

# 2011 Annual Report of Child Deaths in Clark County, Nevada

A Report from the Child Death Review Team in Clark County

August 2012



**Report Prepared by:  
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**About the Nevada Institute for Children's Research and Policy**

The Nevada Institute for Children's Research and Policy (NICRP) is a not-for-profit, non-partisan organization whose primary goal is to advance the well-being of children in Nevada. As a research center in the School of Community Health Sciences at the University of Nevada Las Vegas, NICRP is dedicated to conducting academic and community-based research that helps guide the development of policies, practices, and programs which serve to enhance the health and well-being of children and their families. For more information about NICRP, please contact us or visit our website at <http://nic.unlv.edu>.

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# CHILD DEATH REVIEW IN CLARK COUNTY

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 their focus to address risk factors and preventability in a wide variety of cases. As the largest county in the State, containing approximately 73% of the state's population 19 years of age and younger (Nevada State Demographer 2010 Census Profiles, Retrieved August 2011), the Child Death Review team in Clark County 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.

For the past six years, the Clark County Manager'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 including data on child deaths from 2006 to 2011. 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 Manager's Office, the Child Death Review Team serving Clark County is a multidisciplinary team that conducts independent reviews of cases of child deaths. This team does not report to any county official 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 Child Death Review Team in Clark County includes members representing all of the mandatory categories, as well as additional members from other public and private organizations including the Clark County Department of Juvenile Justice, Local Fire Departments, Safe Kids Coalition, the Office of Suicide Prevention and many others.

A complete list of local Child Death Review Team members for 2011 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 geographic area designated 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 Child Death Review Team for Clark County meets once a month at the Office of the Coroner/Medical Examiner for a period of three hours to conduct reviews. The team reviewed an average of

20 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 includes information on cases from previous months as well as new cases for review. All cases that were brought back from the previous month are listed first on the agenda. After that all new cases are organized by manner of death and by cause of death within each manner. Only cases that have been officially assigned cause and manner of death by the Office of the Coroner/Medical Examiner or the attending physician 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, and for previous years as a comparison. For example, this section displays the total number of accidental deaths the team has reviewed for that year, as well as the number for each of the previous years. 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 one week prior to the meeting. In 2011 all team members were sent the agenda one week prior to the meeting and expected to print and bring their own agenda to 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 review, team members have the opportunity to make and discuss recommendations for improvements to laws, policies and practices which will support the safety of children and prevent future child deaths. Each quarter, the Child Death Review Team for Clark County submits a report to the Administrative Team, through their contracted coordinator, which identifies statistical information regarding the cases that were reviewed in that quarter and recommendations made based on those reviews.

### **Report Changes in 2011**

This year's report contains only data from 2008 to 2011. Data collected in 2006 and 2007 did not include all Natural deaths and due to these differences in methodology, comparisons made with 2006 and 2007 data can be easily misinterpreted. Therefore in the 2011 report, we only include data from 2008 to 2011 as review and data collection protocols were consistent starting in 2008. In addition this report contains information on one fatality that occurred in 2010. This case was not received and reviewed by the team until after the 2010 report was published and therefore the information was included in this report.



# METHODOLOGY

In 2011, the team in 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 were collected using a form that was modeled after the collection tool developed by the National Center for Child Death Review. The data collection tool is used to collect as much information as possible through specific questions about the demographics of the child, the supervisor, caregiver, and the family. The tool is also used to capture detailed information regarding the circumstances surrounding the child's death. In addition, this tool is regularly reviewed to ensure that it is effective in capturing information most pertinent for the prevention of future child deaths.

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 2011 the Child Death Review Team in Clark County continued to review 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 and the manner was natural, the 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 as to whether 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 based on the manner reported by the coroner/medical examiner's office. 2011 is the fourth year where the Child Death Review Team in Clark

County chose to review all deaths referred to the team by the Coroner/Medical Examiner's Office. This process has allowed the team to monitor trends in all fetal and child deaths, including those due to Natural causes.

***Because 2008 was the first year all deaths were reviewed this report only includes data on deaths from 2008 to 2011. These years are much more comparable when reviewing trends or patterns in the data.***

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 2008 - 2011 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. Each section reports the different causes of death under these manners as well as some general demographic information on the cases. 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.

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.



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/medical examiner 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

# LIMITATIONS

As with any research there are limitations associated with this dataset. Since we are in the sixth 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 accuracy of 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 is due to a variety of circumstances including differences in the focus of various investigating agencies. The information that is important for tracking and prevention may not be pertinent to a medical examiner or law enforcement investigation and is therefore not available in their reports. 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 several cases 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 Child Death Review Team's database was compared with records from the Clark County Office of the Coroner/Medical Examiner. Data used in this report from the Child Death Review Team was consistent with records from the Office of the Coroner/Medical Examiner, with the exception of Natural deaths. Because the team does not review fetal deaths less than 20 weeks gestation, the records from the Clark County Office of the Coroner/Medical Examiner indicate a higher number of Natural deaths than were reviewed by the team. These cases were cross verified to ensure that all fetal deaths over 20 weeks gestation were included in the data.

In 2011, data collection processes remained consistent. This year the child death review team was again able to gain access to important pieces of information including hospital records, school records, and police investigation reports. Additionally, the ages of the parents continued to be available in 2011 as the system

of information sharing was developed in 2010 with the Southern Nevada Health District. This information was used to complete the review and later the data collection tool.

Agencies have become very familiar with the team and its purpose and, upon request, are sharing the information for these purposes. The team anticipates that information will be continue to be accessible in the future as relationships for data sharing are processes and protocols are institutionalized 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. NRS also states that any team member who discloses confidential information is personally liable for a civil penalty of up to \$500.

All records kept by NICRP are also kept confidential and are securely stored in a locked cabinet in a locked office. In addition, only team members are sent the full agenda with case details prior to the review 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 fits 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 of fatalities from 2008-2011 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 2011 child fatalities, because some variables presented too few cases to provide information that is not identifiable.



# FINDINGS

## SECTION I: SUMMARY STATISTICS

In 2011, the Child Death Review Team in Clark County reviewed ALL child deaths and all fetal deaths over 20 weeks gestation. (See Table 1 below).

Table 1: Total Child Deaths Reviewed by Year

Year	2008	2009	2010	2011
Count	311	283	251	237

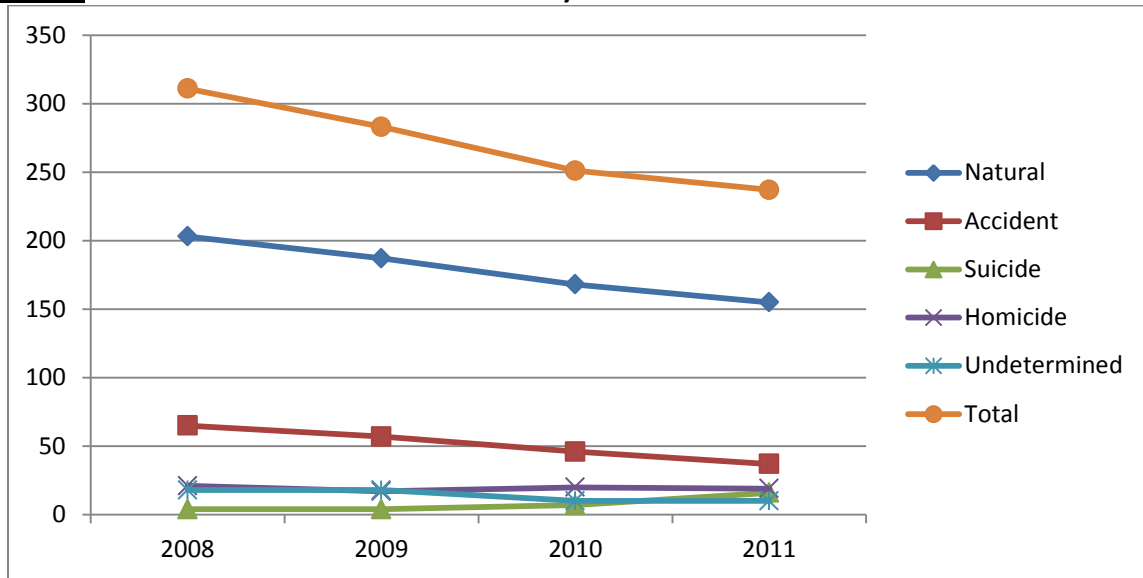
Beginning in 2008 all child deaths were reviewed by the team in Clark County and from that date forward we see a steady decline in the number of child fatalities in Clark County. The 237 cases in 2011 represent 100% of all child and fetal deaths referred to the team from the Clark County Office of the Coroner/Medical Examiner (Comparison to Clark County Office of the Coroner/Medical Examiner Data, June 2012). Because the same methodology was used to select cases for review since 2008 this represents a **23.8% decrease in Child Deaths in Clark County from 2008 to 2011.**

Deaths are categorized based on their 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/medical examiner'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/medical examiner'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 the circumstances of the death do not warrant an investigation. Since the team reviews all deaths, it is not surprising that the majority of all deaths reviewed are natural deaths. In 2011 65.4% of all deaths reviewed were natural (155 cases). The next most frequent category was accidental deaths at 15.6% or 37 cases. This is the smallest number of accidental deaths since NICRP began creating this report with 2006 deaths, and the fewest natural deaths since the team started reviewing all natural deaths in 2008. There was a large increase in the number of suicides in 2011 at 16 cases compared to only seven cases in 2010. This is the highest number of youth suicides recorded since NICRP started creating this report in 2006.

These overall counts are important to understanding the general trends in child deaths in Clark County. The majority of child deaths are due to Natural causes. This is due to the fact that all deaths (including fetal deaths over 20 weeks gestation) 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. To further illustrate this, overall statistics regarding cause of death have been broken out to display those that are due to medical causes and those that are due to external injuries (see page 15).

## MANNER OF DEATH

**Figure 1.1: 2008-2011 Manner of Death Counts by Year**

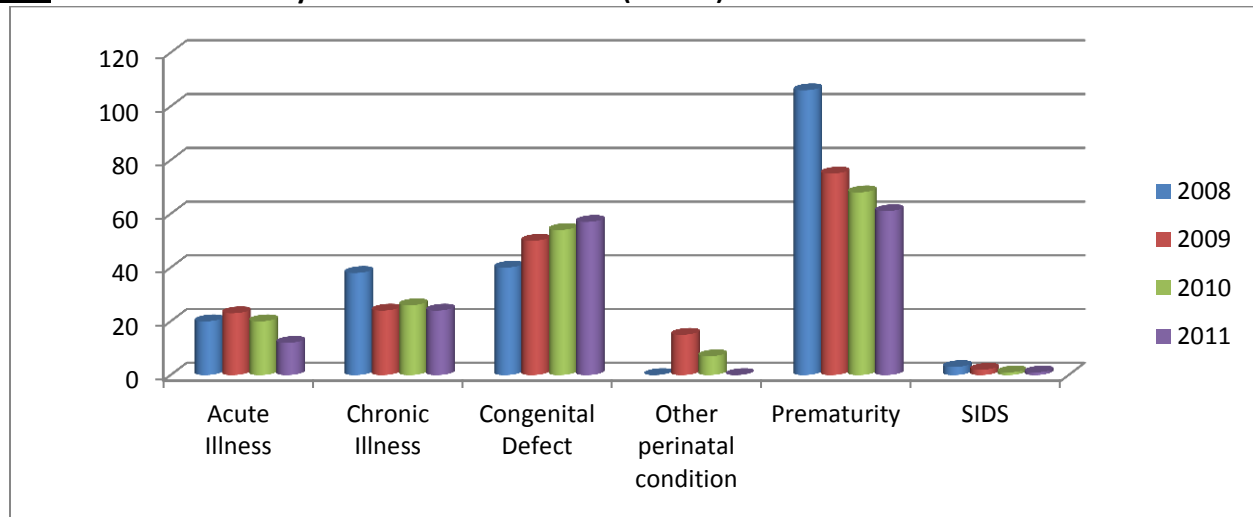


Manner	2008	2009	2010	2011	% Change 2010 to 2011
Natural	203	187	168	<b>155</b>	-7.7%
Accident	65	57	46	<b>37</b>	-19.6%
Suicide	4	4	7	<b>16</b>	128.6%
Homicide	21	17	20	<b>19</b>	5.0%
Undetermined	18	18	10	<b>10</b>	0%
Total Cases Reviewed	311	283	251	<b>237</b>	-5.6%

## CAUSE OF DEATH

Cause of death is displayed in two different graphs on the following pages. Figure 1.2a below represents those cases where the primary cause of death was a medical cause for all child deaths reviewed 2008 - 2011. The leading medical cause of death for children in Clark County in 2011 was prematurity (n=61), second was congenital defects (n=57), and third was chronic illness (n=24).

**Figure 1.2a: 2008-2011 Primary Medical Causes of Death (Counts)**



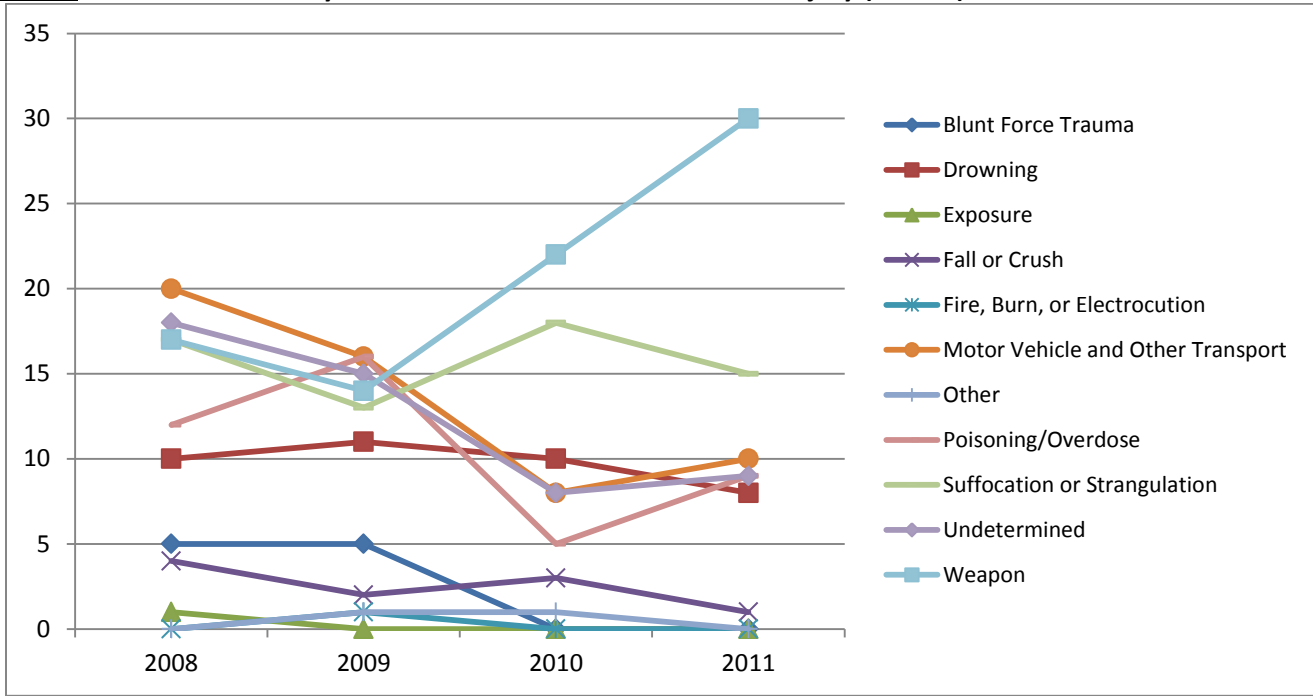
	2008	2009	2010	2011	% Change (2010 to 2011)
<b>Medical Causes</b>					
Acute Illness	20	23	20	12	-40%
Chronic Illness	38	24	26	24	-8%
Congenital Defect	40	50	54	57	6%
Other perinatal condition	0	15	7	0	-100%
Prematurity	106	75	68	61	-10%
SIDS	3	2	1	1	0%

Figure 1.2b displays those cases 2008 - 2011 where the primary cause of death was due to some type of external injury. For the second time since this report has been published, weapons (n=30) are the leading cause of death due to external injury. These cases include firearms, knives/sharp objects, and abuse related deaths where the weapon used was actually a person's body part (hand, fist, foot, etc.). Suffocation/strangulation is the second leading cause of child death due to external injury at 13 cases, with motor vehicle incidents in third place at 10 cases. This Figure also displays the overall declines in deaths due to motor vehicle incidents from 16 cases in 2009 to only 8 cases in 2010, and now 10 in 2011. In addition, those related to overdose or poisoning have declined from 16 cases in 2009 to only 5 cases in 2010, and 9 in 2011.

