charles for a matter of weeks. Upon information and belief, these medications were not medically necessary and subjected Charles to risk of serious harm. Charlotte, who was less than a year old at the time, was administered asthma medications even though she does not have asthma and such medications were not medically necessary. Upon information and belief, both children were medicated at the request of foster parents, rather than as a result of assessments and examinations by qualified health professionals. During Charles and Charlotte's time in Defendants' custody, Defendants' caseworkers rarely visited them and did not monitor their health to verify that they were receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address their physical and mental health needs has injured Charles and Charlotte.

(h) Defendants failed to provide Olivia with a timely mental health assessment or needed services despite her history of physical abuse. Although she had been placed in foster care in January 2006, it was not until October 2007 that Olivia received a mental health assessment, and that occurred only because her elementary school referred her to a licensed psychologist for evaluation. The evaluation recommended that she receive psychotherapy, be evaluated for medication by a psychiatrist, and be tested for Fetal Alcohol Syndrome. Following that evaluation, she was prescribed three different psychotropic drugs simultaneously but did not

receive ongoing psychiatric care and has not been tested for Fetal Alcohol Syndrome. The drugs made Olivia extremely lethargic and made it difficult for her to do school work. In March 2009, she was placed in Monte Vista. Defendants discharged her to a foster parent with no transition plan and no ability to obtain her medications, forcing her to suffer abrupt withdrawal from the medications. During Olivia's time in Defendants' custody, Defendants' caseworkers rarely visited her and did not monitor her health to verify that she was receiving all necessary medical screenings, assessments, and treatment services. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address her physical and mental health needs has injured Olivia.

(i) Christine is a medically fragile child who fell out of a second-story window while in her mother's custody. Following the injury, Christine had a titanium plate permanently installed in her head to protect her brain. As a result, she has severe developmental delays and medical needs, including a seizure disorder, and requires a high level of medical care. In July 2008, Defendants allowed Christine to remain in a hospital for four to six weeks longer than medically necessary rather than placing her in an appropriate foster home. Defendants then placed Christine in E.F.'s custody but failed to provide E.F. with her seizure medication or any training on how to care for a child with such a high level of medical needs. Defendants also failed to arrange for medical and therapeutic professionals to treat Christine or to provide her with therapeutic or early intervention services. During Christine's time in Defendants' custody, Defendants' caseworkers rarely visited her and did not monitor her health to verify that she was receiving all necessary medical screenings, assessments, and treatment services. When Christine required emergency surgery to replace a screw in her titanium plate, Defendants took approximately two weeks to approve the procedure. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address her physical and mental health needs has injured Christine.

(j) Defendants failed to provide Mason with the mental health, medical, and education services he needed. Mason has severe-to-profound hearing loss in both ears. To communicate with those who do not know sign language, he needs an interpreter proficient in

American Sign Language. For substantial periods of time, Defendants failed to provide or ensure that Mason was provided with a qualified interpreter. Only one of the more than eight different mental health professionals who treated Mason from 2005 to 2007 was capable of communicating with Mason in American Sign Language. As early as the fall of 2004, after at least three psychiatric hospitalizations, his treating psychiatrist and other professionals recommended that he be placed in a residential treatment center able to handle his hearing impairment. Defendants refused to place Mason in a placement recommended by his treating professionals and instead subjected him to a series of foster home placements and hospitalizations, none of which was capable of meeting his long-term mental health needs. Defendants also failed to obtain diagnostic tests recommended by physicians to whom they took him for an assessment. For example, a geneticist who examined him in May 2007 recommended "a comparative genomic hybridization array study be performed." The recommended tests were never completed. Defendants also failed to provide Mason with necessary medical and other treatment, including speech therapy, following his receipt of a cochlear implant, both before and after his placement at the National Deaf Academy (NDA). NDA unilaterally made the decision to remove the external device necessary to the proper functioning of the cochlear implant, rendering it largely inoperative and depriving Mason of the use and benefit of the cochlear implant. Mason was discharged from NDA and returned to Las Vegas. Upon information and belief, Defendants failed to arrange for any therapy prior to bringing him back to Las Vegas from NDA. Defendants' conduct in failing to provide prompt, periodic, and necessary screening, assessments, and treatment services to address his physical and mental health needs has injured Mason.

111. As the direct and proximate result of Defendants' policies, customs and omissions, including but not limited to the State and County Defendants' failure to properly train and supervise caseworkers, regarding the failure to provide care, treatment, and services necessary to prevent foster children from deteriorating or being harmed physically, developmentally, psychologically, or otherwise while in government custody, including adequate mental, dental, psychiatric, and psychological services to which they are entitled, as alleged herein, Plaintiffs have suffered bodily harm, substantial physical and emotional pain and suffering, humiliation,

extreme and severe mental anguish, acute anxiety, emotional and physical distress, and fear and depression, all to their damage and detriment.

4. It Is Likely that Plaintiffs and Others Will Continue to Suffer Harm as a Result of Defendants' Policies, Customs and Omissions

112. Rather than address these grave problems, Defendants adhere to policies and customs that ensure the problems will continue. Defendants are well aware that many children entering foster care have serious mental health problems, yet Defendants fail to train their caseworkers to recognize and address these problems. Defendants also fail to provide caseworkers with basic information regarding available children's mental health services or how to access and advocate for those services. As a direct and foreseeable result, caseworkers routinely fail to secure mental health services for children who need them.

113. Similarly, Defendants are well aware that many children entering foster care have serious developmental delays or disabilities resulting from abuse or neglect. Defendants fail, however, to train caseworkers on developmental milestones or to educate them on how to identify a child's developmental delay or disability.

114. Defendants' policies, customs and omissions regarding their failure to provide necessary medical and mental health services reflect a deliberate indifference to the health and safety of children in their custody, constitute a substantial departure from professional standards, and evidence a lack of professional judgment.

115. Unless Defendants change their policies and customs to ensure foster children are provided necessary medical and mental health services to which they are entitled, Plaintiffs and other foster children face likely future injury in Defendants' custody.

