

# Clark County Child Death Review

## 2008 Annual Report

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*This report was commissioned by the Clark County Manager's Office*



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## BACKGROUND ON CLARK COUNTY CHILD DEATH REVIEW

In an effort to identify risk factors and prevent future child deaths, in 1992 the State of Nevada joined many other states in mandating Child Death Review Teams. Since that time, both the law and the regional teams throughout Nevada have evolved to facilitate the growing need for collaborative efforts to identify interventions necessary to reduce the rate of child deaths in Nevada. While the primary legislative focus of Nevada Child Death Review Teams has been on addressing fatalities related to child maltreatment and/or involvement with the child welfare system, the teams have expanded that focus to address risk factors and preventability in a wide variety of cases. As the largest county in the State, containing approximately 72% of the state's population under 19 years of age (UNLV Center for Business and Economic Research, 2008), the Clark County Child Death Review team has been, and will continue to be, a crucial part of identifying risk factors as well as recommending and implementing policies and procedures to minimize preventable child deaths in the State.

Starting in 2007 the Clark County Manger's Office has contracted with the Nevada Institute for Children's Research and Policy in the School of Community Health Sciences at the University of Nevada Las Vegas to collect case specific data from case reviews and compile an annual report of child deaths in Clark County. This report is a result of Clark County's commitment to make this information more visible and available to the public. While this report is commissioned by the Clark County Manger's Office, the Clark County Child Death Review Team is a multidisciplinary team that conducts independent reviews of cases of child deaths. This team does not report to any county officials and the information found in this report is a result of those independent reviews.

### Goals & Purpose for Teams

The primary goal of all Child Death Review Teams is to prevent future child deaths. The child death review process enables jurisdictions to come together in a collaborative, multidisciplinary forum to openly discuss detailed circumstances in an effort to gain a better understanding of child deaths. The team provides a venue for representatives from a variety of both public and private agencies as well as community organizations to share information in a confidential and non-threatening environment. The National Center for Child Death Review (hereinafter, National Center), which is supported by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, has developed a "Program Manual for Child Death Review" (hereinafter, Program Manual) to assist States in developing and conducting Child Death Review Teams. Many of the recommendations provided in that document have been adopted by both the State and local Child Death Review Teams in Nevada.

*Through a comprehensive and multidisciplinary review of child deaths, we will better understand how and why children die and use our findings to take action to prevent other deaths and improve the health and safety of our children.*

National Center for Child Death Review

## The Purpose

The Nevada State Legislature has defined the purpose of organizing local child death review teams in NRS 432B.403 as a means to:

- Review records of selected cases of deaths of children in Nevada;
- Review the records of selected cases of deaths of children who are residents of Nevada, but die in another state;
- Assess and analyze such cases;
- Make recommendations for improvements to laws, policies and practice;
- Support the safety of children; and
- Prevent future deaths of children.

## The Operating Principles of Child Death Review

The National Center has established the following operating principles for conducting reviews, which have been adopted by the Nevada Child Death Review teams:

- The death of a child is a community responsibility.
- A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.
- A death review requires multidisciplinary participation from the community.
- A review of case information should be comprehensive and broad.
- A review should lead to an understanding of risk factors.
- A review should focus on prevention and should lead to effective recommendations and actions to prevent deaths and to keep children healthy, safe and protected.

## The Objectives

As provided in the Program Manual, the National Center has identified ten primary objectives of the child death review process, which are provided below. These objectives should serve as guidelines for all regional child death review teams in Nevada. It is important to note that all ten objectives are designed to prevent future child deaths.

Each regional child death review team should:

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.
3. Improve agency responses in the investigation of child deaths.
4. Improve agency response to protect siblings and other children in the homes of deceased children.
5. Improve criminal investigations and the prosecution of child homicides.
6. Improve delivery of services to children, families, providers and community members.
7. Identify specific barriers and system issues involved in the deaths of children.
8. Identify significant risk factors and trends in child deaths.
9. Identify and advocate for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.
10. Increase public awareness and advocacy for the issues that affect the health and safety of children.

## **Composition of Child Death Review Teams**

In an effort to gain a holistic perspective of risk factors that may have contributed to the death of a child, Child Death Review Teams are organized to include representatives from a variety of both public and private entities that may have information or insight on a particular child or family. The collaborative nature of this process allows the team to understand the child and family in a more global perspective, providing more insight into circumstances which may have led to the fatality and, ultimately, to preventative measures that may be implemented to prevent future child deaths.

The Nevada State Legislature has mandated participation in local child death review teams in NRS 432B.406, which provides that local team membership, should include, but may not be limited to:

- 1) A representative of any law enforcement agency involved with the case under review,
- 2) Medical personnel,
- 3) A representative of the local district attorney's office,
- 4) A representative of any school that is involved with the case under review,
- 5) A representative of any child welfare agency that is involved with the case under review, and
- 6) A representative of the coroner's office.

The Clark County Child Death Review Team includes members representing all of the mandatory categories, as well as additional members from other public and private organizations including the Department of Juvenile Justice, Safe Kids Coalition, the Office of Suicide Prevention and many others. A complete list of Clark County Child Death Review Team members for 2008 is located in Appendix A.

## **The Review Process**

Regional child death review teams are charged with the periodic review of child deaths which occur in the area represented by the team. Regional teams may review the death of any child who either resides in or died in the State of Nevada, within their respective regions. The Clark County Child Death Review Team meets once a month at the Coroner's Office for a period of three hours to conduct reviews. The team reviews an average of 26 new cases per month. At the beginning of each meeting, the chairs of the team remind members of the confidential nature of the review process and ask any new members to sign a confidentiality statement. All attendees in the meeting are required to sign an annual confidentiality agreement stating that all information shared in the meetings may not be discussed or shared outside of the child death review meeting (see page 10 for a full description of measures taken to preserve the confidentiality of information shared during meetings).

The monthly agenda is organized first according to status and all cases that were brought back from the previous month are listed first. After that all cases are organized by manner of death and by cause of death within each manner. Only cases that have been officially signed out by the Coroner's Office are placed on the monthly agenda. The first few pages of the agenda contain summary information for all cases that month organized by cause and manner of death. This section allows the team to see any trends at first glance. In addition the front page of the agenda contains summary information for each manner of death year to date. For example, this section displays the total number of accidental deaths the team has reviewed for that year. For each individual case, a summary sheet is created that contains basic demographic information about the child and also a short description regarding the circumstances of the child's death.

This full agenda with all information is provided to the team to review during the meeting, but in an effort to protect the confidential nature of the information, it is returned to NICRP staff at the end of the meeting. During the review meeting cases are reviewed in groups based on their cause of death. Agencies with additional information are asked to present their case information. All team members are then given the opportunity to ask questions regarding the case. After the case assessment, team members have the opportunity to make and discuss improvements to laws, policies and practices which will support the safety of children and prevent future child deaths. Each quarter, the Clark County Child Death Review Team submits a report to the Nevada Division of Child and Family Services, on behalf of the Administrative Team, which identifies statistical information regarding the cases that were reviewed and recommendations made based on those reviews.

### **Team Changes in 2008**

In 2008, the Clark County Child Death Review Team finalized its team protocols and set forth a process for team creation, member selection and decision making. These protocols specify that there are “core members” and “at-large members” of the review team. The core team members were appointed by each agency identified in NRS 432B, and these are the decision makers for the group. The team also elected a pediatrician from the community to serve on the core team. In 2008, all child deaths were reviewed by the local team. In addition, fetal deaths over 20 weeks gestation were also reviewed by the local team. Cases on the monthly agendas are organized based on cause and manner of death so that all cases with a similar cause are reviewed together to facilitate the discussion of prevention recommendations. This format allows the team to easily identify trends in circumstances across causes of death. In 2008, additional measures to protect the confidentiality of information shared in the meetings were taken. Only the small group of core team members receives the full agenda in advance of the meeting. All other team members or invited guests are given an agenda at the meeting. These agendas are each assigned a number and are checked out to the meeting attendees when they sign in at the meeting. At the end of the meeting these agendas are collected by NICRP staff and destroyed. This practice reduces the number of people that have identifying information about the cases reviewed, outside of the meeting. At large members are sent a summary agenda one week prior to the meetings. This agenda displays the number of cases to be reviewed and provides basic demographic information regarding the cases to be reviewed organized by cause and manner of death. This allows specialty at-large team members to be prepared for the meetings. For example, if one month there are youth suicides being reviewed, then the member from the Office of Suicide Prevention would want to know that in advance to ensure that he/she can attend, and on the other side if we are not reviewing any cases of youth suicide in a given month he/she could choose not to attend that meeting.

All of the above described changes have helped to streamline and facilitate the review process in Clark County.

## METHODOLOGY

In 2008, Clark County continued to collect and maintain a county-level database to manage the review information on child fatalities. The Nevada Institute for Children’s Research and Policy (NICRP) continues to collect the data and maintain a database of information as well as produce the annual report. The data was collected using a form that was modeled after the collection tool developed by the National Center for Child Death Review. The data collection tool collects as much information as possible through specific questions about the demographics of the child, the supervisor, caregiver, and the family. It also captures detailed information regarding the circumstances surrounding the child’s death. In addition, efforts were made to improve the data collection tool for the 2008 data based on lessons learned in collection during 2006 and 2007.

Data presented in this report is drawn from information gathered at each of the monthly child death review meetings. The Clark County Office of the Coroner/Medical Examiner forwards information for all fetal and child deaths to NICRP for review by the child death review team on a monthly basis. In 2008 the Clark County team reviewed 100% of the child deaths referred to the team by the Clark County Coroner/Medical Examiner’s Office; this included all natural deaths, as well as all accidents, homicides, suicides and undetermined cases. The team also reviewed all fetal deaths over 20 weeks gestation. If a case was referred to the team that was less than 20 weeks gestation at the time of death the

*“In 2008 the Clark County team reviewed 100% of the child deaths referred to the team by the Clark County Coroner/Medical Examiner’s Office; this included all natural deaths, as well as all accidents, homicides, suicides and undetermined cases.”*

case was screened out and not reviewed by the team. The team made the decision to use 20 weeks as a conservative cut off point for potential viability of a fetus. In all cases where these fetal deaths were due to natural causes the manner “natural” was assigned. In these cases it is often the choice of the family if a fetal death certificate is issued. Although fetal death certificates do not indicate a manner of death, for the purposes of child death review and this report, these cases were classified as natural deaths. 2008 is the first year where the Clark County Child Death Review Team chose to review all deaths referred to the team by the Coroner/Medical Examiner’s Office. This process will allow the team to monitor trends in all fetal and child deaths. ***It is important to note this change when reviewing the total number of child deaths in 2008, which due to the change in methodology looks substantially larger than 2006 and 2007. This is because the team reviewed ALL deaths and not just a selection of the natural deaths.***

During the review meeting representatives from various agencies provide information on the case that is then used to complete the data tool. If agencies are unable to attend the meetings requests are made to the agency for the pertinent information on the case. Information that was unavailable at the meeting or unknown by agencies at the meeting is listed as “unknown” in the database. The Clark County Office of the Coroner/Medical Examiner provides copies of death

certificates as well as investigation summaries for each case for data collection purposes when it is available to them. Clark County Department of Family Services also screens each case for prior history with the child welfare agency and if there is history, then that agency completes a form containing the pertinent facts of their involvement with the child and the family.

Data forms were completed by NICRP staff, numerically coded and then entered into a statistical data analysis software package. The data was cleaned, or checked for errors using a process of generating frequencies and identifying outliers, then verifying their accuracy. At this time no additional case information was requested, if the information did not exist in the file, it was simply listed as "unknown". This dataset was then used to produce the statistics that appear in this report. Descriptive statistics are used in this report to present summary information about all cases as well as the leading causes under each manner of death. Frequencies and cross-tabulations were used, however due to the small sample size, tests for statistical significance were not completed. In many cases the subset of cases being discussed is too small to make accurate statements about a number's statistical significance. In addition to simple descriptive statistics, comparative data for 2006, 2007, and 2008 are also presented in this report. The goal is to be able to track the major causes of child death to identify trends and improve the ability to design prevention strategies in Clark County.

This report is organized in terms of manner of death. The different causes of death under these manners are reported as well as some general demographic information on the cases is presented in each section. Determinations of the official cause and manner of death are made by the Clark County Office of the Coroner/Medical Examiner for all coroner cases. According to the National Association of Medical Examiners (NAME), "medical examiners and coroners have the sole legal authority to investigate deaths that are sudden, unexpected, unexplained, and potentially due to external causes such as injury." For natural deaths that are not deemed to be coroner cases the attending physician at the time of death will make the determination regarding cause and manner and sign the death certificate.

The cause of death is indicated by the actual physiological event that caused the person to die and is generally determined through autopsy. Manner is a ruling about intent and is determined by the investigation and circumstances surrounding the death. Therefore, the exact same physiological cause of death could have five possible manners of death. There are five standard manners used: 1) Natural, 2) Accidental, 3) Suicide, 4) Homicide, and 5) Undetermined. The coroner may rule a death "undetermined" when sufficient evidence or information cannot be adduced, usually about intent, to assign a manner of death. For example, a youth may die of a gunshot wound, which would be the actual cause of death. Assigning the manner depends on how the individual was shot. If the youth shot himself, that would be suicide. If he was shot by someone else on purpose, that is homicide. If he discharged a weapon while cleaning it and was hit, that is an accident (although it is important to note that this scenario also presents an element of neglect which the team may identify at review). It is important to pay attention not only to cause of death, but manner as well, because understanding the manner of death can provide reviewers a greater understanding of the circumstances surrounding the death, which increases the potential for preventing future child fatalities.



## LIMITATIONS

As with any research there are limitations associated with this dataset. As we are in the third year of data collection there have been changes made to the data collection tool as well as some of the methods for collection to improve the data presented in this report. However certain limitations could not be avoided. Again this year not all information could be gathered regarding every case reviewed. This missing information can be due to a variety of circumstances including differences among investigating agencies, as information that is important for tracking and prevention may not be pertinent to a coroner or law enforcement investigation and is therefore not available. In other instances a child may not be a resident of this state and therefore the team did not have access to all of the family's background information. This limits the level of detail provided for each case in this report. Additionally, there are many sections where the total number of cases discussed is so small that statistical generalizations cannot be made. Finally, to ensure consistency in data reporting, the Clark County Child Death Review database was compared with records from the Clark County Office of the Coroner/Medical Examiner. The cases matched with a few exceptions. There were several cases of fetal deaths that the team reviewed, but the coroner's office did not count as a child death in their statistics. According to the coroner's office, fetuses that die in-utero and never take a breath are often issued a fetal death certificate which does not assign a manner of death, while a fetus that is delivered and takes a breath is considered a child and will be issued a death certificate.

In an effort to ensure the accuracy of the data presented in this report, NICRP obtains a list of all child deaths for the current year and compares total numbers in the child death review database and the coroner's office statistics. Any differences in total numbers are then reviewed and explanations are provided. In 2008 there were two categories of death where the total number of deaths reported from the coroner's office did not match the total number of deaths in the Child Death Review (CDR) database. First, there were more natural deaths listed in the child death review database than in the coroner's database. This is because the CDR team reviewed all deaths of those people under 18 years of age including fetal deaths. If the fetal death was due to natural causes it was assigned a manner of "natural" even though fetal death certificates do not list a manner of death. The second manner of death with a discrepancy between reported coroner numbers and CDR team numbers was the homicide category. There was one more homicide case in the CDR database than in the coroner's database. This was a case of a 17 week old fetus whose death was ruled a homicide, but no death certificate was issued due to the fact that the fetus was less than 20 weeks gestation. Although the team's policy is NOT to review cases of fetal deaths less than 20 weeks gestation, this case was determined to be a homicide and therefore due to the manner of death it was reviewed by the team and included in the statistics presented in this report. If a death certificate or fetal death certificate was not issued, then the death is not reflected in the coroner's database numbers; however this case was reviewed by the CDR team so it is included in the homicide section of this report creating the discrepancy between the two databases.

In 2008, data collection processes have become even more firm and routine. This year the child death review team was able to gain access to more pieces of information including hospital records, school records, and police investigation reports. In addition in 2008, the ages of the parents were more readily available as a system of information sharing was developed with the Southern Nevada Health District. This information was used to complete the review and later the data collection tool. Agencies have become more familiar with the team and its purpose and, upon request, are sharing

the information for these purposes. However, the team was still unable to obtain all information for all cases. Therefore, this information was listed as unknown. The team anticipates that this information will be more readily available in the future as relationships for data sharing are developed between the team and the relevant agencies.

## CONFIDENTIALITY

All cases reviewed by the Child Death Review Team are kept completely confidential. Information shared in the meetings is protected under NRS 432B.407 and cannot be shared with anyone outside the meeting. All records kept by NICRP are also kept confidential and are securely stored in a locked cabinet in a locked office. In addition, only core team members are sent the full agenda with case details prior to the meeting. All other team members and guests are issued an agenda at the regular review meeting and then required to return the agendas at the end of the meeting. These agendas are then destroyed by NICRP staff following the meeting. Because this information is confidential, every effort was made in this report to discuss cases in general terms and not make reference to any specific details of one case. Therefore, in instances where only one case fit specific criteria details are not provided in this report.

This report is intended to provide summary statistics about all child fatalities in Clark County, offer a comparison between 2006, 2007, and 2008 fatalities where appropriate, as well as provide descriptive statistics regarding specific circumstances surrounding causes and manners of death to assist in generating data driven prevention initiatives. This report does not represent all data collected regarding 2008 child fatalities, because some variables presented too few cases to provide information that is not identifiable.

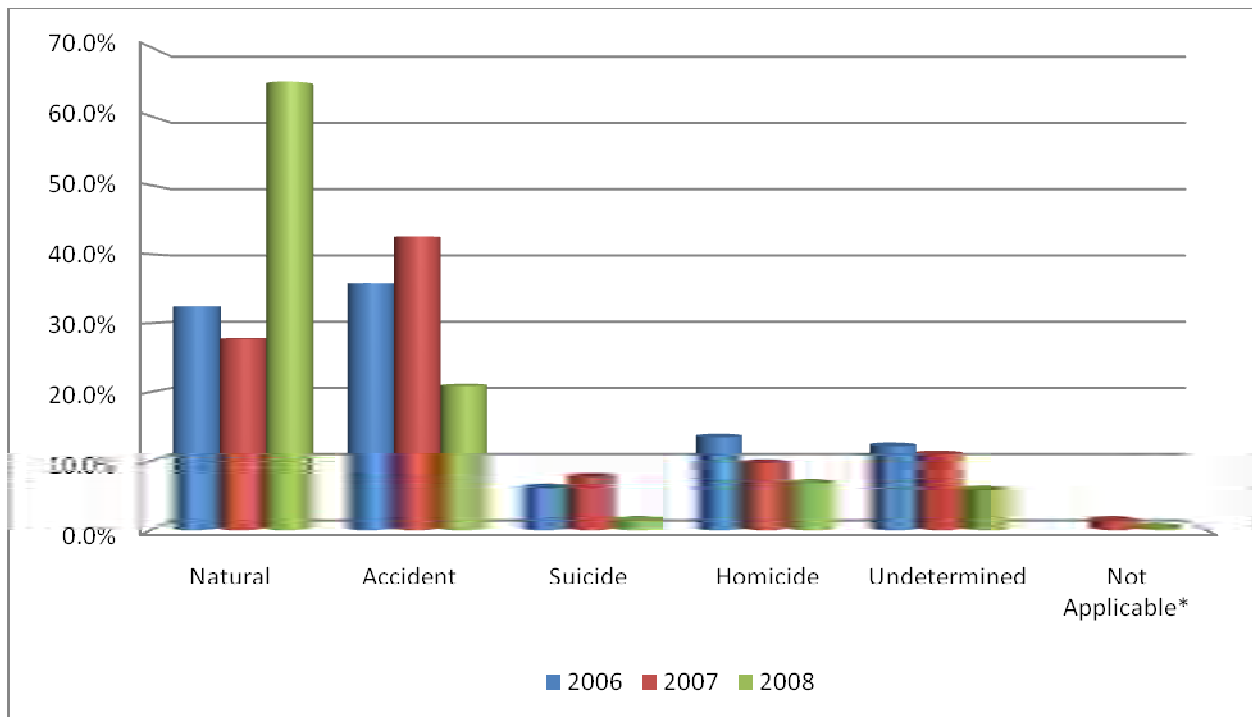
### Section I: Summary Statistics

In 2008, the Clark County Child Death Review Team reviewed ALL child deaths and all fetal deaths over 20 weeks gestation. This resulted in the large difference in the total number of cases reviewed in 2008 compared with 2006 or 2007. In 2008, the team reviewed 311 cases compared to 148 in 2006 and 155 in 2007. However this was due to the change in the methodology for 2008 when all cases of child and fetal deaths (over 20 weeks gestation) were reviewed by the team, not a drastic increase in the number of children that died in 2006 and 2007. These 311 cases represent 100% of all child and fetal deaths referred to the team from the Clark County Office of the Coroner/Medical Examiner (Comparison to Clark County Office of the Coroner/Medical Examiner Data, June 2009). In 2007 there were 215 deaths referred (but not reviewed) as well as 155 deaths reviewed for a total of 370 child and fetal deaths (including those less than 20 weeks). Therefore in 2008 there was a slight decrease as the team reviewed all deaths and there were 311 deaths reviewed. This decrease could partially be attributed to the fact that the team did not review and did not collect information on any fetal deaths where the fetus was less than 20 weeks gestation.

Deaths are categorized based on the official manner of death and can be placed in one of five categories: natural, accidental, suicide, homicide, or undetermined. These classifications are determined by the coroner's office during an investigation or by a physician signing the death certificate in the hospital, if it is not a coroner's case. "Coroner's case" refers to the cases that the coroner's office investigates in order to assign manners of death and sign the death certificate. If hospital physicians sign the death certificate, it is because they do not feel the death needs to be investigated. Since all deaths were reviewed in 2008 it is not surprising that the majority of all deaths reviewed were natural deaths at 65% (202 cases). The next most frequent category was accidental deaths at 20.9% or 65 cases. This is around the same number of cases as in 2007 and slightly more than in 2006. There were more homicides in 2008 than in 2006 and 2007, and there were far less suicides in 2008 than either of the preceding years.

These overall counts are important to understanding the general trends in child deaths in Clark County. As expected there are far more Natural deaths in 2008 than in any other year. This is due to the fact that in 2008 all deaths were reviewed, while in previous years natural deaths were screened for review and only selected cases were reviewed by the team. This is important to remember when comparing percentages of all deaths over the past three years. This is especially clear when looking at the overall causes of death. The majority are Natural causes where in the past the majority of these causes have been Accidental. This is due to the fact that all deaths (including fetal deaths) were reviewed and Natural deaths are the most frequently occurring among children less than one year of age, which is also the most frequently occurring age category.

**Figure 1.1: 2006-2008 Manner of Death (2006 n=148, 2007 n=155, 2008 n=311)**



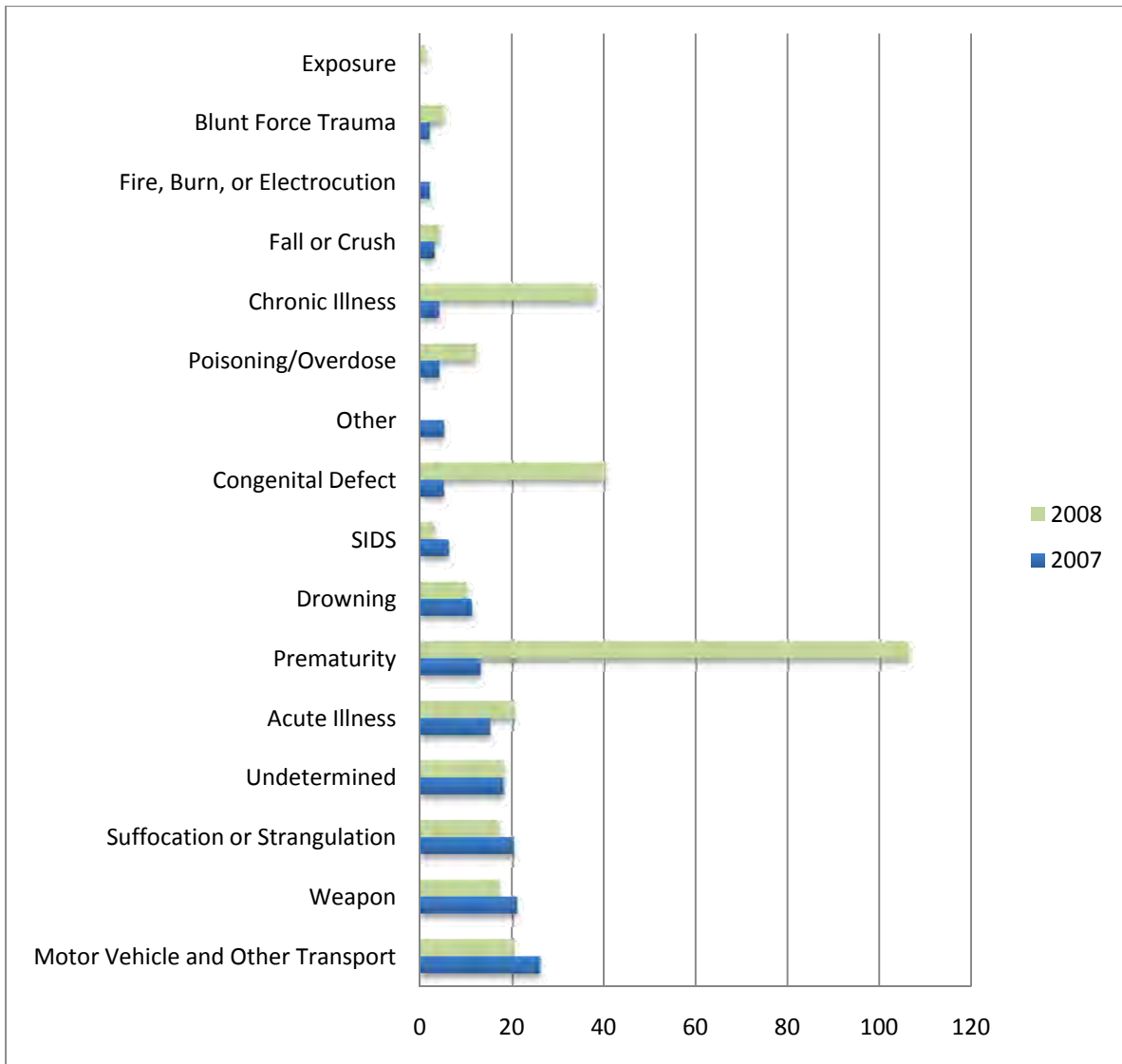
Manner	2006 (n=148)		2007 (n=155)		2008 (n=311)	
	Count	Percent	Count	Percent	Count	Percent
Natural	48	32.4%	43	27.7%	202**	65.0%
Accident	53	35.8%	66	42.6%	65	20.9%
Suicide	9	6.1%	12	7.7%	4	1.3%
Homicide	20	13.5%	15	9.7%	21	6.8%
Undetermined	18	12.2%	17	11.0%	18	5.8%
Not Applicable*	--	--	2	1.3%	1	0.3%

\*Manner is not recorded on fetal death certificate; therefore in cases of fetal deaths in 2007 no manner was recorded. In 2008 all deaths were reviewed including fetal deaths over 20 weeks gestation. Therefore those fetal deaths with natural causes were categorized as natural deaths although they were not issued a death certificate. However in one case the circumstances of the death were not natural and therefore no manner of death was assigned by NICRP in analysis (See methodology section on page 7 for further explanation)

\*\*This change reflects the increase in the number of cases reviewed, NOT an increase in total natural deaths

Figure 1.2 below represents the primary cause of death for all child deaths reviewed in 2007 and 2008. The leading primary cause of death in 2007 were those deaths related to motor vehicles and other transport (16.8%), followed by weapons (13.5%) and suffocation/strangulation (12.9%). In 2008 the leading cause of death was prematurity (34.1%). This is likely because for the first time the Clark County CDR team reviewed all child and fetal deaths over 20 weeks gestation.

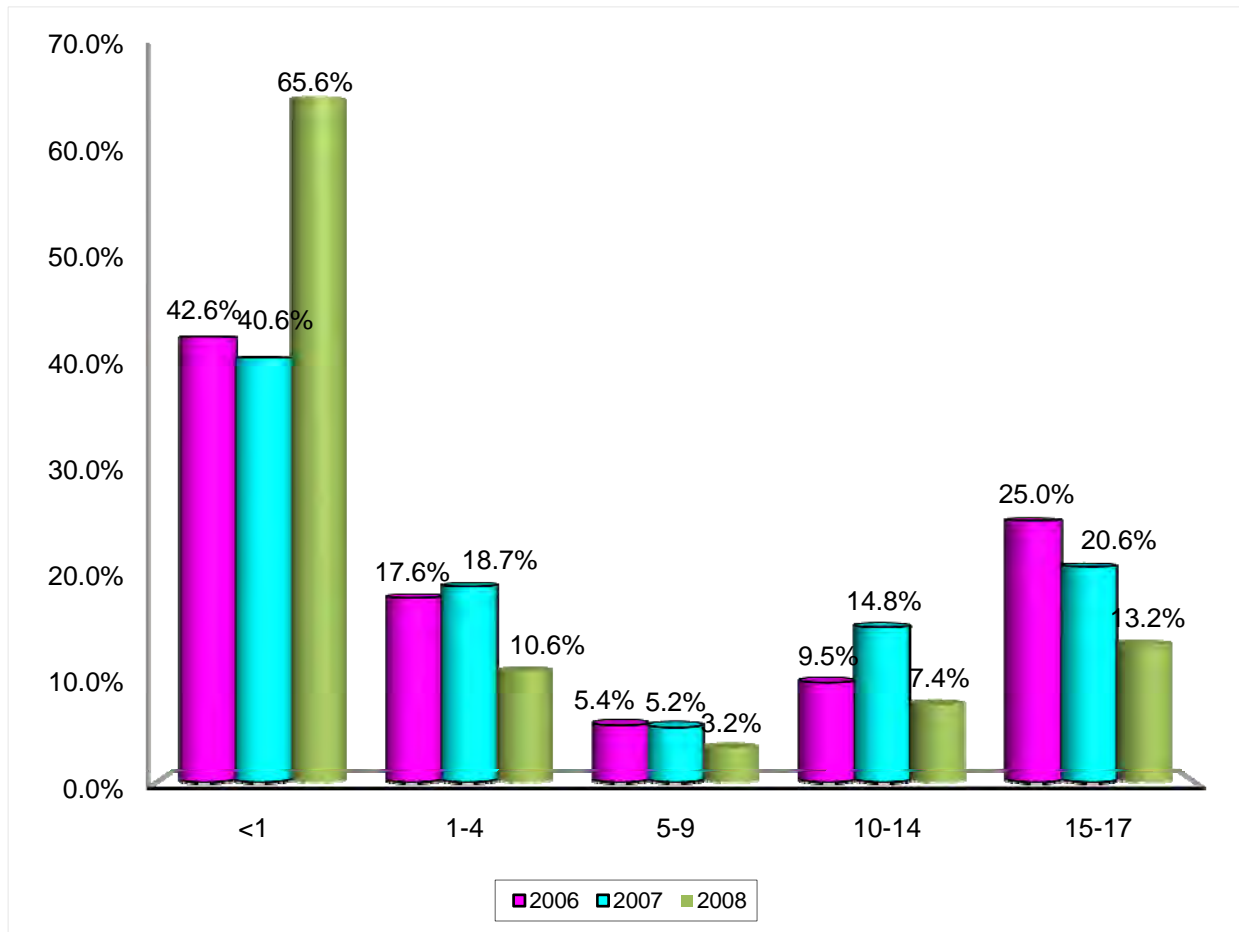
**Figure 1.2: 2007-2008 Primary Cause of Death (2007 n=155, 2008 n=311)**



Primary Cause of Death	2007 (n=155)		2008 (n=311)		Primary Cause of Death	2007 (n=155)		2008 (n=311)	
	Count	Percent	Count	Percent		Count	Percent	Count	Percent
Motor Vehicle and Other Transport	26	16.8%	20	6.4%	Congenital Defect	5	3.2%	40	12.9%
Weapon	21	13.5%	17	5.5%	Other	5	3.2%	0	0.0%
Suffocation or Strangulation	20	12.9%	17	5.5%	Poisoning/Overdose	4	2.6%	12	3.9%
Undetermined	18	11.6%	18	5.8%	Chronic Illness	4	2.6%	38	12.2%
Acute Illness	15	9.7%	20	6.4%	Fall or Crush	3	1.9%	4	1.3%
Prematurity	13	8.4%	106	34.1%	Fire, Burn, or Electrocution	2	1.3%	0	0.0%
Drowning	11	7.1%	10	3.2%	Blunt Force Trauma	2	1.3%	5	1.6%
SIDS	6	3.9%	3	1.0%	Exposure	0	0.0%	1	0.3%

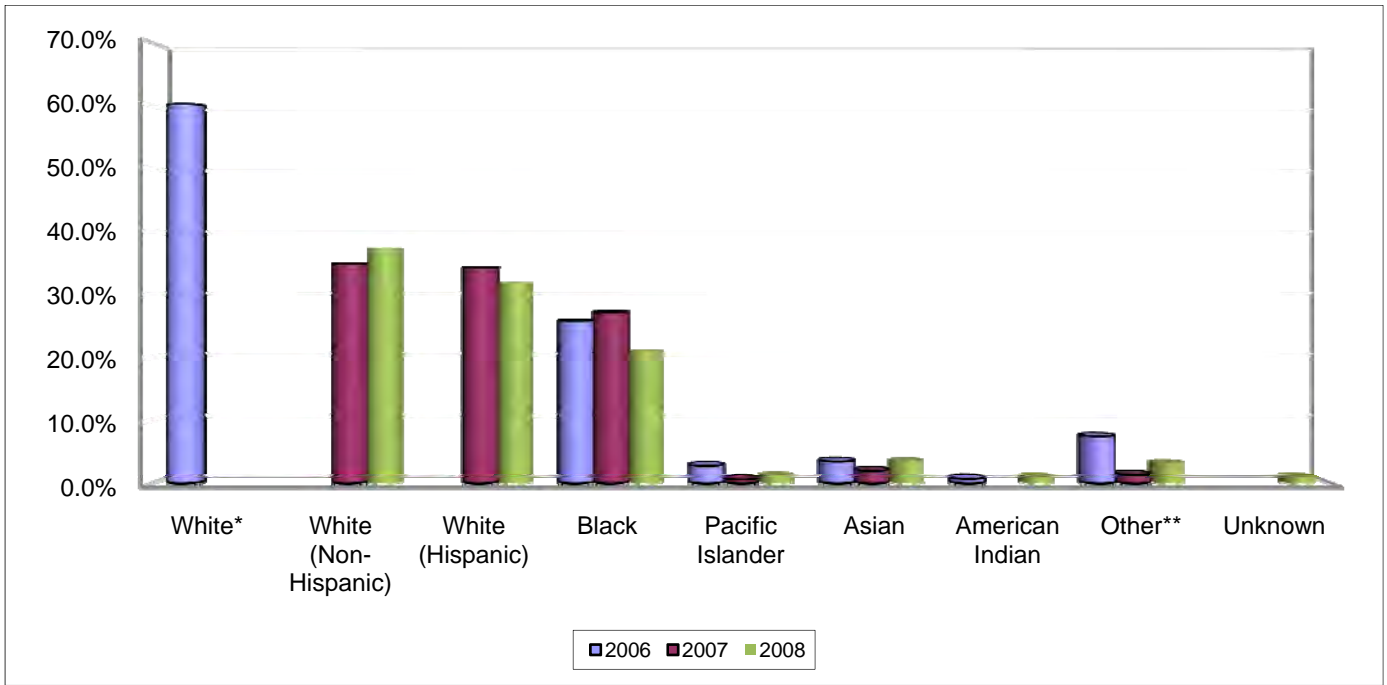
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2008 again the vast majority of deaths are those children less than one year of age (65.6%). However in 2008 the proportion of deaths in each age group was slightly smaller than it had been in 2006 or 2007.