### Top Three Causes of Child Deaths Related to External Injury:

- Weapons (including a person's body part) (n=30)
- Suffocation/Strangulation (n=15)
- Motor Vehicle Incidents (n=10)

**Figure 1.2b: 2008-2011 Primary Causes of Death Related to External Injury (Counts)**



	2008	2009	2010	2011	% Change (2010 to 2011)
<b>Injury Causes</b>					
Drowning	10	11	10	8	-20%
Exposure	1	0	0	0	N/A
Fall or Crush	4	2	3	1	-67%
Fire, Burn, or Electrocutation	0	1	0	0	N/A
Motor Vehicle and Other Transport	20	16	8	10	25%
Other	0	1	1	0	-100%
Poisoning/Overdose	12	16	5	9	80%
Suffocation or Strangulation	17	13	18	15	-17%
Undetermined	18	15	8	9	13%
Weapon (including person's body part)	17	14	22	30	36%

Figure 1.2c displays the crude death rates for children (ages 0-17 years) in Clark County for 2008 - 2011 as well as the change in the rates from 2008 to 2011. Causes of death with an increase in the rate in 2011 are highlighted in pink on the chart.

**Figure 1.2c: Crude Child Death Rates for Clark County population under 18 years (per 100,000)**

Medical Cause	2008	2009	2010	2011	Change 2008-2011	% Change
Prematurity	20.53	14.66	13.23	12.49	-8.04	-39.2%
Congenital Defect	7.75	9.58	10.51	11.67	3.92	50.5%
Chronic Illness	7.36	4.89	5.06	4.91	-2.45	-33.3%
Acute Illness	3.87	4.5	3.89	2.87	-1.00	-26.0%
Other perinatal condition	0	2.93	1.36	0.00	0.00	n/a
External Injury	2008	2009	2010	2011	Change 2008-2011	% Change
Motor Vehicle and Other Transport	3.87	3.13	1.56	2.05	-1.82	-47.1%
Poisoning/Overdose	2.32	3.13	0.97	1.84	-0.48	-20.6%
Undetermined	3.49	2.93	1.56	1.84	-1.65	-47.2%
Weapon	3.29	2.74	4.28	6.14	2.85	86.6%
Suffocation or Strangulation	3.29	2.54	3.50	2.66	-0.63	-19.1%
Drowning	1.94	2.15	1.95	1.64	-0.30	-15.6%
Fall or Crush	0.77	0.39	0.58	0.20	-0.57	-73.4%
SIDS	0.58	0.39	0.19	0.20	-0.38	-64.7%
Fire, Burn, or Electrocutation	0	0.2	0.00	0.00	0.00	n/a
Exposure	0.19	0	0.00	0.00	-0.19	-100.0%
Total population of Clark County under 18*	516398	511619	513184	488553	-27845	-5.4%

\*Total population estimates for Clark County for 2008 and 2009 come from the Las Vegas Perspective 2009, 2010.

2010-2011 total population estimates come from the US Census Bureau Quickfacts (Retrieved August 2011 and August 2012)

Figure 1.2d below displays the overall child death rates for all deaths, all unintentional injuries, suicides and homicides and provides a comparison to Nevada and national rates from 2009. In Clark County, our overall death rate and unintentional injury rate is lower than the Nevada and national rates, but the homicide and suicide rates for Clark County in 2011 are higher than the national rate.

**Figure 1.2d: Overall Crude Child Death Rates 2008 to 2011 (per 100,000)**

	2008	2009	2010	2011	Change 2008 to 2011	Nevada Rate*	National Rate*
All Deaths under 18	60.22	55.31	48.91	48.51	-11.71	54.5	55.9
All Unintentional Injuries (Accidents)	12.59	11.14	8.96	7.57	-5.02	11.3	8.5
Suicide	0.77	0.78	1.36	3.27	2.50	1.4	1.3
Homicide	4.07	3.32	3.90	3.89	-0.18	2.3	2.4

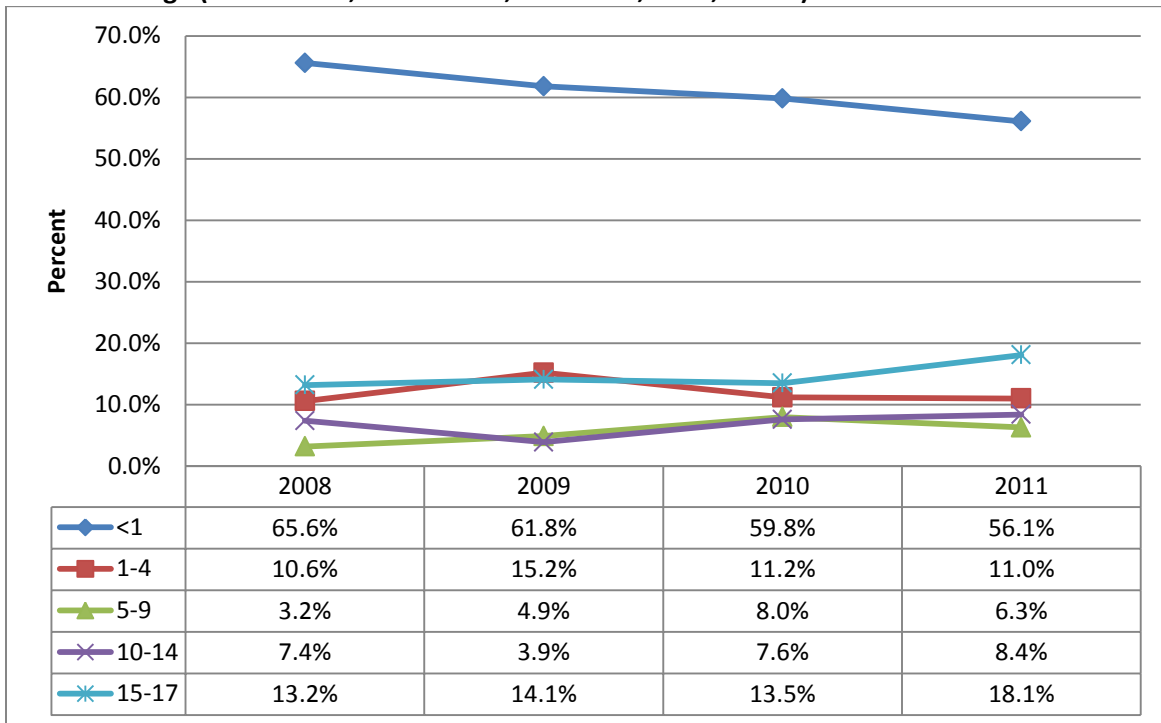
\*National and Nevada rates come from CDC estimates of crude child death rates from 2009 ([http://205.207.175.93/hdi/ReportFolders/ReportFolders.aspx?IF\\_ActivePath=P,21](http://205.207.175.93/hdi/ReportFolders/ReportFolders.aspx?IF_ActivePath=P,21))



# OVERALL DEMOGRAPHICS

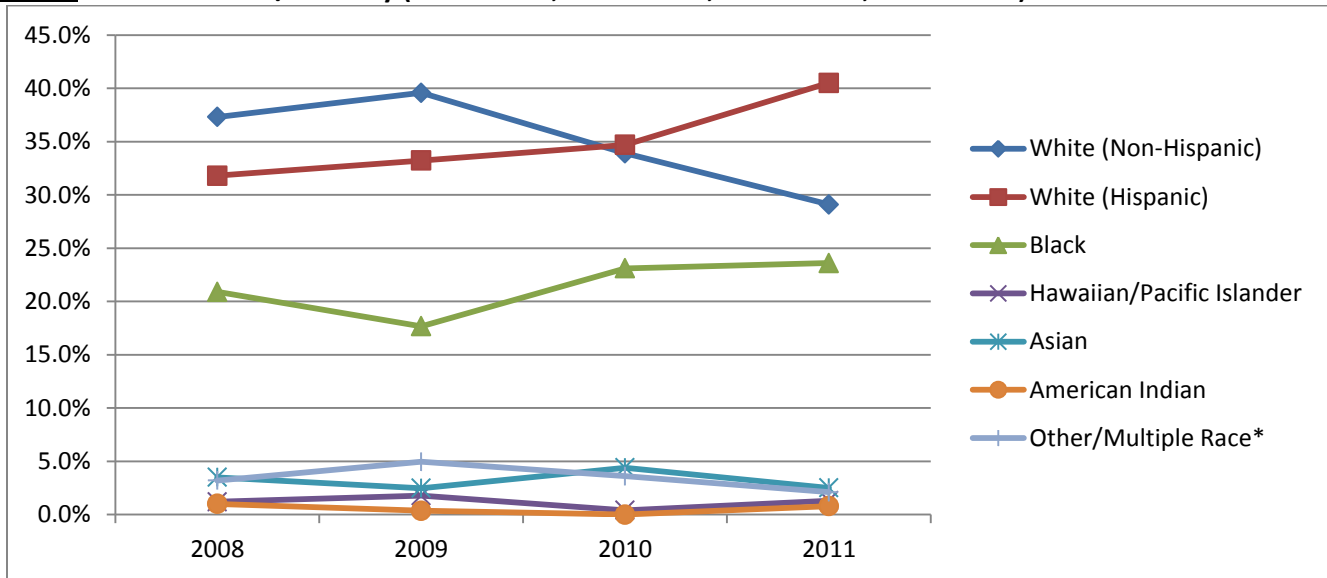
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2011 again the majority of deaths occurred in children less than one year of age (56.1%). The proportion of children in the other age categories has remained fairly consistent, however in 2011 there more in the 15 to 17 year old age group as compared to previous years.

**Figure 1.3: 2008-2010 Age (2008 n=311, 2009 n=283, 2010=251, 2011, n=237)**



Data regarding race and ethnicity are collected from the child's death certificate, and presented in Figure 1.4 below. The data indicate that White Non-Hispanic children have historically had the highest number of deaths, however starting in 2010, and continuing in 2011 this group (White Non-Hispanic, n=69 in 2011) is exceeded by White Hispanic children (n=96 in 2011). Although starting in 2008 there was a decrease in the percentage of deaths of Black children, overall this trend started to reverse in 2010 with an increase from 17.7% in 2009 to 23.1% in 2010 to 23.6% in 2011. These statistics are presented in Figure 1.4 below.

**Figure 1.4: 2008-2011 Race/Ethnicity (2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237)**



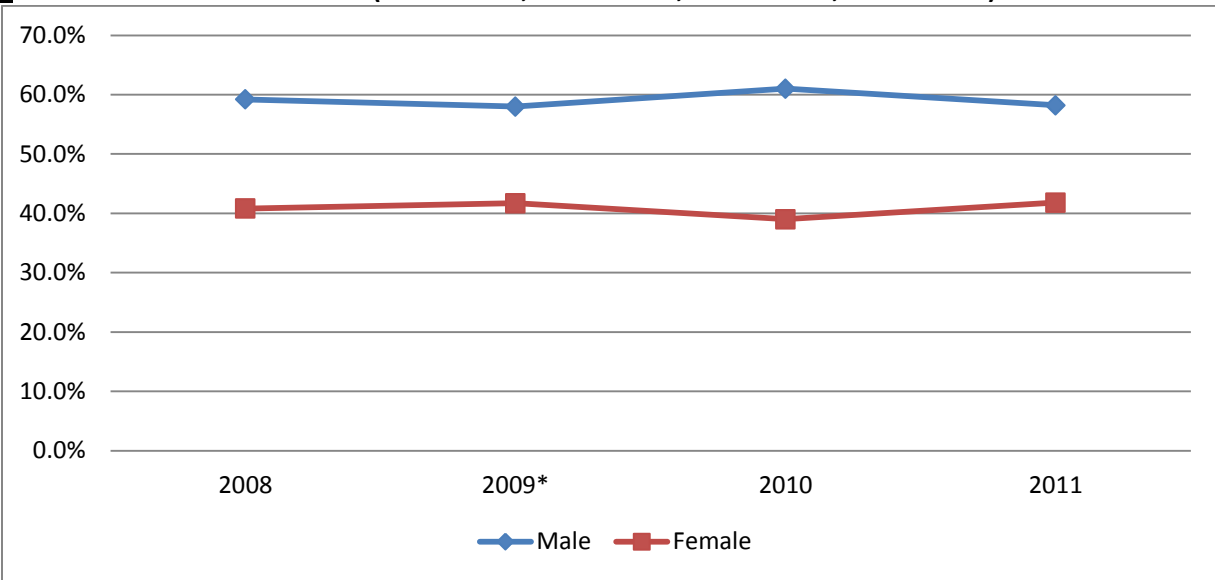
	White (Non Hispanic)	White (Hispanic)	Black	Native Hawaiian/Pacific Islander	Asian	American Indian	Other/Multiple Race	Unknown
<b>2008</b>	37.3% (116)	31.8% (99)	20.9% (65)	1.2% (4)	3.5% (11)	1% (3)	3.2% (10)	1% (3)
<b>2009</b>	39.6% (112)	33.2% (94)	17.7% (50)	1.8% (5)	2.5% (7)	.4% (1)	4.9% (14)	--
<b>2010</b>	33.9% (85)	34.7% (87)	23.1% (58)	0.4% (1)	4.4% (11)	0	3.6% (9)	--
<b>2011</b>	29.1%(69)	40.5% (96)	23.6% (56)	1.3% (3)	2.5% (6)	0.8% (2)	21% (5)	--

\* Not shown in the graph are the 3 cases in 2008 where race/ethnicity was unknown. These were fetal deaths where little information was collected.

\*\* "Other/Multiple Race" 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 four years presented below, with consistently a higher proportion of males than females in each year. In 2009 there was one case that at the time of death sex was unable to be determined (fetal death); that case is listed as unknown in Figure 1.5 below.

**Figure 1.5: 2008-2011 Sex of Decedent (2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237)**



\* In 2009 there was one case where the child's sex could not be identified at the time of the investigation.