C. Defendants Fail to Ensure the Safety and Well-being of the Foster Children in Their Care and Custody

1. Defendants Fail to Protect Foster Children by Failing to Investigate Reports of Abuse and Neglect

a. The Law Requires Defendants to Promptly and Thoroughly Investigate Suspected Abuse and Neglect of Foster Children

116. When Defendants remove a child from her home and cause her to live in a foster care placement, Defendants are obligated to ensure that the child is safe in the placement they

have chosen for her. Nevada law mandates that Defendants must immediately investigate any report of possible abuse or neglect involving a child under the age of six, who is at a high risk for serious harm, or who has visible signs of physical abuse. NEV. REV. STAT. § 432B.260. Defendants must evaluate all other reports within three days. *Id*. If during the evaluation the Defendants conclude that an investigation is warranted, they must initiate the investigation within three days from the end of the evaluation. *Id*.

117. When Defendants receive a report of abuse, they must conduct an evaluation. NEV. ADMIN. CODE § 432B.150. Defendants must determine how the child is being affected by the situation and whether the child is currently safe, at risk of abuse or neglect, or threatened with harm. NEV. ADMIN. CODE § 432B.160. In making these determinations, Defendants must consider a number of factors, including age, any exceptional needs of the child, the child's need for medical care, whether the child has sustained a serious injury for which there is no reasonable or credible explanation, and whether safety risks are created because of a caretaker's lack of knowledge, skill, or motivation relating to parenting. NEV. ADMIN. CODE § 432B.160.

118. State law also mandates that Defendants follow a specific protocol in investigating suspected abuse. If the allegations suggest imminent harm, then the caseworker assigned to investigate must see the child immediately and must assess the safety of all children in the home. NEV. ADMIN. CODE § 432B.150. In other cases, the caseworker must attempt a face-to-face meeting with the child and his family on the next business day and on each successive business day until a supervisor deems the matter resolved. NEV. ADMIN. CODE § 432B.155. Further, the caseworker investigating the report of abuse must consider a multi-factored list of considerations, including the risk posed to children by others living in the home. NEV. ADMIN. CODE §432B.160. The manner in which the investigation was initiated and any information obtained must be documented in writing. NEV. ADMIN. CODE § 432B.155. Upon completing an investigation, Defendants must file a report with the Central Registry detailing the facts of the alleged abuse or neglect and the ultimate disposition of the investigation. NEV. REV. STAT. § 432B.310. Defendants have thirty days to complete a Child Protective Services (CPS) investigation, make recommended investigative findings, and submit a complete file to the CPS Supervisor from the

receipt of the report at the hotline. *Investigations Policies and Procedures* (9/5/2008), Discussion Draft. In addition, Clark County DFS policy requires caseworkers to contact the child who is the subject of the report of abuse, as well as the child's siblings.

b. Defendants' Policies, Customs, and Omissions Do Not Comply with Laws Mandating Investigations of Suspected Abuse

119. Defendants' policies, customs and omissions, including, but not limited to the State and County Defendants' failure to properly train and supervise employees, result in their failure to regularly and routinely conduct required investigations and evaluations of suspected or reported instances of abuse and neglect of children they have placed in foster care. When Defendants do investigate or evaluate such reports, caseworkers routinely fail to investigate the factors required by NEV. ADMIN. CODE § 432B.160, including the requirement that they assess the risk posed to a child by others living in the home.

120. Defendants also fail to train their investigators in techniques for gathering and evaluating facts on which to determine whether a child has been a victim of abuse or neglect.

121. Similarly, Defendant supervisors fail to supervise caseworkers to ensure that they are conducting investigations in accordance with law, regulations, and policy.

122. Defendants' failure to adequately investigate suspected abuse and neglect of the foster children in their custody reflects a deliberate indifference to the health and safety of those children, constitutes a substantial departure from professional standards, and evidences a lack of professional judgment.

123. As a direct and foreseeable result of Defendants' failure to comply with the requisite procedures for evaluations and investigations, Defendants routinely fail in their duty to protect the children in their custody and care, and children suffer abuse and neglect at the hands of their caregivers.

124. State and County Defendants have long had knowledge of their failure to conduct required investigations and evaluations of suspected or reported abuse and neglect. In independent reports commissioned by Clark County in 2006, child welfare consultant Ed Cotton concluded that Clark County DFS failed to complete required safety assessments in 43% of the

cases reviewed and failed to gather sufficient information to make a reasonable judgment about the child's safety in more than half the cases. Edward E. Cotton, Report of Data Analysis, Findings and Recommendations (2006) at 5; Edward E. Cotton, Administrative Review of Child Abuse and Neglect Investigations Clark County DFS (November 20, 2006) at 10. Defendant Clark County, which Defendant Valentine oversaw, contracted for the creation of this report, and its authors interviewed staff from Clark County DFS, which Defendant Morton oversaw. State Defendants were made aware of Mr. Cotton's findings and State DCFS, which Defendant Comeaux oversaw, specifically investigated 53 cases where the safety of the child under protection may have been jeopardized. State of Nevada Department of Health and Human Services, Division of Child and Family Services Family Programs Office, Case Review of the 53 Cases in Clark County Identified by Ed Cotton's Report (April 27, 2007) at 2. As Defendant Willden is responsible for carrying out the administration of DCFS, Defendant Willden would have been aware of the Cotton studies and the subsequent DCFS 53 case investigation.

125. Subsequently, Defendant Morton cited the findings of the Cotton reports in his Report to U.S. Representative Shelley Berkley. He noted that reviewers found safety assessments in only 57% of the cases and family risk assessment protocols in only about one-third of the cases. Berkley Report at 6. He further expressed distress at the lack of training to prepare caseworkers for the fundamental task of assessing child safety. In the report, he lamented, "Training needs are evident in regards to safety assessments and family risk assessments. Reviewers found that almost all workers were unclear of the milestones that require a safety assessment . . . ." *Id*.

126. State Defendants have been well aware of the tragic consequences of failing to investigate a case appropriately. In 1995, the State created Child Death Review Teams to investigate the circumstances surrounding children who died as a likely result of maltreatment. State policy dictates that any information about the death or near death of a child with child welfare involvement "must be made available to DCFS Administration not later than 48 hours after a fatality and not later than 5 business days after a near fatality." *Child Fatality Disclosures*, Statewide Policy 0401, http://www.dcfs.state.nv.us/DCFS_ChildFatalities_Disclosures.htm.