**Figure 1.3: 2006-2008 Age (2006 n=148, 2007 n=155, 2008 n=311)**



In 2006 the child’s race and ethnicity were recorded separately on the data tool in an effort to be consistent with methods used on the death certificate. First the child’s race was recorded (White, Black, Asian, Native American/Pacific Islander, Other), and then a separate question asks whether or not the child was of Hispanic or Latino ethnicity. However, for 2007 and 2008 data were recorded to reflect the distinction between White Hispanic children and White Non- Hispanic children. This resulted in much fewer cases that were coded as “other” in the race/ethnicity field. Many of these cases are multi-racial children. Frequencies for race and ethnicity are very similar across all three years. However in 2008 we can see a slight increase in White (Non-Hispanic) children and a slight decrease in Black children. These statistics are presented in Figure 1.4 below.

**Figure 1.4: 2006-2008 Race/Ethnicity (2006 n=148, 2007 n=155, 2008 n=311)**



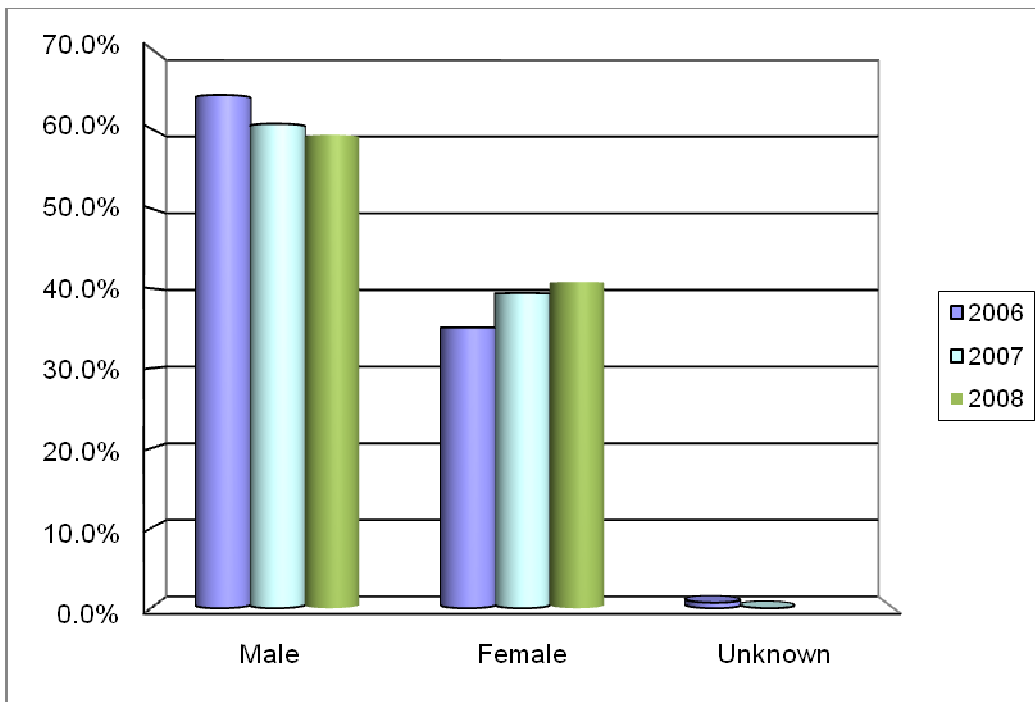
	White	White (Non Hispanic)	White (Hispanic)	Black	Native Hawaiian/Pacific Islander	Asian	American Indian	Other	Unknown
<b>2006</b>	60.1%	--	--	25.7%	2.7%	3.4%	0.7%	7.4%	--
<b>2007</b>	--	34.8%	34.2%	27.1%	0.6%	1.9%	0%	1.3%	--
<b>2008</b>	--	37.3% (116)	31.8% (99)	20.9% (65)	1.2% (4)	3.5% (11)	1% (3)	3.2% (10)	1% (3)

\* Race/Ethnicity data were collected differently in 2006 and 2007. Dashed lines (--) indicate where this separate data was not collected in that year. Also not shown in this graph are the 3 cases where race/ethnicity was unknown. These were likely fetal deaths where little information was collected.

\*\* "Other" includes all decedents with a mixed race, or a race other than those listed on the data collection tool

The distribution of males and females is very similar for all three years. While we seem to be seeing a decrease in male child deaths from 2006 to 2008, there also seems to be an increase in female deaths. This will be an important trend to watch in the coming years. Additionally, in 2006 there was one case that at the time of death sex was unable to be determined, that case is listed as unknown in Figure 1.5 below.

**Figure 1.5: 2006-2008 Sex (2006 n=148, 2007 n=155, 2008 n=311)**



\* In 2006 there was one case where the child's sex could not be identified at the time of the investigation.

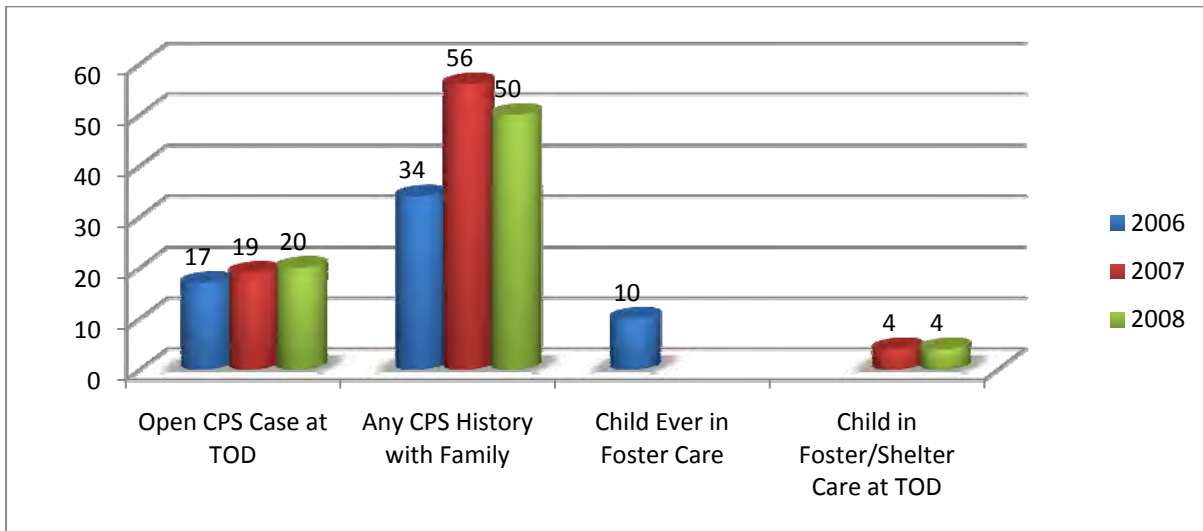
	2006	2007	2008
<b>Male</b>	64.2%	60.6%	59.2% (184)
<b>Female</b>	35.1%	39.4%	40.8% (127)
<b>Unknown</b>	0.7%	0.0%	0.0%

Information was also collected regarding the child or family's history with child welfare. The table below illustrates the comparison of child welfare involvement from 2006 to 2008. All categories in the table below are NOT mutually exclusive meaning that the same child may fall into multiple categories. Additionally, the reader should note that in 2007 there was one case with unknown child welfare history. This information could not be collected because verification data regarding the birth date of the mother could not be obtained.

Figure 1.6 illustrates that there seems to be a steady increase in the number of cases that had an open CPS case at the child's time of death, but a slight decrease from 2007 to 2008 in the total number of families with any CPS history. This year total counts are presented in the table below because the total number of cases reviewed has increased over the years as the team and case selection methodology has changed. Therefore the numbers presented in Figure 1.6 below represent total counts in each of the categories.

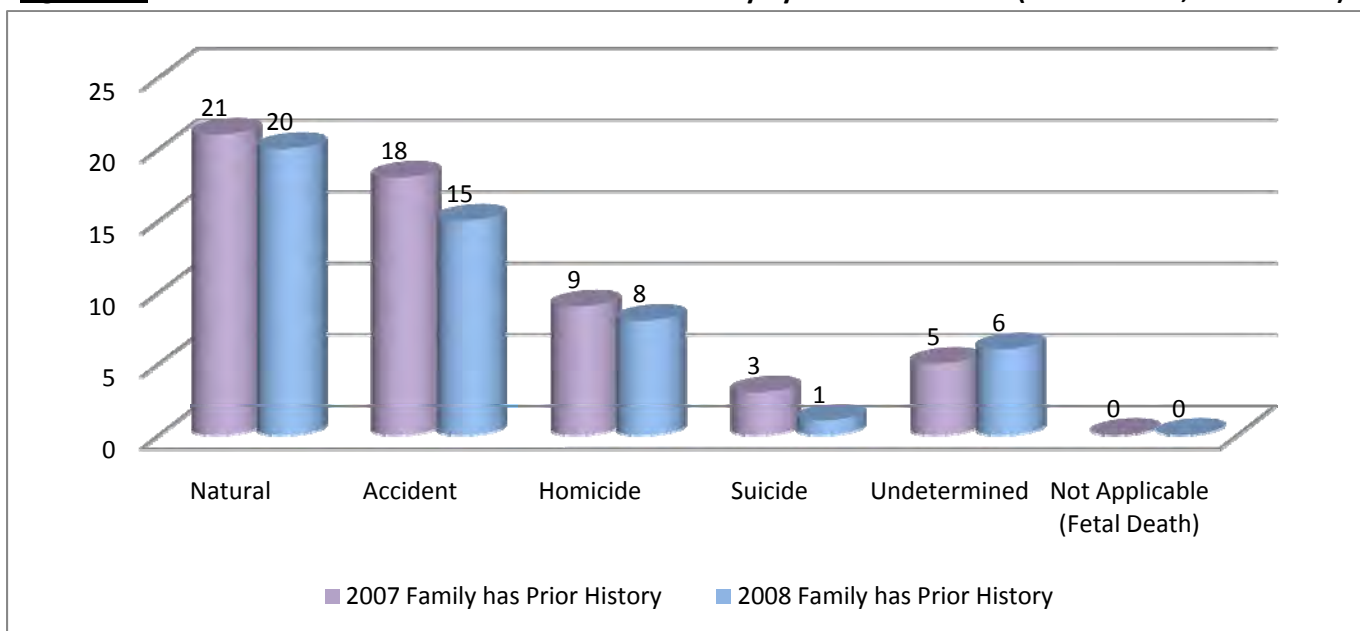


**Figure 1.6: 2006-2008 Type of Child Welfare Involvement (2006 n=148, 2007 n=155, 2008 n=311)**



\* Starting in 2007 data were collected on whether or not the child was in foster or shelter care at the time of death, not ever in their life as it was collected in 2006. Therefore information is not available in both years for that information.

**Figure 1.7: 2007-2008 Cases with Prior Child Welfare History by Manner of Death (2007 n=154\*, 2008 n=311)**



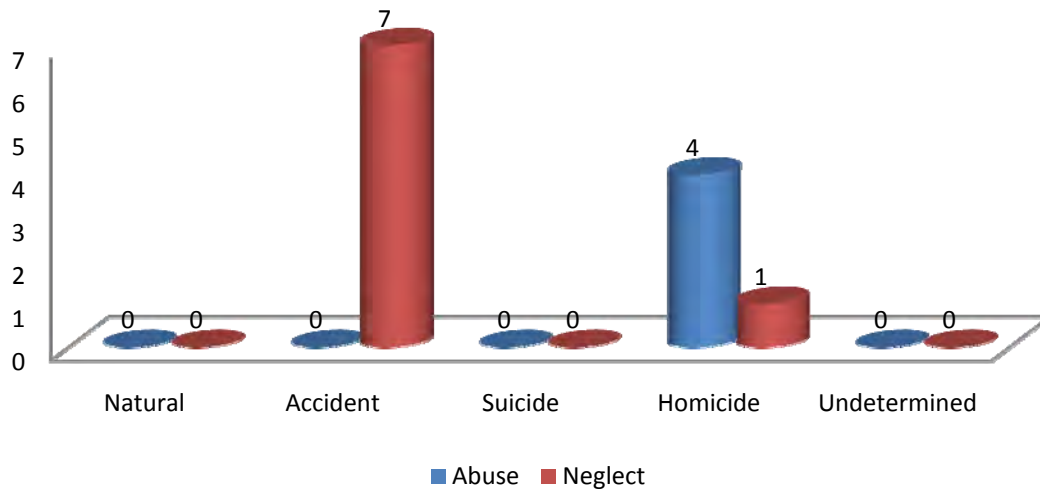
\* This table only shows information for 154 deaths in 2007 because in one case family history with child welfare was unknown as the team had limited information regarding a fetal death.

The graph above illustrates the manner of death for cases with family history of involvement in child welfare. For cases where the family did have a history of involvement in child welfare, the most frequently occurring manner of death was Natural (40%), followed by Accident at 30%, which follows the same pattern as in 2007. For those cases where the family had no prior history of involvement with child welfare, in 2007, Accident was the most frequent manner of death at nearly half (49.0%) of these cases, followed by Natural at 22.4%, however the reverse was true in 2008, with Natural

being the most frequently occurring category at 69.7% and then followed by Accident at 19.2%, this is likely due to the change in methodology in 2008 which resulted in the review of ALL infant/child deaths.

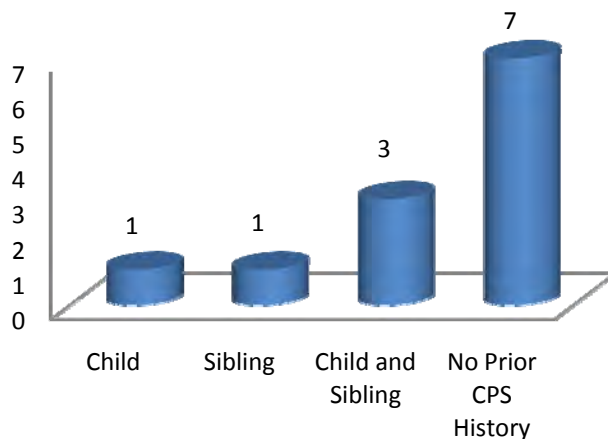
In addition to these statistics, which are collected at each CDR team meeting, the Clark County Department of Family Services (CCDFS) provided NICRP statistics regarding the 2008 child fatalities where their office received a death allegation of child abuse or neglect, and this allegation was substantiated. A report of abuse or neglect is “substantiated” when credible evidence of abuse/neglect has been found in accordance with criteria established in Nevada Revised Statutes and the Nevada Administrative Code 432B. **In 2008, there were 12 substantiated death allegations of child abuse or neglect, this represents only 3.9% of all child deaths in 2008.** Additional information regarding these cases is presented in the figures below.

**Figure 1.8: Manner of Death for Substantiated Death Allegations (n=12)**



Death Allegations of abuse or neglect were only substantiated in two manners of death, accidents and homicides. All substantiated allegations for accidental deaths were due to neglect. However in homicides, four cases were due to abuse and one was due to neglect.

**Figure 1.9: Counts by Type of Prior Family History with Child Protective Services (CPS) (n=12)**



In more than half of these cases the family had no prior history of involvement with child protective services. In four of the remaining five cases the history with the family was regarding the deceased child.

The following sections will discuss in more detail the factors surrounding cases as organized by their manner of death. Each section will begin with a brief description of what that manner of death means, then will present the demographics of the children assigned that manner of death. Finally, each section will discuss pertinent data points that may be important to preventing future child fatalities for that specific manner of death.

## Section II: Natural Deaths

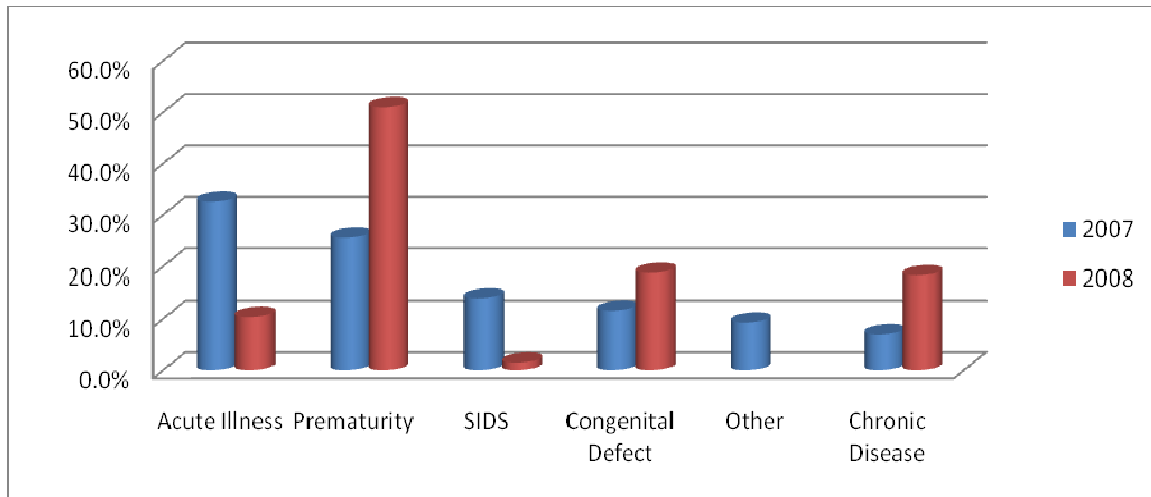
Natural deaths are those deaths that result from natural causes, which include chronic or acute diseases, congenital defects, or genetic disorders. Major risk factors for natural deaths among children under one year include prematurity and low birth weight. For children over one year, the National Center for Child Death Review reports that natural causes are the second leading cause of death behind unintentional injuries. According to the National Center for Child Death Review, children under one year of age who die from causes other than SIDS usually die within the first 28 days of life.

In 2006 and 2007 not all natural deaths were reviewed, only those selected for review by a physician. However, in 2007 some limited data, including basic demographic information and cause and manner, were collected for those cases that were not selected for review. In 2008 all natural deaths were reviewed, including fetal deaths. This information is reflected in this section and accounts for the dramatic increase in the total number of natural deaths reviewed from 2007 (43) to 2008 (202). This difference in data collection should be noted when reviewing this section.

In 2008 the top three causes of natural deaths reviewed included: Chronic Illness, Prematurity, and Congenital Anomalies. This is different from other years because the team reviewed all natural deaths including fetal deaths. This increased the proportion of deaths due to birth defects because in prior years these were often not selected for review as prevention initiatives may be difficult. Therefore this report will focus on Chronic Illness, Prematurity and SIDS, because although it wasn't one of the leading causes of natural deaths, SIDS is a category of death for which a review is mandatory under Nevada Revised Statutes. Additionally, most natural deaths reviewed were children less than one year old. This is consistent with 2006 and 2007 data and is to be expected because 52.5% of these deaths were due to complications of prematurity or SIDS.

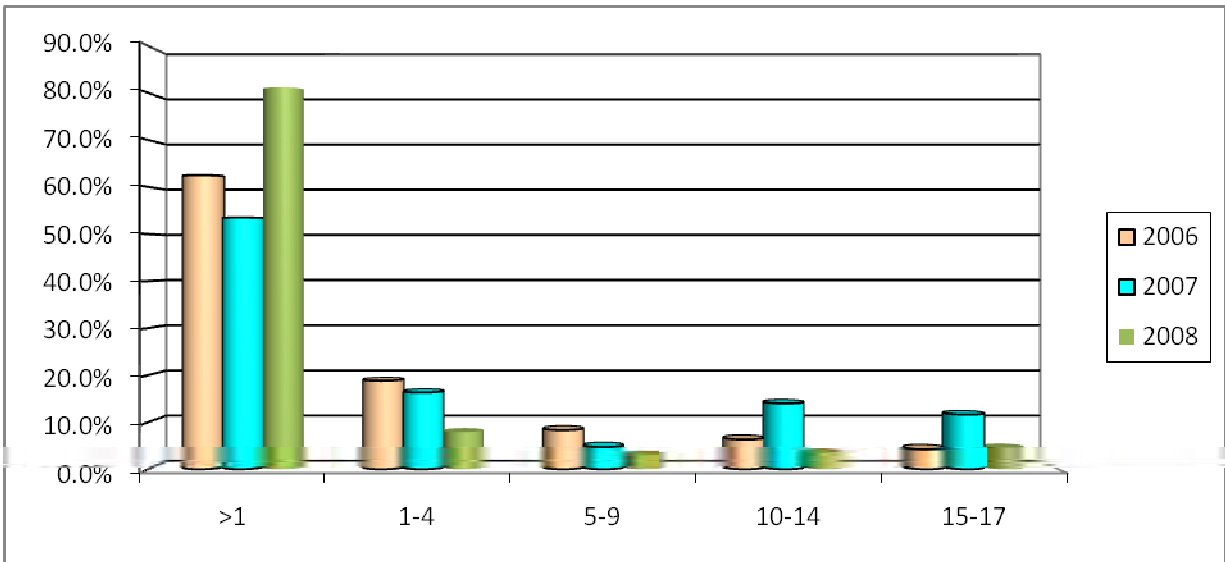
The following graph presents all the causes of natural deaths among cases reviewed in 2007 and 2008. As illustrated, the category "Acute Illness" is the most frequent in 2007 (32.6%), while in 2008 this most frequent category is "Prematurity" (51%). Because all natural deaths were reviewed, including fetal deaths, the number of cases of prematurity drastically increased in 2008.

**Figure 2.1: 2007-2008 Natural Causes of Death (2007 n=43, 2008 n=202)**



Cause	2007	2008	Cause	2007	2008
<b>Acute Illness</b>	32.6%(14)	10.4%(21)	<b>Congenital Defect</b>	11.6%(5)	18.8%(38)
<b>Prematurity</b>	25.6%(11)	51%(103)	<b>Other</b>	9.3%(4)	--
<b>SIDS</b>	14.0%(6)	1.5%(3)	<b>Chronic Disease</b>	7.0%(3)	18.3%(37)

**Figure 2.2: 2006-2008 Natural Deaths Age (2006 n=48, 2007 n=43, 2008 n=202)**



	2006	2007	2008
<b>&gt;1 year</b>	62.5%	53.5%	81.2%(164)
<b>1-4 years</b>	18.8%	16.3%	7.9%(16)
<b>5-9 years</b>	8.3%	4.7%	3.0%(6)
<b>10-14 years</b>	6.3%	14.0%	3.5%(7)
<b>15-17 years</b>	4.2%	11.6%	4.5%(9)

Figure 2.2 illustrates the ages of all natural deaths from 2006 to 2008. The patterns are very similar from 2006 to 2008 as the majority of natural deaths continue to be children under one year of age. Interestingly the proportion of children

in the other four age categories is smaller than it has been in any other year. This is likely another result of reviewing all deaths in 2008.

**Figure 2.3: Natural Deaths - Sex (2006 n=48, 2007 n=43, 2008 n=202)**

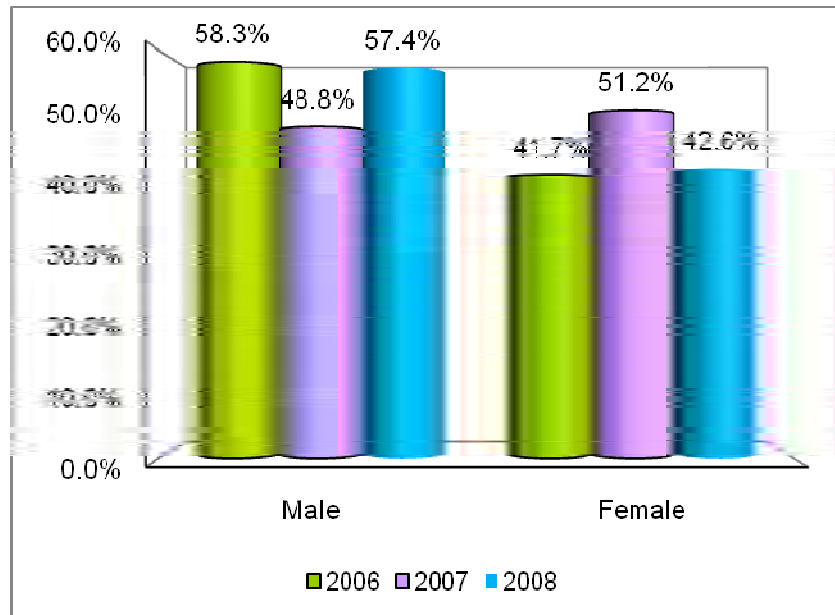
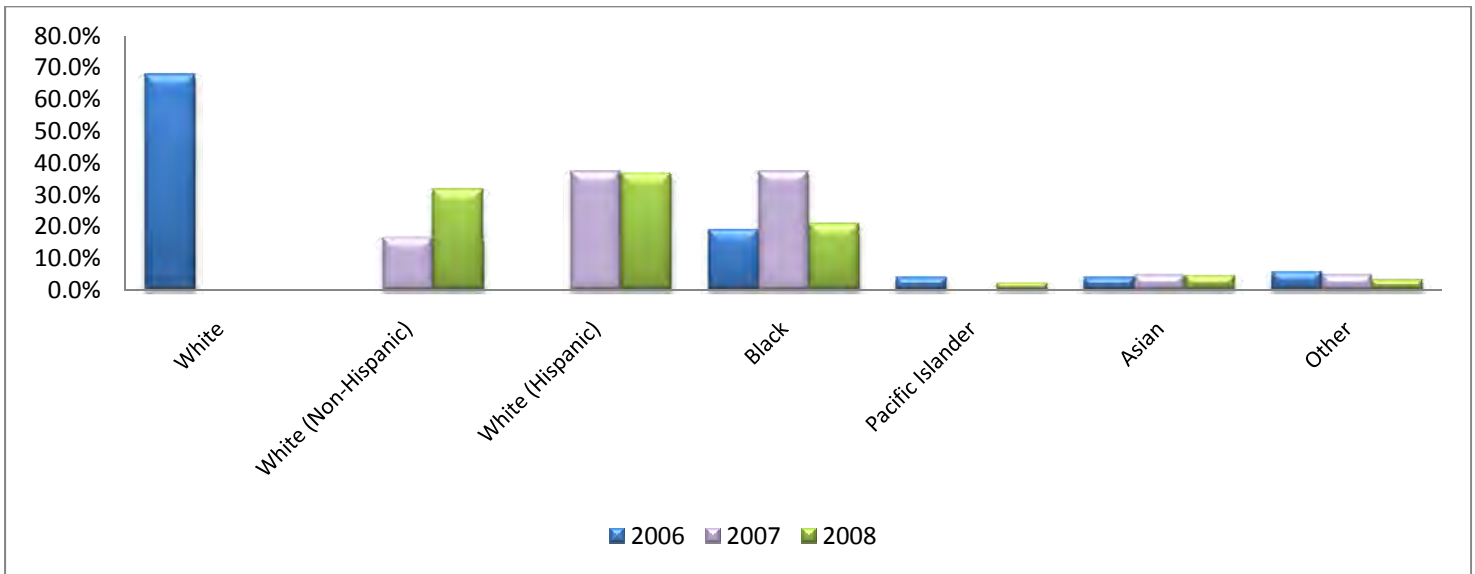


Figure 2.3 shows that in 2008 the gender distribution switches to one more similar to 2006 where more males than females died from natural causes. However, the distribution is still fairly equal.

Figure 2.4 shows the racial and ethnic breakdown of the Natural deaths for 2006 through 2008. After 2006 race and ethnicity data were collected slightly differently to capture the distinction between those who identified as White Hispanics and those who identified as White Non-Hispanics. In 2008 nearly one third or 31.7% (n=64) of all natural deaths were White Non-Hispanic children as opposed to only 16.3% in 2007. There was roughly the same percentage of White Hispanic children in both 2007 and 2008. Additionally, the number of Black children who suffered natural deaths in 2008 has decreased in 2008 to roughly the same level it was in 2006 at 20.8%.

**Figure 2.4: Natural Deaths – Race/Ethnicity (2006 n=48, 2007 n=43, 2008 n=202)**



	White	White (Non-Hispanic)	White (Hispanic)	Black	Native Hawaiian/ Pacific Islander	Asian	Other	Unknown
<b>2006</b>	67.9%	--	--	18.9%	3.8%	3.8%	5.7%	0%
<b>2007</b>	--	16.3%	37.2%	37.2%	0%	4.7%	4.7%	0%
<b>2008</b>		31.7% (64)	36.6% (74)	20.8%(42)	2%(4)	4.5% (9)	3.0%(6)	1.5% (3)

\*Dashed lines (--) indicate data collection variations in 2006

## Chronic Illness

About one sixth (18.3%) of natural deaths reviewed were attributed to complications associated with some kind of chronic illness. The category of chronic illness includes many different illnesses, such as:

- Asthma
- Cerebral Palsy
- Anemia
- Leukemia
- Brain Tumor
- Renal Failure
- Cardiac Arrhythmia
- Cystic Fibrosis

Slightly more females (59.5%) than males (40.5%) died from complications associated with chronic illness in 2008. The most frequent age category for chronic illness was less than one year of age (29.7%, followed by ages 15 to 17 years (21.6%).

**Figure 2.5: 2008 Natural Deaths - Chronic Illness – Age in Years (n=37)**

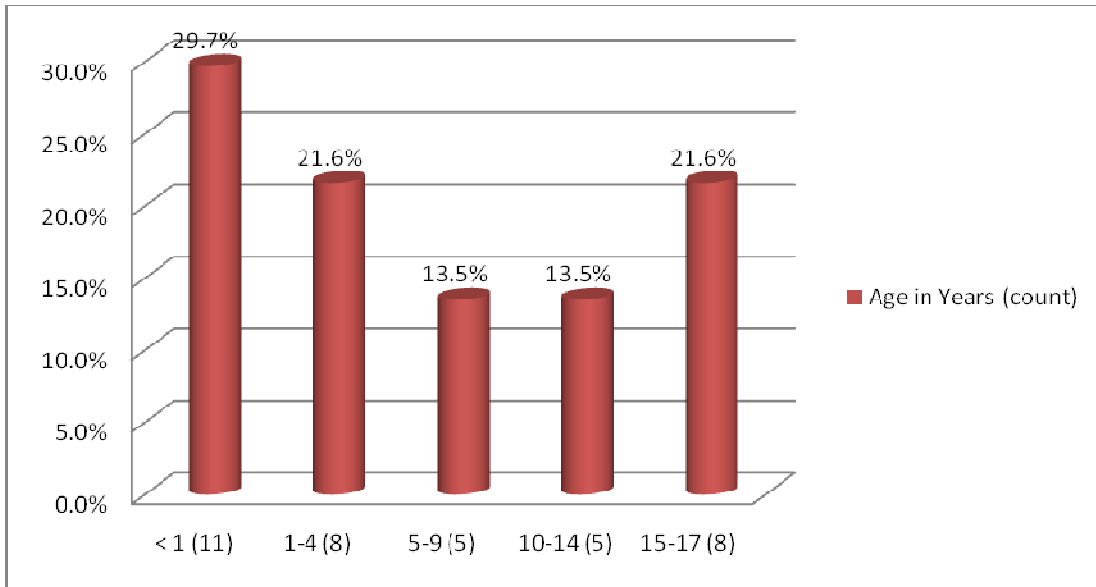
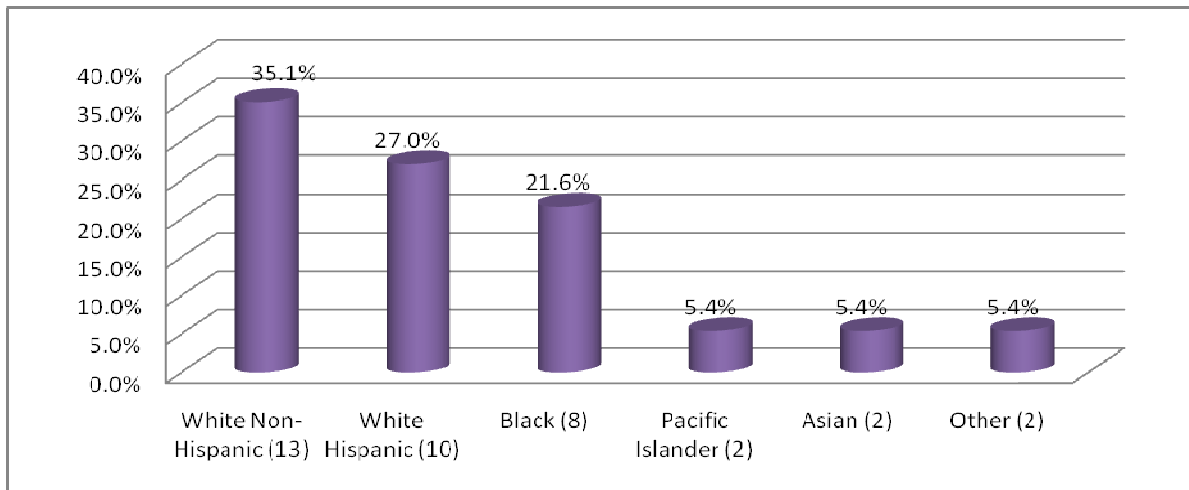


Figure 2.6 displays the racial and ethnic breakdown for deaths associated with chronic illnesses in 2008. One third of these cases were White Non Hispanic children (35.1%). This is fairly representative as overall 37% of the deaths reviewed were White Non Hispanic children.