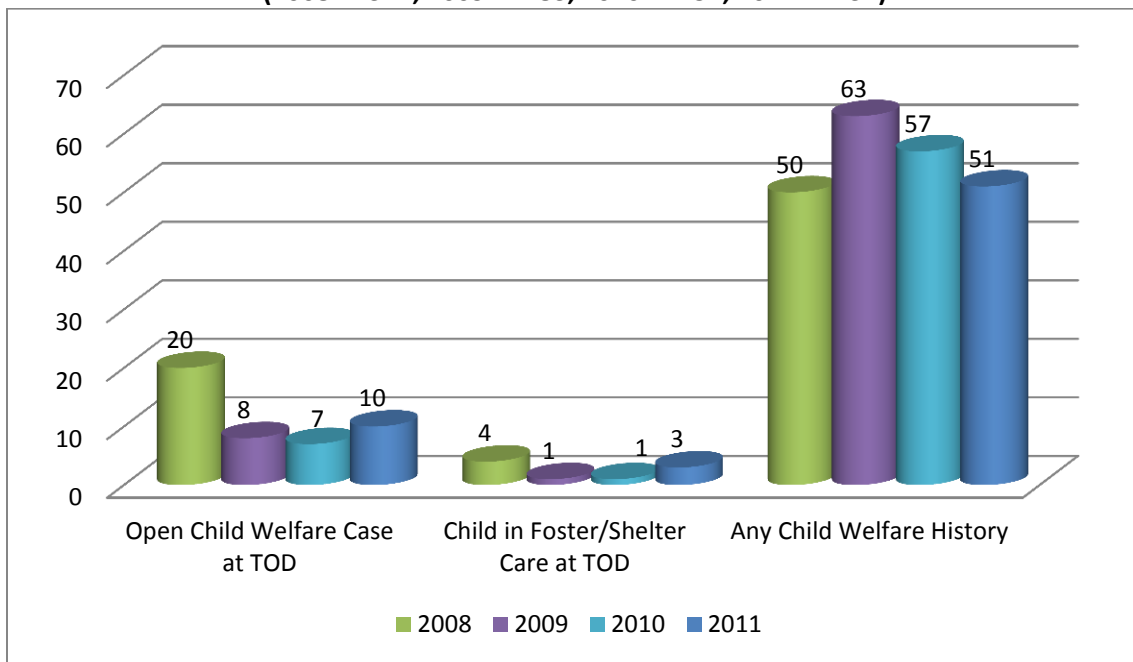
	2008	2009*	2010	2011
<b>Male</b>	59.2% (184)	58% (164)	61% (153)	58.2% (138)
<b>Female</b>	40.8% (127)	41.7% (118)	39% (98)	41.8% (99)
<b>Unknown</b>	0	0.4% (1)	0	0

# CHILD WELFARE INVOLVEMENT

Information was collected by the team regarding the child’s or family’s history with child welfare. The graph below illustrates the number of deaths reviewed from 2008-2011 that the family had some child welfare involvement, organized by type. The categories in the graph below are NOT mutually exclusive, meaning that the same child may fall into multiple categories. Additionally, the reader should note that in 2009 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 in that case.

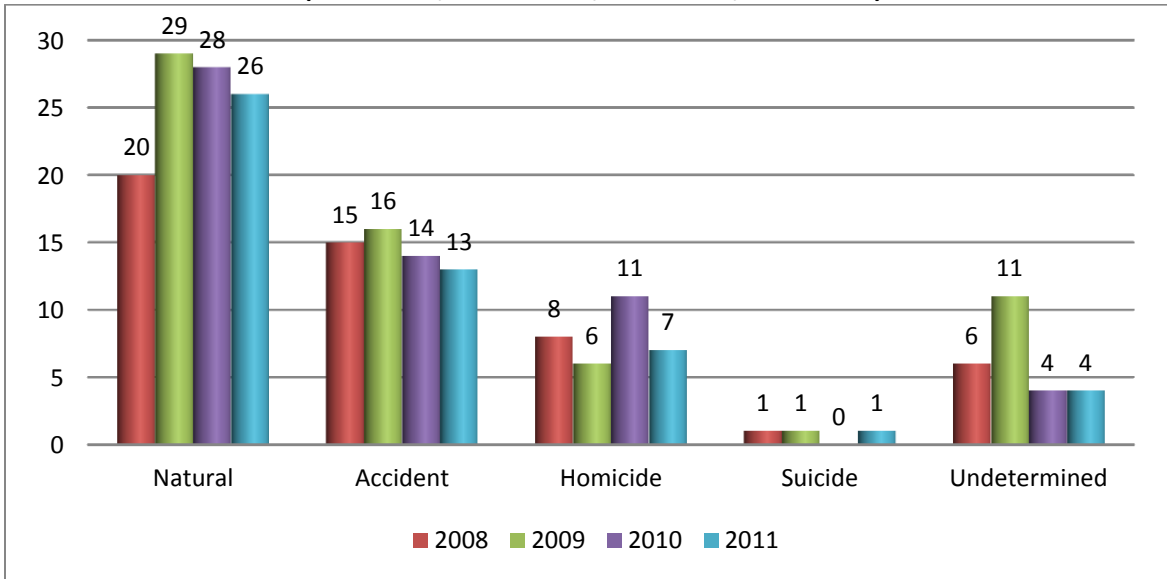
Figure 1.6 illustrates the decline in the number of child welfare cases that were open at the time of the child’s death from 2008 through 2010, but we saw an increase of three cases in 2011. In addition, we see a steady decline in the number of cases with any child welfare history with the family starting in 2009. The numbers presented in Figure 1.6 below represent total counts in each of the categories.

**Figure 1.6: 2008-2011 Type of Child Welfare Involvement**  
**(2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237)**



NOTES (1) These categories are not mutually exclusive  
 (2) The category “Any Child Welfare History” includes any record of a case with the Department of Family Services for either of the parents, siblings, or the decedent.

**Figure 1.7: 2008-2011 Cases with Prior Child Welfare History by Manner of Death  
(2008 n=50, 2009 n=63\*, 2010 n=57, 2011 n=51)**



\*In 2009 family history with child welfare was unknown on one case because the team had limited information regarding a fetal death.

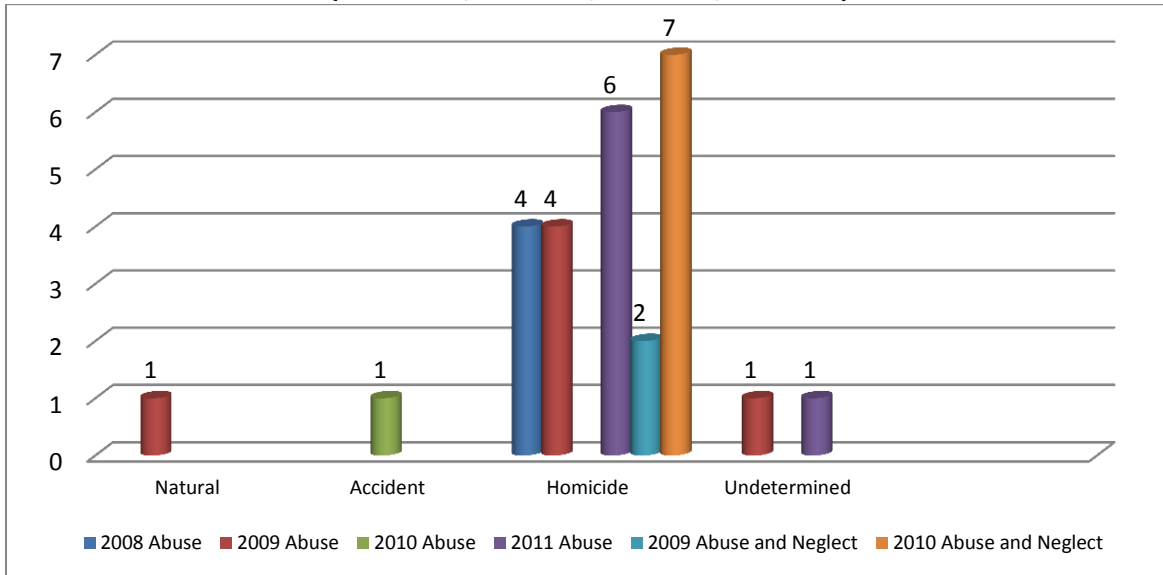
The graph above illustrates the manner of death for cases with family history of involvement in child welfare. In 2011 there were 237 child deaths and in 51 of those cases (21.5%) there was some family history of involvement with child welfare.

- For those deaths occurring in 2011 in which the family did have a history of involvement in child welfare, the most frequently occurring manner of death was Natural (51%), followed by Accident at 26%, which follows the same pattern as in 2008-2010.
- Interestingly we saw a spike in Homicides with a prior child welfare history (from 6 cases in 2009 to 11 cases in 2010). However in 2011 that number is back down to similar figures from 2008 and 2009.
- For those deaths occurring in 2011 in which the family had no prior history of involvement with child welfare, Natural was the most frequently occurring category at 69.5%, followed by Accident at 12.8%, which is comparable to the findings in 2010 where Natural deaths represented 72.2%, followed by Accidents at 16.5%.

# SUBSTANTIATED ABUSE/NEGLECT DEATHS

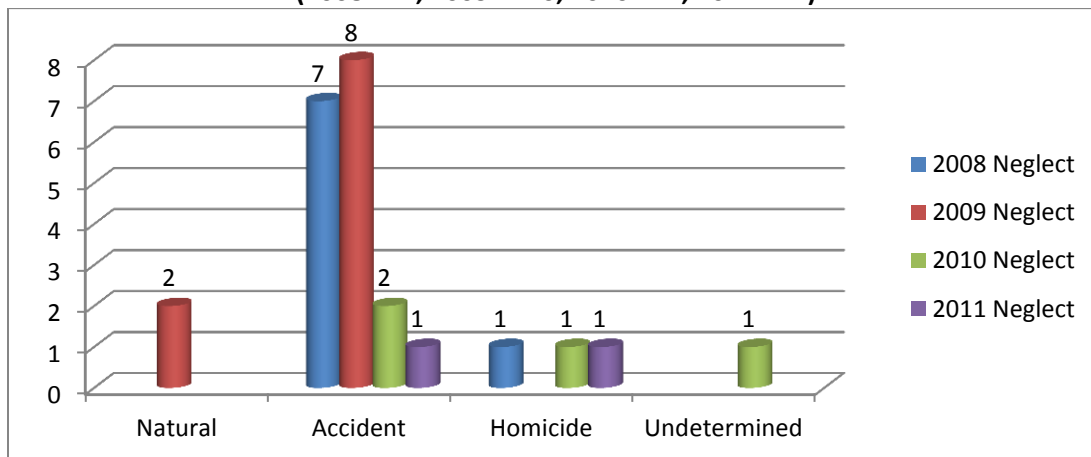
Starting with 2008 child deaths, the Clark County Department of Family Services (CCDFS) provided NICRP with statistics regarding child fatalities where their office received a death allegation of child abuse or neglect, and this allegation was substantiated. A report of abuse or neglect is “substantiated” when credible evidence of abuse/neglect has been found by the local child welfare agency in accordance with criteria established in Nevada Revised Statutes and the Nevada Administrative Code 432B. In 2011, there were 9 substantiated death allegations of child abuse or neglect; this represents 3.4% of all child deaths in 2011. This is a decrease from 2010 when 4.8% of all child deaths had substantiated death allegations. Additional information regarding these cases is presented in the figures below.

**Figure 1.8a: 2008-2011 Manner of Death for Substantiated Death Allegations of Abuse and Both Abuse and Neglect (2008\* n=4, 2009 n=8, 2010 n=8, 2011 n=7)**



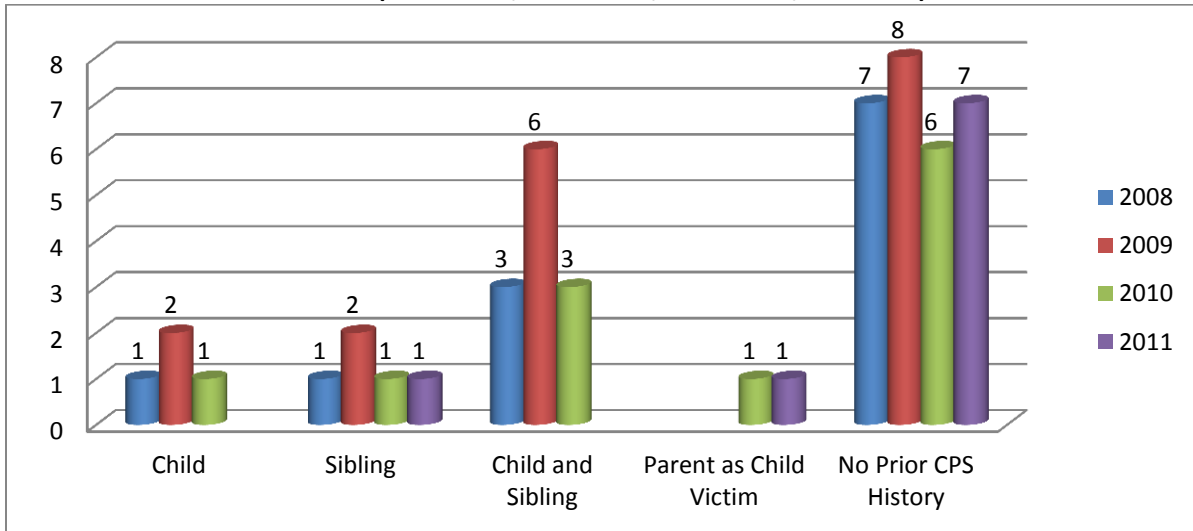
*\*In 2008 and 2011 there were no cases of substantiated abuse and neglect*

**Figure 1.8b: 2008-2010 Manner of Death for Substantiated Death Allegations Neglect Only (2008 n=7, 2009 n=10, 2010 n=4, 2011 n=2)**



In 2011 the majority of substantiated allegations was due to abuse, and a majority of these were homicides (see Figure 1.8a). In 2011, for those cases with substantiated allegations of neglect, one death was accidental, and the other was a homicide (see Figure 1.8b).

**Figure 1.9: Counts by Type of Prior Family History with Child Protective Services (CPS)  
(2008 n=12, 2009 n=18, 2010 n=12, 2011 n=9)**



With regard to the distribution of the number of types of prior family history with CPS, 2011 looks very similar to 2008 and 2010. In 2011, in more than three fourths of these cases with a substantiated death allegation (7 of 9), the decedents' and their family did not have prior history with CPS. In one case the history was regarding the decedent's siblings, and in the other the only history was related to the decedent's parent as a child victim.

## SECTION II: NATURAL DEATHS

Natural deaths are those deaths that result from natural causes, which include; chronic or acute illnesses, 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 Sudden Infant Death Syndrome (SIDS) usually die within the first 28 days of life.