Nevada DCFS then posts the available information on its website. Federal oversight further ensures that State Defendants are aware of the circumstances surrounding child deaths. Between October 2005 and August 2006, for example, Federal DHHS's Administration for Children and Families made at least six requests to State Defendants for investigation into the deaths of children in Clark County. The findings reveal several instances of children dying after Clark County CPS failed to investigate or substantiate a prior report of abuse or neglect or dying after CPS substantiated the reports but failed to take further action. In one case, a child died despite the fact that CPS had substantiated three reports of neglect and there had been an open case on the child for two years. *See* August 29, 2006 Letter from Fernando Serrano to Sharon Fujii. The Child Fatality Disclosures posted since 2011 indicate that in more than one-third of the deaths or near deaths of children in Clark County related to child abuse or neglect, prior reports of abuse and/or neglect had been made against the child's caregivers. In one such case, a child died after seven CPS referrals involving his family went either uninvestigated or unsubstantiated. January 23, 2011 Child Welfare Agency Public Disclosure.

127. Defendant Willden testified in support of a bill enacted during the 2007 legislative session that gave DCFS responsibility for overseeing the child fatality review process. Child fatality reviews are conducted when a child dies as the result of abuse or neglect. A significant number of such children or their families are known to child protective services prior to the abuse or neglect leading to their deaths. Defendant Willden acknowledged that child fatality reviews revealed deficiencies in the investigation of child abuse investigations including the failure to interview siblings of children who were reported victims of suspected abuse. *Assembly Bill 263: Makes Various Changes to Provisions Governing the Abuse and Neglect of Children.: Hearing on A.B. 263 Before the S. Comm. on Human Resources & Ed.*, 74th Sess. (Nev. May 7, 2007) (statement of Michael J. Willden), http://leg.state.nv.us/Session/74th2007/Minutes/Senate/HR/Final/1135.pdf at 11.

128. The 2009 Federal Review concluded that following reports of neglect or abuse, the State of Nevada fails to meet national standards for appropriately conducting ongoing risk assessments to assess safety-related concerns, including whether a child is likely to be in

immediate or imminent danger of serious physical harm. U.S. DEP'T OF HEALTH AND HUMAN SERVS., Final Report Nevada Child and Family Services Review, dated January 2010, at 14-16. Defendants Clark County, Valentine, and Morton were also well aware of their failure to properly investigate incidents of alleged abuse, as t the report is disclosed on the Clark County website. Clark County Family Services, http://www.clarkcountynv.gov/Depts/family_services/Pages/CFSRReport.aspx (last visited July 19, 2012).

c. Plaintiffs Have Been Injured by Defendants' Inadequate Investigation of Suspected Abuse

129. Defendants' policy and practice of failing to conduct adequate investigations and evaluations of suspected or reported instances of abuse and neglect of children they have placed in foster care has injured Plaintiffs. For example:

(a) When Linda was five years old and living with her aunt, she ran away to a friend's house to escape the abuse she suffered at home. Upon information and belief, the parents of the friend to whom she ran contacted Defendants and reported their suspicion that Linda's aunt was abusing and neglecting her. On information and belief, these reports were not investigated pursuant to the requisite procedures, and Defendants returned Linda to her abusive aunt.

(b) Linda continued to suffer abuse in other homes into which Defendants placed her. During her stay in one such home, Linda told her caseworker that her foster mother and another child in the home had physically abused her. During another stay in her aunt's home, Linda reported to her caseworker that her aunt was abusing her. Defendants did not investigate pursuant to the mandatory procedures either of Linda's reports of abuse.

(c) After Defendants took protective custody of Leo and Victor, caseworkers returned the boys to live with their mother while Defendants retained legal custody of the boys. During their stay with their mother, both children suffered physical abuse from their mother and her boyfriend. Leo and Victor's grandmother called the CPS hotline multiple times to report the abuse. On information and belief, these reports were not investigated by Defendants pursuant to the requisite procedures.

(d) Defendants later placed Leo and Victor into a series of other foster care settings, including a home with a foster parent who had a history of CPS complaints of neglect. On information and belief, CPS failed to adequately investigate the foster parent and placed the boys with her despite her mistreatment of children in her care.

(e) In the summer of 2007, Defendants placed Victor in a group home. Victor reported to his caseworker that the staff at the group home had withheld medical and psychiatric treatments from him as a form of punishment. Withholding treatment constitutes neglect that triggers Defendants' obligation to investigate. On information and belief, Victor's complaints were not investigated pursuant to the requisite procedures.

(f) As detailed above, the relatives with whom Defendants placed Olivia abused her repeatedly over the course of several years. On information and belief, this abuse was not investigated pursuant to the requisite procedures.

(g) Despite knowledge that Mason had been abused while living in his grandparents' home, after obtaining legal custody of Mason, Defendants required him to visit with his grandparents, where he was again physically and possibly sexually abused. Defendants' failure to investigate and monitor Mason's visitations with his grandparents caused Mason to suffer abuse.

130. As the direct and proximate result of Defendants' failure to conduct adequate investigations of reports of abuse and neglect, as alleged herein, Plaintiffs have been subjected to abuse and neglect resulting in bodily harm, substantial physical and emotional pain and suffering, humiliation, extreme and severe mental anguish, acute anxiety, emotional and physical distress, and fear and depression, all to their damage and detriment.

d. It Is Likely That Plaintiffs and Others Will Continue to Suffer Harm as a Result of Defendants' Policies, Customs and Omissions

131. Defendants' policies, customs and omissions regarding failure to investigate reports of abuse adequately, or at all, make it likely that Plaintiffs will suffer harm in the future. As demonstrated above, foster children in Clark County, including Plaintiffs, routinely experience multiple placements while they are in Defendants' custody. As a result, Plaintiffs still in

Defendants' custody, and others, are likely to be again placed in homes where they will suffer abuse.

132. Unless Defendants change their policies and customs to institute a proper protocol for investigating abuse and to train their caseworkers on how to do so, these policies, customs and omissions will continue to injure children, including Plaintiffs.