**Figure 2.6: 2008 Natural Deaths – Chronic Illness Race/Ethnicity (n=37)**

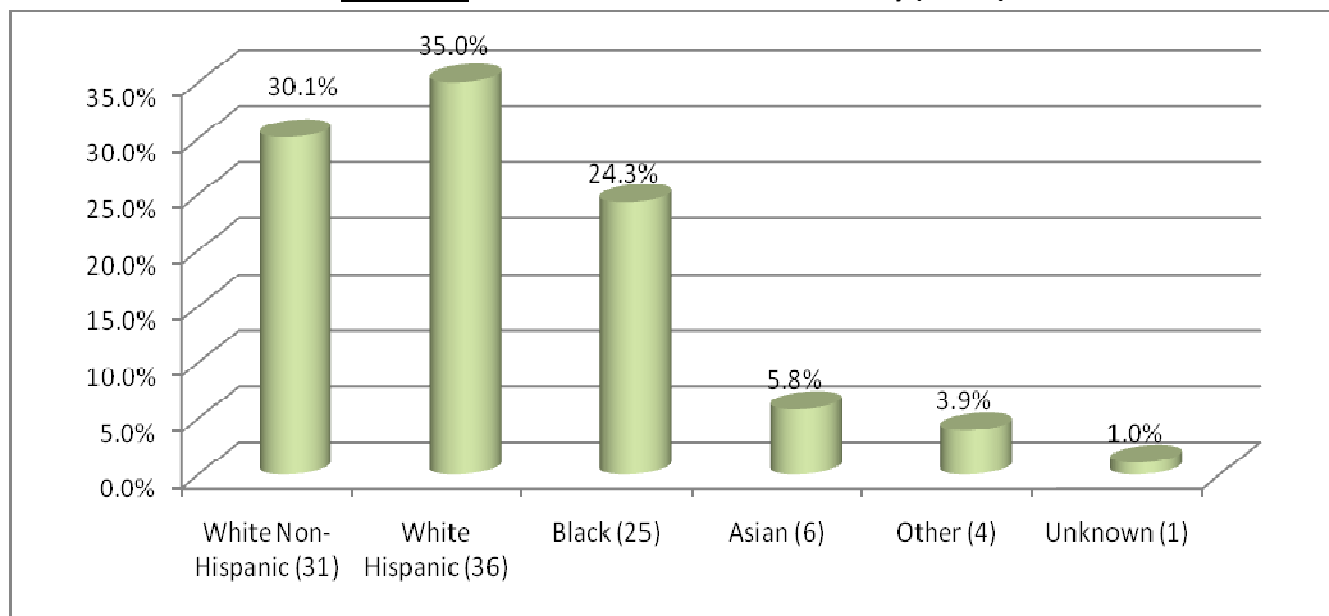


In nearly half of the cases (48.6%) the child had the condition since birth, while another 29.7% had the illness for a number of years. In 83.8% (31) of the cases death was expected as a result of the condition. 97.3% were receiving medical care for the chronic condition and the same proportion of families was following the doctors’ prescribed care plan. In 5% (n=2) of cases there was a known issue with accessing appropriate health care or following through with prescribed care plans. In one case this was a language barrier, and in the other it was a limitation of their health insurance.

## Prematurity

About 51% of all natural deaths reviewed in 2008 were caused by complications of prematurity. All children in this category were less than one year of age at the time of their death. In 2008 there were more males (60.2%) than females (39.8%) which was similar to the distribution in 2007. The most frequently occurring racial/ethnic category was White Hispanic infants, followed by White Non Hispanic infants. This indicates a slight disparity among White Hispanic children because they represent only 31.8% of all child deaths. Similarly 24.3% of all deaths due to prematurity were Black, which is nearly 4% greater than the percentage of all Black children that died in 2008. This is a reflection of national statistics that indicate that both Black and Hispanic infants are more likely than White infants to be born premature (March of Dimes, 2008).

**Figure 2.7: 2008 Natural Deaths – Prematurity (n=103)**

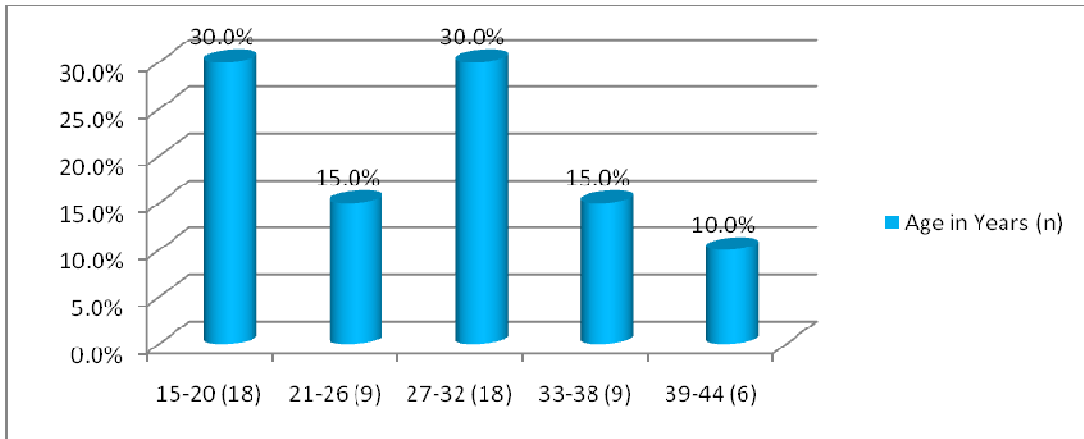


Gestational age was known in 55% of cases (n=57) where the cause was listed as prematurity, ranging from 20 to 35 weeks. Only 21.4% of the cases indicated that the mother received prenatal care. In 34% of the cases the mother had known medical complications or infections. In 13.4% (n=14) the mother admitted to smoking tobacco during the pregnancy, and in only 2 cases there was a known history of illicit drug use among mothers.

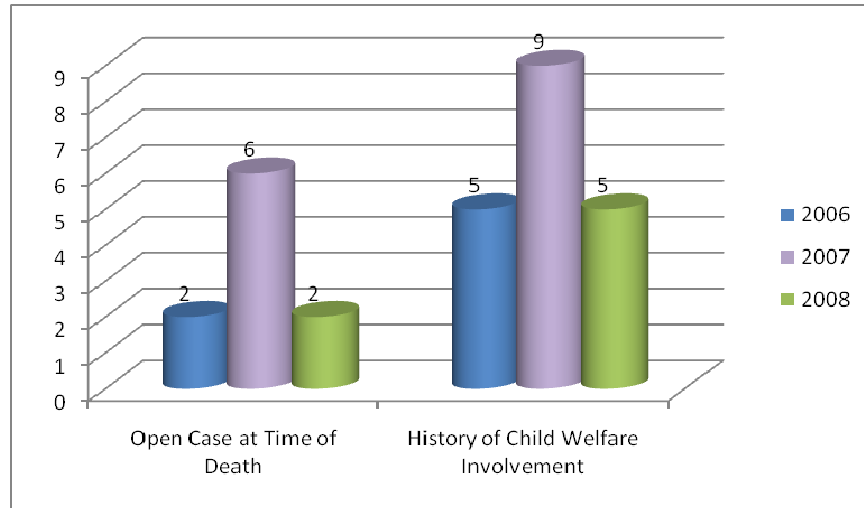
The age of the mother was known in 58% of cases (n=60), and ranged from 15 to 44 years. Since maternal age is a factor that influences the likelihood of complications and premature birth this is an important variable to track. The graph below illustrates the age categories of mothers of infants who died from complications associated with prematurity in 2008.



**Figure 2.8: 2008 Natural Deaths – Prematurity – Mother’s Age in Years (n=60)**



**Figure 2.9: 2006-2007 Prematurity – Child Welfare Involvement (2006 n=7, 2007 n=13, 2008 n=103)**



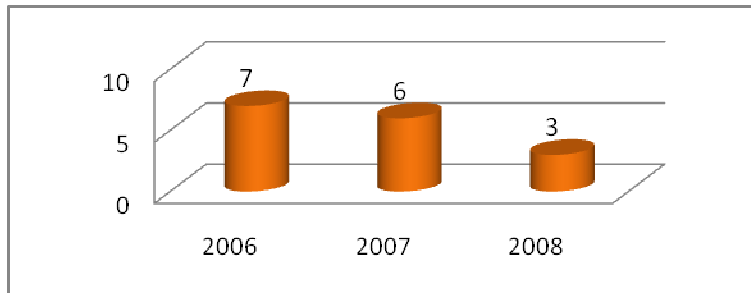
	2006		2007		2008	
	Count	%	Count	%	Count	%
<b>Open Case at Time of Death</b>	2	28.6%	6	46.2%	2	1.9%
<b>History of Child Welfare Involvement</b>	5	71.4%	9	69.2%	5	4.9%

In previous years only certain natural deaths were selected to be reviewed, this included all cases with a history of child welfare involvement. In 2008 all child deaths were reviewed so when looking at child welfare involvement across the past three years it is important to look at the counts and not just the percentages. Percentages are calculated out of total reviewed deaths due to prematurity, since in 2006 and 2007 only selected cases were reviewed (and all cases with child welfare history were reviewed) those cases would represent a greater proportion of the total. In 2008 all natural deaths were reviewed and therefore we can see that of all natural deaths due to prematurity only a very small proportion (4.9%) had any family history of involvement with child welfare and an even smaller percentage (1.9%) had an open case at the time of their death.

## Sudden Infant Death Syndrome (SIDS)

In 2008, all child deaths were reviewed and so SIDS was no longer one of the top three leading natural causes of death for children less than one year of age. In addition, in 2008 SIDS was at its lowest in the past three years.

**Figure 2.10: 2006-2008 Natural Deaths – SIDS Cases (counts)**



According to the National Center for Child Death Review:

*“Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age which remains unexplained after completion of a full autopsy, examination of the death scene and review of the baby’s health history. If any of these three steps are not conducted, a SIDS diagnosis should not be made. A diagnosis of SIDS reflects the clear admission by medical examiners that an infant’s death remains completely unexplained.”*

(<http://www.childdeathreview.org/causesSI.htm>, 2008).

In 2008 again there were almost twice as many males as females that died due to SIDS. This is down slightly from 2006 when 71.4% of SIDS deaths were male.

**Figure 2.11: 2006-2008 Natural Deaths due to SIDS – Sex (2006 n=7, 2007 n=6, 2008 n=3)**

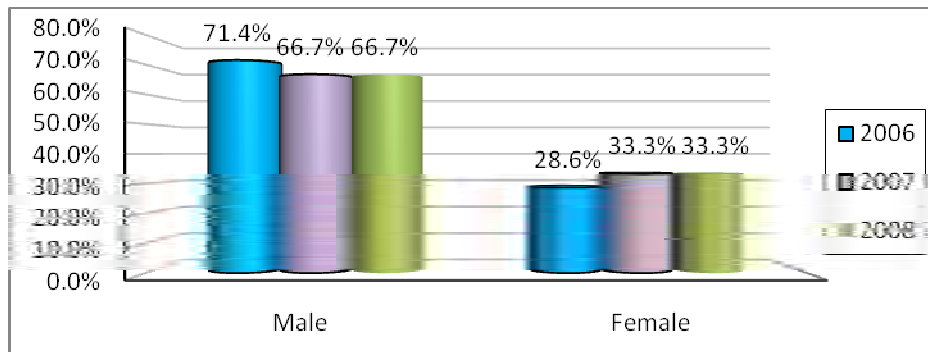
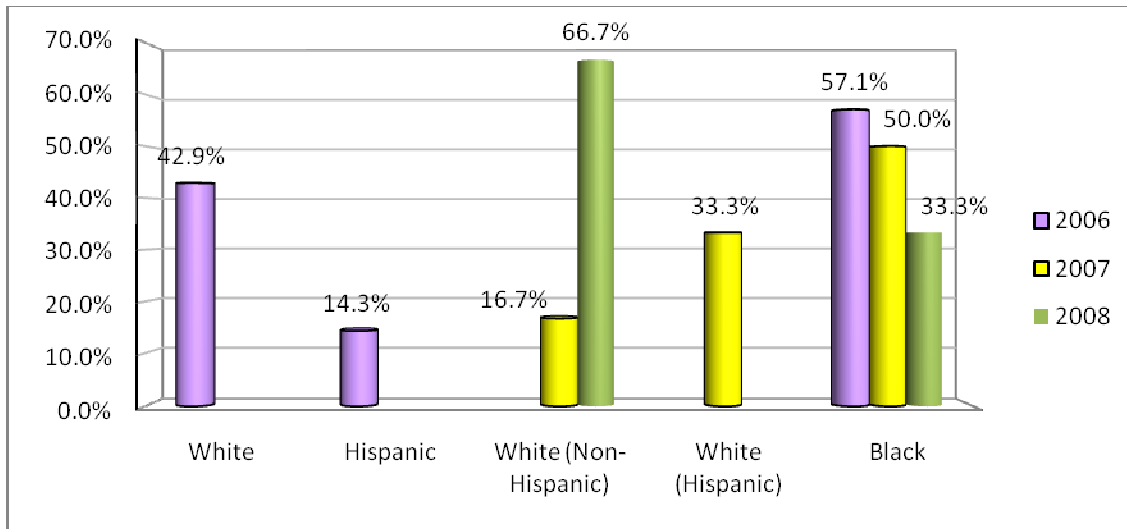


Figure 2.12 illustrates the race and ethnicity of child deaths due to SIDS. Because there were so few SIDS deaths this year it is difficult to make any definitive statements regarding race and ethnicity. In terms of the proportions we can see that the percentage of Black infants dying of SIDS decreased by nearly 20% from 2007(50%) to 2008 (33.3%). However we also see a sharp increase in White Non Hispanic infant up to 66.7% in 2008 from only 16.75% in 2007. In interpreting these numbers it’s important to remember that the 66.7% represents only 2 cases while the 33.7% represents only one case.

**Figure 2.12: 2006-2008 Natural Deaths Due to SIDS – Race/Ethnicity (2006 n=7, 2007 n=6, 2008 n=3)**

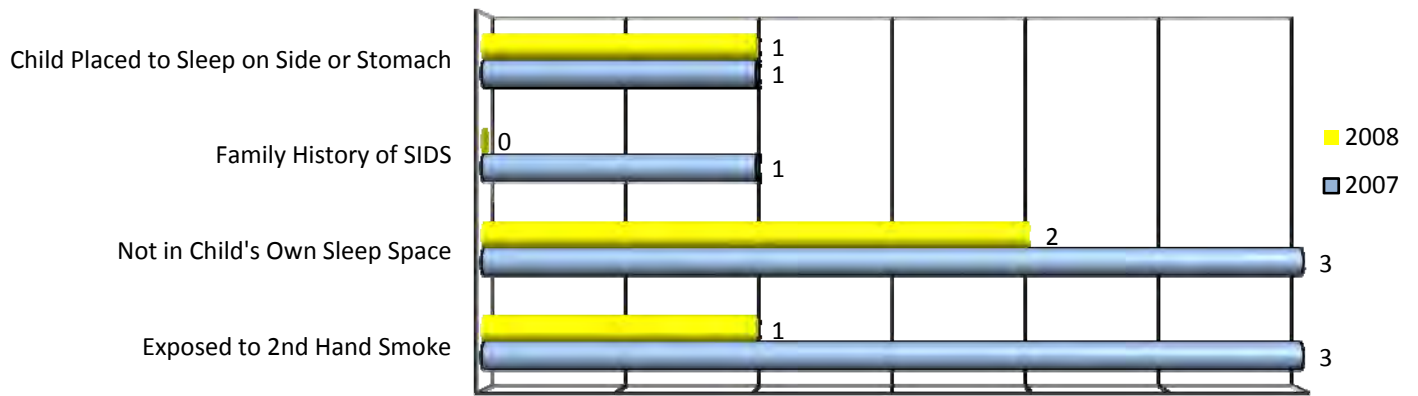


	2006	2007	2008
<b>White</b>	42.9%	--	--
<b>Hispanic</b>	14.3%	--	--
<b>White (Non-Hispanic)</b>	--	16.7%	66.7% (2)
<b>White (Hispanic)</b>	--	33.3%	--
<b>Black</b>	57.1%	50.0%	33.3% (1)

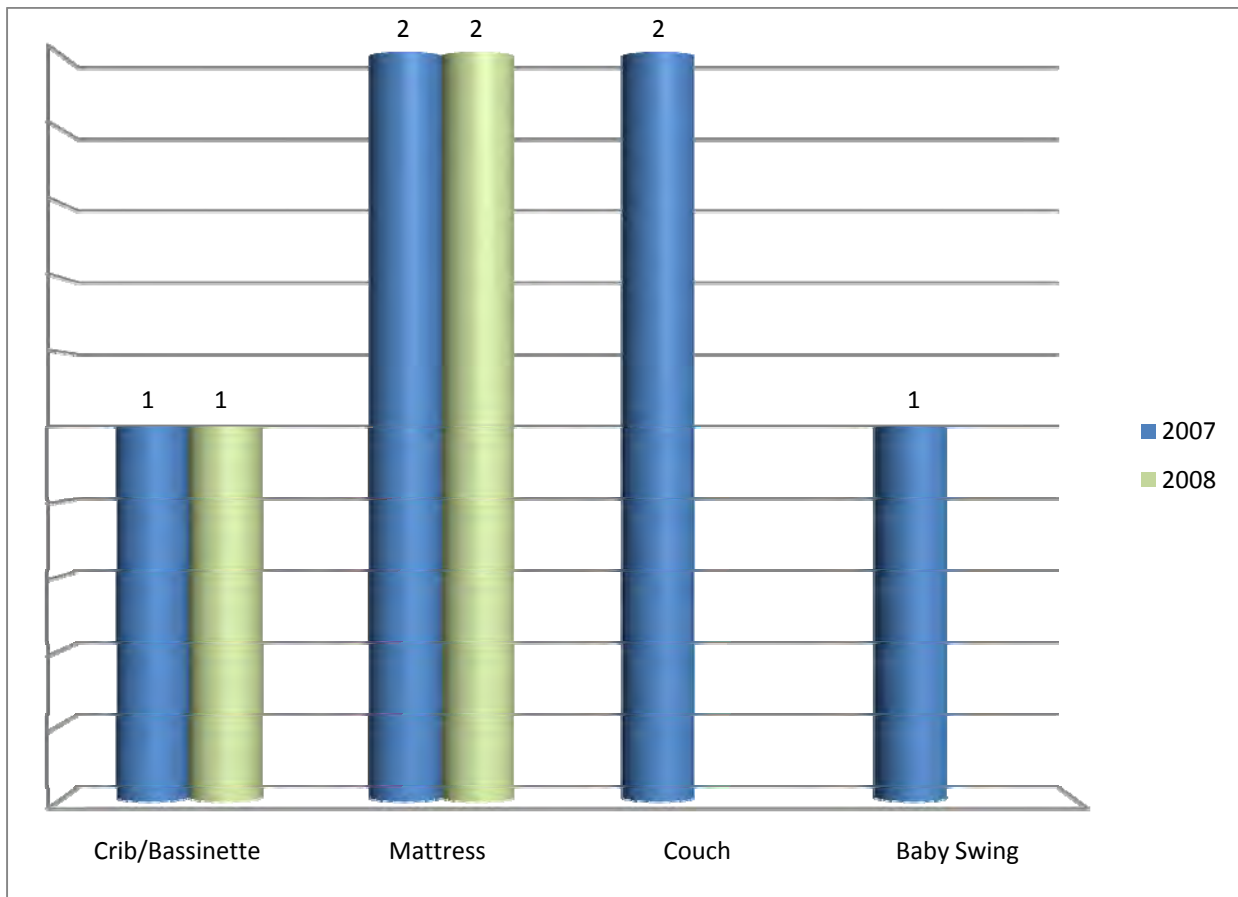
Figure 2.13 illustrates associated risk factors for SIDS. In 66.7% of all SIDS fatalities in 2008 the child was not in their own sleeping space. In 33.3% of all cases the child was exposed to second hand smoke, which is a decrease from 50% in 2007. In all cases the child was in a sleeping environment.

Figure 2.14 shows where the child was sleeping at the time of death. Additionally, in 2008 none of the families had a history of SIDS and another 33.3% (n=1) of these children were placed to sleep on their side or stomach.

**Figure 2.13: 2007-2008 Natural Deaths due to SIDS – Associated Risk Factors (2007 n=6, 2008 n=3)**



**Figure 2.14: 2007-2008 Natural Deaths due to SIDS – Incident Sleep Place (2007 n=6, 2008 n=3)**



## Natural Deaths: Recommendations for Prevention

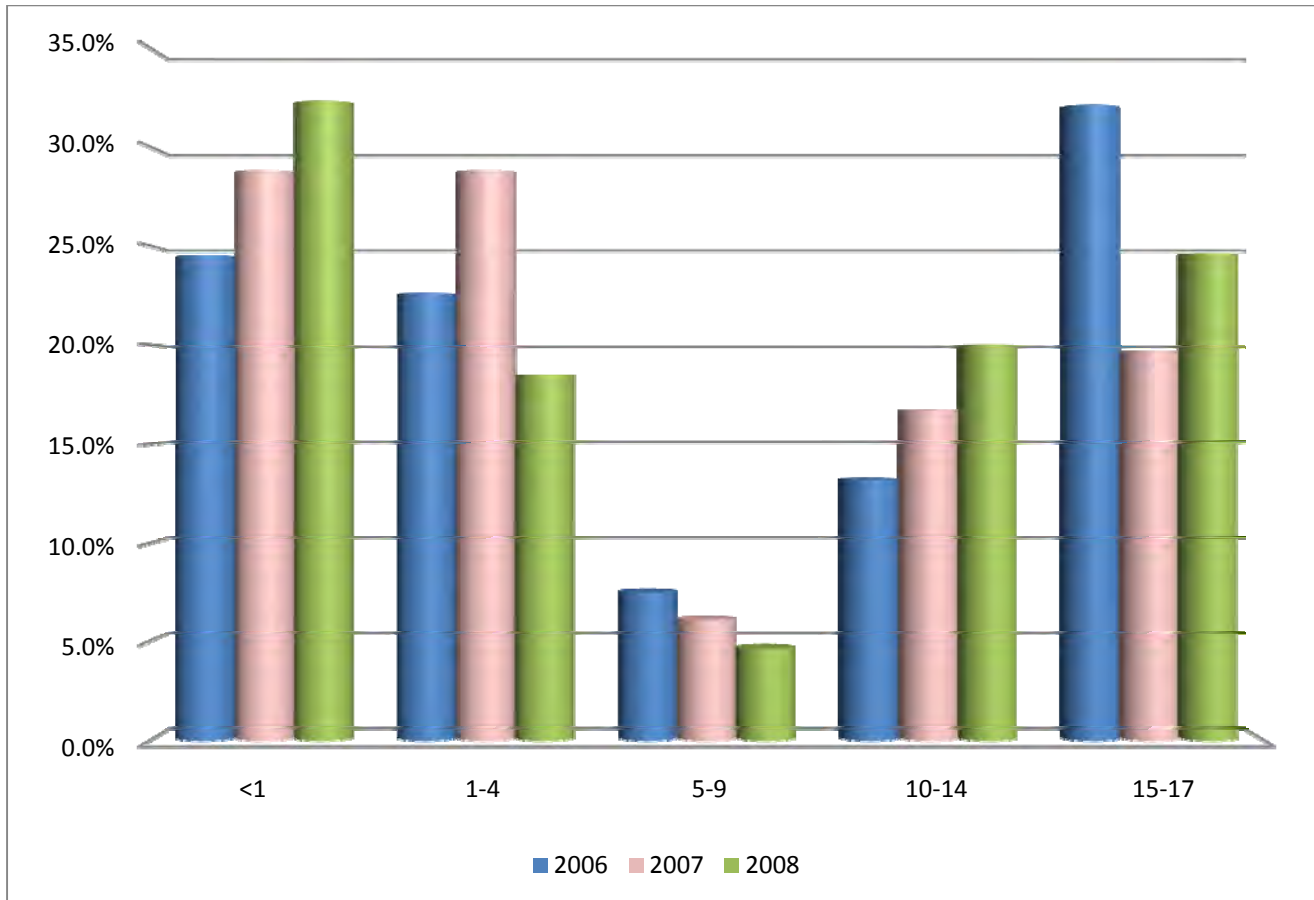
Natural deaths are some of the most difficult cases in which to identify preventative factors that could lead to recommendations for change to prevent future child deaths. By definition, natural deaths are those that occur from natural causes, leaving little room for prevention. The data does present, however, several areas that warrant some attention in regard to prevention efforts.

1. Again in 2008 the vast majority (81.2%) of natural deaths occurred among children less than one year of age. This number is even higher than in 2006 or in 2007 because the team reviewed all child deaths and that included fetal deaths. In addition, the high proportion of deaths attributed to complications of prematurity (51%) really points to the need to improve and continue research and tracking regarding prenatal care, parental substance abuse, exposure to environmental pollutants, etc.
2. This year one of the leading causes of natural deaths was chronic illness (18.3%). This category included those children who suffered from asthma, diabetes and cerebral palsy. These chronic conditions, while dangerous, can be managed with proper medical care. For the third year in a row we continue to see children die from complications associated with these conditions. Simple monitoring and maintaining regimented medication administration can allow children with both asthma and diabetes to live long and normal lives. Increased educational campaigns should be created and directed toward parents to remind them of the severity of these illnesses if not carefully monitored.
3. In 2008 a concerted effort was made to collect the ages of mothers whose children died from complications of prematurity, and this information was collected in 58% (n=60) of these cases. 30% of these mothers were between the ages of 15 and 20 and another 30% were ages 27 to 32. This may point to a need to focus health education regarding prenatal care on younger mothers. Statistically, teenage mothers have a much higher proportion of low birth weight babies and this again points to the importance of prenatal care, as it is a key factor in preventing preterm births and low birth weight babies. Prenatal care is also important in identifying problems and lifestyles that can increase the risk of preterm labor and birth.
4. In 2008 SIDS was no longer a leading cause of natural deaths among infants in Clark County, and was at its lowest frequency in three years, at only three SIDS deaths last year. However, even with this small number, there were disproportionately more males than females (2 to 1, and Black infants represented one third of these deaths which is still higher than we would expect compared to the proportion of Blacks in the population. According to the National Center for Child Death Review, "Blacks and American Indians still have rates two to three times higher than the national average. Many believe one major reason for this is that the Back to Sleep message is not effectively reaching these populations of parents and caregivers" ([www.childdeathreview.org](http://www.childdeathreview.org), 2008). Therefore these populations may benefit from more focused prevention messages and social marketing campaigns.

### Section III: Accidental Deaths

Accidental deaths are defined by the National Center for Child Death Review as “a manner of death indicating non-intentional trauma.” In 2008, there were 65 deaths of children in Clark County that were ruled as accidental, showing a slight decrease from the 66 in 2007. All 65 cases were investigated by the coroner. Of those 65 cases, 56.9% were male and 43.1% were female. Over half of the cases were children ages zero to 4 years of age, and the other half were ages ten to seventeen years. This pattern is very similar to 2007, however there were more cases of children less than one year of age and nearly 5% more cases of children 15 to 17 years.

**Figure 3.1: 2006-2008 Percent of Children by Age category for All Accidental Deaths (2006 n=53, 2007 n=66, 2008 n=65)**

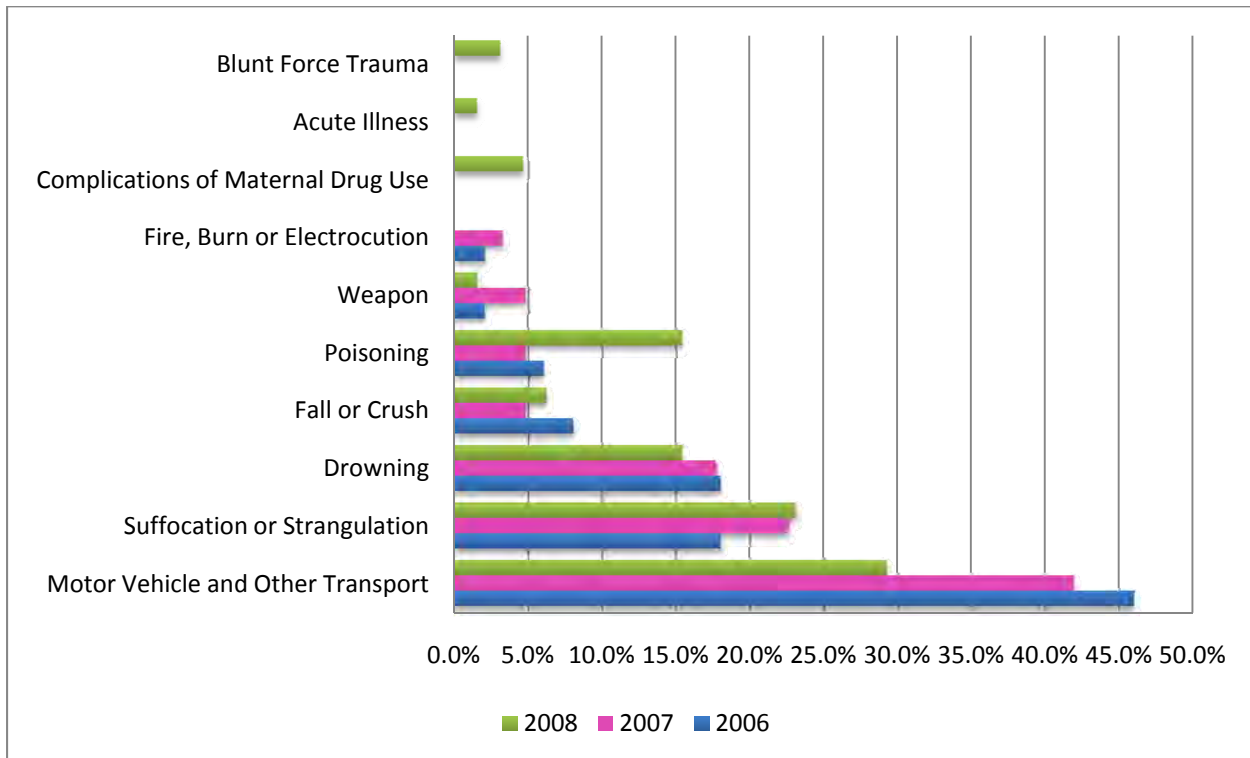


Half of all accident victims were White Non Hispanic (49.2%), another quarter were White Hispanic, followed by another 18.5% that were Black. The remaining cases were children who were multiracial and Asian. There were no Native American/Alaska Natives who died from accidental causes in Clark County in 2008. This distribution is very similar to those seen in 2006 and in 2007.

In one quarter (23.1%) of accidental cases the child's family had some history with the child welfare system, making these cases mandatory reviews. In 16.9% of accidents, the child welfare history was regarding the decedent. In 9.2% of all accidents there was a child welfare case open at the time of the child's death. In 80% (n=52) of cases supervision was needed, but in 3.8% of those cases the child was not supervised at the time of death. For the majority of cases (60%) the child's biological parent was the person responsible for supervision at the time of the child's death. Other responsible supervisors included grandparents, friends, or adoptive parents. In 13.5% of all accidents reviewed, the supervisor was 22 years of age or younger. The majority of accidental deaths in 2008 occurred either in the child's home (55.4%) or in a roadway, driveway or sidewalk (27.7%). Additionally, there were four accidental deaths where children out of state died while in Clark County. These children were from Texas, California, and Arizona.

For the third year in a row the leading cause of accidental deaths were motor vehicle accidents (MVA) at 29.2% of all accidental deaths, however by a smaller margin than the last two years. Following MVAs were accidental suffocations (choking or infant rollover deaths) at 23.1%, then drowning and poisoning each at 15.4% of the all accidental deaths. This is the first time that accidental poisoning has been one of the leading causes of accidental child deaths. This percentage is four times as high as 2007 and more than twice as high as in 2006. These cases were primarily accidental drug overdoses in youth age 15 to 17 years. These will be examined in more detail in the following sections. A graph illustrating the comparison of all causes of accidental deaths from 2006 to 2008 is displayed in Figure 3.2 below.

**Figure 3.2: 2006-2008 Percent of Accidental Injury Deaths by Cause (2006 n=53, 2007 n=66, 2008 n=65)**



	2006	2007	2008
<b>Motor Vehicle and Other Transport</b>	46.0%	41.9%	29.2% (19)
<b>Suffocation or Strangulation</b>	18.0%	22.6%	23.1% (15)
<b>Drowning</b>	18.0%	17.7%	15.4% (10)
<b>Fall or Crush</b>	8.0%	4.8%	6.2% (4)
<b>Poisoning</b>	6.0%	4.8%	15.4% (10)
<b>Weapon</b>	2.0%	4.8%	1.5% (1)
<b>Fire, Burn or Electrocutation</b>	2.0%	3.2%	--
<b>Complications of Maternal Drug Use</b>	--	--	4.6% (3)
<b>Acute Illness*</b>	--	--	1.5% (1)
<b>Blunt Force Trauma**</b>	--	--	3.1% (2)

\*There was one case in 2008 ruled an accident where a child went into cardiac arrest while on a roller coaster

\*\* There were 2 cases coded as "blunt force trauma" due to fatal attacks by dogs

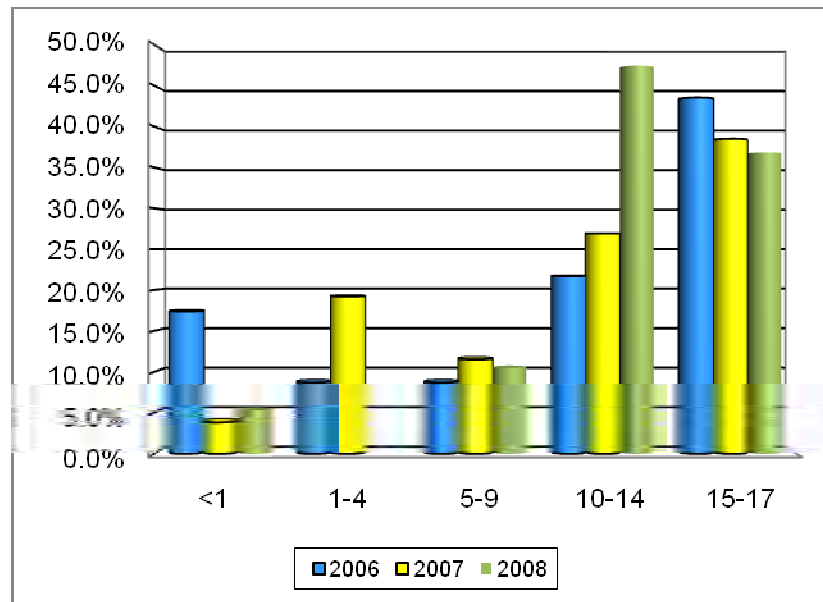
Prosecution was pending at the time of review in 23.1% of cases (n=15). In just over one quarter of the cases (26.2% or 17 cases), CPS took action as a result of the death. Of those 17 cases, CPS substantiated abuse or neglect in five of them and in two cases the surviving children were removed from the home as a result of the death.