Starting in 2008, all Natural deaths were reviewed, including fetal deaths over 20 weeks gestation. In 2011 the majority of natural deaths (72.9%) were among children less than one year old, which about the same as in 2010 when this age group represented 70% of natural deaths. The top causes of natural deaths (n=155) reviewed included:

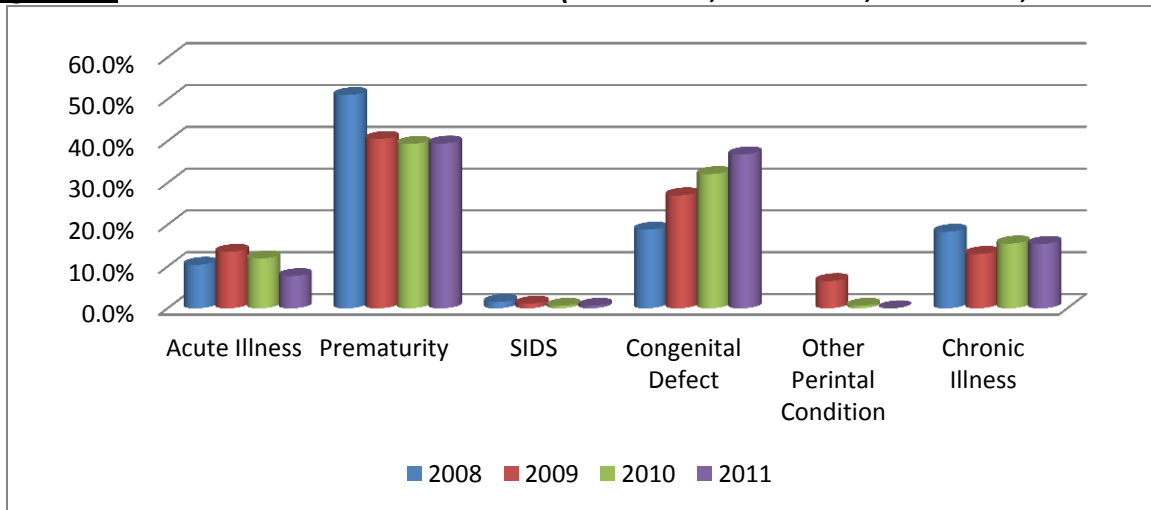
- Prematurity (n=61)
- Congenital Anomalies (n=57)
- Chronic Illness (n=20)
- Acute Illness (n=16)

The focus of child death review is prevention, and therefore this section of the report will focus on Chronic Illness, Acute Illness and Prematurity. In the past SIDS has been one of the causes of natural death that was a focus of this report as it is one category of death for which a review is mandatory under Nevada Revised Statutes. In 2010 and in 2011 there was only one SIDS death each year, which marks a decrease from seven cases in 2006. Some of this decline is likely attributed more to a nationwide shift among medical examiners away from the classification of SIDS as the cause of death and more toward accidental suffocation or undetermined as a cause of death. This shift is led by the Centers for Disease Control and Prevention's Sudden Unexplained Infant Death Initiative (SUIDI) which aims to standardize and improve data collected for infant deaths to help guide prevention activities. These changes in data collection likely account for much of the decline in this particular cause of death.



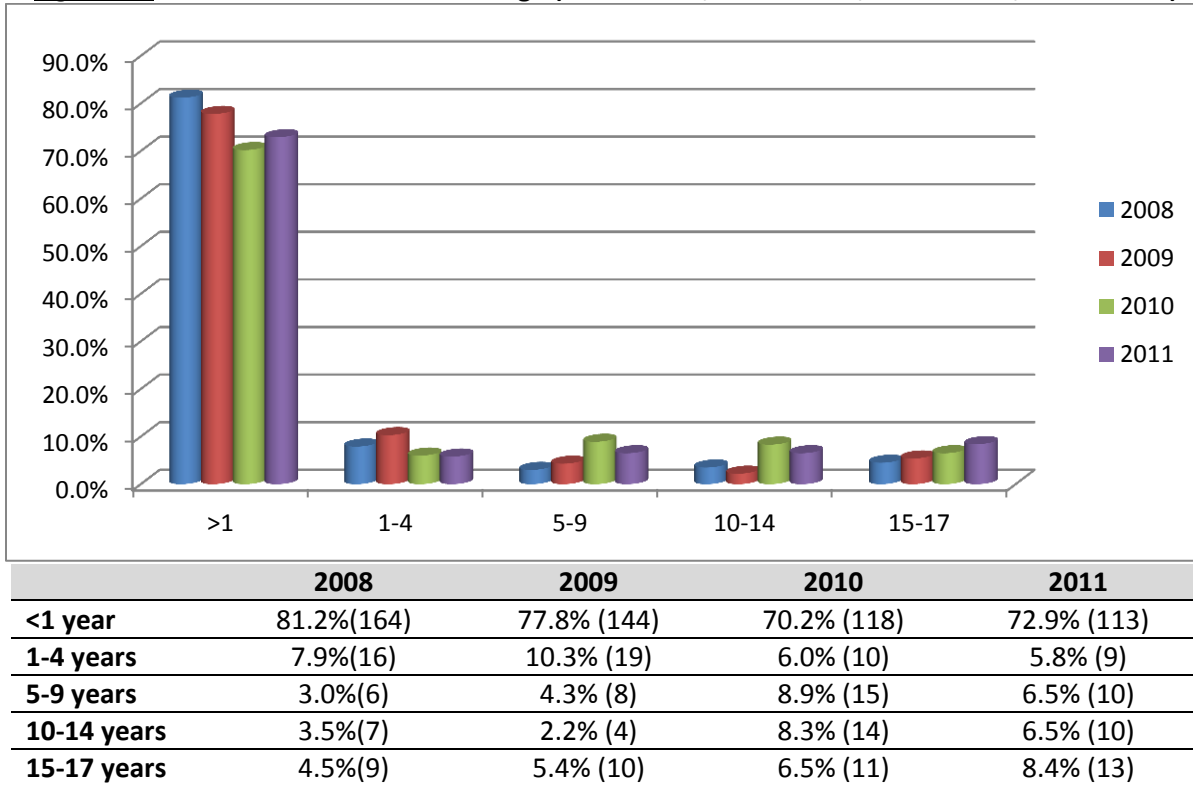
The following graph (Figure 2.1) presents all the causes of natural deaths among cases reviewed from 2008 to 2011. As illustrated, the category “Prematurity” is again the leading cause of natural death in children at 39.4% which is a decrease compared to the 51% in 2008, but very similar to the number in 2009 and 2010.

**Figure 2.1: 2008-2011 Natural Causes of Death (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155)**



Cause	2008	2009	2010	2011
<b>Acute Illness</b>	10.4%(21)	11.9%(22)	11.9% (20)	7.7% (12)
<b>Prematurity</b>	51%(103)	40.5% (75)	39.3% (66)	39.4% (61)
<b>SIDS</b>	1.5%(3)	1.1% (2)	0.6% (1)	0.6% (1)
<b>Congenital Defect</b>	18.8%(38)	27% (50)	32.1% (54)	36.8% (57)
<b>Other Perinatal Condition</b>	--	6.5% (12)	0.6% (1)	--
<b>Chronic Illness</b>	18.3%(37)	13% (24)	15.5% (26)	15.4% (24)

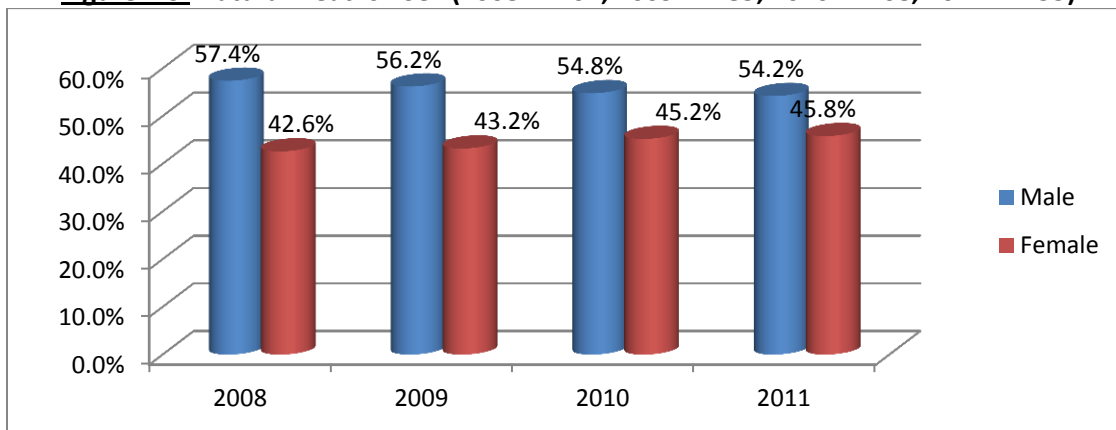
**Figure 2.2: 2008-2011 Natural Deaths Age (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155)**



The graph in Figure 2.2 above illustrates the ages of all natural deaths from 2008 to 2011. We can see that the majority of natural deaths are among children less than one year of age from 2008 through 2011. However, we do see a decrease in the number of children under one year from 2008 to 2011 (81.2% in 2008 compared to 72.9% in 2011), and at the same time slight increases in the number of Natural deaths among children in older age groups. 2011 represents the largest number of children ages 15 to 17 years dying of natural causes. The majority of these were chronic illnesses, including several different types of cancer and cystic fibrosis.

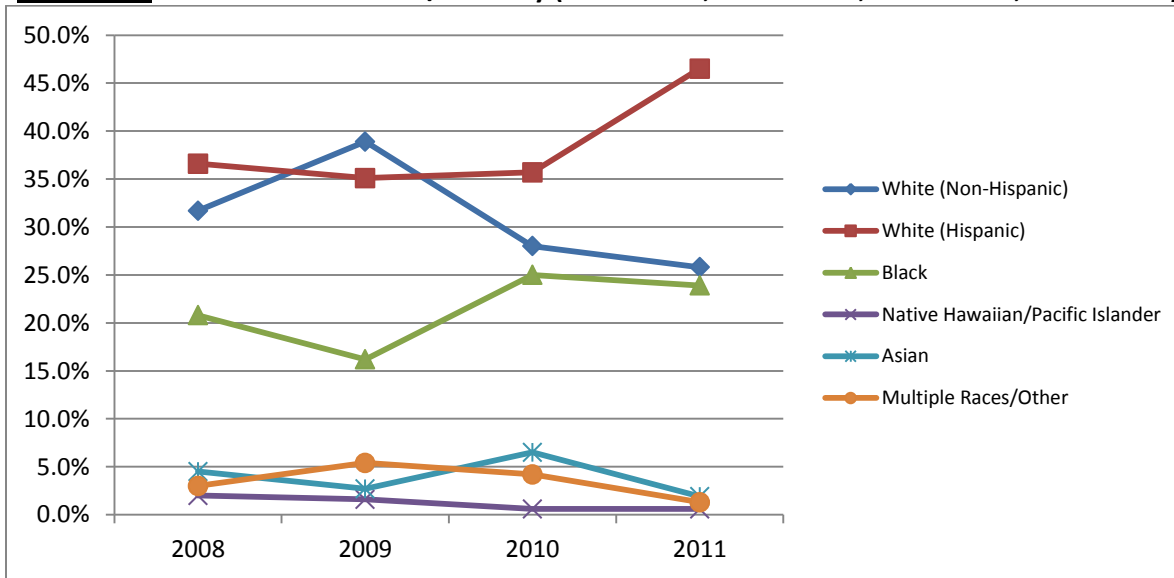
Figure 2.3 below consistently demonstrates that more males than females die from natural causes with the distribution being very similar from year to year.

**Figure 2.3: Natural Deaths - Sex (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155)**



The graph in Figure 2.4 below shows the racial and ethnic breakdown of the natural deaths for 2008-2011. In 2011, nearly half of natural deaths were White Hispanic children (46.5%), followed by White Non Hispanic children at 25.8%, and then 23.9% Black children. This follows a decreasing trend from 2009 in the number of White Non-Hispanic children that died from natural causes; however we also see a sharp increase in the number of White Hispanic children in this category (65 cases in 2009, 72 in 2011).

**Figure 2.4: Natural Deaths – Race/Ethnicity (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155)**



	2008*	2009	2010	2011
White (Non-Hispanic)	31.7% (64)	38.9% (72)	28.0% (47)	25.8% (40)
White (Hispanic)	36.6% (74)	35.1% (65)	35.7% (60)	46.5% (72)
Black	20.8% (42)	16.2% (30)	25.0% (42)	23.9% (37)
Native Hawaiian/Pacific Islander	2.0% (4)	1.6% (3)	0.6% (1)	0.6% (1)
Asian	4.5% (9)	2.7% (5)	6.5% (11)	1.9% (3)
Multiple Races/Other	3.0% (6)	5.4% (10)	4.2% (7)	1.3% (2)

\*In 2008 there were 3 cases of fetal deaths where race could not be identified, these cases are NOT represented in Figure 2.4

# CHRONIC ILLNESS

Less than one sixth (15.4%) 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
• Cancer	• Epilepsy
• Cardiac Arrhythmia	• Diabetes

In 2011 more males (58.3%) compared to females (41.7%) died from complications associated with chronic illness. The most frequent age category for chronic illness was 5 to 9 years (29.2%) followed by 15 to 17 years, and less than 1 year at 20.8% for both age groups. See Figure 2.5 below.

**Figure 2.5: 2008-2011 Natural Deaths - Chronic Illness – Age in Years (2008 n=37, 2009 n=24, 2010 n=26, 2011 n=24)**

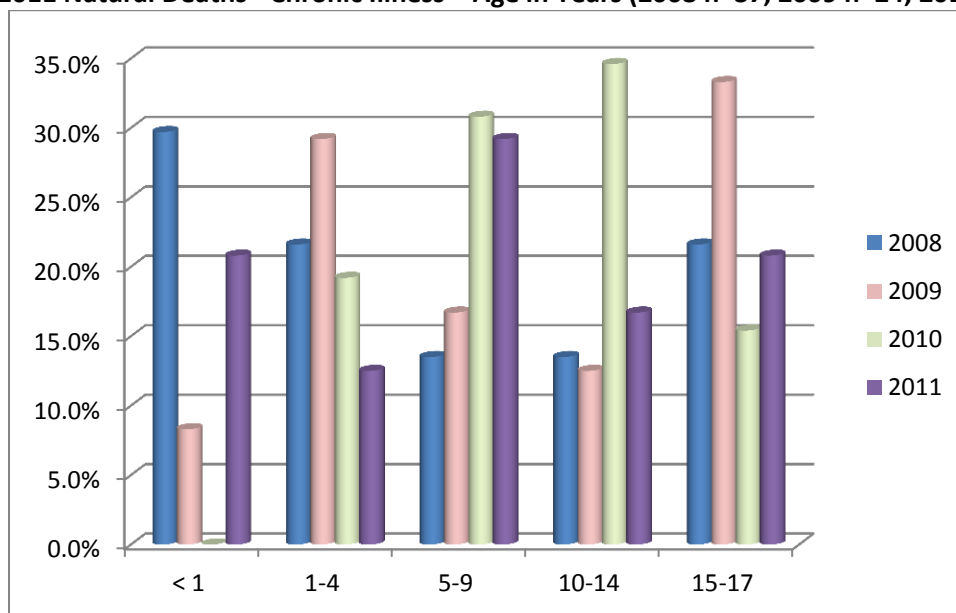
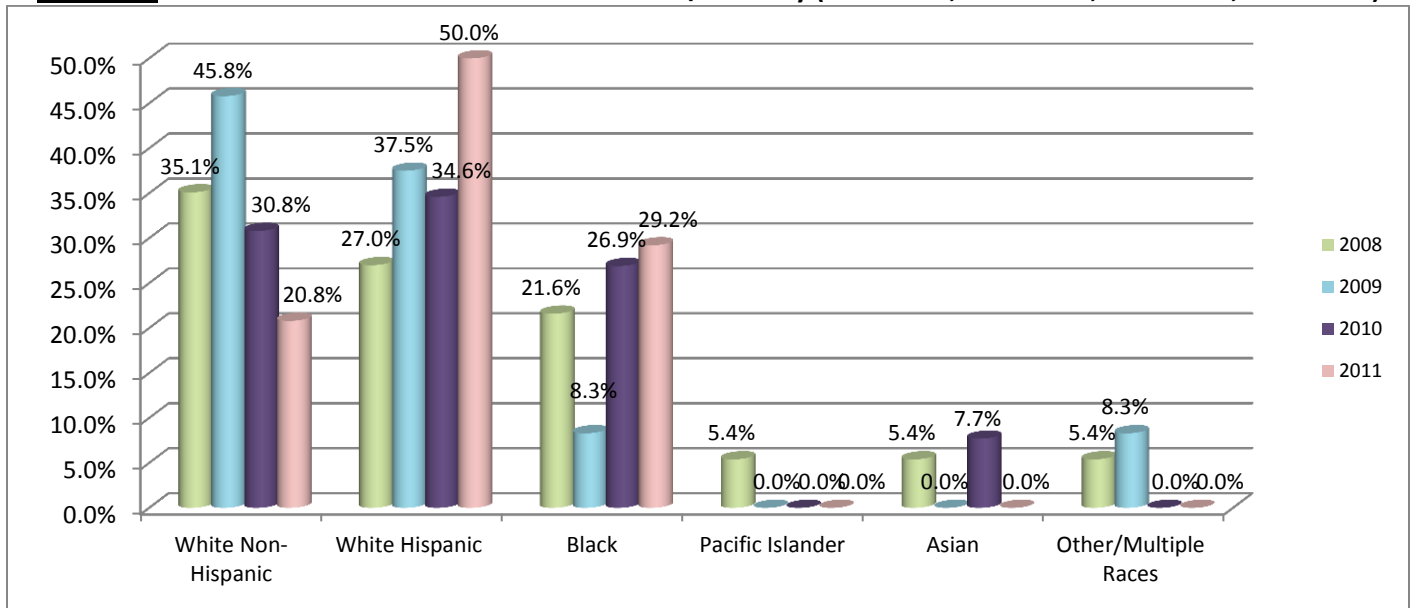


Figure 2.6 displays the racial and ethnic breakdown for deaths associated with chronic illnesses in 2008-2011. Half (50%) of these cases were White Hispanic Children, which is the largest proportion since we started collecting this data in 2008. In 2011 we also see a continued increase in the proportion of Black children who died as a result of chronic illnesses going from only 8.3% in 2009 to 29.2% in 2011.