2. Defendants Fail to Protect Foster Children When Transferring Them to Out of State Facilities

a. The Law Requires Defendants to Physically Inspect and Monitor Treatment and Services Provided to Foster Children by Out of State Facilities

133. When transferring foster children to facilities outside of Nevada, Defendants are required to physically inspect such facilities before or at the time of the transfer and placement to determine whether the facility provides the services or treatment necessary for the child, is accredited or licensed and in good standing with the entity that accredits or licenses the facility, and is subject to health inspections. Defendants are also required to review the results of any health inspections conducted within the immediately preceding three years. NEV. REV. STAT. § 432.0177(1).

134. The Interstate Compact on the Placement of Children ("ICPC") is an agreement that establishes uniform legal and administrative procedures governing the interstate placement of foster children. It has been enacted by all 50 states and is codified in Nevada as NEV. REV. STAT. § 127.330.

135. The ICPC also governs Defendants' transfer of foster children outside of Nevada, and requires, among other things, that before any such transfer Defendants receive a written notice from the receiving state that the proposed placement does not appear to be contrary to the interests of the child, and also provides that Defendants retain jurisdiction over the foster child sufficient to determine all matters in relation to the custody, supervision, care, treatment, and disposition of the child. NEV. REV. STAT. § 127.330, Art. III, V.

136. State law requires Defendants to monitor the continued appropriateness of the placement by, at least one time each year, physically inspecting each out of state facility and

reviewing the services being provided to the child at the facility and any treatment plan established for the child, and interviewing each foster child placed at an out of state facility at least one time each year. NEV. REV. STAT. § 432.0177(2). These laws are meant to ensure that the placement of a foster child in a facility in another state is safe and capable of meeting the child's needs.

137. In addition, federal law mandates that with respect to children "placed in foster care outside the State in which the home of the parents of the child is located," Defendants are required to "periodically, but not less frequently than every 6 months" have "a caseworker on the staff of the State agency of the State in which the home of the parents of the child is located, of the State in which the child has been placed, or of a private agency under contract with either such State, visit such child in such home or institution and submit a report on such visit to the State agency of the State in which the home of the parents of the child is located." 42 U.S.C. § 675(5)(A)(ii) (as amended by 109 P.L. 239). Thus, for all out of state placements of foster children, federal law requires Defendants to ensure that each child in an out of state placement receives a visit at least every six months and to record a report about each such visit. *Id*. NEV. REV. STAT. § 432.0177(2), which requires visits to out of state placements only once per year, directly contradicts the congressional mandate in 42 U.S.C. § 675(5)(A)(ii), which requires visits every six months.

b. Defendants' Policies, Customs and Omissions Do Not Comply with Federal and State Laws Governing Transfer of Foster Children Outside of Nevada

138. Defendants' policies, customs and omissions, including, but not limited to the State and County Defendants' failure to properly train and supervise employees, result in their routine failure to regularly and routinely fail to physically inspect out of state facilities at least annually and before placing foster children at such facilities. Further, on information and belief, Defendants also regularly and routinely fail to ensure that foster children in out of state placements receive visits at least every six months, to submit reports regarding such visits, and to annually review the services provided to, and any treatment plans established for, foster children in out of state placements.

139. State participation in Titles IV-B and IV-E of the Social Security Act (the "Act") is voluntary. Despite the voluntary nature of state participation, acceptance of federal funding under the Act is contingent on adherence to the requirements set forth in the Act. By accepting federal funds under the Act, Nevada has implicitly consented to the Act's requirements, including the requirements under 42 U.S.C. 675(5)(a)(ii) that children placed out of state be visited at least every six months by a caseworker.

140. As a direct and foreseeable result of Defendants' failure to comply with statutory requirements governing out of state placements, Defendants routinely fail in their duty to protect the children in their custody and care by placing them in dangerous and poorly supervised out of state placements that result in the abuse and neglect of foster children in Defendants' custody.

141. Defendants' policies, customs and omissions concerning out of state visitations and the inspection of out of state facilities reflect a deliberate indifference to the health and safety of children placed out of state, constitute a departure from professional standards, and evidence a lack of professional judgment.

142. State and County Defendants knew or were deliberately indifferent to their failure to protect foster children placed in out of state facilities. Ed Cotton's 2006 Administrative Case Review noted that DFS was not well-trained on the information that was needed to transfer children out-of-state. Edward E. Cotton, Report of Data Analysis, Findings and Recommendations (2006) at 29. DFS sometimes took weeks to even identify information that was missing. *Id.* The fact that the County Defendants were not even aware of the procedures or requirements needed to place children out-of-state demonstrates that County Defendants were unable to effectively evaluate out-of-state placements. Defendant Clark County, which Defendant Valentine oversaw, contracted for the creation of this report, and its authors interviewed staff from Clark County DFS, which Defendant Morton oversaw. Defendant Willden would also have been aware of the report, as DCFS did a follow-up study on Cotton's findings. *See* State of Nevada Department of Health and Human Services, Division of Child and Family Services Family Programs Office, Case Review of the 53 Cases in Clark County Identified by Ed Cotton's Report (April 27, 2007) at 2. As noted in section I.C.1.b, both County and State

Defendants were well aware of Mr. Cotton's findings. As recently as 2011, the Nevada Legislative Audit acknowledged the receipt of complaints from out of state facilities. Nevada Legislative Auditor, Review of Governmental and Private Facilities for Children (October 2011), at 5. As the legislative audit evaluated both State and County facilities, State and County Defendants were aware of the results of the audit. *See id.* at 4 (thanking the management and staff of the audited facilities for their assistance during the reviews).

c. Plaintiff Mason Has Been Injured by Defendants' Failure to Physically Inspect and Monitor Out of State Facilities in Which Foster Children Are Placed

143. Defendants' policy and custom of failing to physically inspect and monitor out of state facilities and other placements in which foster children are placed has injured Plaintiff Mason. For example:

(a) In approximately May 2008, Defendants transferred Mason from Nevada to the National Deaf Academy ("NDA"), an out of state facility located in central Florida. Mason's placement at NDA in Florida is a placement controlled by the provisions of ICPC, NEV. REV. STAT. § 127.330, NEV. REV. STAT. § 432.0177, and 42 U.S.C. § 675(5)(a)(ii).