## Motor Vehicle Accidents

There were 19 deaths due to motor vehicle accidents (MVAs) in Clark County in 2008, a nearly 27% decrease from 26 cases in 2007 and down 17.4% from the 23 cases in 2006. In 2008 far more males (73.7%) died in MVAs than females (26.3%), which is a difference from both 2006 and 2007 where nearly equal numbers of males and females died in MVAs. The majority (63.2% or n=12) of decedents were White Non Hispanic and the remaining 36.8% (n=7) were White Hispanic. Approximately one quarter (26.3% or 5 cases) of victims' families had a prior history with the child welfare system and approximately 21.1% (n=4) of decedents had a juvenile justice history. More than one third (36.8%) were between the ages of 15-17, and more than three quarters (84.2%) were over the age of 10. In 2008 there were no cases of children between one and four years and in only three cases the victims were less than nine years old. The most dramatic increase in 2008 was among those victims between 10 and 14 years old, which for the first time represented nearly half (47.4%) of all MVAs.

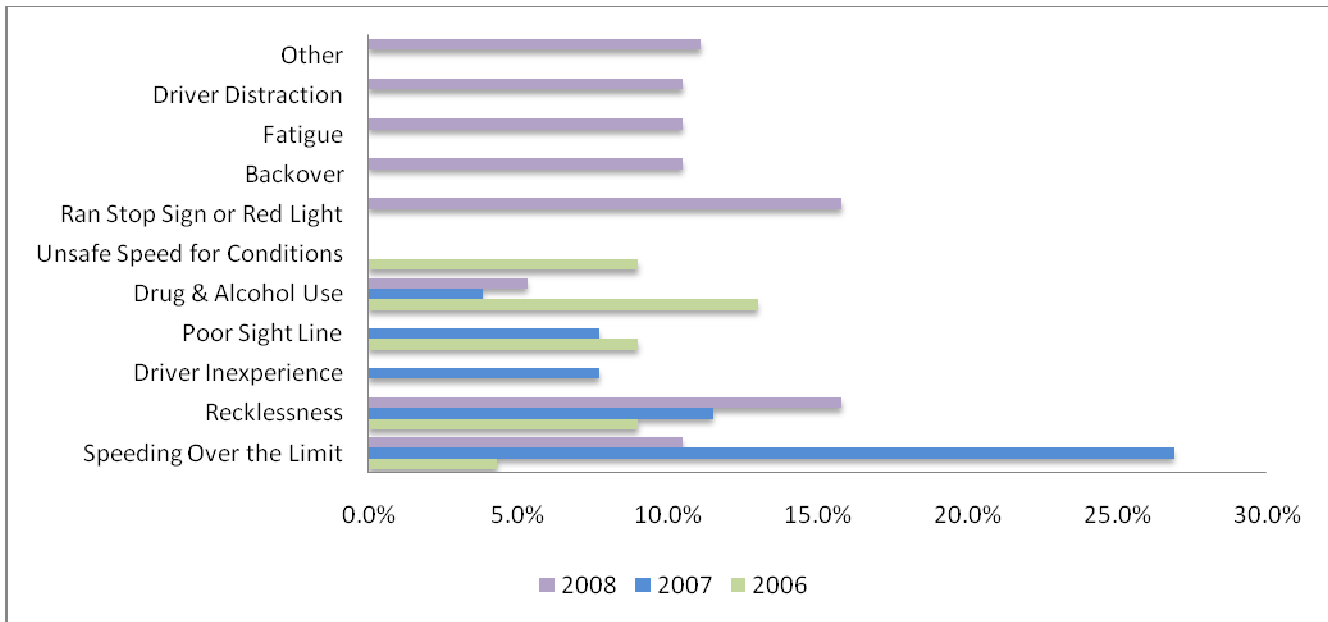
**Figure 3.3: 2006-2008 Percent of Motor Vehicle Accident Victims by Age Category**  
(2006 n=23, 2007 n=26, 2008 n=19)



	<1 year	1-4 years	5-9 years	10-14 years	15-17 years
<b>2006</b>	17.4%	8.7%	8.7%	21.7%	43.5%
<b>2007</b>	3.8% (1)	19.2% (5)	11.5% (3)	26.9% (7)	38.5% (10)
<b>2008</b>	5.3% (1)	--	10.5% (2)	47.4% (9)	36.8% (7)

In all accidents, there were either one or two vehicles (vehicles include golf carts, bicycles, and watercrafts) involved. Approximately 47.4% of cases involved only one vehicle. The majority of accidents occurred on city (31.6%) or residential streets (31.6%), which is different from 2007 where the majority of MVAs (39%) occurred on highways. Primary causes of accidents included recklessness (15.8%), ran stop sign/light (15.8%), and driver distraction (10.5%). At the time of the accident, 26.3% of drivers were alcohol or drug impaired, and this was listed as a secondary cause of the accident.

**Figure 3.4: Primary Cause of Motor Vehicle Accidents (2006 n=23, 2007 n=26, 2008 n=19)**



	2006	2007	2008
Speeding Over the Limit	4.3%	26.9%	10.5% (2)
Recklessness	9.0%	11.5%	15.8% (3)
Driver Inexperience	0.0%	7.7%	
Poor Sight Line	9.0%	7.7%	
Drug & Alcohol Use	13.0%	3.8%	5.3% (1)
Unsafe Speed for Conditions	9.0%	0.0%	
Ran Stop Sign or Red Light			15.8% (3)
Back Over			10.5% (2)
Fatigue			10.5% (2)
Driver Distraction			10.5% (2)
Other*			11.1% (4)

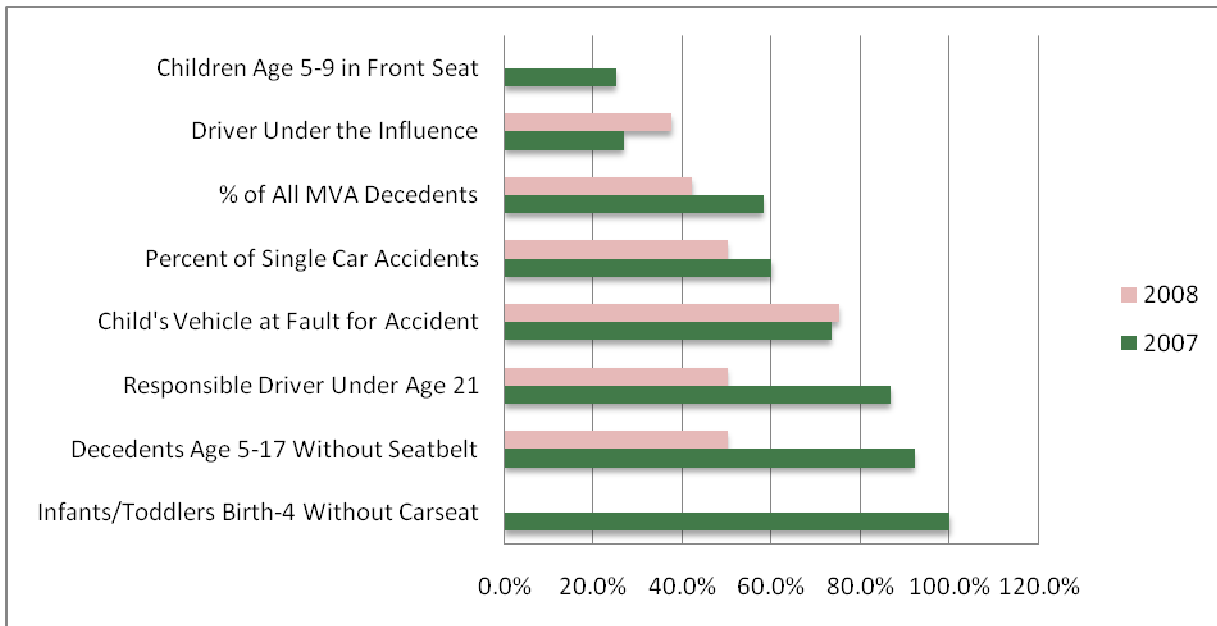
\*Other causes included poor tires, other driver error, and pedestrian running into the street

In almost half (42.2%) of cases, the child’s vehicle was a car, van, SUV or truck. Approximately 21% of cases involved a bicycle, and in 26.3% (n=5) of cases the child was not in a vehicle of any kind. In 57.9% of cases, the child’s vehicle was at fault for the incident.

Nearly half of decedents (42.1%, n=8) were passengers. Of those passengers killed, 12.5% were younger than age 10, more than one third (37.5%) were between the ages of 10-14, and half (50%) were between the ages of 15-17. In the passenger fatalities, 50% of these accidents were single car accidents, and the other half were two-car accidents. In 75% of these cases, the child’s vehicle was at fault for the accident. Primary causes of accidents were attributed to speed (25%) and driver fatigue (25%). Other causes included poor tires, driver distraction, fatigue/sleeping, and other driver error. In 50% of cases, the driver responsible was under age 21, and in three of the cases the age of the responsible driver was unknown to the team at the time of the review. In half of these cases the decedent was not wearing a seatbelt. The driver was under the influence in more than one third of cases (37.5%). In 2008 there were no MVA fatalities where children under the age of ten were sitting in the front seat, which is an improvement from 2007 where

25% of those fatalities involved children ages 5-9 in the front seat. In 2008 there were no infants that deceased in MVAs.

**Figure 3.5: 2007-2008 Circumstances of MVA Passenger Fatalities (2007 n=15, 2008 n=8)**

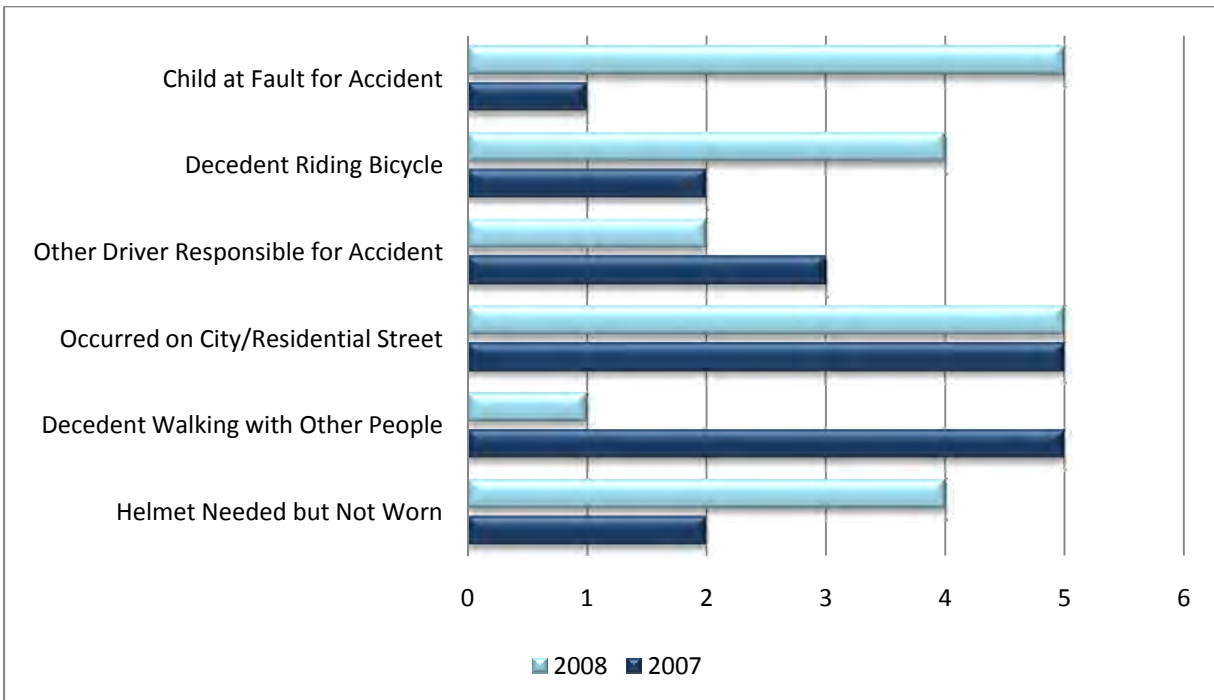


	2007	2008		2007	2008
<b>Infants/Toddlers Birth-4 Without Car seat</b>	100.0%	--	<b>Percent of Single Car Accidents</b>	60.0%	50.0% (4)
<b>Decedents Age 5-17 Without Seatbelt</b>	92.0%	50.0% (4)	<b>Driver Under the Influence</b>	26.7%	37.5% (3)
<b>Responsible Driver Under Age 21</b>	86.7%	50.0% (4)	<b>Children Age 5-9 in Front Seat</b>	25.0%	
<b>Child's Vehicle at Fault for Accident</b>	73.3%	75.0% (6)			

\* This percentage represents the total number of all MVA fatalities (n=19) where the child was the passenger.

In approximately one third (36.8%) of motor vehicle accident cases, the decedent was a pedestrian. Five of the seven pedestrian fatalities were children over ten years of age. The majority of pedestrian fatalities were children on bicycles (57.1%, n=4), the other three pedestrians were walking either alone or with other people. In 28.6% (n= 2) of these cases the other vehicle was at fault, in the remaining cases the child either ran into the street or was on a bicycle and failed to yield to traffic. Five of the seven pedestrian fatalities occurred on a city street or residential street. In all cases where the child was on a bicycle (n=4), a helmet was needed but not worn (n=4) by the decedent. Primary causes of these accidents included a child riding through an intersection on a bicycle (28.6%, n=2)), and incidents where the child was backed over by a vehicle (28.6% n=2).

**Figure 3.6: 2007-2008 Circumstances of MVA Pedestrian Fatalities (2007 n=8, 2008 n=7)**



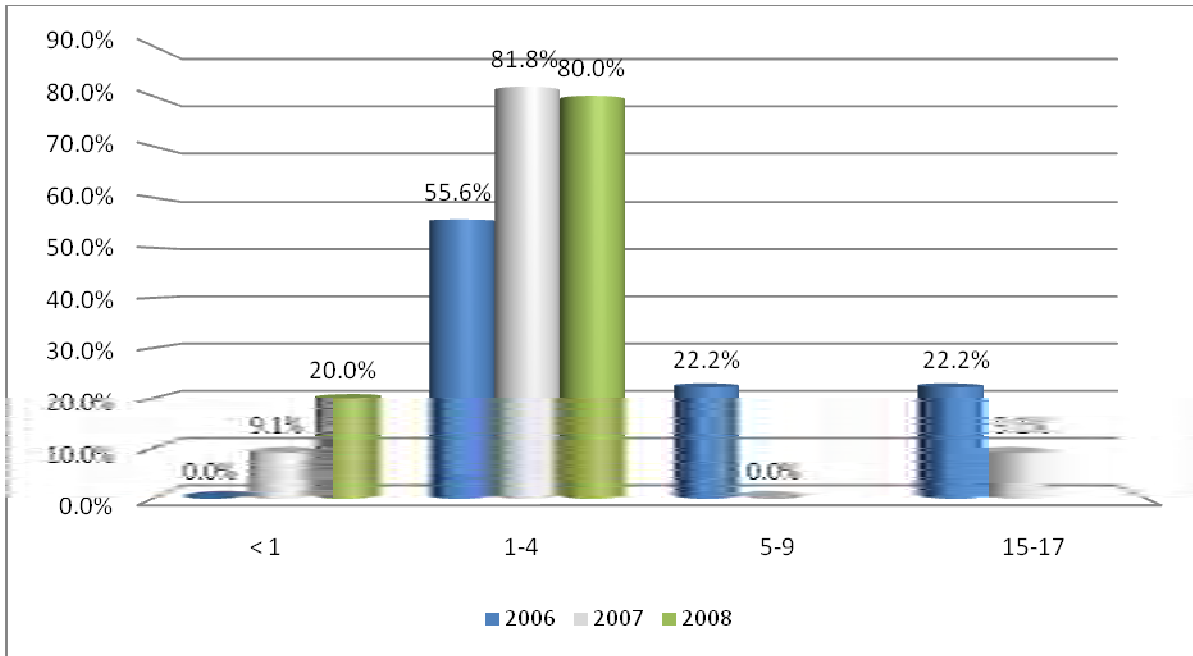
	2007	2008
<b>Helmet Needed but Not Worn</b>	2	4
<b>Decedent Walking with Other People</b>	5	1
<b>Occurred on City/Residential Street</b>	5	5
<b>Other Vehicle Responsible for Accident</b>	3	2
<b>Decedent Riding Bicycle</b>	2	4
<b>Child at fault for Accident</b>	1	5

In only one case, was the decedent the driver of the vehicle involved in the accident, and in that case the decedent did have a valid driver's license, but was under the influence at the time of the accident. For all other MVAs, 68.4% of the drivers had valid licenses, and 26.3% of the drivers were under the influence at the time of the accident. There was one case involving a golf cart and another that involved a jet ski, however in neither of these cases was the child the driver of the vehicle.

## Drowning

In 2008, drowning tied with accidental overdose as the third leading cause of accidental deaths among children in Clark County, with 10 deaths in this category. This is still higher than in 2006 with 9 drowning deaths; however it is one less than in 2007. Again this year, the vast majority (80%) of these children were ages 1 to 4 years, while the remaining cases were children less than one year (20%). There were no children over four years of age that died from drowning in 2008. These numbers are different from 2006 and 2007 in that for the first year there were no children over the age of four who drown in 2008. Therefore prevention efforts should focus on those children under 5 years of age.

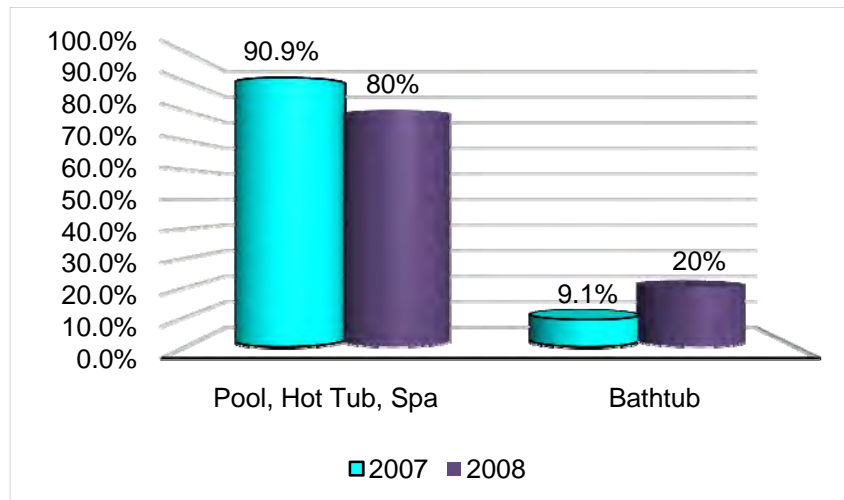
**Figure 3.7: 2006-2008 Accidental Drowning – Age (2006 n=9, 2007 n=11, 2008 n=10)**



	2006	2007	2008
< 1 year	0.0%	9.1%	20.0% (2)
1-4 years	55.6%	81.8%	80.0% (8)
5-9 years	22.2%	0.0%	
15-17 years	22.2%	9.1%	

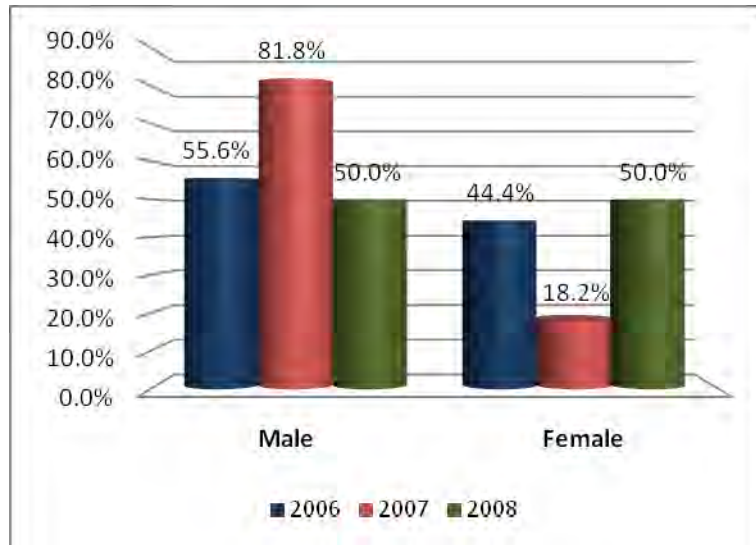
Again in 2008 nearly all drowning cases in 2008 occurred in a pool, hot tub or spa (80%), while the remaining 20% of cases were in a bathtub.

**Figure 3.8: 2006-2008 Accidental Drowning Type of Water (2007 n=11, 2008 n=10)**



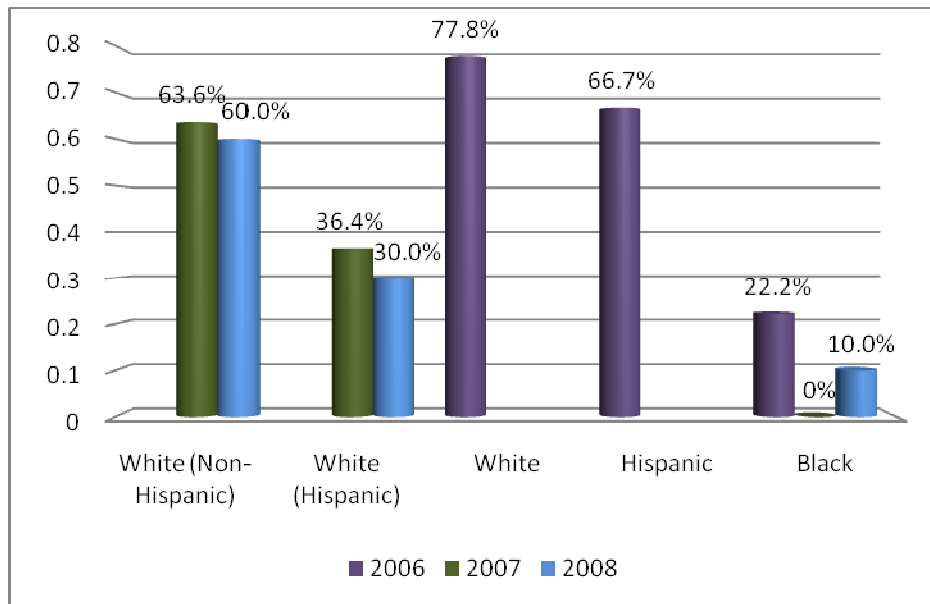
In 2007 the distribution of male and female drowning victims is very skewed, however in 2008 the distribution was evenly split. In 2007, 81.8% of drowning victims were male, while only 18.2% were female, however in 2008 50% were male and 50% were female, which is much more similar to the distribution seen in 2006.

**Figure 3.9: 2006-2008 Accidental Drowning – Sex (2006 n=9, 2007 n=11, 2008 n=10)**



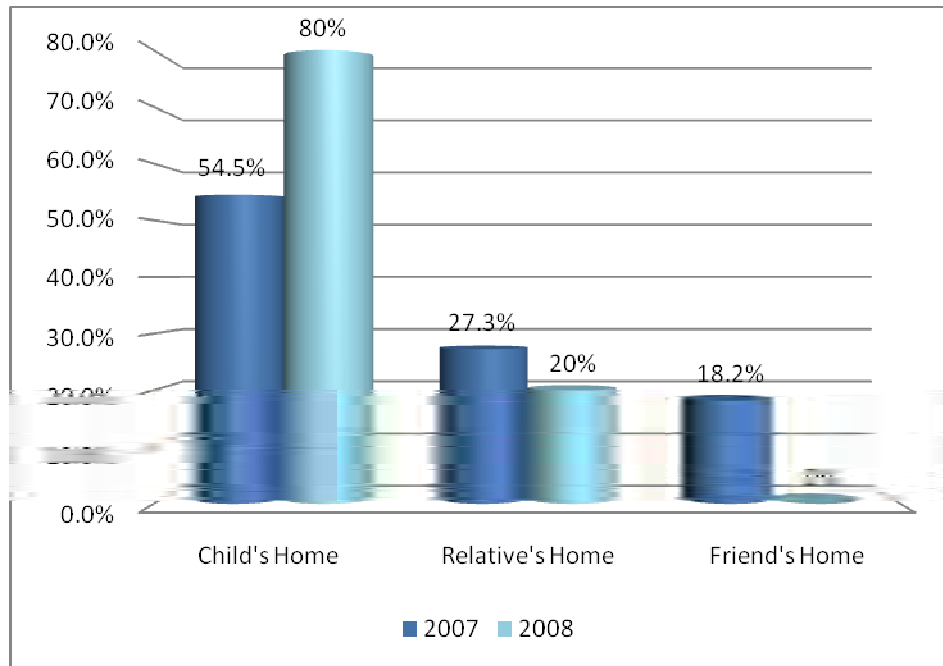
The race/ethnicity data for drowning victims in 2008 looks very similar to the distribution of that in 2007. However, there were no Black children who drown in 2007, but 10% of the drowning in 2008 were Black children. This distribution is displayed in Figure 3.10.

**Figure 3.10: 2006-2008 Accidental Drowning – Race/Ethnicity (2006 n=9, 2007 n=11, 2008 n=10)**



In regard to specific risk factors in drowning deaths, in 2008 the majority (80%) of drowning cases occurred at the child’s home. The remaining drowning fatalities occurred at a relative’s home (20%). No cases in 2008 occurred at a public or apartment pool.

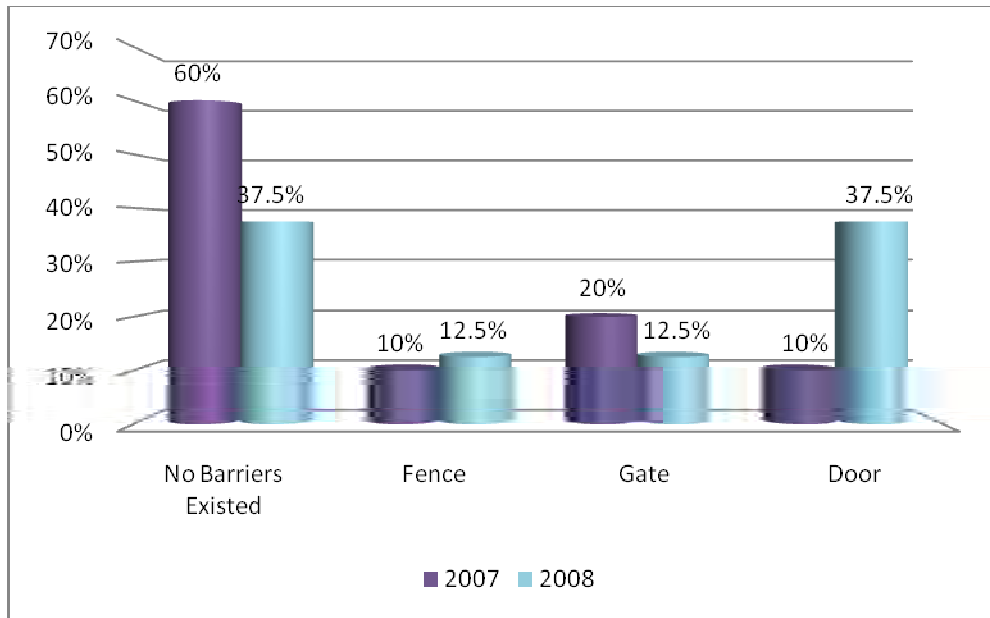
**Figure 3.11: 2007-2008 Accidental Drowning – Drowning Location (2007 n=11, 2008 n=10)**



In one of the pool drowning deaths the child had been supervised swimming in the pool within the previous 24 hours. Most frequently (70%) the biological parent was the supervisor at the time of the incident, followed by “other relatives” at 30%. In 60% of cases the child was last seen in the house and was subsequently left unsupervised between ten minutes and five hours. The average period of elapsed time was around 15 minutes since the child was last seen. In all cases the child was not wearing a floatation device and in two cases there was a gathering or event going on at the same time as the incident.

Figure 3.12 below shows that in 37.5% of cases no barrier existed to prevent access to the pool or spa. In the remaining cases, 12.5% had a gate and another 50% had either a fence or a door blocking entrance to the pool.

**Figure 3.12: 2007-2008 Accidental Drowning – Barriers to Pool/Spa (2007 n=10, 2008 n=8\*)**



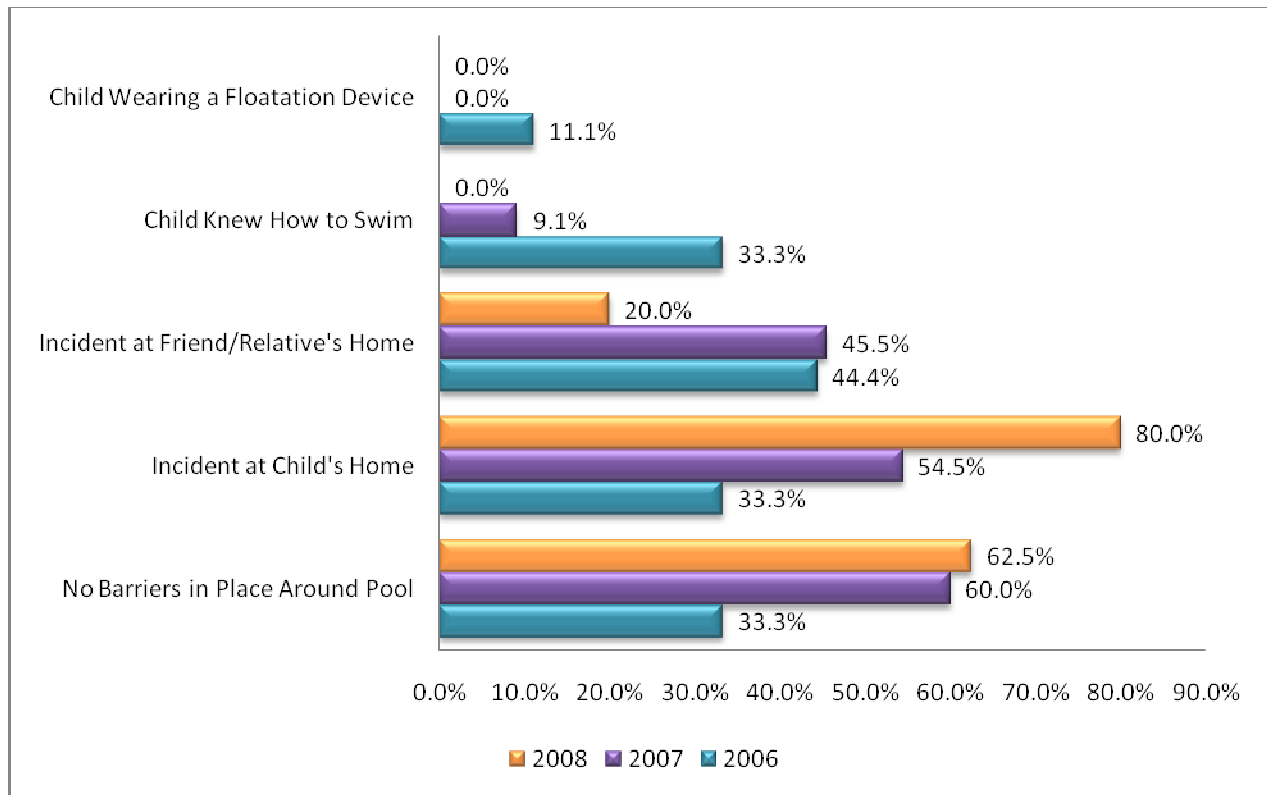
*\*This table represents only those cases where the drowning occurred in a pool/spa, two cases happened in a bathtub*

	2007	2008
<b>No Barriers Existed</b>	60% (6)	37.5% (3)
<b>Fence</b>	10% (1)	12.5% (1)
<b>Gate</b>	20% (2)	12.5% (1)
<b>Door</b>	10% (1)	37.5% (3)

None of these pools had alarms, and only one case had a cover as a barrier to entrance. Children were able to breach existing barriers to the pools in 40% of these cases. In 20% of cases the door was broken and in one case the cover was left open. In another case the child gained access through a doggy door. None of the families of the drowning victims had a history of involvement in the child welfare system.



**Figure 3.13: Items Relative to Drowning Prevention (2006 n=9, 2007 n=11, 2008 n=10)**

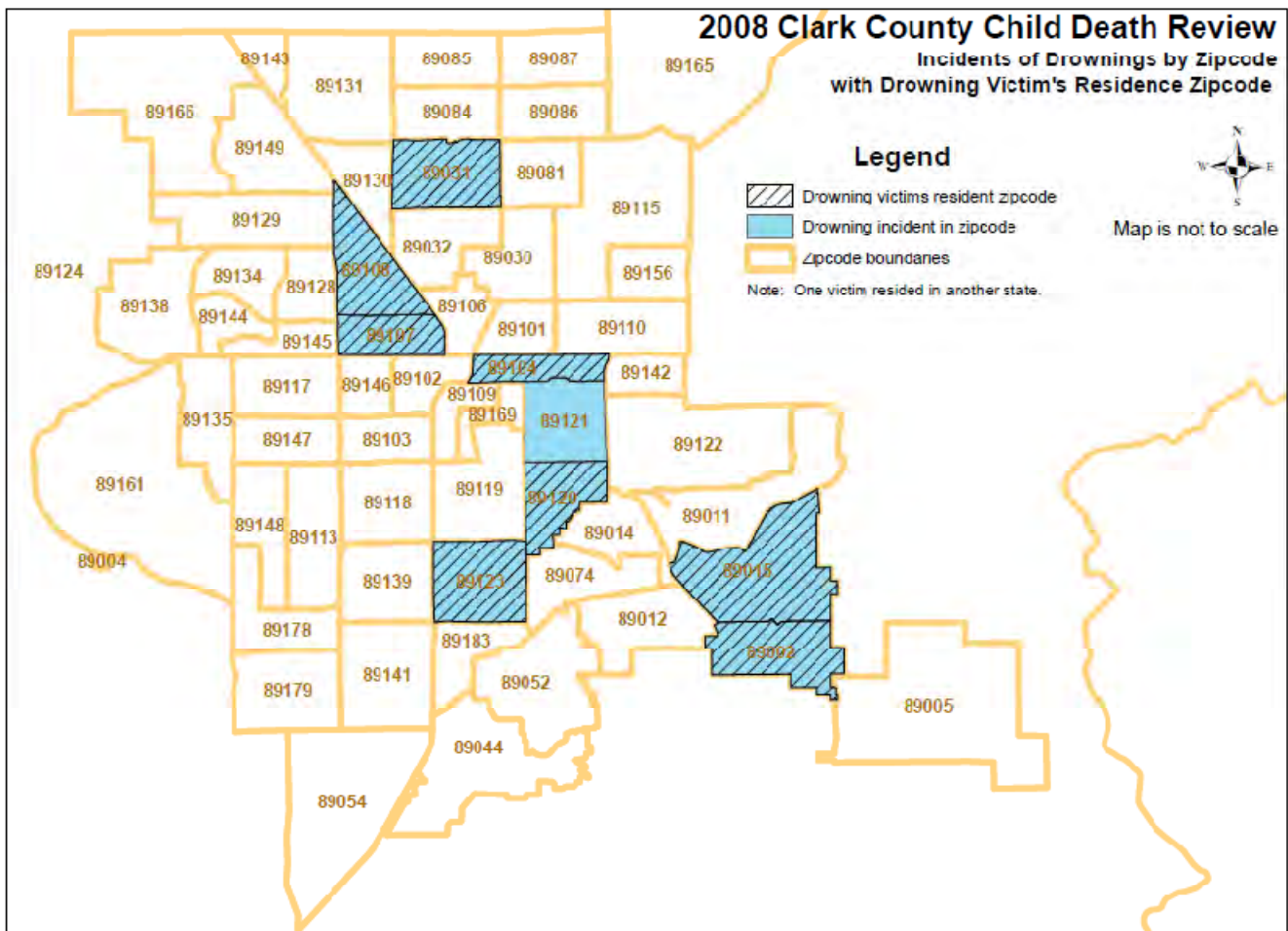


	2006	2007	2008
<b>No Barriers in Place Around Pool*</b>	33.3%	60.0%	62.5% (5)
<b>Incident at Child's Home</b>	33.3%	54.5%	80.0% (8)
<b>Incident at Friend/Relative's Home</b>	44.4%	45.5%	20.0% (2)
<b>Child Knew How to Swim</b>	33.3%	9.1%	0.0%
<b>Child Wearing a Floatation Device</b>	11.1%	0.0%	0.0%

*\*This percentage is calculated out of the total number of drowning cases that occurred in a pool or spa*

Figure 3.13 above illustrates the comparison between 2006, 2007, and 2008 in terms of some of the items relative to drowning prevention. Note in interpreting this figure that categories are NOT mutually exclusive, meaning that one child can fall into more than one category. In 2007, compared to 2006, there were nearly twice as many drowning fatalities where no barriers to the pool existed, and there were slightly more in 2008 (62.5%). Additionally, the number of incidents occurring at the child's home is increasing. This trend supports the prevention recommendation to promote pool safety for families with pools or spas at their homes.