**Figure 2.6: 2011 Natural Deaths – Chronic Illness Race/Ethnicity (2008 n=37, 2009 n=24, 2010 n=26, 2011 n=24)**



In one fifth of the cases (20%) the child had the condition since birth, while another 33.1% had the illness for a number of years. In the other cases the illness was undiagnosed before death or had only recently been diagnosed. In 50% (12) of the cases, death was expected as a result of the condition. 91.7% were receiving medical care for the chronic condition and almost all families were following the doctors’ prescribed care plan (91.7%).

### **SPECIAL CONCERN IN CHRONIC ILLNESS: ASTHMA**

In 2011 nearly one third (29.2%) of deaths due to chronic illness were related to complications associated with Asthma. 57.1% (n=4) of these children were Black, 28.6% (n=2) were White Hispanic, and the remaining case was White. 57% (n=4) of these children were males and ranged in age from four to 13 years old with the majority of children being between five and nine years (57.1%). In 71% (n=5) of cases the child was receiving some medical care for their asthma, however in many of these cases the child was only using a rescue inhaler or other “as needed” treatments and not consistently taking long term control medications to prevent an attack. The Child Death Review Team continues to seek out prevention initiatives to ensure that children with asthma are properly diagnosed and treated.

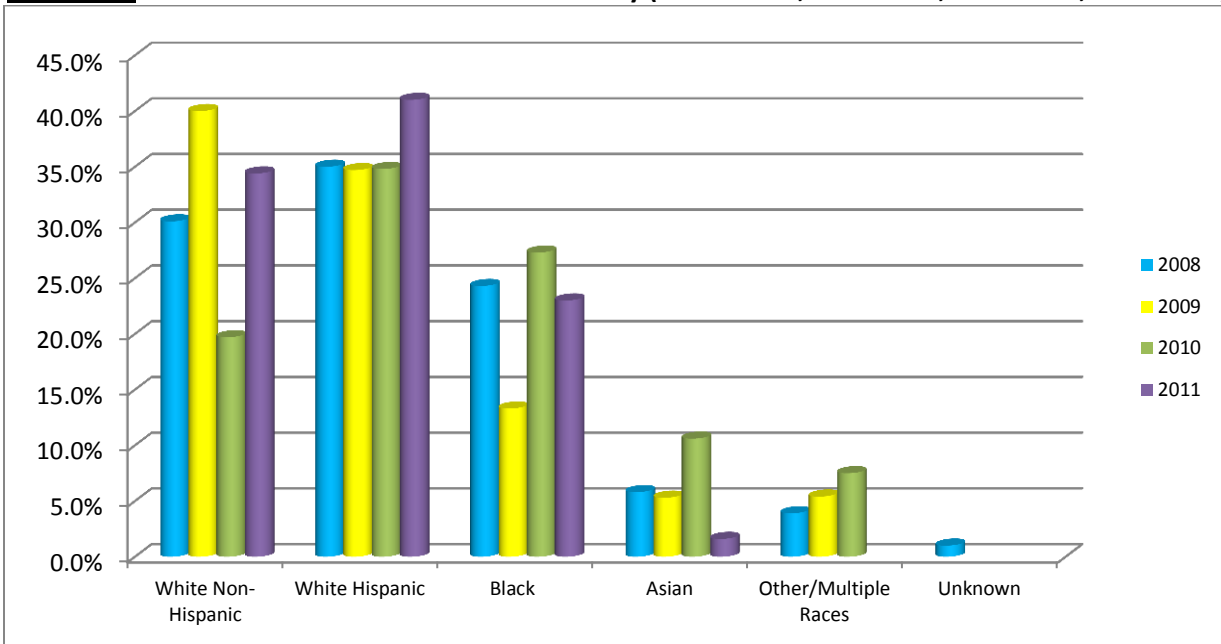
# PREMATURITY

Pre-term birth and complications associated with prematurity is a serious concern in the United States. According to the Centers for Disease Control and Prevention, 1 in 8 babies are born premature (prior to 37 weeks gestation) in the United States each year, costing the US health care system more than \$26 billion each year.

More than one third (39.4%) of all natural deaths in Clark County reviewed in 2011 were caused by complications of prematurity, about the same as the 40.5% in 2009 and 39.3% in 2010. As expected, all but one of the children in this category were less than one year of age at the time of their death (the older child was in hospice their whole life due to complications associated with prematurity). In 2011, there were slightly more males (52.5%) than females (47.5%) consistent with the distributions from 2008 to 2010.

The most frequently occurring racial/ethnic category was White Hispanic infants (41%), followed by White Non-Hispanic infants (34.4%). This year there was a decrease in the percentage of Black decedents, from 27.3% in 2010 to 23% in 2011. This is similar to national statistics that indicate that both Black and Hispanic infants are more likely than White infants to be born premature (Centers for Disease Control and Prevention, 2012).

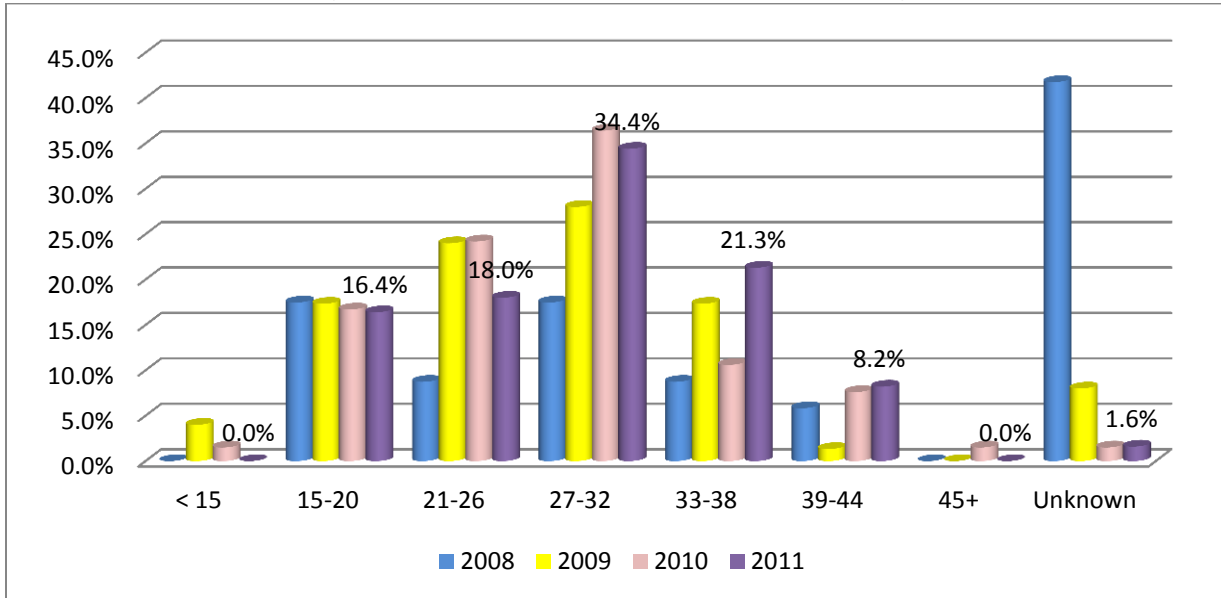
**Figure 2.7: 2008-2011 Natural Deaths – Prematurity (2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61)**



Gestational age was known in 52.4% of cases (n=32) where the cause was listed as prematurity, ranging from 20 to 34 weeks. Only 39.3% (n=24) of the cases indicated that the mother received prenatal care, but this is about the same as in 2010, but an increase from the 34.7% of cases in 2009. In 93.4% (n=57) of the cases the mother had known medical complications or infections. In only 1.6% (n=1) the mother admitted to the use of illicit and prescription drugs.

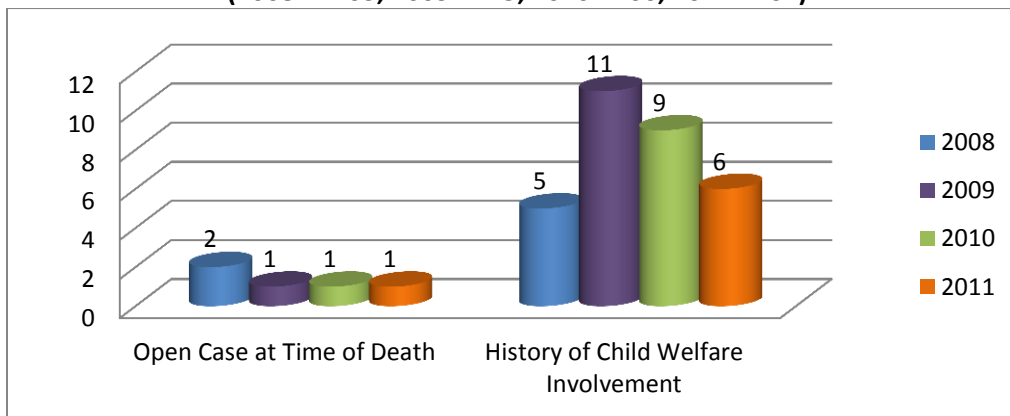
In 2011 the age of the mother was known in 98.4% of cases (n=60), and ranged from 16 to 41 years. Since maternal age is a factor that influences the likelihood of complications and premature birth, this is an important variable to track. The graph below illustrates the age categories of mothers of infants who died from complications associated with prematurity in 2008-2011. Note that in 2008, mother’s age was only known in 58% of these cases, while in 2009 it was known in 92% of cases, and in 2010 and 2011 it was known in all but one case.

**Figure 2.8: 2008-2011 Natural Deaths – Prematurity – Mother’s Age in Years**  
(2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61)



Of all natural deaths due to prematurity in 2011, 9.8% (compared to 4.9% in 2008) had any family history of involvement with child welfare (this could be siblings, or the parent as a child victim), and an even smaller percentage (1.6% in 2011) had an open case at the time of their death.

**Figure 2.9: 2008-2011 Prematurity – Child Welfare Involvement**  
(2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61)



	2008		2009		2010		2011	
	Count	%	Count	%	Count	%	Count	%
<b>Open Case at Time of Death</b>	2	1.9%	1	1.3%	1	1.5%	1	1.6%
<b>History of Child Welfare Involvement</b>	5	4.9%	11	14.7%	9	13.6%	6	9.8%

# SUDDEN INFANT DEATH SYNDROME (SIDS)

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 the past SIDS has been one of the causes of natural death that was a focus of this report as it is one category of death for which a review is mandatory under Nevada Revised Statutes. In 2010 and 2011 there was only one SIDS death in each year, which marks a decrease from seven cases in 2006. Starting in 2008 SIDS was no longer one of the top three causes of natural death in children in Clark County. Some of this decline is likely attributed more to a nationwide shift among medical examiners away from the classification of SIDS as the cause of death and more toward accidental suffocation or undetermined as a cause of death. This shift is led by the Centers for Disease Control and Prevention’s Sudden Unexplained Infant Death Initiative (SUIDI) which aims to standardize and improve data collected for infant deaths to help guide prevention activities. These changes in data collection likely account for much of the decline in this particular cause of death.

Because there was only one case in 2011 information about that case will not be presented in this report. Information regarding all other infants who died in a sleeping environment can be found in the section on accidental suffocations (page 45) and undetermined deaths (page 71).



# 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. CONTINUE TO IMPROVE DATA COLLECTION AND RESEARCH ON CHILD DEATHS RELATED TO PREMATUREITY.**

Again in 2011 the majority (72.9%) of natural deaths occurred among children less than one year of age. This represents a slight increase from the 70% in. Again this year there were a high proportion of deaths attributed to complications of prematurity (39.4%) which continues to provide support for improvements and continued research and tracking regarding prenatal care, parental substance abuse, exposure to environmental pollutants, etc.

## **2. IMPROVE ACCESS AND OUTREACH FOR ADEQUATE PRENATAL CARE, PARTICULARLY FOR YOUNG WOMEN.**

Starting in 2009 the team worked with the Southern Nevada Health District to screen birth records for all cases reviewed to collect data on the ages of decedent's parents. Age of the mother was known in 92% (n=69) of prematurity cases in 2009 and this number increased to nearly all (98.4% (n=60) cases in 2011. Before this process was developed, in 2008 the team only had information about the mother's age in 58% of cases. 16.4% of these mothers were 20 years old or younger and another 18% were between the ages of 21 and 26 years. While this is a decrease from 2010 when 42.5% of these mothers were 26 years old or younger, we are still seeing more than one third (34.4%) in this age group. This information supports the continued efforts focusing 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 preexisting medical conditions and lifestyle choices that can increase the risk of preterm labor and birth. Currently the Southern Nevada Health District is working to address these issues with the start of a Teen Pregnancy Prevention Program designed to provide family planning and sexual education information to at risk youth, as well as their Nurse Family Partnership Program that provides prenatal care and health education to low income pregnant and parenting mothers in Southern Nevada.