(b) On information and belief, before transferring Mason to NDA, Defendants did not review any health inspections, nor did they take certain mandatory steps to determine whether NDA would provide Mason with necessary services and treatment, as required by Nevada Revised Statute section 432.0177. In the seventeen months between January 1, 2008 and May 27, 2009, local police responded to 369 calls at NDA, and while Mason was a resident at NDA, Florida Health Care Agency Administration investigated numerous reports of patient abuse or neglect, lack of supervision, and improper use of restraint. The Agency confirmed many of those complaints.

(c) Mason remained at NDA from approximately May 2008 until the end of December 2009. During Mason's approximately nineteen-month placement at NDA, Defendants never visited him, nor participated in any of Mason's monthly treatment sessions or the development and review of his Individualized Education Program.

(d) Before being transferred to NDA, Mason requested and underwent surgery for a cochlear implant. A cochlear implant is a surgically implanted electronic device that provides a sense of sound to individuals who, like Mason, are profoundly deaf. Mason's medical providers informed Defendants that after he received the cochlear implant, Mason would need follow-up care, and that Mason and his care providers would need to take special precautions to keep the implant properly functioning. Defendants, however, failed to provide Mason with the necessary follow-up or to ensure the proper care of his cochlear implant. In approximately May 2008, shortly after his transfer to NDA, NDA staff removed the external device for Mason's cochlear implant, rendering it largely inoperative and depriving Mason, against his wishes, of the use and benefit of the cochlear implant. As a result of NDA's destruction of Mason's cochlear implant, Mason has suffered severe impairment to his language development.

(e) In June 2008, approximately one month after his transfer to NDA, Mason complained of sexual abuse by a resident. Upon information and belief, NDA staff notified Defendants of this report shortly thereafter and provided them with the police report number and the e-mail address and phone number of the investigating officer. Additional persons, including Mason's former therapist in Las Vegas and his foster mother in Las Vegas, also notified Defendants of this report. Defendants nonetheless failed to investigate Mason's complaint. Defendants left Mason at NDA for approximately eighteen months, and took no steps to verify his safety or well-being or to visit him during this time.

144. As the direct and proximate cause of Defendants' failure to physically inspect and monitor out of state facilities in which foster children are placed and ensure that they receive visits at least every six months as alleged herein, Plaintiff Mason has been subjected to abuse and neglect resulting in bodily harm, substantial physical and emotional pain and suffering, humiliation, extreme and severe mental anguish, acute anxiety, emotional and physical distress, and fear and depression, all to his damage and detriment.

d. It Is Likely That Plaintiff Mason and Others Will Continue to Suffer Harm as a Result of Defendants' Policies, Customs and Omissions

145. Defendants' failure to physically inspect out of state facilities before and during the placement of foster children to such facilities, to ensure that foster children in out of state facilities receive visits at least every six months, and to at least annually review the services provided to foster children placed at out of state facilities, has caused, and is continuing to cause, widespread harm throughout the foster care system and makes it likely that Plaintiff Mason and others will continue to suffer harm in Defendants' custody.

146. Unless Defendants cease their failure to implement and enforce applicable law regarding out of state placement of foster children, including by training and supervising caseworkers to do so, it is likely that Plaintiff Mason and others face future injury from the failure of Defendants to physically inspect and monitor treatment of foster children in out of state facilities.

II. CLASS ACTION ALLEGATIONS

147. Plaintiffs bring certain claims for injunctive and declaratory relief in this action on behalf of themselves and a distinct class of foster children in the legal custody of Clark County DFS pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2).

148. Defendants routinely fail to develop a case plan for each foster child as required under Nevada and Federal law. The class for these children is defined as follows:

> All children removed from their homes and placed in foster care in the legal custody of Clark County for whom a case plan in compliance with federal and state requirements has not been prepared (the "Case Plan Class").

149. The Case Plan Class Representatives are Henry A. and Mason I. On information and belief, the Case Plan Class Representatives are members of the class they seek to represent.

150. The Case Plan Class consists of numerous individuals, making joinder of all members impracticable. Furthermore, the Case Plan Class is fluid in that new members are regularly created. There are more than 3,600 children in foster care in Clark County. Throughout the year, many more children enter care than are reflected in any single-day census. During 2004,

for example, a total of 4,548 were removed from their homes and placed in foster care. Nearly half of the children in Clark County foster care are not provided with written case plans within 45 days of removal from the home.

151. There are material issues of law and fact common to the members of the Case Plan Class. The material questions of law and fact common to the Case Plan Class include:

(a) Whether Defendants developed a written case plan containing the requisite information for each class member within the statutorily required time limit;

(b) Whether the failure to develop a written case plan for each class member is a denial of class members' rights under Nevada and federal law;

(c) Whether class members are entitled to declaratory and injunctive relief for the rights they have been denied.

152. The claims of the Case Plan Class Representatives are typical of the claims of the Case Plan Class. The Case Plan Class Representatives will fairly and adequately represent and protect the interests of the Case Plan Class. Case Plan Class Representatives know of no conflict of interest among the Case Plan Class members. Each Case Plan Class Representative 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.

153. As noted above, when Defendants remove a child from his home and take him into protective custody, the Federal Foster Care and Adoption Assistance Act requires that caseworkers develop a case plan for each foster child that includes the child's health and education records, known medical problems and prescribed medications, and other relevant related information. 42 U.S.C. §§ 671(a)(16), 675(1). Federal regulations mandate that the case plan be developed within a reasonable period, to be established by the State, but in no event later than 60 days from the child's removal from the home. 45 C.F.R. §1356.21 (g)(2).

154. Nevada law requires the inclusion of medical and educational information collected about each child in a written case plan within 45 days after the removal of that child from his home. NEV. ADMIN. CODE § 432B.400.

155. The development of a case plan is crucial in identifying each child's needs and ensuring that those needs are met. Federal and state laws require caseworkers to prepare case plans in order to ensure that each child receives safe and proper care by identifying barriers to the provision of a safe environment for the child, clarifying responsibilities of the involved persons to address any identified barriers, and defining overall goals for the case, including step-by-step proposed actions of all persons to reach the goal. Without a case plan, for example, there is an increased risk that a child's special behavioral, emotional, or medical needs will not be met.