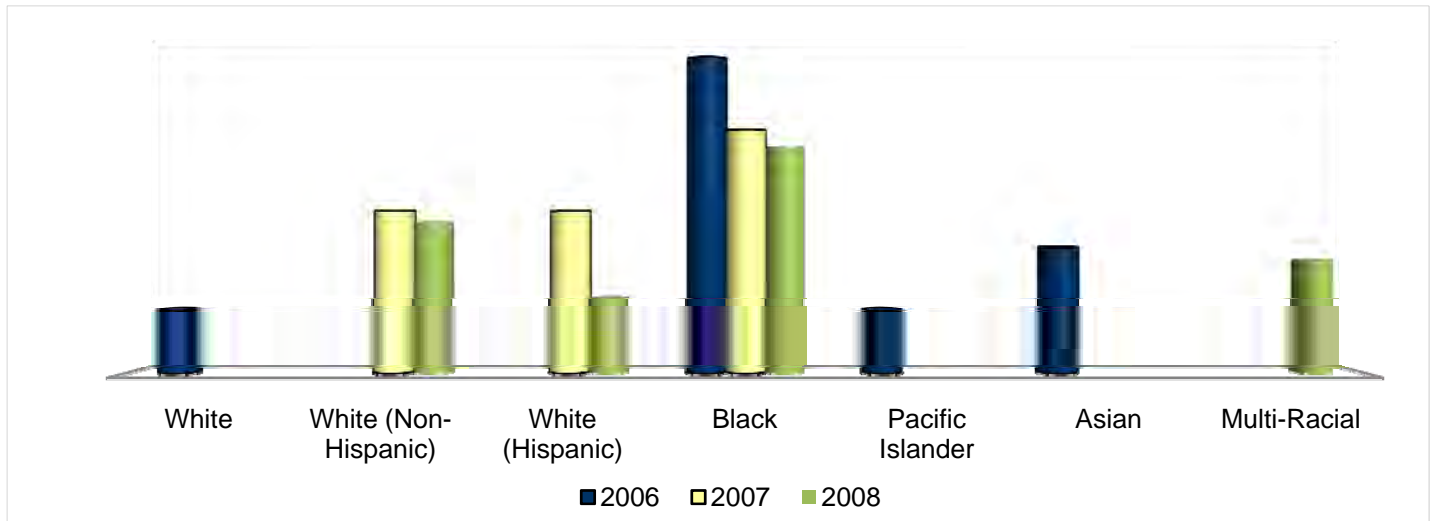
The following map illustrates that most drowning incidents occurred in the central zip codes in Clark County (shown in blue on the map). As was the case in 2006 and in 2007, most drowning cases occurred in these older areas of Las Vegas and Henderson, showing support for the movement to improve safety barriers for existing pools that were not required to install fences, alarms, or other safety barriers.



## Suffocation

In 2008, there were 15 accidental suffocations in Clark County, an increase from the nine that occurred in 2006, and one more than in 2007. All cases were infants less than one year old. This pattern is different from 2006 and 2007, showing an increase in infants who suffocated in 2008. Two thirds of the decedents (66.7%) were female, and 33.3% were male, which is the opposite trend from 2007. Slightly less than half (40%) were Black, with 26.7% listed as White Non-Hispanic. 13.3% of these decedents were White Hispanic, which is a slight decrease from 2007.

**Figure 3.13: Percentage of Accidental Suffocations by Race/Ethnicity (2006 n=9, 2007 n=14, 2008 n=15)**



\*\* Race/Ethnicity data were collected differently in 2006 and 2007. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

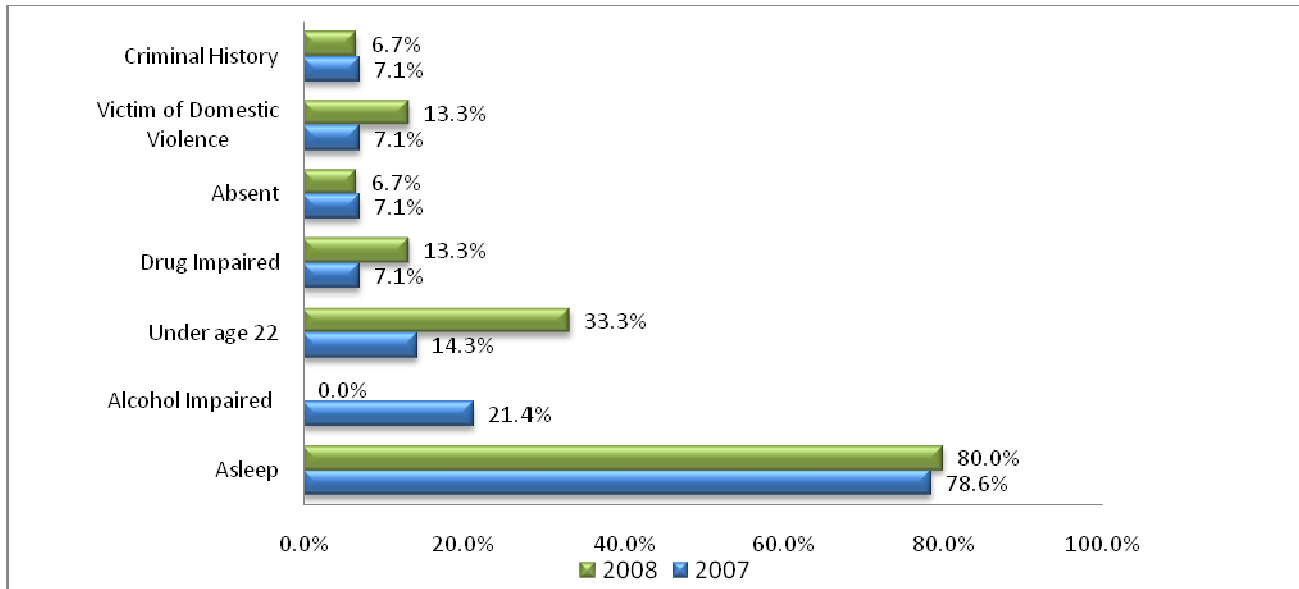
	2006	2007	2008		2006	2007	2008
<b>White</b>	11.1%	--	--	<b>Pacific Islander</b>	11.1%	--	--
<b>White (Non-Hispanic)</b>	--	28.6%	26.7% (4)	<b>Asian</b>	22.2%	--	--
<b>White (Hispanic)</b>	--	28.6%	13.3% (2)	<b>Multi-Racial</b>	--	--	20% (3)
<b>Black</b>	55.6%	42.9%	40.0% (6)				

None of these decedents suffered from a disability, none had a chronic illness, and none were acutely ill in the two weeks preceding their death. In all cases, the primary caregiver at the time of the incident was a parent. In all cases, the mother had no prior child deaths. Mother's ages ranged between 19 and 30 years, with the most frequently occurring age being 22 years. Fathers ranged in age from 22 to 41 years and the most frequently occurring age was 33 years. In 7 of these cases one of the parents had a prior history of substance abuse. In these cases, the mother was six times as likely to have a substance abuse history, compared to the father.

In more than half of cases (53.7%) the infant had been carried to full-term (37-40 weeks). The mother had received prenatal care in only 53.3% of cases. In four cases, the mother had smoked during pregnancy, and in three of the cases, the mother had used illegal drugs or misused prescription/over the counter drugs. In one case, the mother had been the victim of domestic violence while pregnant.

All children had supervision at the time of their deaths, and all children were being supervised by their biological parent. In less than half of cases (46.7%) the child was in the sight of the supervisor, and in 53.3% of cases it had been hours since the supervisor had seen the child. The minimum number of hours listed was one, and the maximum was 11, with 5.1 hours as the average number of hours since the supervisor had seen the child. In more than three quarters of cases (80%), the supervisor was asleep at the time, and in two cases the supervisor was drug impaired.

**Figure 3.14: 2007-2008 Supervisor Circumstances (2007 n=14, 2008 n=15)**



Supervisor Circumstances	2007	2008	2007	2008
<b>Asleep</b>	78.6%	80.0% (12)	<b>Absent</b>	7.1%
<b>Alcohol Impaired</b>	21.4%	--	<b>Victim of Domestic Violence</b>	7.1%
<b>Under age 22</b>	14.3%	33.3% (5)	<b>Criminal History</b>	7.1%
<b>Drug Impaired</b>	7.1%	13.3% (2)		6.7% (1)
				13.3% (2)

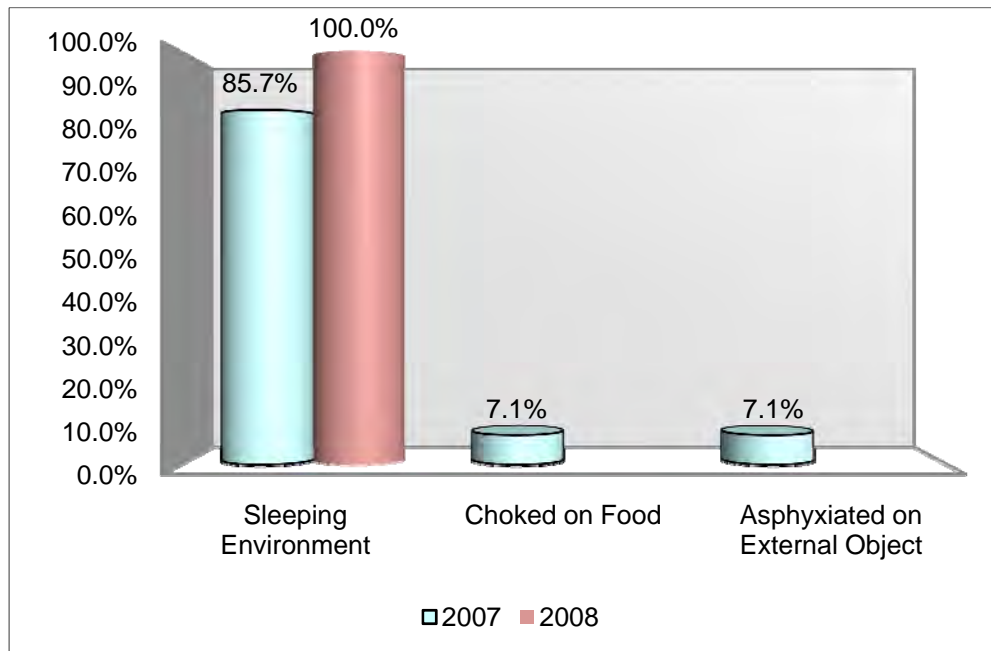
Nearly all incidents (93.3%) occurred in the child’s home, and only 6.7% occurred at a relative’s home. 911 was called in all but one case. CPS action was taken as a result of the death in 40% of cases, and prosecution of the parents was pending at time of review in one of the cases.

Exactly one third (33.3%, n=5) of families had a prior child welfare history. In three of the five cases, there was CPS history on the decedent, and in all five of these cases, there was some CPS history regarding a sibling. In three of these five cases, there was an open child welfare case at the time of death, and in one case, a CPS case had been closed within the past 12 months. For all five cases there were five allegations of neglect and three allegations of abuse. Perpetrators listed in these allegations included both the mother and the father. Six of these allegations were substantiated at the time of their investigation.

All suffocations occurring in a sleeping environment involved infants less than one year of age. 80% (12 of the 15) of the decedents suffocated in bedding due to overlay of bedding items, and two cases were due to overlay by a person. In one

case the decedent was wedged in a sleep environment. None of the decedents were strangled or confined in a tight space.

**Figure 3.15: 2007-2008 Type of Accidental Suffocation (2007 n=14, 2008 n=15)**



Of those decedents who died in a sleeping environment, in eight of the cases the infant was sleeping on an adult mattress, couch, swing, bath seat or the floor, while the remaining seven were in an age appropriate sleeping environment such as a crib or bassinette. In just over a quarter (26.7%) of these cases, this was a new sleep location for the child. In over half (53.3%) of these cases, the infant was sleeping with other people including both parents and/or siblings. 66.7% of all decedents were placed to sleep on either their stomach (40%) or sides (26.7%). Only 13.3% (n=2) of infants were found on their backs – 80% were found on their stomachs. In 13 cases the child was found in bedding or with bedding wrapped around them. In the other two cases, the child was found under an adult or sibling.

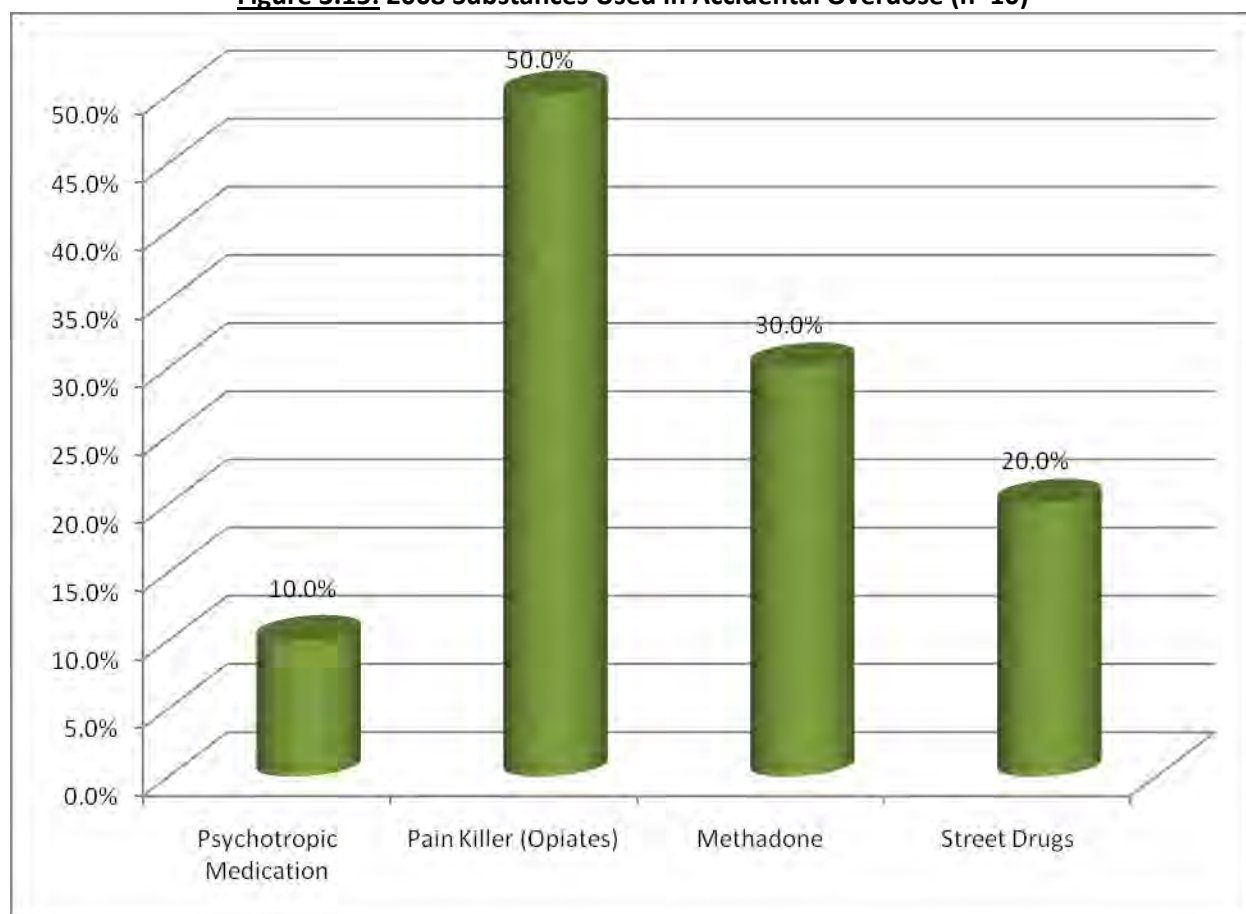
## Overdose

For the first time in the past three years the number of accidental overdose cases equals that of accidental drowning. In 2008 there were ten cases of accidental overdose which accounts for 15.4% of all accidental deaths. This is more than three times the number in 2007 and twice as many as in 2006.

Nearly all (90%) of these deaths were youth between the ages of 15 and 17 years, the remaining case was a child between the ages of 10 and 14 years. Also the majority (80%) were male, with 20% being female youth. In terms of race/ethnicity, these youth were primarily White Non Hispanic (70%) followed by White Hispanic (20%) and Multi-Racial (10%).

There were a variety of substances involved in these accidental overdose cases, however the majority were prescription drugs. Figure 3.15 illustrates the different substances used.

**Figure 3.15: 2008 Substances Used in Accidental Overdose (n=10)**



\*Categories are NOT mutually exclusive, one person could be represented in more than one category.

In only one case the prescription for the medication was for the decedent. In 90% of cases the youth had a history of substance abuse. This history included alcohol, cocaine, marijuana, methamphetamine, and prescription medications. In 70% of cases the youth had received substance abuse treatment and in 30% of cases the youth had received some mental health treatment. The majority of these cases seemed to be related to the recreational use of drugs and alcohol. Additionally, in 30% of cases the family had a history of involvement with a child welfare agency.

## Accidental Deaths: Recommendations for Prevention

Accidental deaths are defined by the National Center for Child Death Review as “a manner of death indicating non-intentional trauma.” The majority of accidental deaths of children in Clark County in 2008 were due to motor vehicle accidents, suffocation/strangulation, drowning and overdose. By their nature, all accidental deaths are preventable and thus provide ample data to make recommendations aimed at preventing future child deaths.

1. Again in 2008 the leading cause of accidental death was motor vehicle accidents, accounting for 29.2% of all accidental deaths. While this proportion is a decline of more than 10% from 2006 and 2007 it is still an important area to continue prevention efforts.
  - In 2008 we saw the highest proportion of children ages 10 to 14 that were victims of a motor vehicle accident in three years, a higher percentage than those ages 15 to 17. This means that these children are not new teen drivers. Nearly half of all MVA decedents were passengers in vehicles and 36.8% (n=7) were pedestrians. We saw four cases of accidents involving children on bicycles. This new information indicates that prevention messages and public education should also focus on the importance of bicycle safety and supervision. In 57.1% of all pedestrian fatalities a helmet was needed but not worn by the decedent.
2. Nearly all (80%) of drowning victims in 2008 were between the ages of one and four. Also 80% of drowning fatalities occurred in a pool or spa, while only 20% were in a bathtub. In 37.5% of cases, there was no barrier in place to prevent access to the pool/spa. In several of the cases where barriers existed, the children were able to gain access because the gate was left open, or a door latch was broken. A child can drown in a relatively short period of time, from seconds to just a few minutes depending on the circumstances. Therefore, it is imperative that young children are supervised constantly and that appropriate barriers are in place to prevent a young child from accessing a pool or spa.
  - Again in 2008 the majority of pool drowning incidents took place in older areas of Las Vegas, Henderson and North Las Vegas, which may account for the lack of appropriate barrier devices which are mandated by the County for newer pools. Prevention efforts should focus on bringing older pools up to current code by providing fences, gates, and other safety features to prevent drowning. Additionally, 80% of drowning occurred at the child’s home and therefore families with children need to be reminded of the dangers of having small children around pools. Given that housing prices in Clark County have become more affordable it is logical to assume that many families could be purchasing new homes in the coming years and may now be able to afford a home with a pool or spa. For these families once the sale is completed information on how to create a safe environment for children could be sent, either through realtors or through the county assessor’s office.
3. In 2008 all cases of accidental suffocation were children less than one year of age and all occurred while the child was in a sleeping environment. In over half of the cases the child was sleeping on an adult mattress, couch or the floor. In the other 7 cases the child was sleeping in their own crib or bassinette. In over half of the cases (53.3%) the child was bed sharing with another adult or older child and in some cases multiple adults. In addition 66.7% of decedents were placed to sleep on their stomachs. All of this information points to the need for increased efforts to promote safe sleeping practices. This includes the child having their own sleep space

(crib, bassinette, etc) that is free from fluffy pillows, blankets and stuffed animals. Also this means always placing the infant to sleep on his/her back. *Pediatrics* published an article in 2009 that described the results of a study of 20 years of US mortality trends attributable to accidental suffocation. The study found that infant mortality rates attributable to accidental suffocation in bed have quadrupled since 1984 (Shapiro-Medozza, et.al, 2009). These national findings along with our local data support the need for targeted health education focused on creating safe sleep environments for infants.

4. For the first time in the last three years accidental overdose was one of the leading causes of accidental deaths. In 2008 these cases accounted for 15.4% of all accidental deaths, the same amount as accidental drowning. Nearly all (90%) of these deaths were children ages 15 to 17 years, and 80% of cases were male. In 50% of cases the substance was an opiate pain killer. The recreational use of prescription drugs among teenagers continues to increase. It seems that teens fail to understand the danger in misusing prescription medications and they are seen as “safer” than other street drugs. Public education campaigns should focus on providing information on the danger of recreational use of prescription medications and regulatory officials should look for ways to better control the dissemination of these prescription medications. In addition parents need to understand the importance of keeping prescription medications locked in a secure location especially if their child has a history of mental illness or substance abuse. This year in 90% of accidental overdose fatalities the youth had a history of substance abuse.

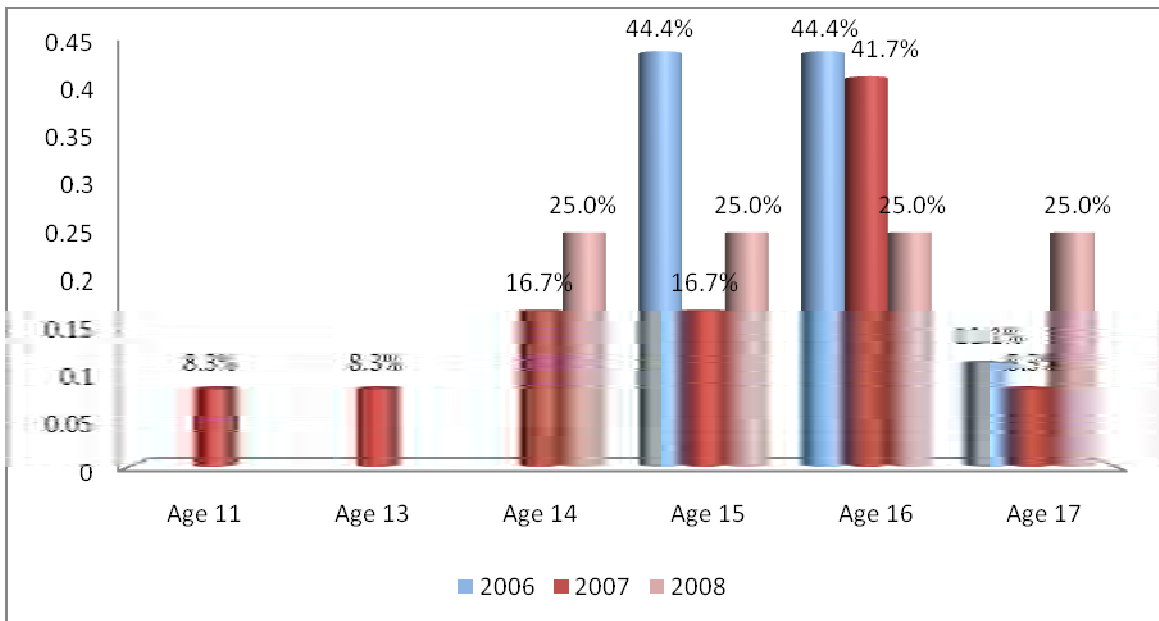


## Section IV: Suicide Deaths

Suicide is defined as the willful termination of one’s own life. According to the National Center for Child Death Review, in 2000, suicide was the third leading cause of death among young people ages 15-24, just behind unintentional injury and homicide. In 2008, we saw a sharp decrease in the number of youth suicides from 12 in 2007 to only 4 in 2008. This number is less than half the number of suicides in 2006 and only one quarter of the suicides in 2007. The percentages for sex, race and ethnicity for all 2006-2008 suicide cases are listed in the figures below. Half of the suicide cases were due to fatal firearm injuries, while the remaining two cases included one hanging and one fatal drug overdose. Only one case had a family history of prior child welfare involvement.

In 2008 ages of youth who died from suicide ranged from 14 to 17, with only one case at each age. Because we saw such a decrease in the number of suicides in 2008 we also saw a decrease in the number of suicides in each age category. This is illustrated in Figure 4.1 below.

**Figure 4.1: 2006–2008 Suicide by Age of Decedent (2006 n=9, 2007 n=12, 2008 n=4)**

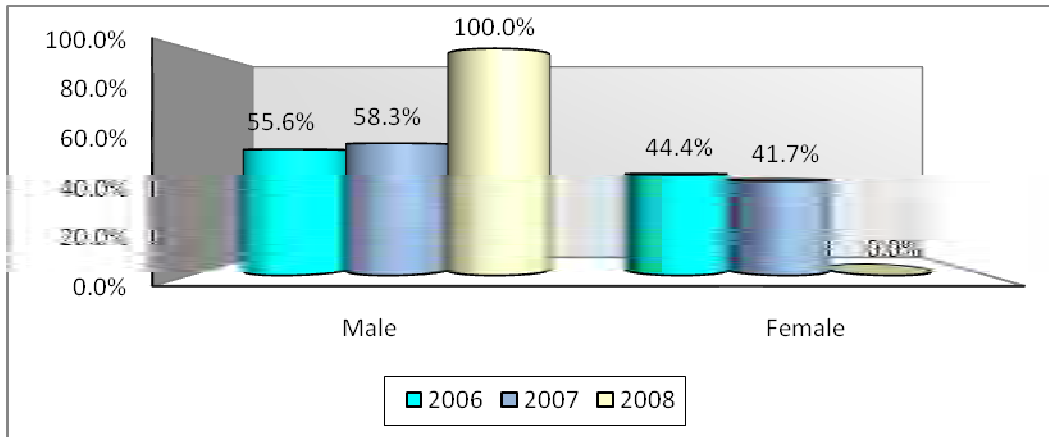


Three of the four cases involved children who were White Non Hispanic. The remaining case was a child who was White Hispanic. There were no other races or ethnicities represented in youth suicide statistics for 2008. All four youth suicides this year were males, an in one case the child had a history with juvenile justice services, in that same case the family had a history of involvement with the child welfare system. Clark County’s data has not historically matched the national profile showing males completing suicide at nearly four times the rate of females<sup>1</sup>, however in 2008 all youth

<sup>1</sup> Centers for Disease Control and Prevention (2004). Suicide Fact Sheet.

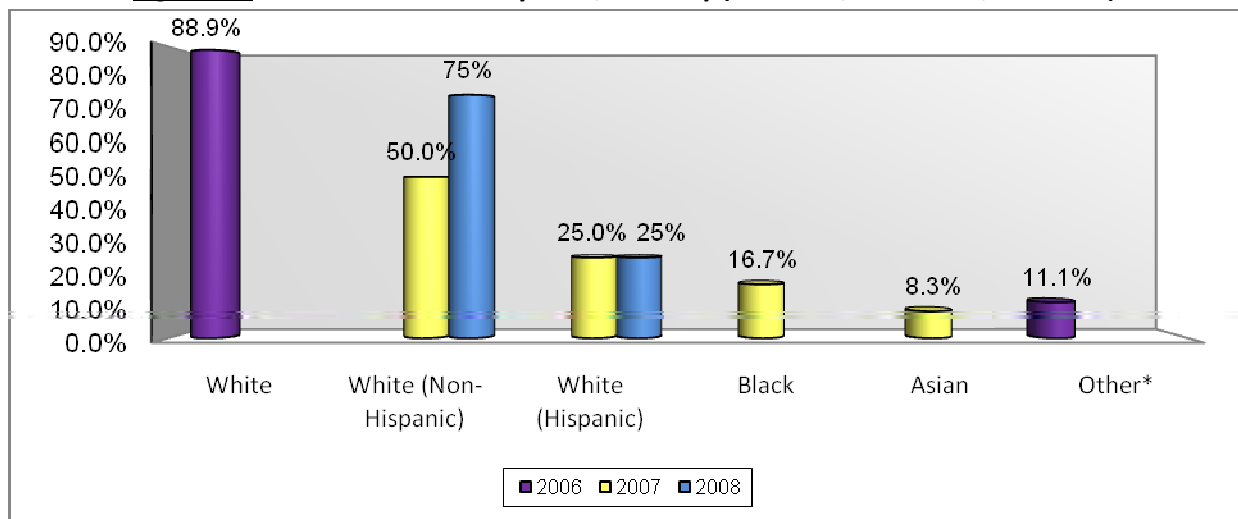
suicides were male indicating that perhaps any targeted prevention efforts for girls have had some impact on youth suicide in Clark County.

**Figure 4.2: 2006–2008 Suicide by Sex of Decedent (2006 n=9, 2007 n=12, 2008 n=4)**



In 2008, nearly all suicide cases were White youth; which is a contrast to 2007 where the racial/ethnic breakdown was much more varied. According to the National Center on Child Death Review, White males make up the greatest percentage of suicides among youth ages 15-24 years. In 2008, all suicide victims were males between the ages of 14 and 17.

**Figure 4.3: 2006–2008 Suicide by Race/Ethnicity (2006 n=9, 2007 n=12, 2008 n=4)**

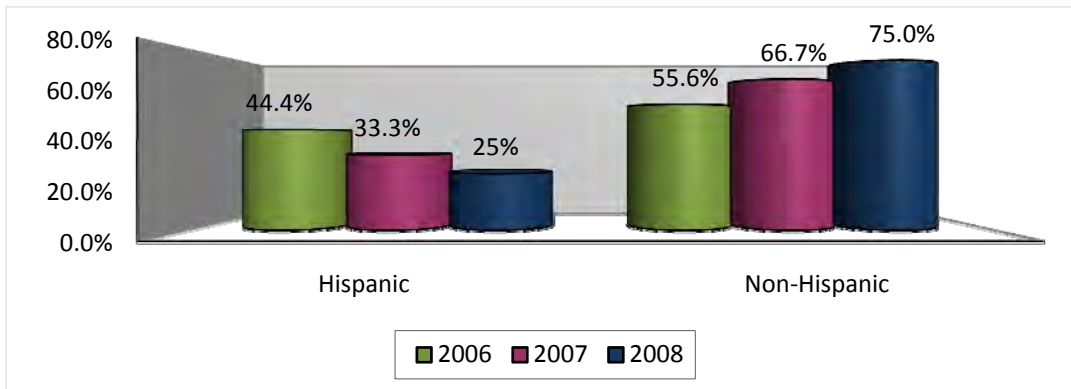


\* The "Other" race in the 2006 data was a person who did not list a race, but listed ethnicity as Hispanic

\*\* Race/Ethnicity data were collected differently in 2006. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

Over the past three years we have seen a decline in the number of Hispanic youth who complete suicide, while conversely we see an increase in Non Hispanic youth completing suicide. This is more in line with national statistics indicating that White youth have the highest incidence of suicide completions.

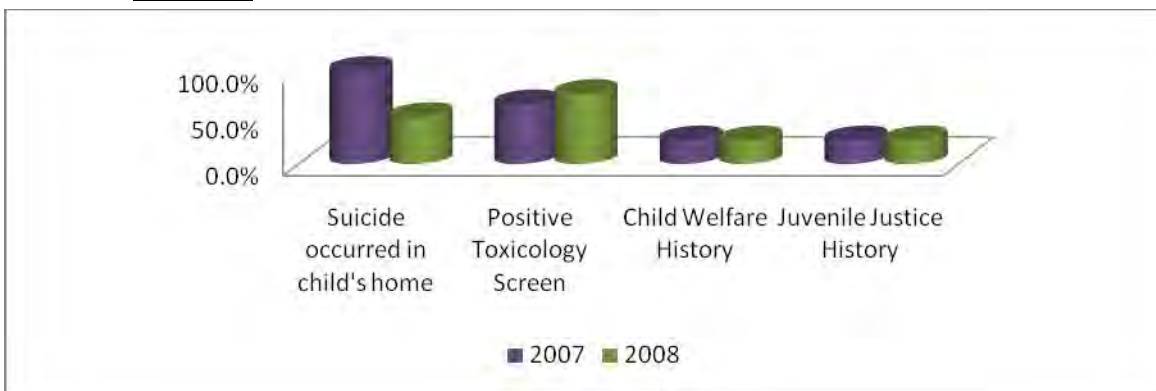
**Figure 4.4: 2006–2008 Suicide by Ethnicity (2006 n=9, 2007 n=12, 2008 n=4)**



### Situational Factors of Suicide

In three of the four suicide cases in 2008 the child had a history of substance abuse and in one case the youth was involved in the juvenile justice system. None of these youth had been diagnosed with a mental illness; however in one case a prior suicide attempt had been made. In half of all cases, the suicide occurred in the child’s home, the other two cases occurred in either a friend or relative’s home. 911 were called in all cases. In three cases, the child was attending school at the time of death. However, in one case the child was experiencing school failure and had dropped out.