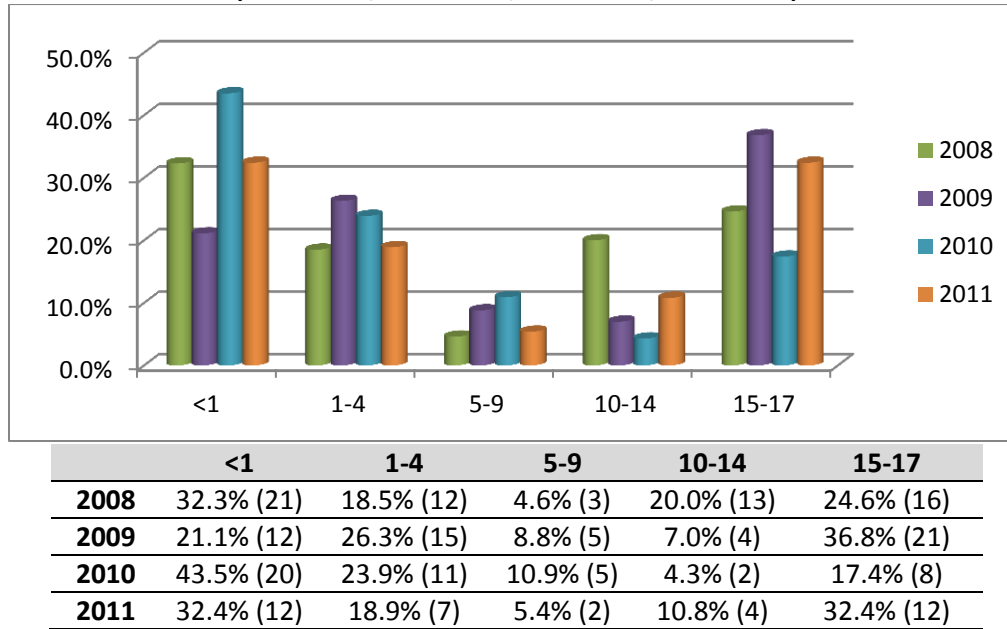
## **3. IMPROVE PARENT EDUCATION ABOUT PROPER MANAGEMENT OF COMMON CHRONIC ILLNESSES IN CHILDREN.**

This year one of the leading causes of natural deaths was chronic illness (15.4%). 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 fifth year in a row we continue to see children die from complications associated with these conditions. Simple monitoring by parents and physicians and maintaining the prescribed medication administration schedule can allow children with both asthma and diabetes to live long and healthy lives. Increased educational campaigns should be created and directed toward parents to remind them of the severity of these illnesses if not carefully monitored. Specifically, in 2011 nearly one third (29.2%) of all deaths due to chronic illness were due to complications associated with Asthma. 57% of those deaths involved Black children, 57% were male and 57.1% were between the ages of 5 and 9 years old. Public education campaigns should target parents of these children specifically.

## 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 2011, 37 child deaths in Clark County were ruled as accidental, showing a continued decrease from 2008 to 2011. All of the 37 cases were investigated by the coroner/medical examiner’s office. Of those 37 cases, 70.3% were male and 29.7% were female. More than half (51.3%) of the cases were children ages zero to 4 years of age.

**Figure 3.1: 2008-2011 Percent of Children by Age category for All Accidental Deaths (2008 n=65, 2009 n=57, 2010 n=46, 2011 n=37)**



About one quarter of all accident victims were White Non-Hispanic (24.3%), nearly half were White Hispanic (43.2%), 21.6% were Black, and the remaining cases were children who were Asian, Pacific Islander and multiracial. This distribution is slightly different to those seen in previous years, as the largest group is White Hispanic, and in prior years the largest group was White Non-Hispanic.

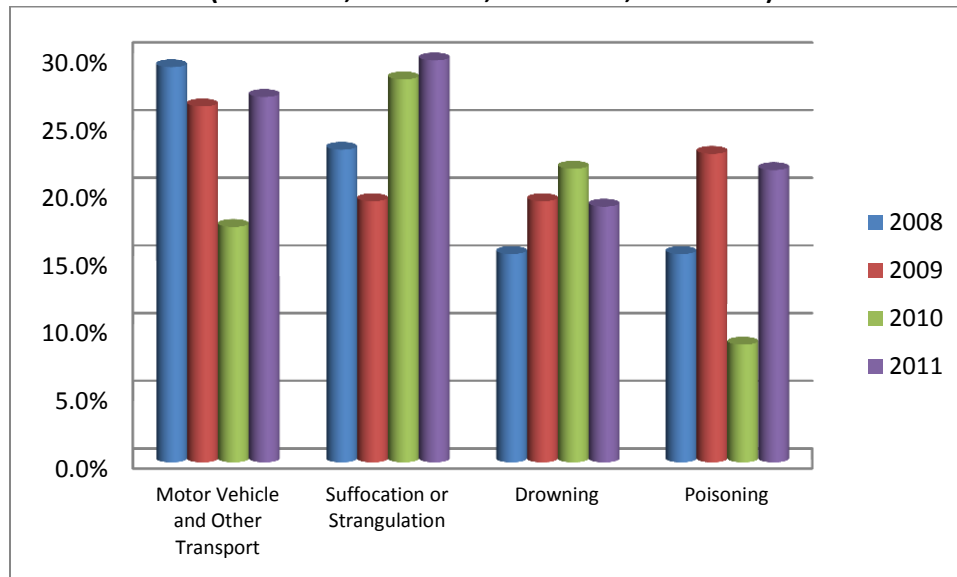
In more than one third (35.1%) of accidental child deaths, the child’s family had some history with the child welfare system, making these cases mandatory reviews. In 18.9% of all accidents with prior child welfare history, the history was regarding the decedent. In 8.1% of all accidents, there was a child welfare case open with the family at the time of the child’s death (in two instances the open case was with the decedent’s siblings, and in one case the decedent was in foster care at the time of their death). In 62.2% (n=23) of cases the team determined that the decedents needed supervision, but in 10.8% of those cases the child was not supervised at the time of the incident that led to their death. For those cases where supervision was necessary, in 45.9% 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 babysitters. In 21.7% of accidents reviewed where a supervisor was present, the supervisor was 23 years of age or younger. The majority of accidental deaths in 2011 occurred either in the child’s home (56.8%), or in a roadway, driveway or sidewalk (24.3%). Additionally, there were three accidental deaths where children from out of state died while in Clark County. These children were from Texas, Utah, and Arizona.

For the second time in five years, the leading cause of accidental death was suffocation (29.7%) and not motor vehicle accidents (MVA) as it has been for the previous four years. This significant decline in MVAs since 2006 is a trend that is seen nationwide. According to a 2010 study from the US Department of Transportation’s National Highway Traffic

Safety Administration (NHTSA), motor vehicle traffic fatalities among all age groups was down 22% in 2008. These numbers continue to decline, and recent 2010 estimates indicate that fatalities have decreased 25% since 2005. This report suggests that this decrease may be explained by the recession in the US economy, higher unemployment rates, as well as improvements in vehicle safety and effective public safety campaigns. In 2011 motor vehicle incidents were the second leading cause of accidental death accounting for 27% of all accidental child deaths in Clark County.

The third leading cause of death was poisoning at 21.6%, and drowning was fourth which accounts for 18.9% of all accidental deaths. Each of these leading causes will be examined in this section. A graph illustrating the comparison of the leading causes of accidental deaths from 2008 to 2011, as well as all causes of accidental deaths in a table is displayed in Figure 3.2 below.

**Figure 3.2: 2008-2011 Percent of Accidental Injury Deaths by Cause**  
(2008 n=65, 2009 n=57, 2010 n=46, 2011 n=37)



	2008	2009	2010	2011
<b>Motor Vehicle and Other Transport</b>	29.2% (19)	26.3% (15)	17.4% (8)	27% (10)
<b>Suffocation or Strangulation</b>	23.1% (15)	19.3% (11)	28.3% (13)	29.7% (11)
<b>Drowning</b>	15.4% (10)	19.3% (11)	21.7% (10)	18.9% (7)
<b>Fall or Crush</b>	6.2% (4)	3.5% (2)	6.5% (3)	2.7% (1)
<b>Poisoning</b>	15.4% (10)	22.8% (13)	8.7% (4)	21.6% (8)
<b>Weapon</b>	1.5% (1)	5.3% (3)	2.2% (1)	0%
<b>Complications of Maternal Drug Use</b>	4.6% (3)	0%	15.2% (7)	0%
<b>Acute Illness*</b>	1.5% (1)	3.5% (2)	0%	0%
<b>Blunt Force Trauma**</b>	3.1% (2)	0%	0%	0%

\*There was one case in 2008 ruled an accident where a child went into cardiac arrest while on a roller coaster. In 2009, one case was a child with cerebral palsy who died from acute pneumonia; the other case was due to an infection from a misplaced gastronomy tube.

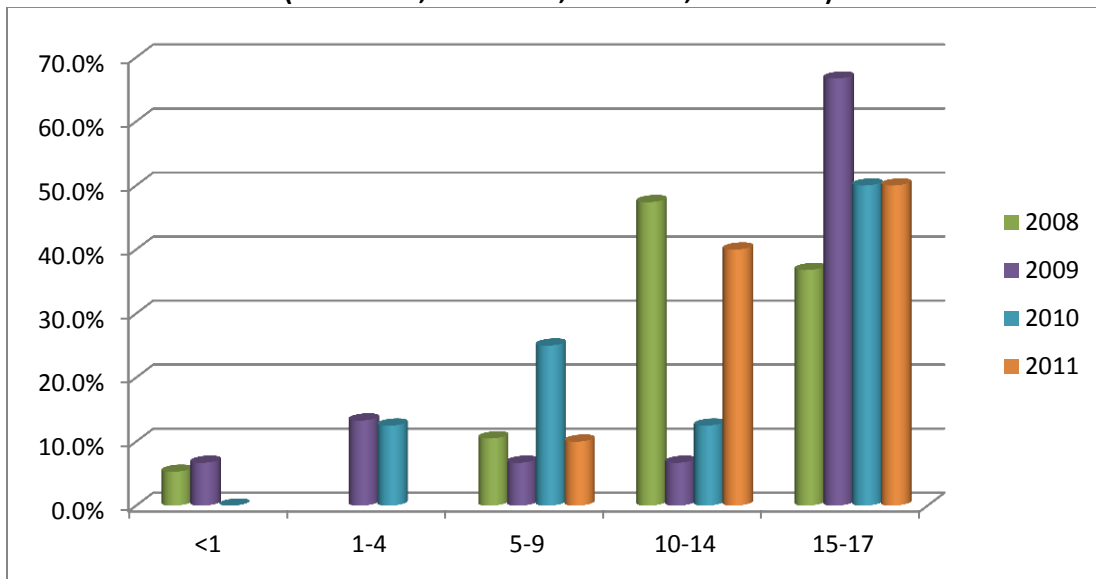
\*\* There were 2 cases in 2008 coded as "blunt force trauma" due to fatal attacks by dogs.

Prosecution was pending at the time of review in 10.8% of accidental deaths (n=4). In just over half of the accidental deaths (51.4% or 19 cases), CPS took action as a result of the death. Of those 19 cases, CPS substantiated abuse or neglect in two of them and in five cases the surviving children were removed from the home as a result of the death.

# MOTOR VEHICLE ACCIDENTS

There were 10 accidental child fatalities due to motor vehicle accidents (MVAs) in Clark County in 2011, a nearly 50% decrease from 2008 when there were 19 cases. In 2011, 60% of these MVA cases involved male victims, which is similar to previous years where there have been more male victims than female. The majority (50% or n=5) of decedents were White Hispanic and the remaining 50% were White Non-Hispanic (n=3), Black (n=1), and Asian (n=1). This year three of the victim’s families had a prior history with the child welfare system and one of the decedents had a juvenile justice history. Half of the decedents (50%) were between the ages of 15-17, and 90% were over the age of 10 years. In 2011 there was one death due to a MVA in which the child was between the ages of 5 and 9 years.

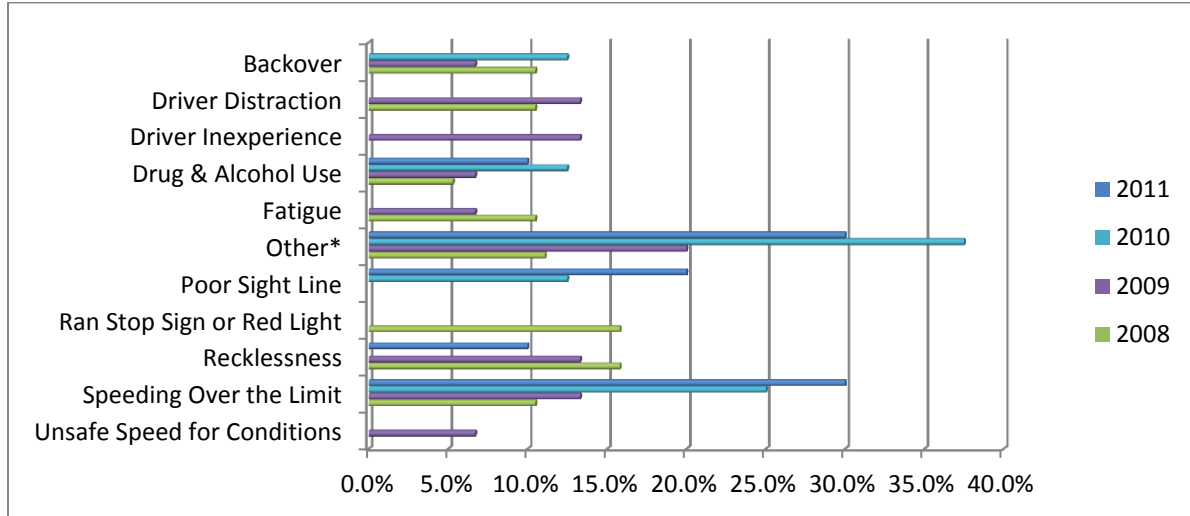
**Figure 3.3: 2008-2011 Percent of Motor Vehicle Accident Victims by Age Category (2008 n=19, 2009 n=15, 2010 n=8, 2011 n=10)**



	<1 year	1-4 years	5-9 years	10-14 years	15-17 years
<b>2008</b>	5.3% (1)	0.0% (0)	10.5% (2)	47.4% (9)	36.8% (7)
<b>2009</b>	6.7% (1)	13.3% (2)	6.7% (1)	6.7% (1)	66.7% (10)
<b>2010</b>	0.0% (0)	12.5% (1)	25.0% (2)	12.5% (1)	50.0% (4)
<b>2011</b>	0.0% (0)	0.0% (0)	10% (1)	40% (4)	50% (5)

In all child fatalities involving motor vehicles in 2011, there were either one or two vehicles (vehicles include golf carts, go carts, and bicycles) involved and the majority of these cases involved only one vehicle. Half of all motor vehicle accidents occurred on a residential or city street (50%) which is similar to 2008, but differs from 2007 and 2009 when the majority occurred on highways. Primary causes of accidents included speeding (30%), drug or alcohol use (10%), and poor visibility (20%). At the time of the accident, 40% (n=4) of drivers were alcohol or drug impaired, and this was listed as a secondary cause of the accident. See Figure 3.4 below.