156. Collection and preparation of case plans is also critical to ensure required information about foster children is recorded and passed on to every foster care provider. Without this information, prospective foster parents cannot make a considered judgment about their ability to provide adequate care for the child nor are they made aware of and able to ensure that the child receives all necessary care, treatment, and services. Children placed with foster care providers who have not received this information are more vulnerable to disruptions in their placements.

157. Defendants' policies, customs and omissions result in Defendants' routine failure to collect the required information about foster children and to incorporate the information into a written case plan.

158. The most recent Federal Review based on statewide data from the UNITY system indicates that only approximately 53% of children had case plans within 45 days of removal from the home. This data confirms that what was an obvious deficiency noted four years earlier during the 2004 Federal Review continues to be a serious problem. Statewide Assessment at 88.

159. State and County Defendants have long had knowledge of this failure to complete case plans in a timely manner. The 2006 Cotton Report notes that only 54.6% of the cases reviewed had a current case plan and 10% had no case plan at all. Edward E. Cotton, Report of Data Analysis, Findings and Recommendations (2006) at 21. As noted in section I.C.1.b, both County and State Defendants were well aware of Mr. Cotton's findings.

160. Defendant Morton cited the findings of the Cotton Report in his own report to U.S. Representative Berkley. He noted that although over half of the cases had a current case plan, nearly 60% had never had a documented family team meeting. Berkley Report at 7.

161. State DCFS's most recent Annual Progress and Service Report, authored by Diane Comeaux, also referenced the fact that "only 53% of children had case plans." Annual Progress & Services Report (APSR) SFY 2011, at 51. As Defendant Comeaux authored the report, State Defendants were aware of its findings. As the County Defendants collaborated on the report, the County Defendants were also aware of its findings. *Id.* at 12.

162. The failure of Defendants' caseworkers to fulfill the obligation to collect required information and develop a timely written case plan for the children in their custody and care is foreseeable. Defendants employ many caseworkers who are not adequately educated or trained on how to collect the necessary and required information regarding foster children and who fail to meet minimal education levels such as a degree in social work. Approximately one-third of the caseworkers have been at their jobs for less than one year. Compounding these caseworkers' lack of education and experience, upon information and belief, Defendants allow new caseworkers to proceed in the field for months before providing them with even the initial basic training. In addition, caseworkers who fail to develop written case plans are not held accountable for such failings through requisite supervision.

163. Defendants' policies, customs and omissions regarding the failure to collect critical and required information and develop it in a written case plan for each foster child causes injury to Case Plan Class members in Defendants' custody, including by causing frequent and avoidable movements from one failed placement to another, and by causing a disruption, delay, and/or a withholding of services needed by Case Plan Class members.

164. As the direct and proximate result of Defendants' policies, customs and omissions regarding the failure to develop a written case plan as alleged herein, Case Plan Class members have endured repeated failed placements, delay, and/or withholding of needed services, lack of access to continuous and/or effective mental health care, abuse, and neglect, and have been forced to take and abruptly withdraw from numerous psychotropic drugs. On information and belief,

written case plans were not prepared for Case Plan Class Members and the Case Plan Class Representatives as required by federal and Nevada law.

165. Defendants' policies, customs and omissions regarding the collection and compilation of critical information about foster children make it likely that Case Plan Class members and others will continue to suffer harm, including failed placements, in Defendants' custody.

166. Defendants' policies, customs and omissions regarding the failure to develop a written case plan reflect a deliberate indifference to the health and safety of those children, constitute a substantial departure from professional standards, and evidence a lack of professional judgment.

167. Unless Defendants change their policies and customs to ensure that a written case plan is developed for each foster child, Case Plan Class members face likely future injury.

168. The proposed class is represented by experienced counsel who will adequately represent the interests of the class members. Plaintiffs are represented by Morrison & Foerster LLP and Wolfenzon Rolle, law firms that have extensive experience litigating complex legal disputes, including class actions. Plaintiffs are also represented by the National Center for Youth Law, a privately funded, nonprofit organization with extensive national experience in complex class action litigation involving child welfare systems. Plaintiffs' counsel have the resources, expertise, and experience to prosecute this action.

169. Members of the class have all suffered, and will continue to suffer, harm as a result of Defendants' unlawful and wrongful conduct. Defendants have acted and failed to act on grounds generally applicable to the Class Representatives and the classes and require court imposition of uniform relief to ensure compatible standards of conduct toward the classes, thereby making appropriate equitable relief to the classes as a whole within the meaning of Federal Rules of Civil Procedure 23(b)(1) and (b)(2).

CAUSES OF ACTION

FIRST CAUSE OF ACTION
(Fourteenth Amendment to the United States Constitution, Substantive Due Process: Duty to Protect)
(42 U.S.C. § 1983)
(Against All Defendants)

170. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 169 of this Complaint.

171. Defendants' conduct as alleged herein deprived Plaintiffs of their clearly established and well-settled rights under the Fourteenth Amendment to the United States Constitution, including their right to be free from harm while involuntarily in government custody and their right to medical care, treatment, and services. Defendants' conduct includes the following acts and omissions:

(a) failure to adequately provide medical, dental, and mental health services, including but not limited to standardized periodic health screenings and treatments, medical services for maximum reduction of physical or mental disability, and monitoring of, administration, and use of psychotropic drugs by foster children;

(b) failure to inform caregivers of essential information;

(c) failure to conduct legally required visits with foster children;

(d) failure to adequately respond to reports of abuse;

(e) failure to ensure adequacy of relative caregiver placements; and

(f) failure to adequately inspect out of state facilities and monitor treatment and services provided to foster children placed in out of state facilities.

172. Each Defendant acted under color of state law as to the matters set forth herein.

173. Defendants' acts and omissions alleged herein reflect a lack of professional judgment and deliberate indifference in depriving Plaintiffs of their Constitutional rights.

174. Defendants' acts and omissions complained of herein constitute a policy, pattern, practice, custom, final policymaking act, and/or ratification of a subordinate's action that deprived Plaintiffs of particular Constitutional rights.