**Figure 4.5: 2007–2008 Situational Factors of Suicide (2007 n=12, 2008 n=4)**



	2007	2008
<b>Suicide Occurred in Child's Home</b>	100.0%	50.0% (2)
<b>Positive Toxicology Screen</b>	64.0%	75.0% (3)
<b>Child Welfare History</b>	25.0%	25.0% (1)
<b>Juvenile Justice History</b>	25.0%	25.0% (1)

In all cases, there was a toxicology screen conducted by the medical examiner. A study done by the Suicide Prevention Research Center and the Harvard Injury Control Research Center demonstrated that most teen suicides do not involve

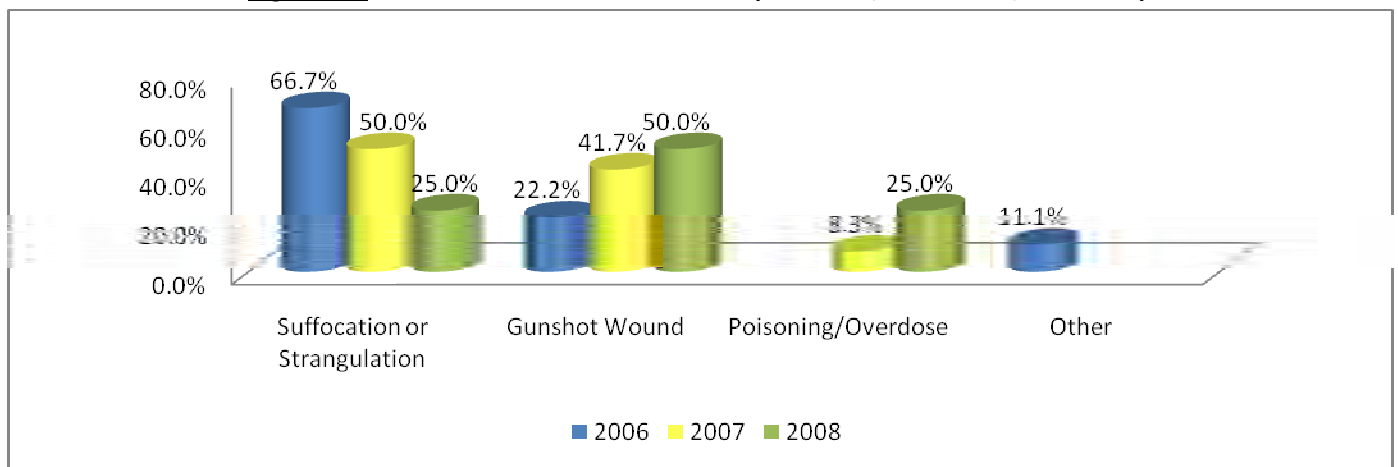
drugs or alcohol (only 4% do as opposed to 36% of adults), meaning that the majority of teen’s postmortem toxicology screens were negative. In 2008 in Clark County, however, the majority of cases (75%) had a positive toxicology screen - the local data does not support the national trend. These positives screens indicated marijuana in one case and an elevated level of a prescription drug in the other two cases.

In addition, “findings from the first national study on the issue indicate that gay or lesbian youths are more than twice as likely to attempt suicide as their heterosexual peers”. (www.childdeathreview.org). In 2008 the local CDR team collected teen’s sexual orientation for suicide deaths. This data showed that all cases involved heterosexual youth. This will be an important data point to continue to track to see if this trend continues in later years.

## Method of Suicide

Firearms (60%) and hanging (26%) were the most common methods of suicide used by young people in the United States<sup>2</sup>. An additional article authored by the Suicide Prevention Research Center and the Harvard Injury Control Research Center suggests that 44% of teen suicides were suffocation deaths (primarily by hanging), followed by 43% of suicides committed using a firearm<sup>3</sup>. Regardless of the actual order, firearms and hanging appear to be the most common methods of suicide for teens, a pattern which is replicated in Clark County for 2006 through 2008. For Clark County teens, firearms are the most common method of suicide.

**Figure 4.6: 2006–2008 Method of Suicide (2006 n=9, 2007 n=12, 2008 n=4)**



In half of the Clark County youth suicides the decedents either hanged himself or used drugs to overdose. This was slightly different compared to 2007 when half of the cases involved suffocation. The other half of cases involved a firearm. Both instances involved a handgun as the fatal firearm. In one case the handgun was owned by the decedent

<sup>2</sup> www.childdeathreview.org, 2007

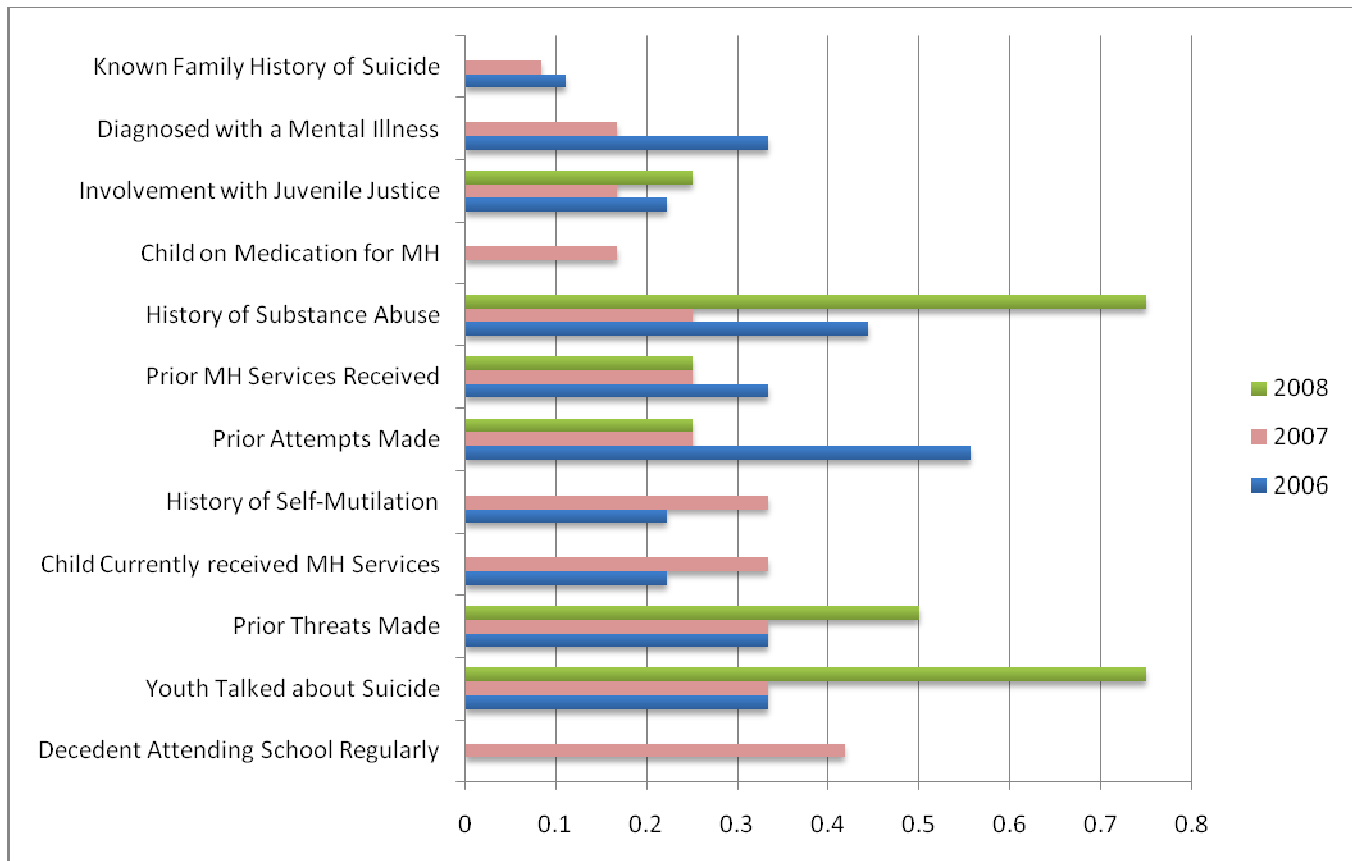
<sup>3</sup> http://www.sprc.org/library/YouthSuicideFactSheet.pdf

and in the other it was unknown who the owner of the firearm was. In only one case the decedent left a note, however in 3 cases the youth talked about suicide and in two cases prior threats of suicide were made, and in one case a prior attempt was made.

## Circumstances of Suicide

There are several factors that have been identified as risk factors for suicide. The circumstances that were present in the 4 cases reviewed are listed in Figure 4.7 below.

**Figure 4.7: 2006-2008 Circumstances of Suicide (2006 n=9, 2007 n=12, 2008 n=4)**

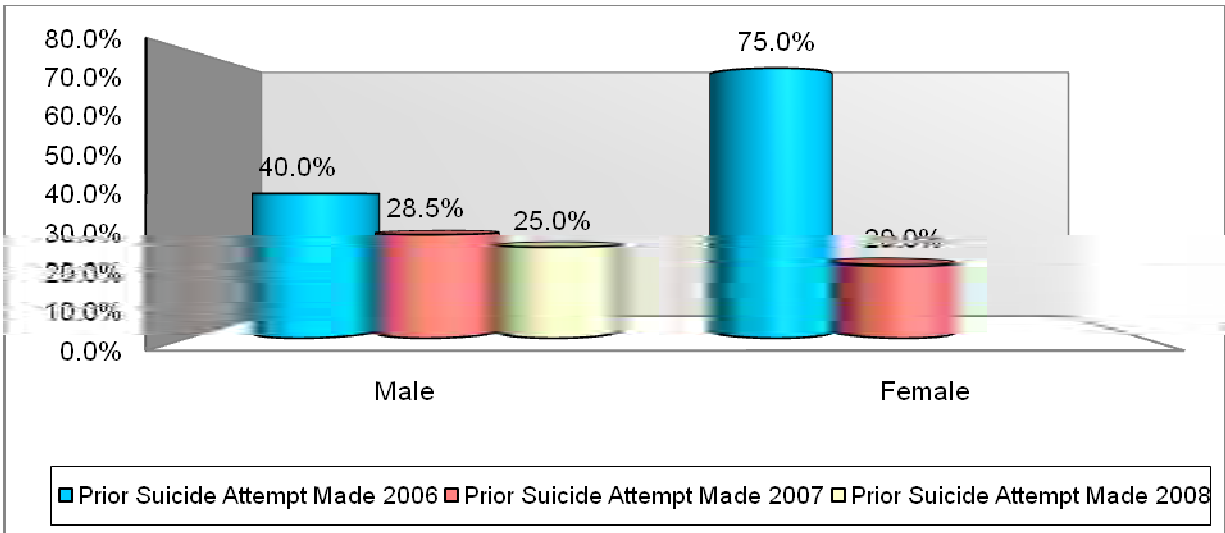


In the 2008 cases, there are clearly identified risk factors, such as the fact that nearly all decedents had a history of substance abuse and had talked about suicide. Half of decedents had made prior threats. According to literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide<sup>4</sup>. In 2006, over half (55.6%) of suicide victims had prior attempts, while in 2007 and in 2008 one quarter (25%) of decedents had a prior attempt. In addition, three quarters (75%) had a history of substance abuse, and none were diagnosed with a

<sup>4</sup> www.KidsHealth.org, Retrieved June 25, 2007

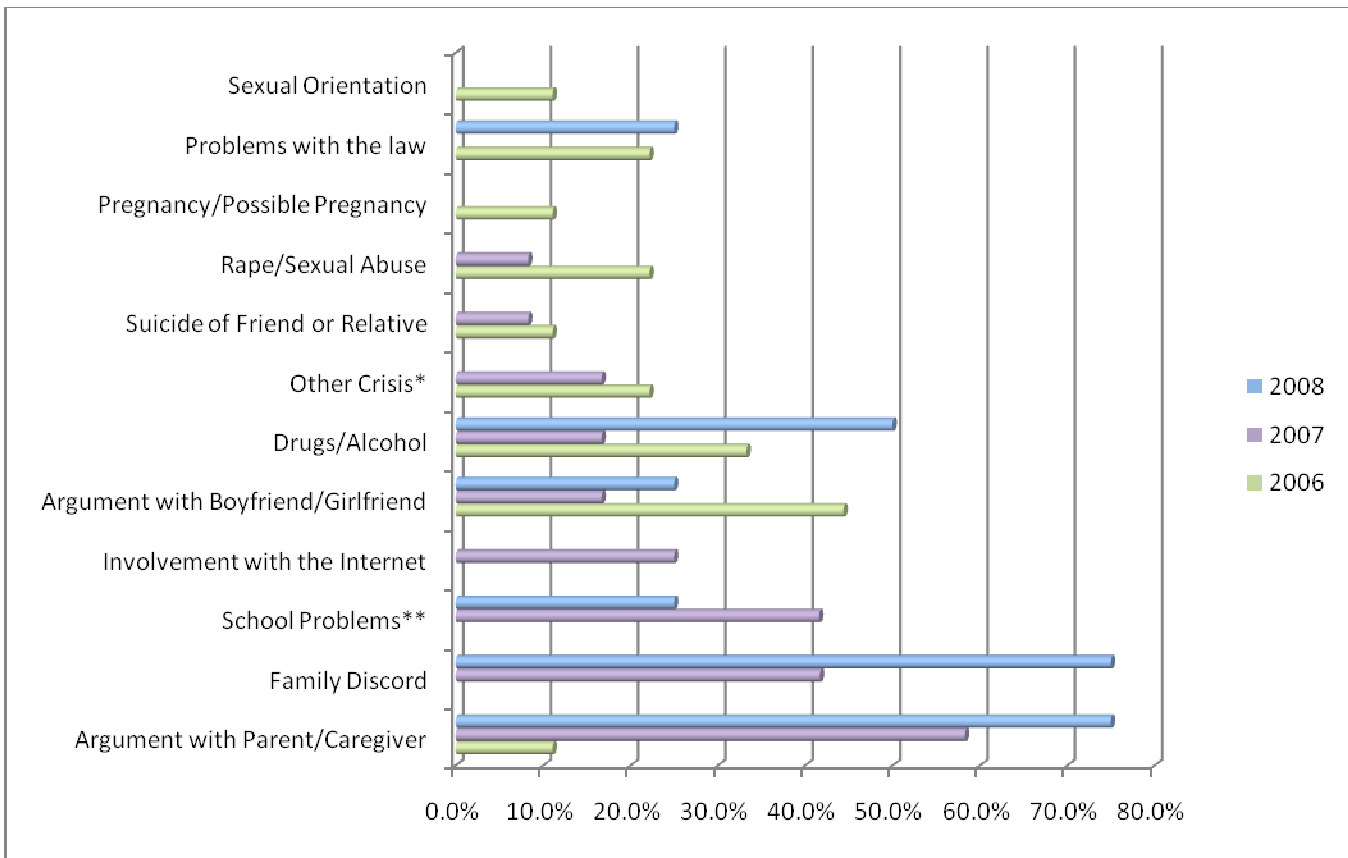
mental illness. National literature clearly shows that adolescent males of all races are four times more likely to commit suicide than females, but adolescent females are twice as likely as adolescent males to attempt suicide. The 2007 Clark County data showing attempts by sex illustrates a different trend, however in 2008 since all deaths were male no trend can be identified. In 2006, girls were nearly twice as likely as males to have made a prior suicide attempt, but in 2007, the percentage of males and females who had prior suicide attempts was approximately equal.

**Figure 4.8: 2006–2008 Prior Attempts Made by Sex (2006 n=9, 2007 n=12, 2008 n=4)**



In taking a look at these cases and the decedent’s history of any acute or cumulative crisis, several factors were shown to be present in these cases. Three quarters of the victims (75%) had recently had a fight with their parent, and one (25%) had recently fought with their boyfriend or girlfriend. Approximately 50% had been involved with drugs or alcohol, and 25% were experiencing problems in school. Problems with the law account for another 25% of suicide deaths in 2008.

**Figure 4.9: 2006–2008 History of Acute or Cumulative Crisis (2006 n=9, 2007 n=12, 2008 n=4)**



\* Other Crisis includes alleged sexual abuse

\*\* School Problems includes "School Failure", "Move/New School", and "Other Serious School Problems"

	2006	2007	2008
<b>Argument with Parent/Caregiver</b>	11.1%	58.3%	75.0%(3)
<b>Family Discord</b>	--	41.7%	75.0% (3)
<b>School Problems**</b>	--	41.6%	25.0% (1)
<b>Involvement with the Internet</b>	--	25.0%	--
<b>Argument with Boyfriend/Girlfriend</b>	44.4%	16.7%	25.0% (1)
<b>Drugs/Alcohol</b>	33.3%	16.7%	50.0% (2)
<b>Other Crisis*</b>	22.2%	16.7%	--
<b>Suicide of Friend or Relative</b>	11.1%	8.3%	--
<b>Rape/Sexual Abuse</b>	22.2%	8.3%	--
<b>Pregnancy/Possible Pregnancy</b>	11.1%	--	--
<b>Problems with the law</b>	22.2%	--	25.0% (1)
<b>Sexual Orientation</b>	11.1%	--	--

## Suicide Deaths: Recommendations for Prevention

Youth suicide is preventable if appropriate measures are taken to educate parents, youth, friends and family regarding the risks and signs of suicidal ideation. The primary prevention recommendation for youth suicide is to raise awareness of the signs and risk factors among parents and peers from middle school through high school. However, there are particular areas in which targeted efforts may be needed.

1. In 2008 there were only four youth suicide deaths. While this is a marked decrease from the previous two years, even one youth suicide in our community is too many. All deaths were among youth ages 14 to 17 years of age indicating that middle and high schools are still the most appropriate place to target prevention interventions. It is essential that mental health screenings occur in children that are middle school aged, and that teachers and other non-family members are educated about the signs and risk factors for suicide.
2. In 2008, 75% of youth that committed suicide were positive for drugs at the time of their death and the same proportion had a history of substance abuse. A study done by the Suicide Prevention Research Center and the Harvard Injury Control Research Center demonstrated that most teen suicides do not involve drugs or alcohol (only 4% do as opposed to 36% of adults), meaning that the majority of teen's postmortem toxicology screens were negative. In 2008 in Clark County, however, the majority of cases (75%) had a positive toxicology screen - the local data does not support the national trend. These positive screens indicated marijuana in one case and an elevated level of a prescription drug in the other two cases. This is a phenomenon that should be closely monitored and researched. Prevention efforts should focus on reducing youth access to substances which may impair their ability to think rationally, particularly if other risk factors exist. Providing quality substance abuse treatment and mental health treatment to youth may be able to reduce the potential suicide risk of these youth.
3. In all but one of the youth suicides in 2008 the youth had talked about suicide prior to their death. Verbalizing suicidal ideation should always be taken seriously. However many parents, teachers, friends, etc. do not take action to get professional help until after an attempt. Prevention efforts including suicide gatekeeper training should attempt to include other youth in recognizing the signs of suicide, as well as measures that can and should be taken to intervene. The Nevada Office of Suicide Prevention currently offers gatekeeper training designed to help people recognize the signs and symptoms of suicidal ideation and provides information on what to do to help. The training also provides information about suicide risk to reduce some of the stigma attached to mental illness and suicide.

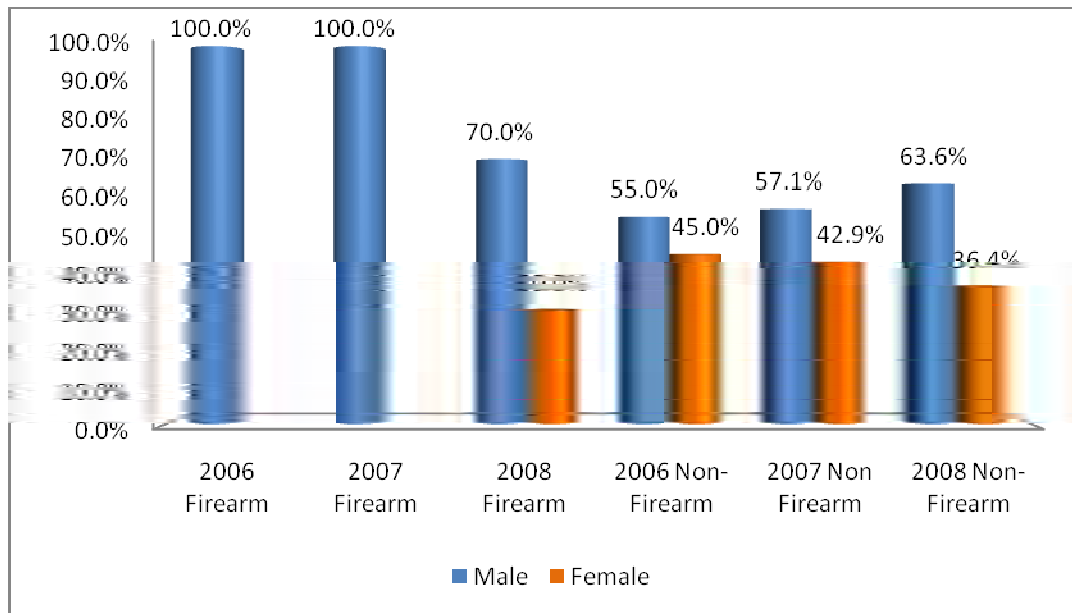


## Section V: Homicide Deaths

Homicide is legally defined as the killing of one human being by another human being. The Center for Disease Control lists youth homicide as the second leading cause of death for the 10-24 age group<sup>5</sup>, and further states that “among 10-24 year olds, 86% of homicide victims were male, and 82% were killed with a firearm.”<sup>6</sup> Further, “among 10 to 24 year olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics and Asian/Pacific Islanders; and the third leading cause of death for American Indians and Alaska Natives.”<sup>7</sup>

In 2008, there were 21 homicides of children and youth, which is an increase of 25% from the 15 in 2007. The 2008 homicides fell into two categories – those that were committed using a firearm (47.6%) and those that were committed without a firearm (52.4%). Overall, victims were twice as likely to be male (66.7%) than female (33.3%), and primarily between the ages of 15-17 (52.4%). All victims of firearm homicides were male in both 2006 and 2007, however in 2008 30% (n=3) of firearm homicides were female.

**Figure 5.1: 2006 – 2008 Homicide Deaths by Sex and Type (2006 n=20, 2007 n=15, 2008 n=21)**



One third of homicide deaths were White Non Hispanic (33.3%) children and another third (33.3%) were Black children. The remaining cases were White Hispanic children ( 23.8%) and American Indian Alaska Native children at 9.5% of all homicide deaths in 2008. This data indicates that Black and Hispanic teens are disproportionately victimized by homicide. It is also interesting to note the bimodality of the age distribution in 2006 through 2008. No children

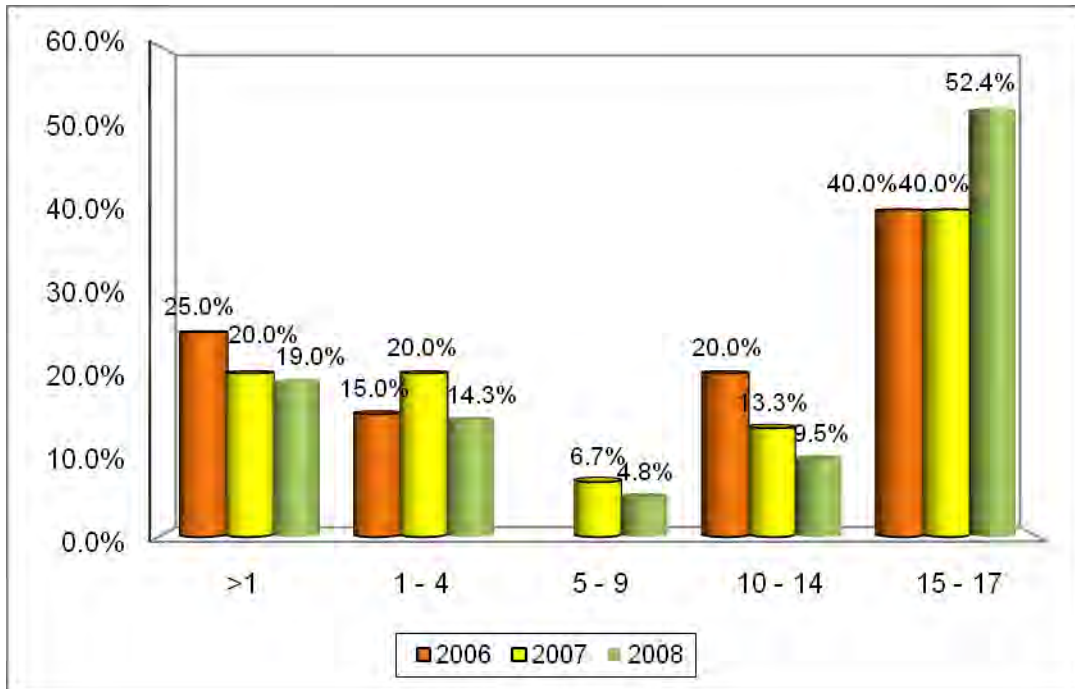
<sup>5</sup> <http://www.cdc.gov/ncipc/pub-res/YVFactSheet.pdf>

<sup>6</sup> [http://www.cdc.gov/ncipc/dvp/YV\\_DataSheet.pdf](http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf)

<sup>7</sup> [http://www.cdc.gov/ncipc/dvp/YV\\_DataSheet.pdf](http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf)

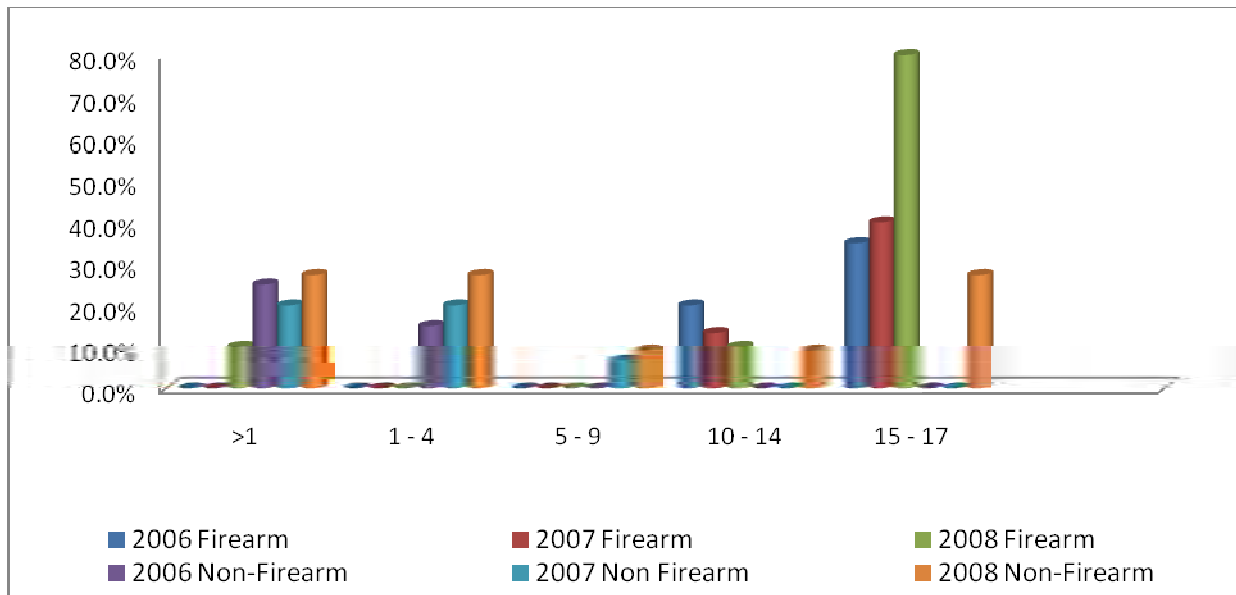
between the ages of 5-9 were homicide victims in 2006 although there were victims in this age group in 2007 and 2008, and the oldest group (ages 15-17) and the youngest group (infants <1 year) demonstrated the highest percentages of victims in all three years.

**Figure 5.2: 2006–2008 Homicide Deaths by Age (2006 n=20, 2007 n=15, 2008 n=21)**



The type of homicide clearly divides the age categories in all three years, showing different trends in victimization by age. In all years, youth ages 10-17 are most frequently victimized by firearms and children 9 years and younger are most frequently victims of non-firearm homicides.

**Figure 5.3: 2006–2008 Homicide Deaths by Age and Type (2006 n=20, 2007 n=15, 2008 n=21)**



	2006 Firearm	2007 Firearm	2008 Firearm (n=10)	2006 Non-Firearm	2007 Non-Firearm	2008 Non-Firearm (n=11)
>1 year	0.0%	0.0%	10.0% (1)	25.0%	20.0%	27.3% (3)
1 – 4 years	0.0%	0.0%	0.0%	15.0%	20.0%	27.3% (3)
5 – 9 years	0.0%	0.0%	0.0%	0.0%	6.7%	9.1% (1)
10 – 14 years	20.0%	13.3%	10.0% (1)	0.0%	0.0%	9.1% (1)
15 – 17 years	35.0%	40.0%	80.0% (8)	0.0%	0.0%	27.3% (3)

## Firearm Homicides

Youth homicides represent the greatest proportion of all firearm deaths<sup>8</sup>. Youth living in neighborhoods with high rates of poverty, social isolation and family violence are particularly at risk for victimization, as these contribute to the prevalence of specific risk factors for youth homicide. “Major contributing factors in addition to poverty include easy access to handguns, involvement in drug and gang activity, family disruption and school failure.”<sup>9</sup> Clark County’s data in 2008 once again supports the importance of these factors. Specifically in Clark County, substance abuse history, gang involvement, and school failure are demonstrated risk factors for youth homicide. In addition, “these homicides usually occur in connection with an argument or dispute. Firearm homicides among teens are almost always committed by casual acquaintances of the same gender, race, and age, and almost always committed using inexpensive and easily acquired handguns.”<sup>10</sup>

<sup>8</sup> www.childdeathreview.org (2007)

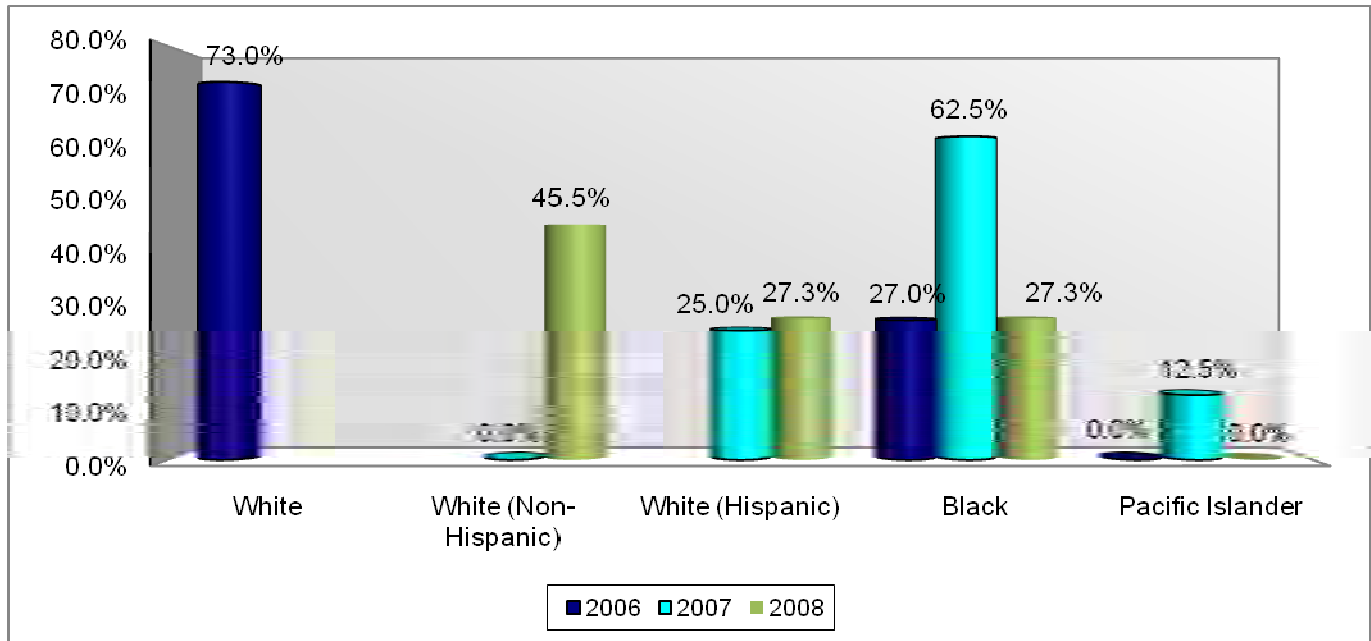
<sup>9</sup> www.childdeathreview.org (2007)

<sup>10</sup> www.childdeathreview.org (2007)

The percent of firearm homicides (47.6%) in 2008 is nearly equal to the percent of non-firearm homicides (52.4%) and does not show significant change in the pattern since 2006. There are unique characteristics of the firearm homicides, however. In 2008, 80% of firearm homicides occurred in the 15 to 17 year old age group. There was one case involving a child less than one year of age and another with a child between 10 and 14 years of age. All (100%) of the firearm homicide victims in both 2006 and 2007 were male, however in 2008 only 80% were male.

Racially, more than half of all victims were minorities: nearly two thirds (27.3%) were Black and one quarter (27.3%) of victims were White (Hispanic). The other half (45.5%) were White Non Hispanic. The percentage of Black victims is disproportionate to the population distribution in Southern Nevada and represents a clear area for intervention.