**Figure 3.4: Primary Cause of Motor Vehicle Accidents (2008 n=19, 2009 n=15, 2010 n=8, 2011 n=10)**



	2008	2009	2010	2011
Back Over	10.5% (2)	6.7% (1)	12.5% (1)	0% (0)
Driver Distraction	10.5% (2)	13.3% (2)	0% (0)	0% (0)
Driver Inexperience	0% (0)	13.3% (2)	0% (0)	0% (0)
Drug & Alcohol Use	5.3% (1)	6.7% (1)	12.5% (1)	10% (1)
Fatigue	10.5% (2)	6.7% (1)	0% (0)	0% (0)
Other*	11.1% (4)	20% (3)	37.5% (3)	30% (3)
Poor Sight Line	0% (0)	0% (0)	12.5% (1)	20% (2)
Ran Stop Sign or Red Light	15.8% (3)	0% (0)	0% (0)	0% (0)
Recklessness	15.8% (3)	13.3% (2)	0% (0)	10% (1)
Speeding Over the Limit	10.5% (2)	13.3% (2)	25% (2)	30% (3)
Unsafe Speed for Conditions	0% (0)	6.7% (1)	0% (0)	0% (0)

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

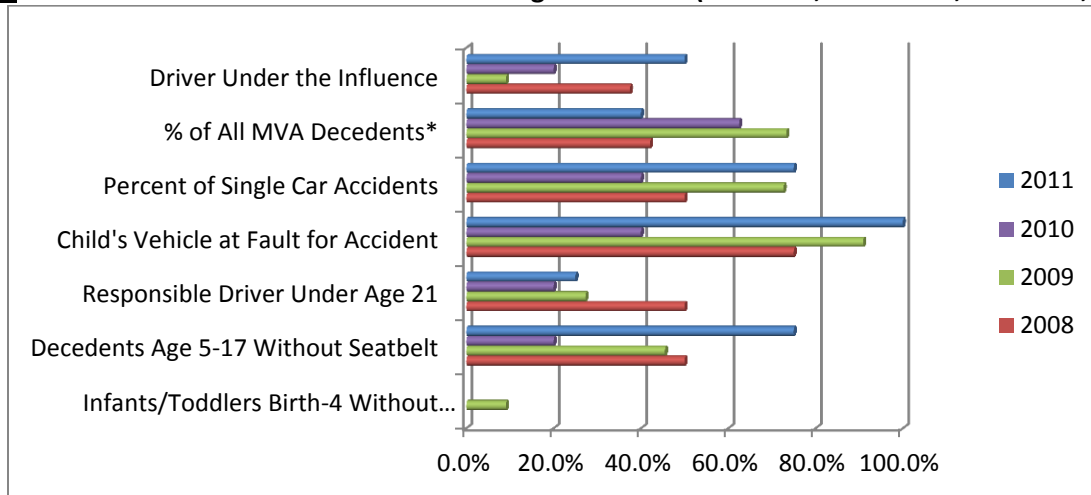
In 40% of cases, the child was in a car, van, SUV, or truck, in 50% of cases the child was a pedestrian or on a bicycle, and in the remaining case the child was on a go cart. In 60% of cases, the vehicle the decedent was in at the time was at fault for the incident (this includes those that were on a bicycle or go cart).

In two cases, the decedent was the driver of the vehicle involved in the accident (one was a car, the other a go cart). In the case involving the car, the decedent did not have a valid driver’s license and was not under the influence of drugs or alcohol.

Nearly half of decedents involved in MVAs (40%, n=4) were passengers in vehicles. Of those passengers killed, 50% were between 10 and 14 years old, and the other half (50%) were between the ages of 15-17. In the passenger fatalities, 75% of these accidents were single car accidents, and the other 25% were two-car accidents. In all of these two-car accidents, the child’s vehicle was at fault for the accident. Primary causes of all motor vehicle accidents were attributed to

speeding, drug or alcohol use, and recklessness. In two of these cases, the driver responsible was over age 21, and in the other two the age of the responsible driver was unknown to the team at the time of the review. In three of the cases the decedent was not wearing a seatbelt. The driver was under the influence in two cases. Again in 2011 there were no MVA fatalities where children under the age of ten were sitting in the front seat, which is a continued improvement from 2007 when 25% of those fatalities involved children ages 5-9 in the front seat.

**Figure 3.5: 2008-2011 Circumstances of MVA Passenger Fatalities (2008 n=8, 2009 n=11, 2010 n=5, 2011 n=4)**

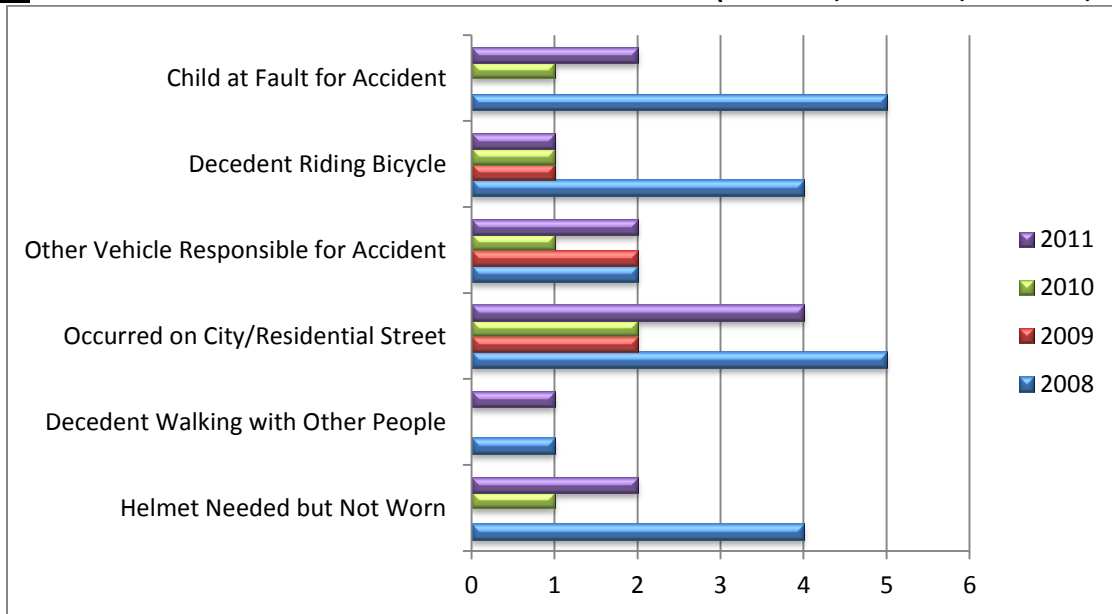


	2008	2009	2010	2011
<b>Infants/Toddlers Birth-4 Without Car seat</b>	0%	9.1% (1)	0%	0%
<b>Decedents Age 5-17 Without Seatbelt</b>	50.0% (4)	45.5% (5)	20% (1)	75% (3)
<b>Responsible Driver Under Age 21</b>	50.0% (4)	27.3% (3)	20% (1)	25% (1)
<b>Child's Vehicle at Fault for Accident</b>	75.0% (6)	90.9% (10)	40% (2)	100% (4)
<b>Percent of Single Car Accidents</b>	50.0% (4)	72.7% (8)	40% (2)	75% (3)
<b>% of all MVA Decedents*</b>	42.1%(8)	73.3%(11)	62.5% (5)	40% (4)
<b>Driver Under the Influence</b>	37.5% (3)	9.1% (1)	20% (1)	50% (2)

\* This percentage represents the total number of all MVA fatalities (n=4 of 10 in 2011) where the child was the passenger.

In four cases of child fatalities involving a MVA, the decedent was a pedestrian. In two of these cases the child was between 15 and 17 years old. In the other two cases the children involved were 14 and 5 years old. In three cases the child was crossing the street when struck by an oncoming vehicle. Only one of those pedestrians was outside of a crosswalk. In the remaining case the youth darted into traffic and was struck by an oncoming vehicle.

**Figure 3.6: 2008-2011 Circumstances of MVA Pedestrian Fatalities (2008 n=7, 2009 n=2, 2010 n=2, 2011 n=4)**



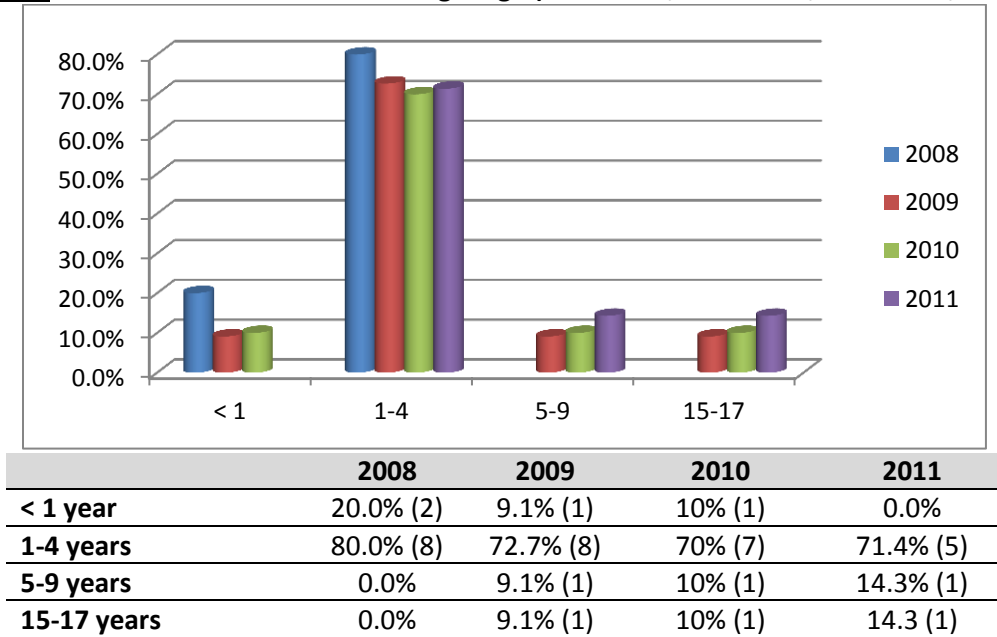
	2008	2009	2010	2011
<b>Helmet Needed but Not Worn</b>	4	0	1	2
<b>Decedent Walking with Other People</b>	1	0	0	1
<b>Occurred on City/Residential Street</b>	5	1	2	4
<b>Other Vehicle Responsible for Accident</b>	2	2	1	2
<b>Decedent Riding Bicycle</b>	4	1	1	1
<b>Child at fault for Accident</b>	5	0	1	2

# DROWNING

According to the data collected by the Southern Nevada Health District, there were 37 submersion incidents in Clark County among children aged 0-14 years of age. The majority of these incidents (n=32) occurred in swimming pools.

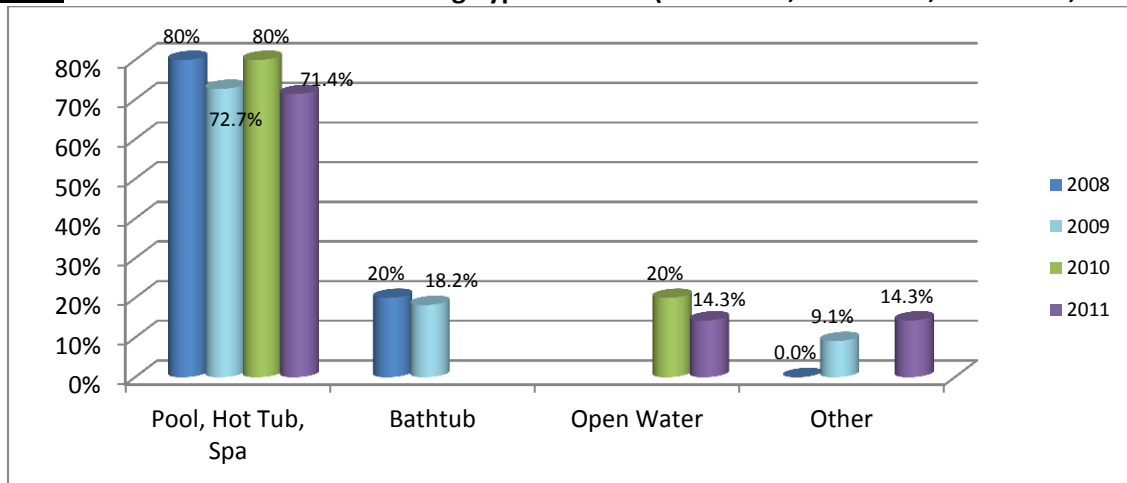
In 2011, drowning was the fourth leading cause of accidental death among children in Clark County, with 7 deaths in this category. In 2011, we see the lowest number of child drowning incidents since data collection was started in 2006. Again this year, the vast majority of fatal drowning victims (70%) were between the ages of 1 and 4 years, indicating that prevention efforts should focus on those children under 5 years of age.

**Figure 3.7: 2008-2011 Accidental Drowning – Age (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**



Similar to previous years, in 2011 nearly all drowning cases occurred in a pool, hot tub or spa (71.4%). Of the two remaining cases, one occurred in open water and the other was in an open cooler filled with water.

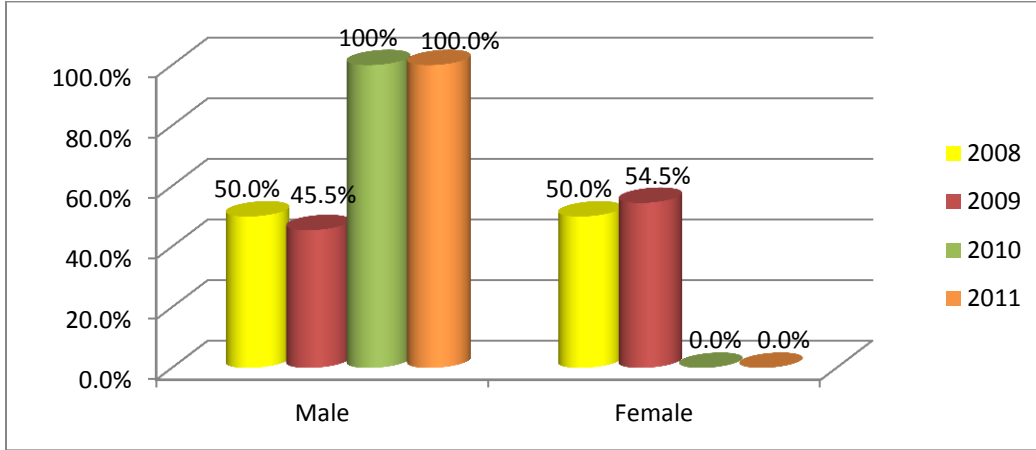
**Figure 3.8: 2008-2011 Accidental Drowning Type of Water (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**





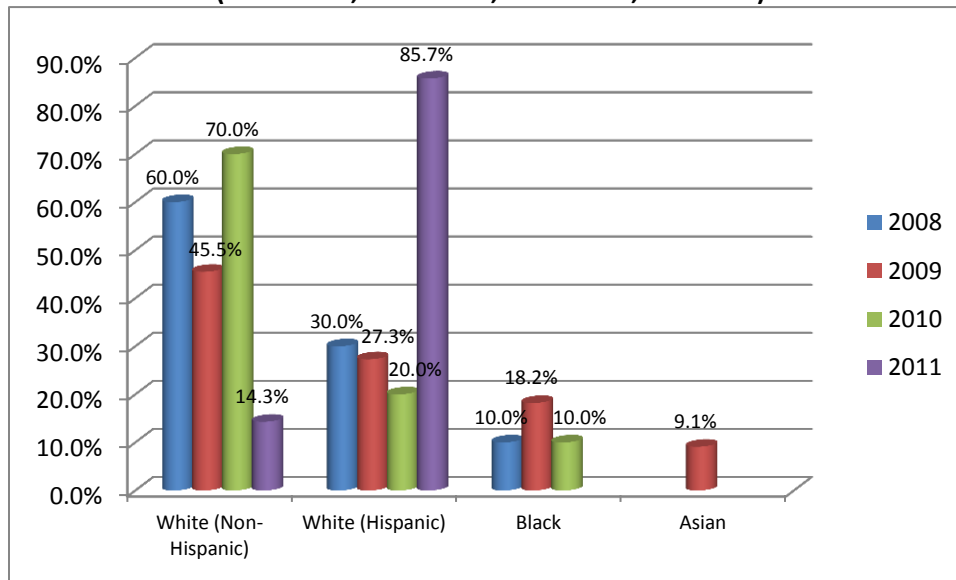
In 2011 all fatal drowning incident victims were male. This is the second year that there were no female victims.