175. Further, Defendants have failed in their duties to properly hire, train, instruct, monitor, supervise, evaluate and investigate Defendants' caseworkers and supervisors. Defendants were deliberately indifferent to the obvious consequences of these failures, and these failures directly resulted in the deprivation of Plaintiffs' Constitutional rights.

176. Defendants' acts and omissions complained of herein have caused the violation of Plaintiffs' Constitutional rights and caused Plaintiffs to suffer damages, including significant physical and emotional harm, in an amount to be determined at trial. These damages are compensable pursuant to 42 U.S.C. § 1983.

177. Plaintiffs are entitled to injunctive relief against Defendants' conduct as described herein because they are suffering and will continue to suffer substantial and immediate irreparable injury from such conduct unless and until Defendants are restrained.

178. As described herein, Defendants' acts or omissions were in willful, malicious, wanton, reckless or callous disregard of Plaintiffs' rights, thereby entitling Plaintiffs to punitive and exemplary damages.

SECOND CAUSE OF ACTION
(Fourteenth Amendment to the United States Constitution, Substantive Due Process: State Created Danger)
(42 U.S.C. § 1983)
(Against All Defendants)

179. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 178 of this Complaint.

180. Defendants' acts and omissions as alleged herein deprived Plaintiffs of their clearly established and well-settled rights to personal liberty under the Fourteenth Amendment to the United States Constitution. Defendants' conduct includes acting with deliberate indifference to known or obvious danger in removing Plaintiffs from their homes and placing them in the care of foster parents, including in the care of relative caregivers and out of state facilities and homes, who were unfit to care for them and posed an imminent risk of harm to Plaintiffs' safety.

181. Each Defendant acted under color of state law as to the matters set forth herein.

182. Defendants' acts and omissions complained of herein constitute a policy, pattern, practice, custom, final policymaking act, and/or ratification of a subordinate's action that deprived Plaintiffs of particular Constitutional rights.

183. Further, Defendants have failed in their duties to properly hire, train, instruct, monitor, supervise, evaluate and investigate Defendants' caseworkers and supervisors. Defendants were deliberately indifferent to the obvious consequences of these failures, and these failures directly resulted in the deprivation of Plaintiffs' Constitutional rights.

184. Defendants' acts and omissions complained of herein have caused the violation of Plaintiffs' Constitutional rights and caused Plaintiffs to suffer damages, including significant physical and emotional harm, in an amount to be determined at trial. These damages are compensable pursuant to 42 U.S.C. § 1983.

185. Plaintiffs are entitled to injunctive relief against Defendants' conduct as described herein because they are suffering and will continue to suffer substantial and immediate irreparable injury from such conduct unless and until Defendants are restrained.

186. As described herein, Defendants' acts or omissions were in willful, malicious, wanton, reckless or callous disregard of Plaintiffs' rights, thereby entitling Plaintiffs to punitive and exemplary damages.

THIRD CAUSE OF ACTION
(Federal Adoption Assistance Act and Child Welfare Act)
(42 U.S.C. § 1983)
(Against All Defendants)

187. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 186 of this Complaint.

188. Defendants' conduct as alleged herein violated Plaintiffs' statutory rights under the federal Adoption Assistance and Child Welfare Act of 1980, as amended by the Adoption and Safe Families Act of 1997, 42 U.S.C. § 671 *et seq.*, and the regulations promulgated under the Act, 45 C.F.R. Parts 1355-1357, including but not limited to: the right of each Plaintiff to have his or her health and educational records reviewed, updated, and supplied to foster care providers with whom the child is placed before or at the time of placement, pursuant to 42 U.S.C.

§§ 671(a)(16), 675(1), and 675(5)(D).

189. Each Defendant acted under color of state law as to the matters set forth herein.

190. Defendants' acts and omissions complained of herein constitute a policy, pattern, practice, custom, final policymaking act, and/or ratification of a subordinate's action that deprived Plaintiffs of particular statutory rights.

191. Further, Defendants have failed in their duties to properly hire, train, instruct, monitor, supervise, evaluate and investigate Defendants' caseworkers and supervisors. Defendants were deliberately indifferent to the obvious consequences of these failures, and these failures directly resulted in the deprivation of Plaintiffs' statutory rights.

192. Defendants' acts and omissions complained of herein have caused the violation of Plaintiffs' statutory rights and caused Plaintiffs to suffer damages, including significant physical and emotional harm, in an amount to be determined at trial. These damages are compensable pursuant to 42 U.S.C. § 1983.

193. Plaintiffs are entitled to injunctive relief against Defendants' conduct as described herein because they are suffering and will continue to suffer substantial and immediate irreparable injury from such conduct unless and until Defendants are restrained.

194. As described herein, Defendants' acts or omissions were in willful, malicious, wanton, reckless or callous disregard of Plaintiffs' rights, thereby entitling Plaintiffs to punitive and exemplary damages.

FOURTH CAUSE OF ACTION
(Substantive Due Process under the Nevada Constitution)
(Against All Defendants)

195. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 194 of this Complaint.

196. Defendants' conduct as alleged herein deprived Plaintiffs of their substantive due process rights conferred upon them by Article I, § 8(5) of the Nevada Constitution, including their right to be free from harm while involuntarily in government custody and their right to medical treatment, services and care which are provided through the exercise of accepted, reasonable professional judgment. Defendants' conduct includes the following acts and omissions:

(a) failure to adequately provide medical, dental, and mental health services, including but not limited to standardized periodic health screenings and treatments, medical services for maximum reduction of physical or mental disability, and monitoring of use of psychotropic drugs by foster children;

(b) failure to inform caregivers of essential information;

(c) failure to conduct legally required visits with foster children;

(d) failure to adequately respond to reports of abuse;

(e) failure to ensure adequacy of relative caregiver placements; and

(f) failure to adequately inspect out of state facilities and monitor treatment and services provided to foster children placed in out of state facilities.

197. Defendants' acts and omissions complained of herein constitute a policy, pattern, practice, custom, final policymaking act, and/or ratification of a subordinate's action that deprived Plaintiffs of particular Constitutional rights.