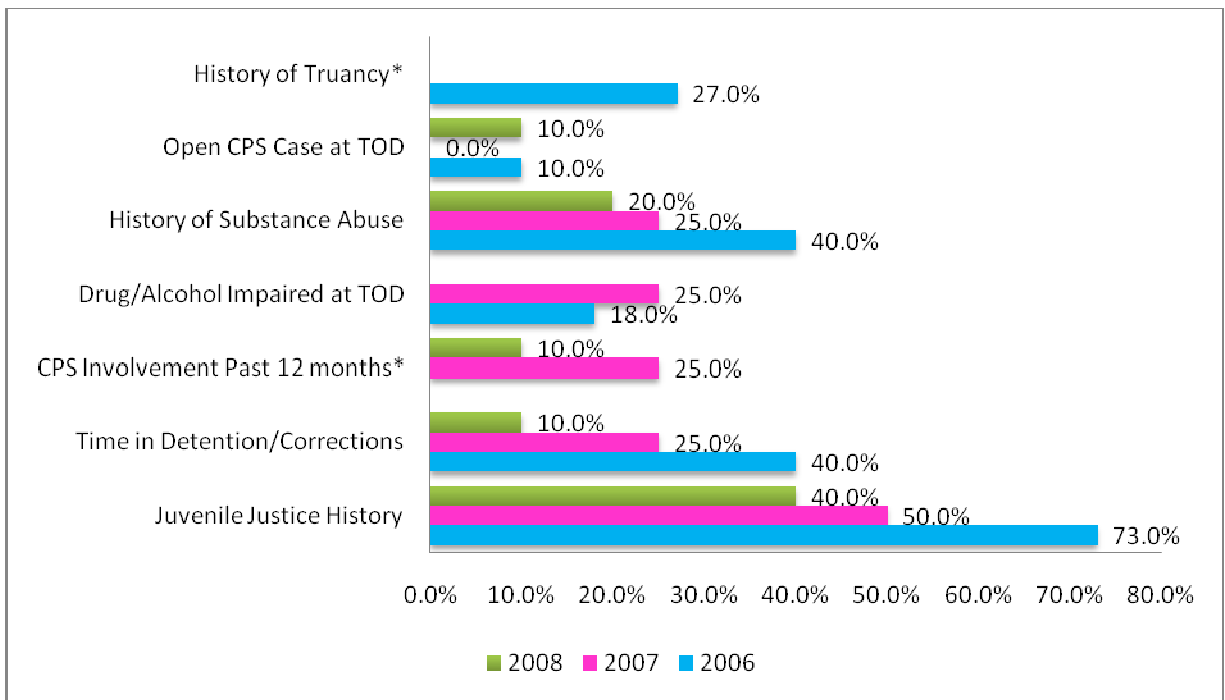
**Figure 5.4: 2006–2008 Race of Victim in Firearm Homicide (2006 n=11, 2007 n=8, 2008 n=10)**



\* Race/Ethnicity data were collected differently in 2006 and 2007. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

Less than half (40%) of victims were attending school regularly. None of the firearm homicide victims had a disability. Less than one quarter (20%) had a known history of substance abuse, and 20% were positive for drugs at the time of death. A toxicology screen was conducted in 60% of firearm homicide cases, and of those who had one, 10% were positive for alcohol and 10% was positive for an unknown substance. In half of these cases prosecution was pending at the time of the case review.

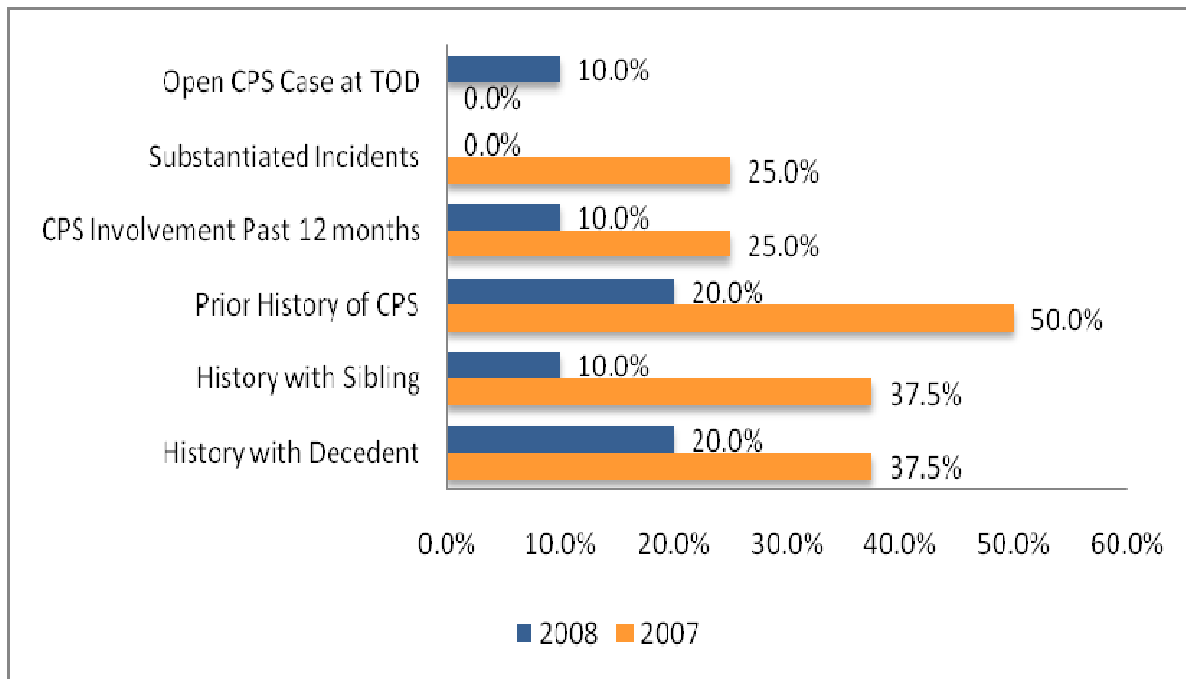
**Figure 5.5: 2006–2008 Characteristics of Firearm Homicides (2006 n=11, 2007 n=8, 2008 n=10)**



*\*NOTE: These questions were not asked in both 2006 and 2007 and therefore data does not exist for both years for the variables; "History of Truancy" or "CPS Involvement Past 12 Months."*

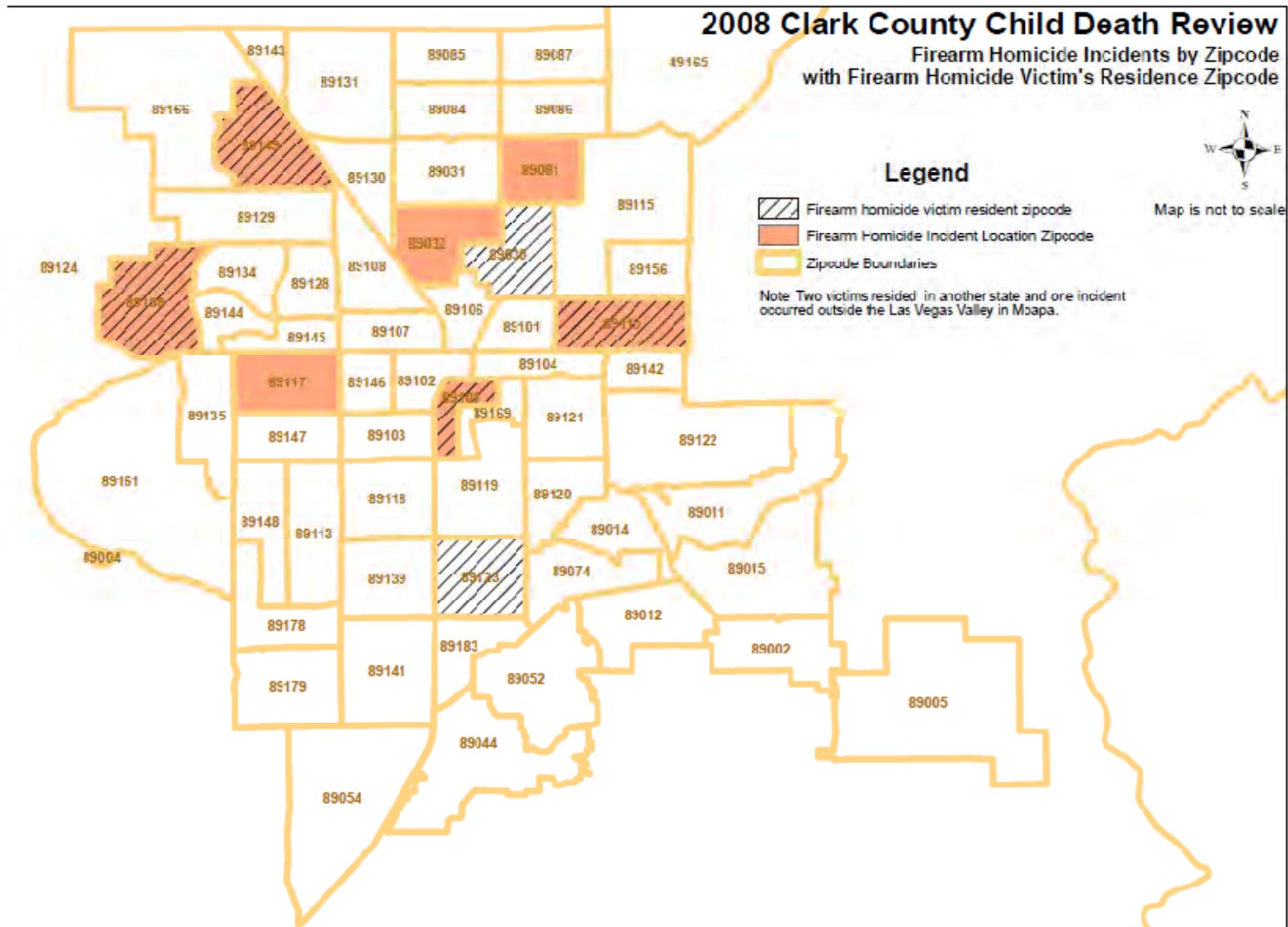
Families of firearm homicide victims had a history with child welfare in only 20% of the cases in 2008. No CPS action was taken as a result of any of these the deaths. There were various circumstances surrounding these fatalities. In three of the cases (30%) there was some kind of argument that preceded the homicide, and in two cases gang involvement was suspected.

**Figure 5.6: 2007–2008 Child Welfare Involvement for Firearm Homicide Victims (2007 n=8, 2008 n=10)**



Nearly one half of firearm homicide victims (40%) had a known juvenile justice history, which is a reduction of approximately 30% from 2006, when approximately three quarters had a known juvenile justice history. Charges included: battery, larceny, solicitation, truancy, drug possession and weapons. In one of these cases the youth had been incarcerated in a juvenile correctional facility.

The map on the following page illustrates the incident location as well as the location of the child’s residence by zip code. Zip codes colored in peach indicate the location of the incident leading to the child’s death, while the diagonal stripes indicate the zip code of the child’s residence. Some zip codes are both colored peach and have diagonal stripes. This indicates zip codes where children were residents as well as those where incidents occurred. You can see that many of the incidents occurred in neighboring zip codes in the north central part of the County, but were more spread out than they were last year.

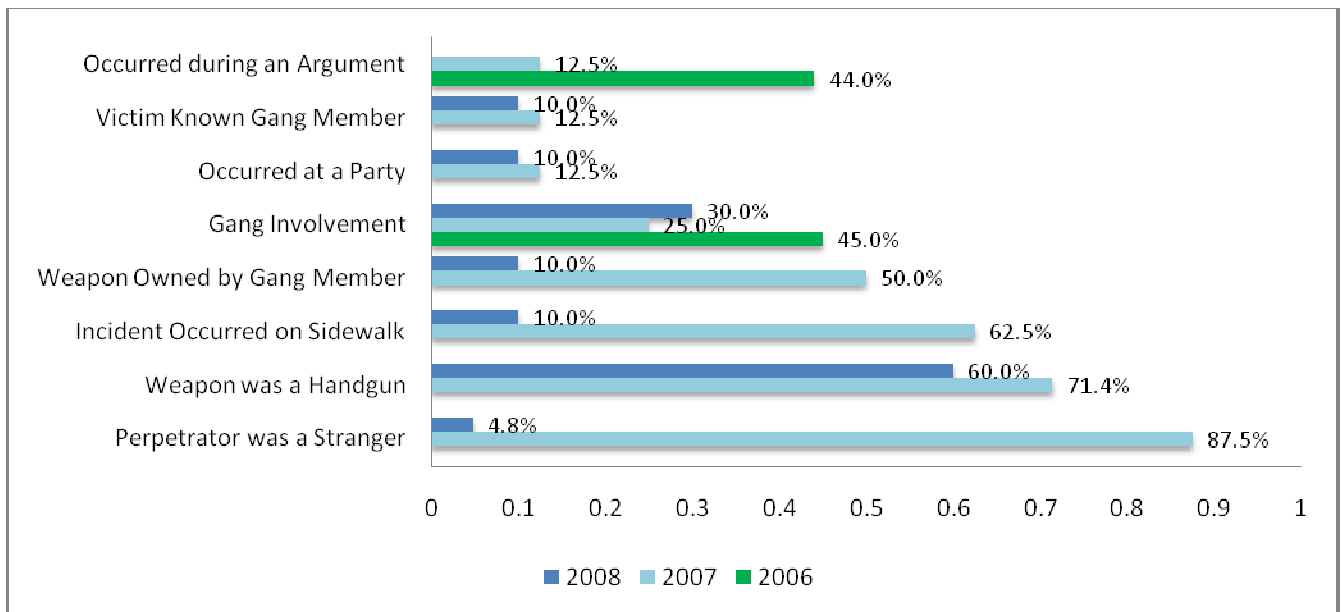


In 60% of the cases the incident occurred either at the child’s residence or the residence of a friend or other family member. The remaining 40% of incidents occurred on a sidewalk, roadway or driveway. The majority (60%) of incidents involved a handgun, one involved an assault rifle and in three cases the type of firearm was unknown at the time of the review. In the majority of cases, the firearms were not owned by family or friends of the decedent’s. In two cases the firearm was owned by an acquaintance, in one case it was owned by a gang member and in another case the firearm was owned by a stranger to the decedent. One incident occurred during the commission of a crime and one case involved a drive-by shooting.

In 2007 and 2008 data collection methods were vastly improved with the participation of law enforcement agencies sharing their investigation reports with the teams. This allowed much more circumstantial data to be reported for 2007 and 2008 homicides. The table below presents the information regarding circumstances for 2007 and 2008 as well as information for the two categories available in 2006.

There was suspected gang involvement in more than one quarter of the cases (30%) which is slightly higher than in 2007. This may be a product of better data collection methods and not necessarily an increase in gang involved youth homicides. In 10% of cases the victim was known or suspected to be in a gang, and in 20% of cases, the perpetrator was known to be in a gang, and in 10% of cases the perpetrator was a suspected gang member. Half of the cases occurred between the hours of one and nine thirty in the morning and the other half were in the afternoon between two o’clock and eight o’clock. Only 10% of incidents occurred at a party, and 30% of incidents occurred during an argument.

**Figure 5.7: 2006–2008 Incident Information for Firearm Homicides (2006 n=11, 2007 n=8, 2008 n=10)**

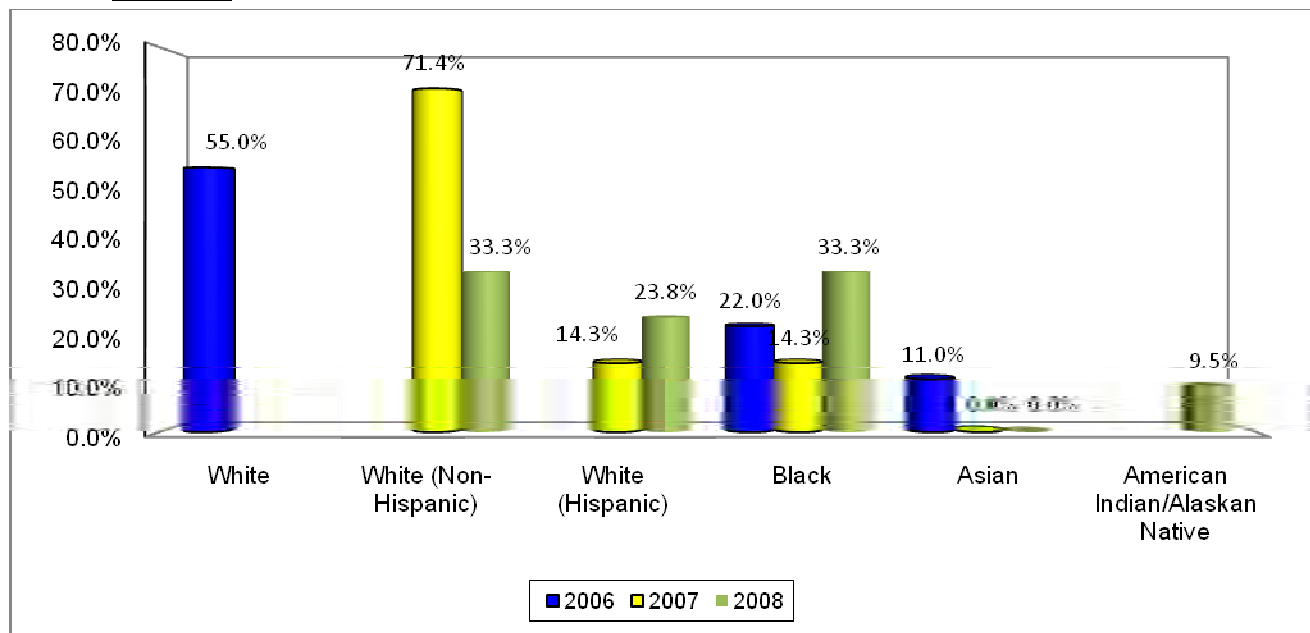




## Non-Firearm Homicides

Clark County's eleven non-firearm homicides again demonstrated an entirely different pattern of circumstances than firearm homicides. Just over half (n=6) of the 11 cases were children under four years of age. Three cases were between 15 and 17 years, one was between 5 and 9 years and one was between 10 and 14 years. Race/ethnicity of these victims was fairly evenly distributed across all categories. One third of victims were White Non Hispanic, one third were Black and 23.8% were White Hispanic and the remaining 9.5% were American Indian/Alaska Native. In 2008 there were more male victims (63.6%) of non firearm homicide than females (36.4%). In 27% (n=3) of cases the child had a disability, and in one case the child had a chronic illness.

**Figure 5.8: 2006–2008 Race of Non-Firearm Victims (2006 n=9, 2007 n=7, 2008 n=11)**

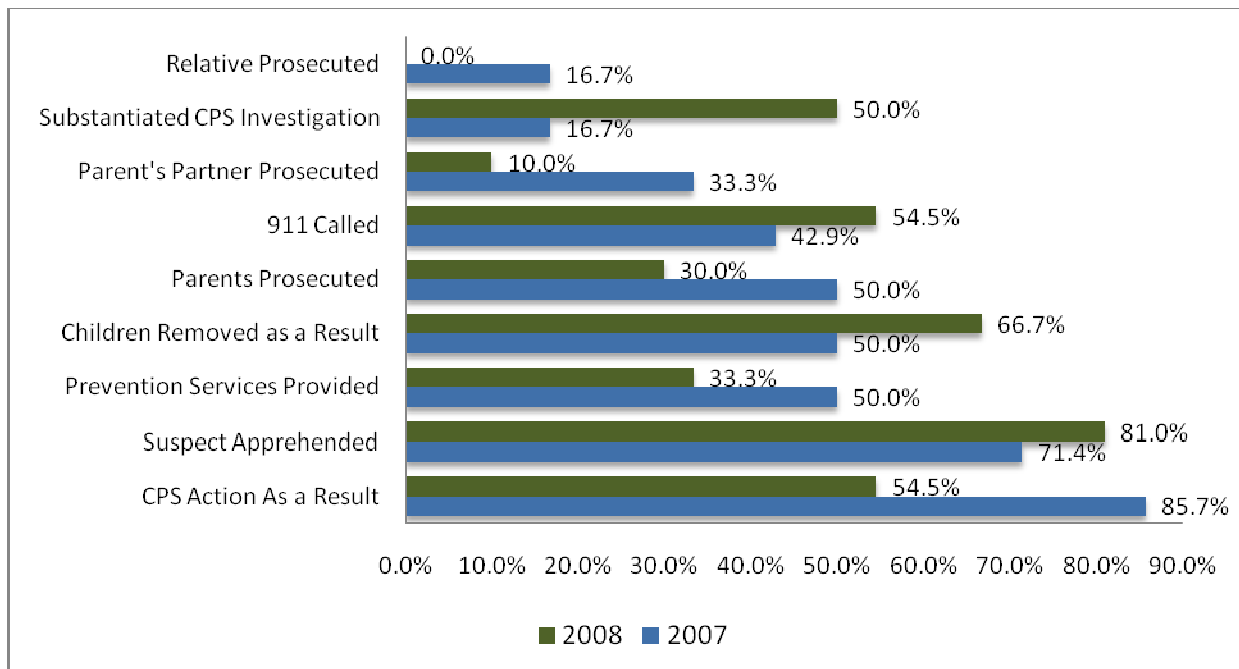


\* Race/Ethnicity data were collected differently in 2006. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

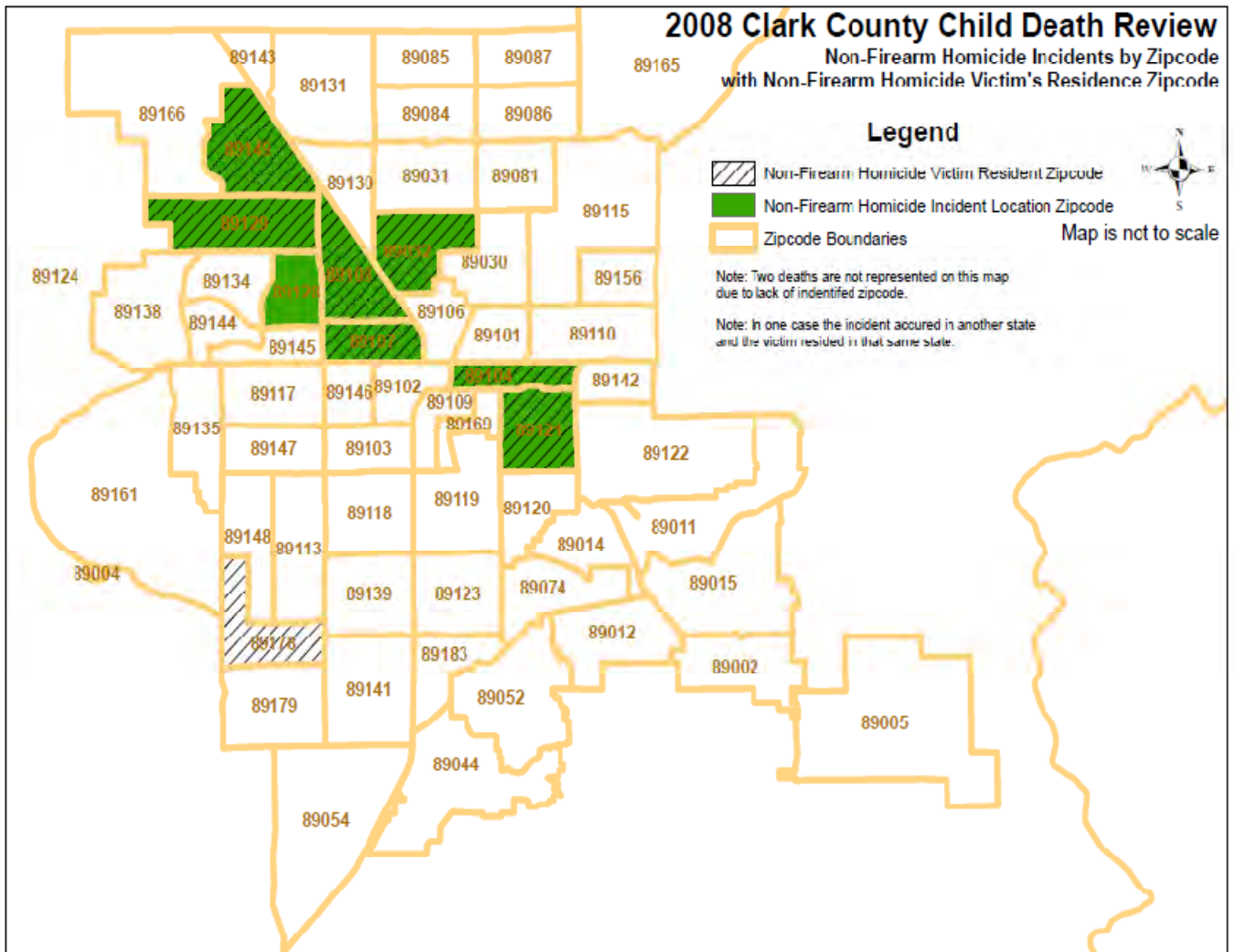
Only 27.3% of victims were regularly attending school at the time of their death. This however is to be expected given that for 45% of cases the child was not of school age. In nearly three quarters (72.7%) of the cases the victim's primary supervisor was a biological parent. In three of these cases there were other adults living in the home, these included a parent's boyfriend/girlfriend and other friends. In one case the mother and the father each had experienced a prior child death. Also in five of the eleven non firearm homicides the child's natural mother had a history of substance abuse and in one case the child's father had a history of substance abuse.

Only one of these homicides was perpetrated by a biological parent. In 36.4% of cases the perpetrator was a relative and in another 36.4% the perpetrator was a friend. In the remaining three cases the perpetrator was an acquaintance. In eight of the eleven cases (72.7%) the crime was committed by a person without using a weapon. In the remaining three cases the child was stabbed with a sharp object. In four cases the child was beaten, kicked or punched, in all other cases the child's death was caused by one of the following; purposive motor vehicle accident, environmental heat stress (child left in a car), complications of injuries sustained from prior physical abuse, and strangulation. In all eleven cases the suspect was apprehended, and in all but one case prosecution was pending at the time of the review. Most frequently parents or their boyfriend/girlfriends were prosecuted as a result of the child's death. These incidents primarily occurred between the hours of 2:30 PM and 5:30 PM (n=4).

**Figure 5.9: 2006–2008 Incident Information for Non-Firearm Homicides  
(2006 n=9, 2007 n=7, 2008 n=11)**



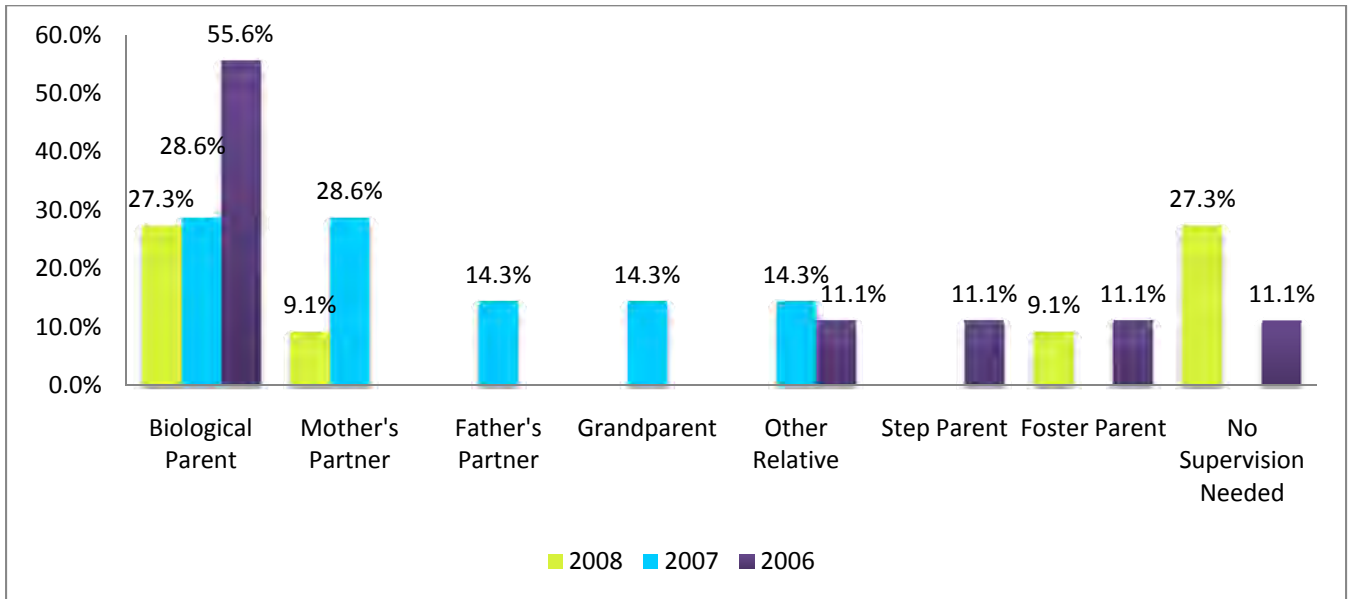
In six of the eleven cases 911 was called. CPS action was taken as a result of the death in six of the eleven cases. Action included, removal of remaining children, prevention services provided, and in four cases the allegations were substantiated by CPS. In the other five cases CPS did not take action for a variety of reasons. Primarily CPS did not take action because in many cases the deceased child was the only child in the home, or the child's death was a result of an injury inflicted by someone other than a family member.



The map above illustrates the zip codes for the incident location that led to the child's death as well as the zip code for the child's residence for all 2008 non-firearm homicides. Because the local team reviews deaths of all children that die in Clark County, unless they reside in another Nevada county, there were some cases that are not represented on this map. There was one case where the child was a resident of another state and the incident occurred in another state, also there were two cases where the zip code of the incident was unknown at the time of the review.

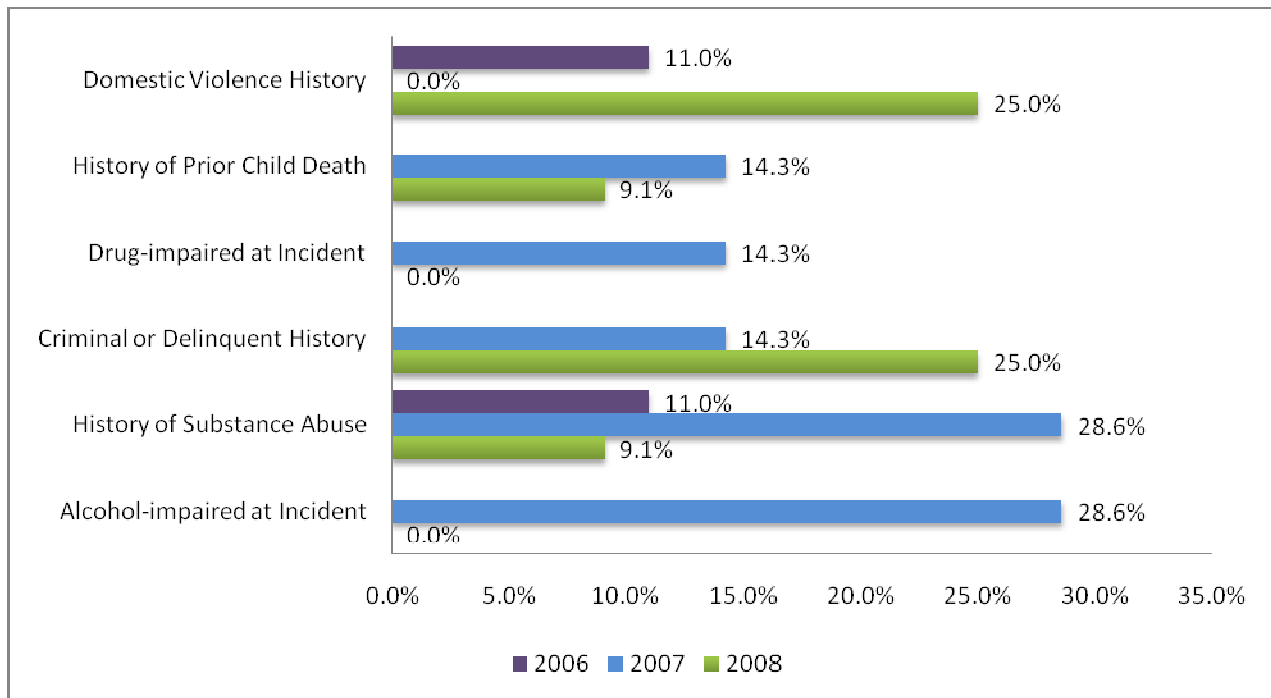
In all but one case the decedent had proper supervision at the time of death. All decedents were supervised at the time of their death. More than half (63.6%) of cases, the child was in sight of the supervisor at the time of the incident. In slightly less than a third (27.3%) of the cases, supervision was provided by the child's biological parent, and in 18.2% of the cases, supervision was provided by a friend.

**Figure 5.10: 2006–2008 Primary Supervisor at Time of Incident (2006 n=9, 2007 n=7, 2008 n=11)**



In 2008, only 9.1% of supervisors had a known history of substance abuse, which is less than half of the number in 2007. None of the supervisors were drug or alcohol-impaired at the time of the incident. In addition, two of the supervisors had a delinquent or criminal history, and one had a history of prior child deaths.

**Figure 5.11: 2006–2008 Supervisor History (2006 n=20, 2007 n=15, 2008 n=21)**



Just over half (n=6) of the cases had a prior family history of involvement in child welfare. Regarding those cases with a previous child welfare history all of them involved both the decedent and his/her siblings. In three of those cases there was an open child welfare case with the family at the time of the child's death.

The majority of non firearm homicides were caused by child abuse (n=7), including one instance of Shaken Baby Syndrome, and four cases of abusive head trauma. Another case was determined to be caused by child neglect. The other three cases involved assault and not child abuse.

When abusive injuries are inflicted upon a child by someone other than a family member this is considered to be assault, and not child abuse. In the remaining three cases assault was determined to be the causal factor in the child's death. All three cases involved adolescents and the fatal injuries were inflicted by another teenager that they knew. Two of the cases were gang related and one involved teen prostitution.

## Homicide Deaths: Recommendations for Prevention

Homicide, by definition, is the intentional killing of another human being. Twenty-one children and youth were the victims of homicide in Clark County in 2008. The data indicates two distinct categories for child homicides: firearm related and non-firearm related, and each category has a distinct pattern of circumstances.

### *Firearm Homicides:*

1. Nearly all firearm homicides occurred among youth ages 10-17 (90%), primarily among 15-17 year olds (80%), and 80% of victims were male. The data indicates that more than half (54.6%) of victims were minorities, evenly split between Black (27.3%) and White (Hispanic) (27.3%) male youth. Again the percentage of Black victims is disproportionate to the population distribution in Southern Nevada and identifies a specific target population for intervention efforts. The data also shows that 40% of the victims had a prior juvenile justice history, and that approximately 30% of the incidents were suspected to be gang related. Prevention efforts aimed at reducing firearm related youth homicides should focus on addressing the needs of these youth through community based outreach programs and gang prevention activities. All efforts should take into consideration the language and cultural needs of the populations most at risk.

### *Non-Firearm Homicides:*

1. In 2008 non firearm homicides represented over half (52.4%) of all youth homicides. The majority of firearm homicide victims were less than four years of age (n=6), the next most frequent age category was 15 to 17 years (n=3). In 2008, only one of the incidents was perpetrated by biological parents, the others involved relatives or friends. In 72.7% of these cases a weapon was not used to inflict the abuse. In eight of the eleven cases child abuse or neglect was determined to have caused the death. Just over half (54%) of the families involved had a history of involvement with the child welfare system. Prevention efforts should focus on developing networks of services in the community to reach out to these at-risk families. Providing services and resources to parents of young children that educate parents and new partners who are willing to participate on basic parenting skills and ways to cope with stress and anger may also reduce the potential for child abuse related homicides.

*Fatal child abuse or neglect is the fatal physical injury or negligent treatment of a child by a person who is responsible for the child's welfare. Most child maltreatment deaths result from physical abuse, especially children receiving injuries to their heads. Known as abusive head trauma, these injuries occur when a child's head is slammed against a surface, is severely struck or when a child is violently shaken. The next most common cause of physical abuse deaths is punches or kicks to the abdomen, leading to internal bleeding. **Young children are the most vulnerable victims.** National statistics show that children under six years of age account for 86% of all maltreatment deaths and infants account for 43% of these deaths. Fathers and mothers' boyfriends are most often the perpetrators in the abuse deaths; mothers are more often at fault in the neglect fatalities. Fatal abuse is interrelated with poverty, domestic violence and substance abuse.*

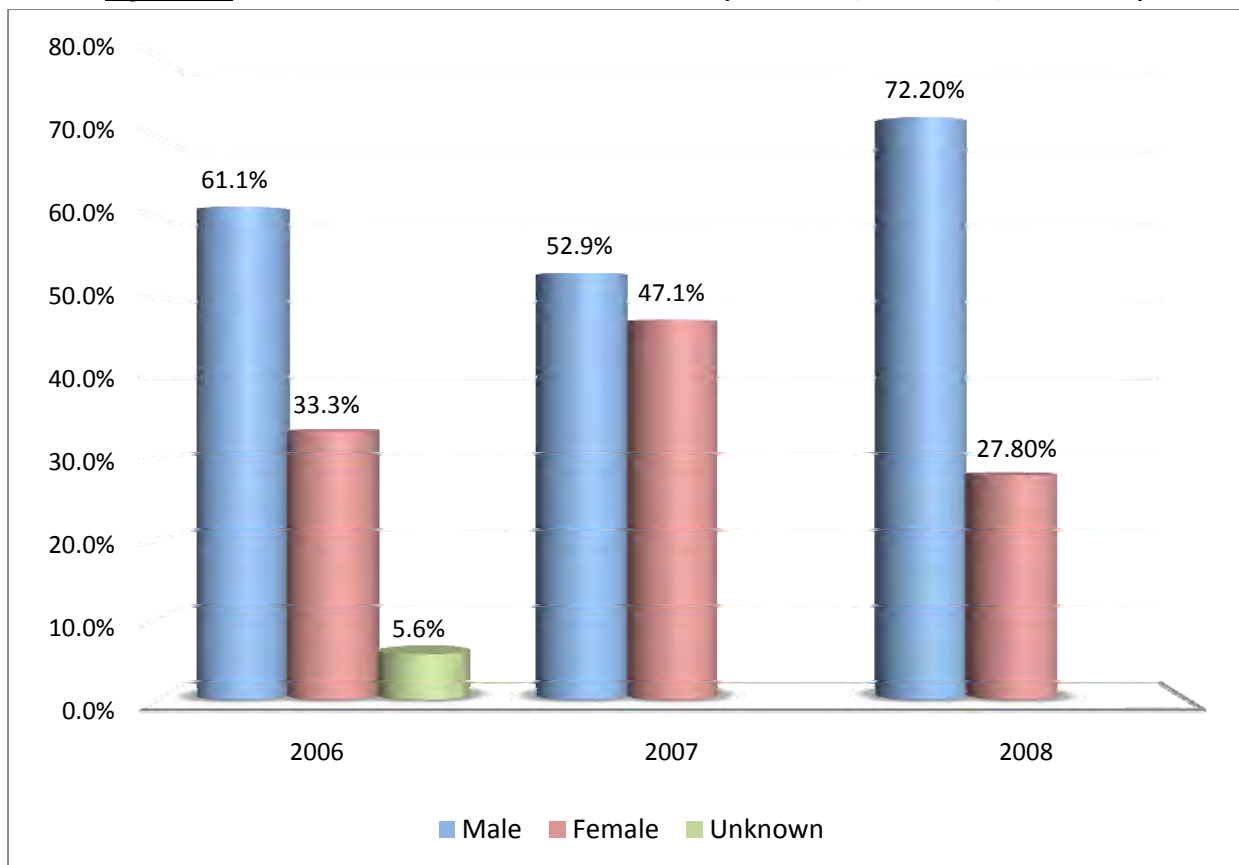
www.childdeathreview.org, 2007

## Section VI: Undetermined Deaths

In 2008 Clark County reviewed 18 cases where the death was ruled “undetermined.” This ruling is used by the Coroner’s office when information regarding the circumstances of the death make it difficult for the medical examiner to make a distinct determination about the manner of the death. The coroner may rule a death “undetermined” when sufficient evidence or information cannot be obtained to assign a manner of death.

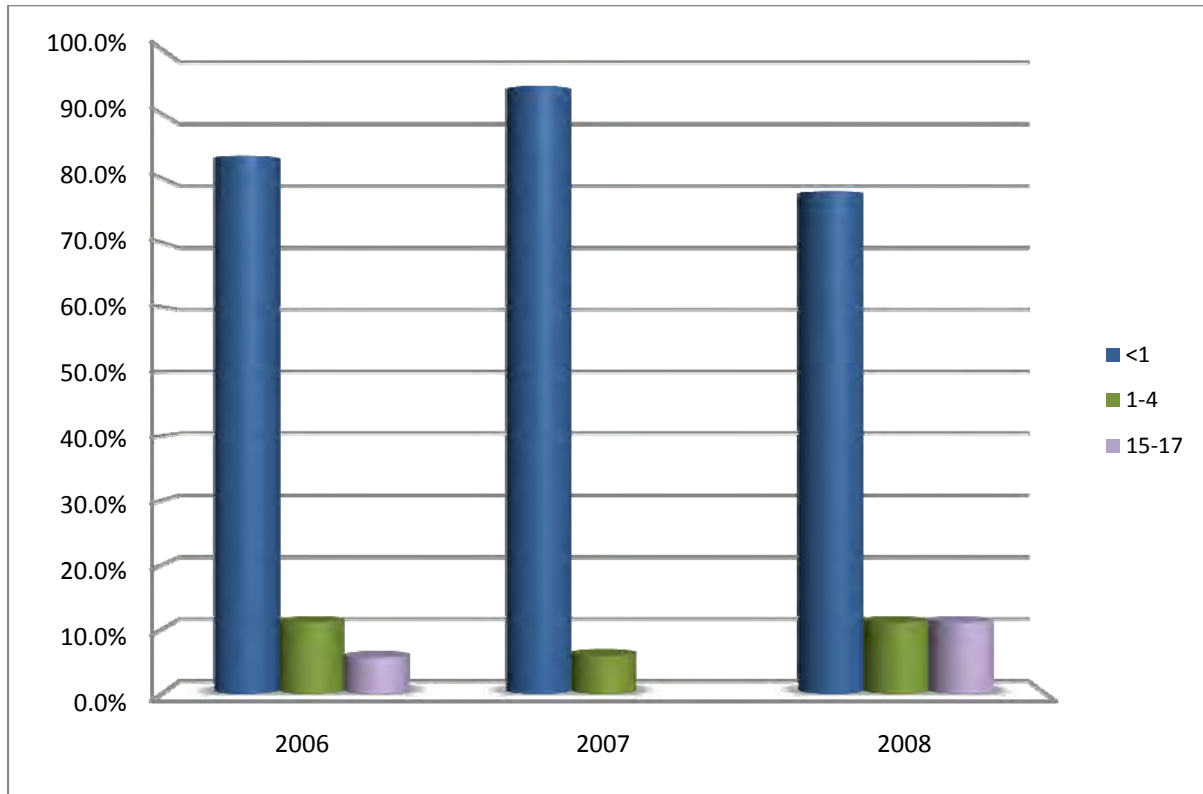
In 17 of those cases the cause was also listed as “undetermined.” For the remaining case the cause listed on the death certificate was “bronchopneumonia due to hypoxic brain injury due to cardiopulmonary arrest of unknown etiology”, which essentially means that the child’s heart stopped for an unknown reason causing brain injury. The following tables represent the descriptive statistics regarding undetermined deaths reviewed by the Clark County Team in 2007.

**Figure 6.1: 2006-2008 Undetermined Deaths: Sex (2006 n=18, 2007 n=17, 2008 n=18)**



In 2008 we see the highest proportion of male (72.2% or 13 cases) as compared to our lowest proportion of female children in the past three years. In 2008 the gender of all cases was known.

**Figure 6.2: 2006-2008 Undetermined Deaths: Age (2006 n=18, 2007 n=17, 2008 n=18)**

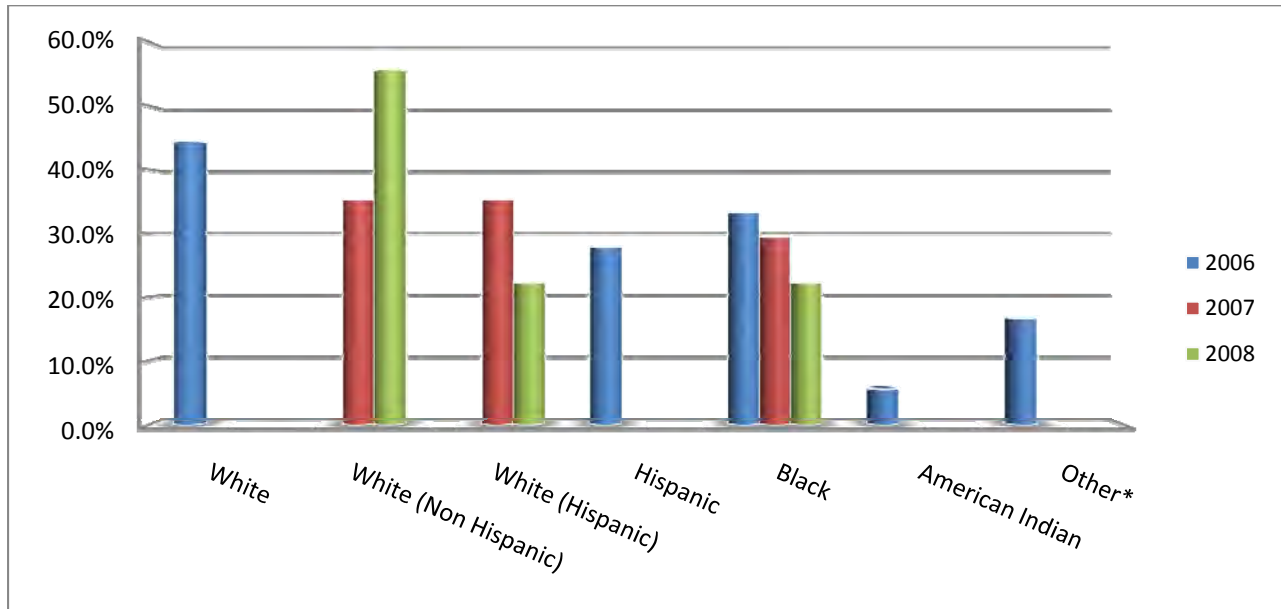


	Less than 1 year	1 to 4 years	15 to 17 years
<b>2006</b>	83.3%	11.1%	5.6%
<b>2007</b>	94.1%	5.9%	--
<b>2008</b>	77.8% (14)	11.1% (2)	11.1% (2)

Again in 2008 the majority of undetermined child deaths were those less than one year of age (77.8% or 14 cases). However in 2008 we see a greater proportion of undetermined cases in the older age categories. This year there were four cases, or 22.2% of all cases, where the manner was “undetermined”, which is more than twice as many as 2007.



**Figure 6.3: 2006-2008 Undetermined Deaths: Age (2006 n=18, 2007 n=17, 2008 n=18)**



	White	White (Non-Hispanic)	White (Hispanic)	Hispanic	Black	American Indian	Other
<b>2006</b>	44.4%	--	--	27.8%	33.3%	5.6%	16.7%
<b>2007</b>	--	35.3%	35.3%	--	29.4%	0%	0%
<b>2008</b>		55.6% (10)	22.2% (4)		22.2% (4)	0%	0%

\* Race/Ethnicity data were collected differently in 2006 and 2007. Dashed lines (--) indicate where this separate data was not collected in that year.

In 2008 there were more undetermined deaths of White Non-Hispanic children than in previous years (55.6% in 2008 compared to 35.3% in 2007). In 2008 we see the lowest percentage of Black children with undetermined deaths at 22.2% overall.

For undetermined deaths the majority did not have any prior history with child protective services, 33.3% (6 cases) had a history of child welfare involvement, and in 22.2% (4 cases) of all undetermined cases was the history on the decedent. Additionally, there were no cases where the child was in foster care at the time of death.

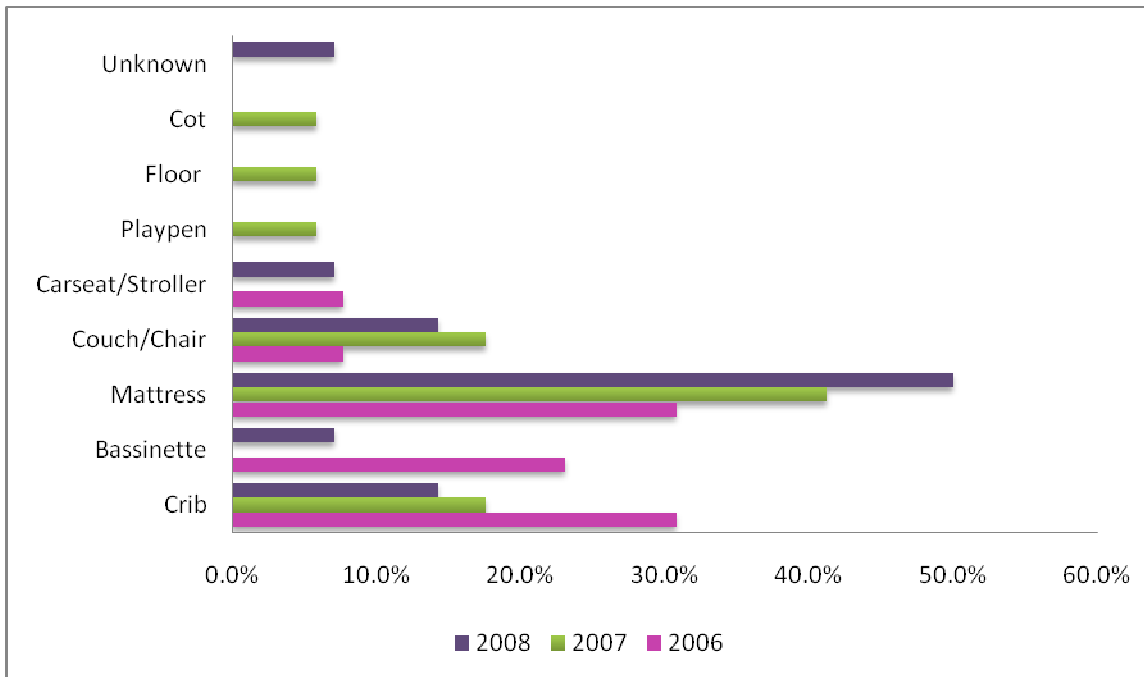
### Undetermined Death – Less than One Year of Age

The majority of undetermined deaths in 2008 were again those children under one year of age (77.8% or 14 cases). In all but one case the child’s death occurred while the child was in a sleeping environment. In 69.2% of these cases (9 cases) the child was sleeping on a mattress, couch or chair at the time of their

death. In all of these cases the child was sleeping with another person, most frequently a parent or a sibling or both.

Figure 6.4 illustrates the various sleep locations for these children. Most notable we see a steep increase from 2006 to 2008 of children less than one year of age sleeping on adult mattresses, increasing from 30.8% in 2006 to 50% (7 cases) in 2008. Additionally, there was an increase in the proportion of children sleeping on couches/chairs, 7.7% in 2006 to 15.4% in 2008.

**Figure 6.4: 2006-2008 Children <1 year old: Sleep Location (2006 n=18, 2007 n=17, 2008 n=18)**



Incident Sleep Place	2006 (n=15)	2007 (n=16)	2008 (n=13)	Incident Sleep Place	2006 (n=15)	2007 (n=16)	2008 (n=13)
Unknown	--	--	7.7% (1)	Couch/Chair	7.7%	17.6%	15.4% (2)
Cot	--	5.9%	--	Mattress	30.8%	41.2%	53.8% (7)
Floor	--	5.9%	--	Bassinette	23.1%	--	7.7% (1)
Playpen	--	5.9%	--	Crib	30.8%	17.6%	7.7% (1)
Car seat/Stroller	7.7%	--	7.7% (1)				

Among the deaths of children less than one year of age that were in sleeping environments, 46.2% (6 cases) of these children were placed to sleep on either their side or stomach, while only 30.8% (4 cases) the child was placed to sleep on his/her back. When found, most children were on their stomach (38.5%), followed by 30.8% of all cases where the child was found on his/her back. These infants were found in a variety of positions, ranging from face down in blankets or pillows, to having a sheet wrapped around the face, face down in a couch or chair cushion, or next to a co-sleeping parent. In 2008 most

undetermined deaths of children under one year of age occurred while the child was in a sleeping environment. There was only one case where the child was in a car seat and this was not his normal sleeping environment.

### Undetermined Deaths – Over One Year of Age

The remaining four undetermined deaths involved two children that were between one and four years of age and two children that were between 15 and 17 years of age. Two of the children were in a sleeping environment at the time of death, while the other two were not. In each of these cases the circumstances surrounding the child's death were not clear, and therefore were ruled undetermined.

### Manner Not Applicable

In addition to these undetermined deaths there was one case where the manner of death was not listed and was recorded as "Not Applicable" in the Child Death Review database. This case was a fetal death that was not natural in its cause, the fetus's mother intentionally overdosed on sleeping medication in an attempt to kill herself. This fetus was over 20 weeks gestation and did not die from a natural cause as the mother intentionally ingested the medication. These deaths when over 20 weeks are reviewed by the team and those with natural causes are recorded as such even when there was not a death certificate issued.

## LOCAL PREVENTION EFFORTS

In 2008 the Clark County Child Death Review Team made an even more concerted effort to act locally to prevent child deaths. There were several primary activities highlighted below. Some initiatives were carried out by the team itself, but others are local agency initiatives that were influenced by team members participation in Child Death Reviews. These are examples of how the local annual report, as well as multidisciplinary participation in the review meetings can have an impact in the community through improved policy and practice as well as prevention activities.

### *Team Structure*

In 2008 the Clark County Child Death Review Team worked to finalize team protocols and formalize team membership. The first elections for team chair and vice chair were held in January and later that year the core team elected a pediatrician to serve on the core team. In addition in 2008 the team set a goal to create a website for the team that could house prevention information. Representatives from the Southern Nevada Health District agreed to link a Child Death Review page to their website. This site was started in 2008 and continues to be reviewed and updated by the team.

### *Team Education and Invited Presentations*

In 2008 the team really worked to utilize experts in the community to understand new initiatives. This continuing education for the review team allows them to make better, more succinct recommendations for prevention. In 2008 the team had the Clark County Ombudsman for Child Welfare attend one of the review meetings to give a presentation on her position. This presentation provided information for the team to use during the reviews as well as in their role as professionals in the community. Additionally the team requested that a representative from the Department of Family Services Foster Care Licensing division come to a meeting and discuss their policies and practices. This information helped the team to understand under which circumstances licenses could be issued and revoked. This allowed the team to make better recommendations within the existing structure.

### *Invited Special Case Reviews*

For the first time in 2008 the Clark County Child Death Review Team's core team membership were invited to participate in an outside multidisciplinary review of one agency's work regarding a specific child death. The group was given access to all agency information regarding the specific case and from this a descriptive report with recommendations for that agency's improvement were provided. This was an excellent opportunity for the community to use the Child Death Review Team as an outside review board and resulted in some important changes to agency policy and practice.

### *Drowning Prevention*

The team continued its work from 2007 to focus on reducing the number of child drowning in Southern Nevada. In 2008 the Child Death Review Team worked with a family who had lost their daughter in a pool drowning to facilitate the creation of an “Adopt-a Fence” program. The team connected the family with the Southern Nevada Health District as a place to house the program and “Clayre’s Pool Fence Program” is currently seeking additional funding to begin work. This program would provide reduced or no cost pool fencing for families who request the service.

### *Safe Sleeping*

Safe sleeping continues to be a focus of the local team. In an effort to ensure that families have separate sleep spaces for infants, the local CDR team did some research and contacted the local SIDS Alliance group to inquire about starting a reduced or no cost crib program in Clark County. This information was compiled and provided to the prevention organization hired to coordinate the state’s prevention activities, CAN Prevent.

In addition, at a more local level one of the team members who is a supervisor at the Clark County Department of Family Services took some time to review the parenting program curriculum that is used at the Department of Family Services. He reviewed the information presented to parents to ensure that safe sleep was something that was taught correctly to parents. The team’s annual report from 2007 was also used in the curriculum to demonstrate the statistics associated with unsafe sleep conditions.

### *Overall Child Safety*

In September of 2008 the Las Vegas Metropolitan Police Department’s (LVMPD) Abuse and Neglect Unit created and distributed a brochure with safety information for parents. The brochure, titled “It’s Never OK!” included information about pool safety, vehicle safety, internet safety, and sexual abuse/exploitation. In addition the brochure included information about the victim’s bill of rights as well as contact information for LVMPD and other hotlines including the child abuse hotline and the SafeNest domestic violence hotline. LVMPD developed a partnership with Albertson’s grocery stores to distribute them to all Albertson’s store locations in Las Vegas. The brochures were placed at the checkout stations so that customers could pick them up after they finish shopping.

Also in response to some of the cases the team reviewed, where items in the home were not securely stowed or displayed, the Department of Family Services sent a notice to all of their in home workers to remind them to look for existing safety hazards. These included unstable television stands or other heavy items that may pose a risk to children in the home. This is just one example of how agency participation in the meetings can help to improve the practice of agency staff and divisions to prevent future child deaths.

## SUMMARY OF RECOMMENDATIONS AND ACCOMPLISHMENTS REPORTED TO THE STATE ADMINISTRATIVE TEAM FOR 2007 CHILD DEATHS

*Every quarter the Clark County Child Death Review Team provides a set of recommendations to the state Administrative Team to Review the Death of Children. These recommendations are reviewed and some action or response is generated. These responses are summarized in reports that are forwarded to the local representatives that serve on the Executive Committee. Listed below are all recommendations that were made by the Clark County Child Death Review team to the Administrative Team to Review the Death of Children in 2008. "Action" listed under each recommendation represents the response from the Administrative Team.*

**2008-1:** In the educational materials about safe sleeping prepared by the Executive Committee, information should be added that addresses the dangers of placing infants on memory foam pillows and mattresses. An additional written PSA/statement should be prepared and distributed to local TV and radio stations for public education.

**Action:** The members agreed to refer this to the Executive Committee regarding public awareness.

**2008-2:** In existing pool safety educational information, statements should be included addressing the need to remove toys and pool items that are attractive to young children/toddlers. Information should then be distributed to local drowning prevention initiatives.

**Action:** Information was forwarded to the Southern Nevada Health District and they indicated that this information was included in their informational materials, therefore no further action was taken by the Administrative Team.

**2008-3:** For future prevention campaigns, the Admin/Executive Teams should consider using advertising space on targeted internet sites. For example, a safe sleeping campaign might utilize space on BabyCenter.com or CafeMom.com, or a youth suicide prevention campaign might utilize space on MySpace (the advertisement link is: <http://www.myspace.com/modules/common/pages/sales.aspx>).

**Action:** The members agreed to refer this to the Executive Committee regarding public awareness.

**2008-4:** The Admin/Executive team (or DCFS) should prepare a public awareness campaign designed to emphasize the importance of reporting known or suspected child abuse to CPS and encourage reporting. Materials could be posted in apartment complexes, community centers, mailrooms, gyms, or other shared spaces that will reach a wide audience without targeting a specific population. The goal should be to educate the public on how to report abuse or neglect as well as encourage people to protect children in their community by becoming involved in these situations. Additionally the team recommends that all policies regarding screening cases that come in via "hotlines" be reviewed to ensure that all cases that merit an investigation receive one promptly.

**Action:** (1) Children’s Trust Fund was contacted and gave a presentation to the Administrative Team about their child abuse prevention campaigns and in particular their focus on abuse and neglect reporting. (2) Policies regarding reporting “hotlines” were reviewed in Clark County as a part of the Clark Policy Redesign as comments from a variety of stakeholders were sought as part of the Policy Redesign project. In addition the new policies were implemented as of November 2008. No further action was taken by the Administrative Team

**2008-5:** The state agency responsible for child care licensing should review licensing criteria in terms of ratios regarding children under the age of three to ensure that there are guidelines and to determine if this is a policy issue or an enforcement issue. Also the state should consider creating a public awareness campaign to remind parents of childcare licensing and how to find licensed care providers.

**Action:** 1) A letter was written from DCFS to the local licensing entities regarding ratios for children under the age of three, and 2) Item was referred the public awareness subcommittee of the CDR Executive Committee.

**2008-6:** The Admin/Executive Team should coordinate with the state Department of Education and the Office of Suicide Prevention to develop and mandate an annual presentation to middle school and high school students and teachers about suicide prevention. This presentation should address awareness of the signs of suicide ideation in peers and knowing who to talk with about it. The presentation could utilize speakers from the local community or national speakers and would be presented to all students and teachers in a mandatory assembly on an annual basis.

**Action:** This was addressed partially in a Clark 2007 recommendation that was referred to the Coalition for Suicide Prevention and the State Department of Education. This was referred to Misty Allen at the Nevada Office of Suicide Prevention for action.

**2008-07:** Educate professionals that are in contact with and providing recommendations to parents of very young children regarding the risks of using over the counter cold medications and antihistamines.

**Action:** This issue was referred to the Executive Committee’s public awareness subcommittee for action.

**2008-08:** The Administrative Team should investigate legislation/regulations in Nevada regarding midwives. Additionally the state could create a public education campaign or PSA that would help educate the public regarding these regulations and the risks associated with using an unlicensed midwife for prenatal care and delivery.

**Action:** A letter was sent to the Nevada State Health Division expressing the concerns of the Child Death Review Team regarding midwives.

**2008-09:** NRS regarding child safety seat regulations should be amended to include height as one of the factors in deciding if a child needs to be restrained. Additionally, questions about the requirements for

child restraints should be included on the Nevada State Driver's Test to promote public awareness of this issue.

**Action:** A letter was sent to the Office of Traffic Safety regarding this recommendation, and a response was received indicating that it was too late to propose new legislation.

**2008-10:** Provide education to parents and foster parents about the importance of fully understanding the specific supervision needs for developmentally delayed children.

**Action:** PRIDE materials were reviewed and a considerable amount of information was found on supervision and child safety. No further action was taken by the Administrative Team.

**2008-11:** The Department of Family Services should review their existing policies regarding foster care licensing and requirements for revocation of those licenses. Perhaps the agency could use an outside agency for licensing, or for investigations into licensing issues.

**Action:** The Administrative Team discussed the difficulty of having another jurisdiction investigate foster home licensing issues although this is permitted in DCFS policy. Also the Administrative Team indicated that the Clark Policy Redesign addresses this recommendation.

**2008-12:** Work with the legislature to create a category of neglect referring to cause of death, even if the coroner doesn't rule the death a homicide. Medical/legal manner of death used for death statistics does not always match law enforcement and district attorney needs to prosecute.

**Action:** This recommendation is currently still under review by the Administrative Team.

**2008-13:** Establish a statewide repository system for prescription drugs that are no longer needed. This would reduce the amount of unused prescription drugs available in homes in the community.

**Action:** This recommendation is currently still under review by the Administrative Team.

**2008-14:** Create and disseminate a public awareness campaign for the general public about the dangers of recreational use of prescription drugs. This could include information on the importance of parents and other caregivers securing and tracking their prescription drugs as well as a focus on the potential for abuse of these medications.

**Action:** This issue was referred to the Executive Committee's public awareness subcommittee for action.

**2008-15:** Public awareness campaigns should be created for parents and other caregivers regarding medication administration to children under one year of age. Some medications have been shown to cause adverse reactions as well as cause long term harm. Parents should be reminded to consult their pediatrician before administering medication to infants. Just because a medication is over the counter and for "kids" doesn't make it safe.



**Action:** The Administrative Team agreed that federal focus on the problem, as well as the national media attention it has received addresses this recommendation.

**2008-16:** Create a campaign regarding proper supervision of children – especially when more than one adult is in the home. Create campaign that promotes a “designated caregiver” for children that is someone who is fully functional and able to care for the children in the home.

**Action:** The Executive Committee’s Public Awareness Subcommittee is working on promoting parental supervision; therefore this recommendation was referred to the Executive Committee.

**2008-17:** Provide public education campaigns to heighten caregiver awareness of anger management and how frustration can easily turn into violence against young children. Also include a component that discusses the importance of being aware of how to identify the symptoms of head trauma.

**Action:** This issue was referred to the Executive Committee’s public awareness subcommittee for action.

**2008-18:** Review Southern Nevada Pool codes regarding the specific exception to access barriers as long as the spa has a lockable cover. Additionally specify in prevention campaigns the importance of being just as vigilant in supervision around free standing spas.

**Actions:** This recommendation was referred to the Southern Nevada Health District’s (SNHD) staff focused on pool safety.

**2008-19:** Create a teen death checklist or even an “overdose checklist” to ensure that all appropriate information is being collected on these cases. This could be similar to the teen suicide checklists that we created a few years ago.

**Actions:** This recommendation was referred back to the Clark County Team to create a draft of an “overdose checklist” or “teen death checklist.” The Clark County Team is currently working on creating this checklist.

**2008-20:** Fund services for families that are involved with the local child welfare agency.

**Action:** This recommendation was referred back to the Clark Team s the Administrative Team could not control funding for services.

**2008-21:** Create services that specifically work with teen prostitutes to get them out of that system and provide wraparound services to continually support them in their decision to leave that lifestyle.

**Action:** This recommendation was referred to the Juvenile Justice Commission as well as the CIP.

**2008-22:** Parent and Nurse education regarding safe sleeping. Create a DVD using scene photos to show unsafe sleep environments to mothers and nurses – then promote that it is shown in hospitals and mothers have to sign off that they have seen the video prior to discharge.

**Action:** This issue was referred to the Executive Committee's public awareness subcommittee for action.

**2008-23:** Implement standard practice in g-tube education for parents including discussion of potential life threatening problems if not done properly. These may include both written and oral instructions.

**Action:** The Administrative Team contacted the Nevada State Health Division about home visitation related to g-tubes and relayed the recommendation.

**2008-24:** Teach new parents and inform grandparents of the dangers of co sleeping.

**Action:** This recommendation is currently in process and is being addressed by the public awareness subcommittee of the Executive Team through increased distribution of safe sleeping brochures.

**APPENDIX A:  
2007 CLARK COUNTY CHILD DEATH REVIEW TEAM MEMBERSHIP LIST**

**2008 Core Members**

Nicholas Bacon	Mesquite Police Department	Vicki Monroe	District Attorney's Office (Vice Chair)
Det. Mike Daniel	Boulder City Police Department	Tom Morton	Clark County Department of Family Services
Dr. Andrew Eisen	Touro University (elected pediatrician)	Alane Olson	Clark County Office of the Coroner/Medical Examiner (Chair)
Troy Hatch	Henderson Police Department	Gwendolyn Osburn	Southern Nevada Health District
Sally Jost	Clark County School District	Joseph Smith	Nevada Highway Patrol/Department of Public Safety
Antony Lettieri	North Las Vegas Police Department	Lisa Teele	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail
Beth Marek	Department of Juvenile Justice Services		

**2008 At Large Members**

Sue Battaglia	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail	Paula Hammack	Clark County Department of Family Services
Marion Biron	Clark County Department of Family Services	Paula Haynes-Green	Clark County Department of Family Services
Julie Bolton	Clark County School District	Marion Hancock	Sunrise Hospital
Mary Brown	District Attorney's Office	Tracy Kingera	Department of Juvenile Justice Services
Catherine Coleman	University Medical Center	Doug Koch	University Medical Center
Ron Cordes	District Attorney's Office	Dave McKenna	Henderson Police
Jeanne Cosgrove	SAFE Kids	Dr. Neha Mehta	Sunrise Hospital
Daphne Dwitz	North Vista Hospital	Lisa Popovsky	Area Health Education Center - Prevent Child Abuse Nevada
Gary Erickson	Mesquite Police Department	Jeffry Radecki	Nevada Department of Child and Family Services
Robert Everett	Mesquite Police Department	Peggy Rowe	Clark County Department of Family Services
Thomas Finn	Boulder City Police Department	Debbie Ruiz	Area Health Education Center - Prevent Child Abuse Nevada
Mark Fitzgerald	Clark County Department of Family Services	Dr. Edith Schmidt	Sunrise Hospital
Linda Flatt	Nevada Office of Suicide Prevention	Victor Hugo Schultze II	Office of the Attorney General
Deborah Flowers	Nevada Department of Child and Family Services	Sgt. Darrell Semper	North Las Vegas Police Department
Dr. Tony Fredrick	Southern Nevada Health District	James Sweetin	District Attorney's Office
John Fudenberg	Clark County Office of the Coroner/Medical Examiner	Rosemary Virtuoso	Clark County School District

## APPENDIX B:

### NEVADA REVISED STATUTES RELATING TO CHILD DEATH REVIEW

**NRS 432B.403 Purpose of organizing child death review teams.** The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.409, inclusive, is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this state;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children.

(Added to NRS by 2003, 863)

**NRS 432B.405 Organization of child death review teams.**

1. An agency which provides child welfare services:
  - (a) May organize one or more multidisciplinary teams to review the death of a child; and
  - (b) Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:

(1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;

(2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;

(3) If the death is alleged to be from abuse or neglect of the child;

(4) If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending;

(5) If the child was adopted through an agency which provides child welfare services; or

(6) If the child died of Sudden Infant Death Syndrome.

2. A review conducted pursuant to subparagraph (2) of paragraph (b) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

(Added to NRS by 1993, 2051; A 2001 Special Session, 47; 2003, 864)

**NRS 432B.406 Composition of child death review teams.**

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:

(a) A representative of any law enforcement agency that is involved with the case under review;

(b) Medical personnel;

(c) A representative of the district attorney's office in the county where the case is under review;

(d) A representative of any school that is involved with the case under review;

(e) A representative of any agency which provides child welfare services that is involved with the case under review; and

(f) A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.

(Added to NRS by 2003, 863)

**NRS 432B.407 Information available to child death review teams; sharing of certain information; subpoena to obtain information; confidentiality of information.**

1. A multidisciplinary team to review the death of a child is entitled to access to:
  - (a) All investigative information of law enforcement agencies regarding the death;
  - (b) Any autopsy and coroner's investigative records relating to the death;
  - (c) Any medical or mental health records of the child; and
  - (d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.
2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.
3. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.
4. Information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

(Added to NRS by 2003, 863)

**NRS 432B.408 Administrative team to review report of child death review team.**

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted to an administrative team for review.
2. An administrative team must consist of administrators of agencies which provide child welfare services, and agencies responsible for vital statistics, public health, mental health and public safety.
3. The administrative team shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

(Added to NRS by 2003, 864)

**NRS 432B.409 Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account.**

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of representatives from multidisciplinary teams formed pursuant to NRS 432B.405 and 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.
2. The Executive Committee shall:
  - (a) Adopt statewide protocols for the review of the death of a child;
  - (b) Designate the members of an administrative team for the purposes of NRS 432B.408;
  - (c) Oversee training and development of multidisciplinary teams to review the death of children; and
  - (d) Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes.
3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.409, inclusive.

(Added to NRS by 2003, 864)