198. Further, Defendants have failed in their duties to properly hire, train, instruct, monitor, supervise, evaluate and investigate Defendants' caseworkers and supervisors. Defendants were deliberately indifferent to the obvious consequences of these failures, and these failures directly resulted in the deprivation of Plaintiffs' Constitutional rights.

199. Defendants' acts and omissions reflect a lack of professional judgment and deliberate indifference to Plaintiffs' Constitutional rights and caused the violation of Plaintiffs' Constitutional rights and caused Plaintiffs to suffer damages, including significant physical and emotional harm, in an amount to be determined at trial.

200. Plaintiffs are entitled to injunctive relief against Defendants' conduct as described herein because they are suffering and will continue to suffer substantial and immediate irreparable injury from such conduct unless and until Defendants are restrained.

201. As described herein, Defendants' malicious and/or oppressive acts and omissions caused injury to Plaintiffs, thereby entitling Plaintiffs to punitive and exemplary damages pursuant to NRS 42.005.

FIFTH CAUSE OF ACTION
(Negligence)
(Against All Defendants)

202. Plaintiffs reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 201 of this Complaint.

203. At all times Defendants owed Plaintiffs the duty to act with due care in the execution and enforcement of their duties to Plaintiffs.

204. Defendants were negligent in performing their duties and failed, neglected, and/or refused to properly and fully discharge their responsibilities, including but not limited to engaging in the following acts or omissions:

(a) Failing to ensure that foster children receive necessary care and services for their mental and emotional health, and receive visits from a caseworker no less often than once per month, as required by NEV. ADMIN. CODE §§ 432B.400, 432B.405 and 424.565;

(b) Failing to initiate a child welfare investigation promptly upon receipt of a report of possible abuse or neglect of a child, as required by NEV. REV. STAT. § 432B.260 and NEV. ADMIN. CODE §§ 432B.150 and 432B.155;

(c) Failing to ensure that Plaintiffs were free from physical and emotional abuse while in a foster home, as required by NEV. ADMIN. CODE § 424.530;

(d) Failing to provide information regarding each Plaintiff's medical history and behavior with prospective foster parents before placing each Plaintiff with those parents, as required by Nevada Revised Statute section 424.038;

(e) Failing to physically inspect, monitor treatment and care at, and interview children transferred to out of state facilities, as required by NEV. REV. STAT. § 432.0177 and § 127.330; and

(f) Failing to inform caregivers of essential information as required by NEV. REV. STAT. § 424.038, NEV. ADMIN. CODE §§ 424.465, 424.810 and 424.805.

205. Additionally, Defendants breached their duties of due care by:

(a) Failing to adequately hire, investigate, train, supervise, and monitor their employees to ensure that those employees act at all times in the public interest and in conformance with the law;

(b) Failing to make, enforce, and at all times act in conformance with policies and procedures that are lawful and that protect individual rights, including Plaintiffs' rights; and

(c) Failing to refrain from making, enforcing, and/or tolerating the wrongful policies and customs set forth herein.

206. Defendants' negligence proximately caused Plaintiffs to suffer damages, including significant physical and emotional harm, in an amount to be determined at trial. The harm Defendants caused through their negligence was reasonably foreseeable.

207. As described herein, Defendants' malicious and/or oppressive acts and omissions caused injury to Plaintiffs, thereby entitling Plaintiffs to punitive and exemplary damages pursuant to NRS 42.005.

SIXTH CAUSE OF ACTION[2]
(Federal Adoption Assistance Act and Child Welfare Act)
(42 U.S.C. § 1983)
(On Behalf of the Case Plan Class Representatives and Case Plan Class Against Defendant Willden, Howell, Burnette, Ruiz-Lee, Clark County)

208. Case Plan Class Representatives reallege and incorporate herein by reference each and every allegation contained in paragraphs 1 through 207 of this Complaint.

209. The conduct of Defendants as alleged herein violated Case Plan Class Representatives' and class members' statutory rights under the federal Adoption Assistance and Child Welfare Act of 1980, as amended by the Adoption and Safe Families Act of 1997, 42 U.S.C. § 671 *et seq.*, and the regulations promulgated under the Act, 45 C.F.R. Parts 1355-1357, including the right of each class member to have a written case plan pursuant to 42 U.S.C. §§ 671(a)(16), 675(1), and 675(5)(D).

210. Each Defendant acted under color of state law as to the matters set forth herein.

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[2] This action was the Eighth Cause of Action in the original complaint.

211. Defendants' acts and omissions complained of herein constitute a policy, pattern, practice, custom, final policymaking act, and/or ratification of a subordinate's action that deprived Case Plan Class Representatives and the class members of particular statutory rights.

212. Further, Defendants have failed in their duties to properly hire, train, instruct, monitor, supervise, evaluate and investigate Defendants' caseworkers and supervisors. Defendants were deliberately indifferent to the obvious consequences of these failures, and these failures directly resulted in the deprivation of Case Plan Class Representatives' and the class members' statutory rights.

213. Case Plan Class Representatives and Case Plan Class members are entitled to injunctive relief against Defendants' conduct as described herein because they are suffering and will continue to suffer substantial and immediate irreparable injury from such conduct unless and until Defendants are restrained.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment against all Defendants, jointly and severally, and for the Court to provide relief as follows:

1. Assert jurisdiction over this action;

2. Order that Plaintiffs may maintain Causes of Action Six as a class actions pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure;

3. Compensatory damages for Causes of Action One through Five, in an amount to be proven at trial;

4. Punitive damages against the individual defendants under 42 U.S.C. § 1983 and Nevada law in an amount to be proven at trial;

5. All other damages, penalties, costs, interest, and attorneys' fees as allowed by 42 U.S.C. §§ 1983 and 1988 and as otherwise allowed by federal or Nevada law;

6. Declare unconstitutional and unlawful Defendants' violations of Plaintiffs' and Class Members' rights;

7. Preliminarily and permanently enjoin Defendants from subjecting Plaintiffs and Class Members to practices that violate their rights;

8. Costs of suit; and

7. Such further relief as the Court deems just, necessary, and proper to protect Plaintiffs from further harm by Defendants.

JURY DEMAND

Plaintiffs hereby demand trial by jury on any and all issues triable by a jury.

Dated: July 20, 2012

By: /s/ Dorothy L. Fernandez
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