**Figure 3.9: 2008-2011 Accidental Drowning – Sex (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**



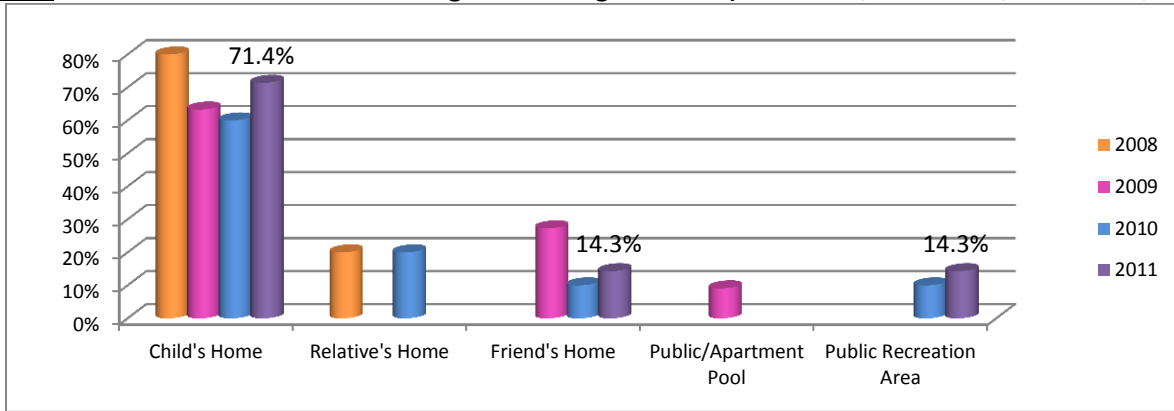
The race/ethnicity data for drowning victims in 2011 is unique in that with the exception of one case, all fatalities involved Hispanic children. The remaining case involved a White Non-Hispanic child. This distribution is displayed in Figure 3.10.

**Figure 3.10: 2008-2011 Accidental Drowning – Race/Ethnicity (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**



In 2011 the majority (71.4%, n=5) of drowning cases occurred at the child’s home. The remaining drowning fatalities occurred at a friend’s home (14.3%) or public recreation area (14.3%).

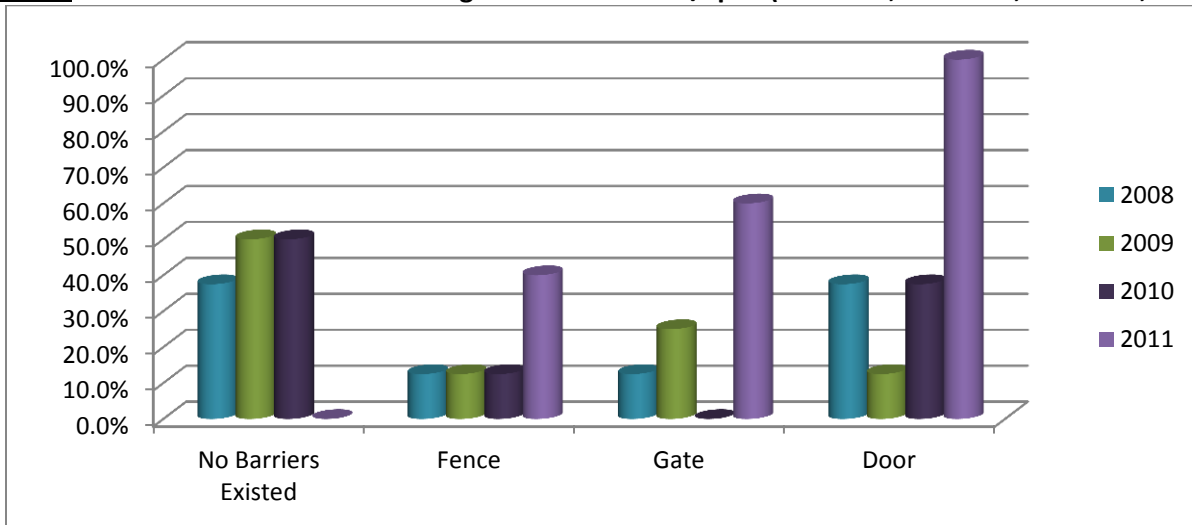
**Figure 3.11: 2008-2011 Accidental Drowning – Drowning Location (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**



For those cases where the team determined the child needed supervision, most frequently (83.3%) the biological parent was the supervisor at the time of the incident, followed by a grandparent at 16.7%. In 71.4% of cases where supervision was needed, the child was last seen in the house and was subsequently left unsupervised between five and fifteen minutes. The average period of elapsed time from when the child was last seen to when they were found unresponsive was around 12 minutes. In all cases the child was not wearing a floatation device and in two cases (28.6% of all pool drowning incidents) there was a gathering or event going on at the same time as the incident.

Figure 3.12 below shows whether or not barriers existed to accessing the pool or spa and if so, what they were. For 2011, in 2 cases the pool or spa had a fence and in all cases the home had a door blocking the entrance to the pool or spa.

**Figure 3.12: 2008-2011 Accidental Drowning – Barriers to Pool/Spa\* (2008 n=8, 2009 n=8, 2010 n=8, 2011 n=5)**



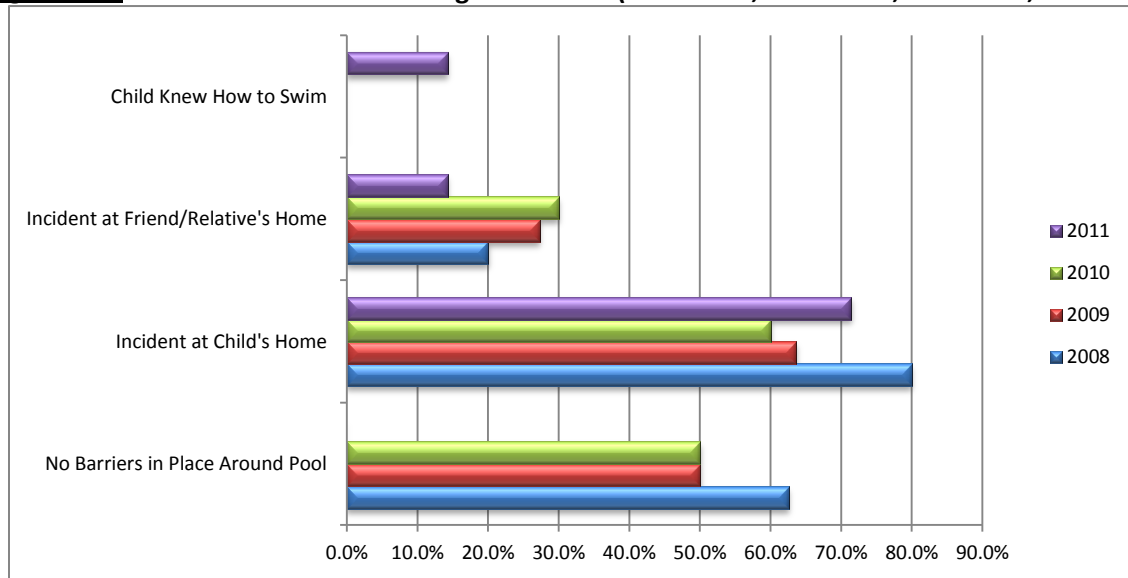
\*This table represents only those cases where the drowning occurred in a pool/spa

	2008	2009	2010	2011
<b>No Barriers Existed</b>	37.5% (3)	50% (4)	50% (4)	0%
<b>Fence</b>	12.5% (1)	12.5% (1)	12.5% (1)	40% (2)
<b>Gate</b>	12.5% (1)	25% (2)	0% (0)	60% (3)
<b>Door</b>	37.5% (3)	12.5% (1)	37.5% (3)	100% (5)

In 2011 one of these pools had an alarm and none of them had covers as barriers to the entrance. Children were able to breach existing barriers to the pools in all of the cases where barriers existed. In all of the cases in which barriers

existed, the barriers were working properly, however they were either left propped open or unlocked, and in one case of an older child, they could open all gates and fences on their own. Two 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 (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7)**



	2008	2009	2010	2011
<b>No Barriers in Place Around Pool*</b>	62.5% (5)	50% (4)	50% (4)	0.0%
<b>Incident at Child's Home</b>	80.0% (8)	63.6% (7)	60% (6)	71.4% (5)
<b>Incident at Friend/Relative's Home</b>	20.0% (2)	27.3% (3)	30% (3)	14.3% (1)
<b>Child Knew How to Swim</b>	0.0%	0.0%	0.0%	14.3% (1)

*\*This percentage is calculated out of the total number of drowning cases that occurred in a pool or spa and categories are NOT mutually exclusive so totals will not add to 100%.*

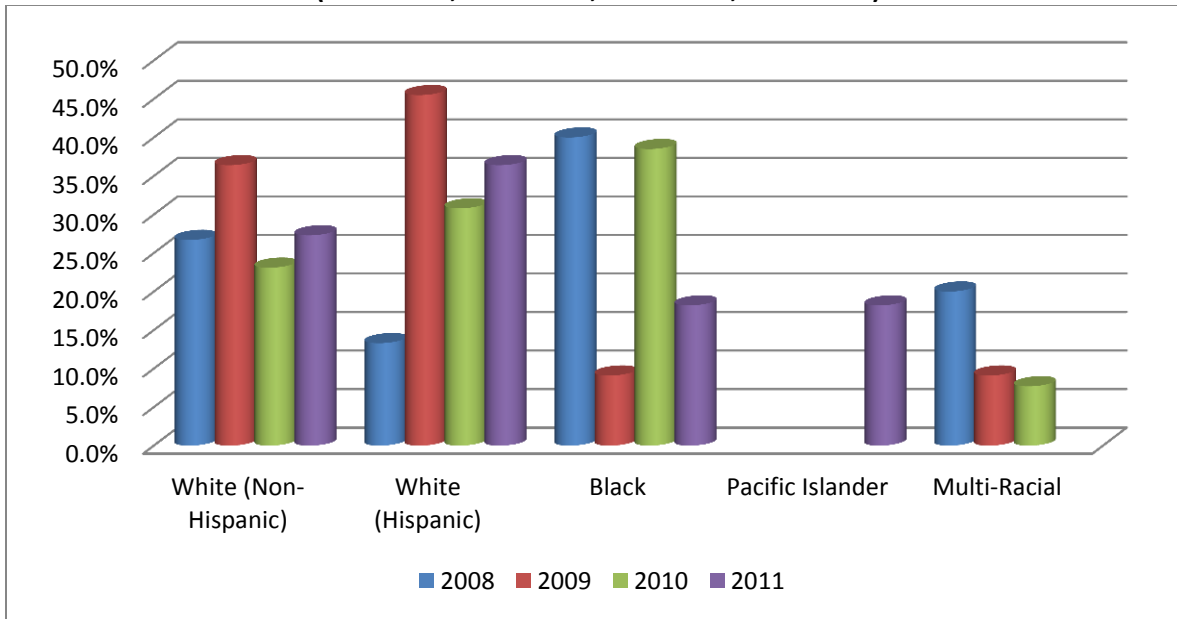
Figure 3.13 above illustrates the trends from 2008 to 2011 in terms of some of the items relative to drowning prevention. Note in interpreting this figure that categories are NOT mutually exclusive, meaning that one case can fall into more than one category. This is the first year when all cases had some barrier to accessing the pool and this is also the lowest number of drowning incidents in the four year period displayed. In addition, over the four year period, most of the pool drowning incidents occurred at the child's home, providing support for the prevention recommendations that promote pool safety for families with pools or spas at their homes.



# SUFFOCATION

In 2011, there were 11 accidental suffocations in Clark County, which is fairly consistent with the past three years. All but one of the cases involved infants less than one year old. Nearly half of the decedents (45.5%) were female, and 54.5% were male. More than one third (36.4%) of decedents were White Hispanic, and 27.4% were White Non-Hispanic. As seen in Figure 3.13 below, the number of accidental suffocation deaths for Black children decreased from 38.5% in 2010 to 18.2% in 2011..

**Figure 3.13: Percentage of Accidental Suffocations by Race/Ethnicity**  
(2008 n=15, 2009 n=11, 2010 n=13, 2011 n=11)



	2008	2009	2010	2011
<b>White (Non-Hispanic)</b>	26.7% (4)	36.4%(4)	23.1% (3)	27.3% (3)
<b>White (Hispanic)</b>	13.3% (2)	45.5%(5)	30.8% (4)	36.4% (4)
<b>Black</b>	40.0% (6)	9.1% (1)	38.5% (5)	18.2% (2)
<b>Pacific Islander</b>	0%	0%	0%	18.2% (2)
<b>Multi-Racial</b>	20% (3)	9.1% (1)	7.7% (1)	0%

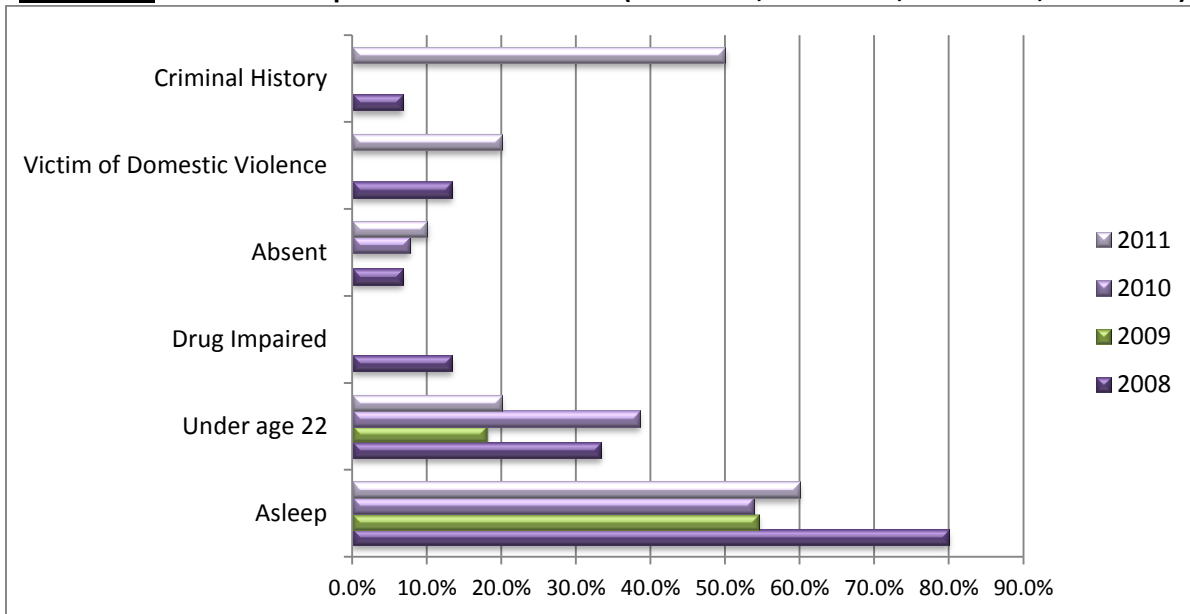
None of the decedents of accidental suffocation in 2011 suffered from a disability or had a chronic illness. However, four were acutely ill in the two weeks preceding their death. In all cases, the primary caregiver at the time of the incident was a parent. In all cases the mother had experienced no prior child deaths. Mothers' ages ranged between 21 and 43 years, with the average age being 28 years. Fathers ranged in age from 22 to 45 years and the average age was 29 years. In 3 of these cases one of the child's parents had a known history of substance abuse.

In two cases involving infants, the infant was born prematurely and in 50% of cases involving infants, the mother was known to have received prenatal care. In one of the cases involving an infant the decedent's mother had a history of using illicit drugs during her pregnancy, in two cases the decedent's mother used tobacco during her pregnancy, and in another case the mother reported medical complications during her pregnancy.

The majority (81.8%) of children had supervision at the time of their deaths, and all but one of those children was being supervised by their biological parent (the other was being supervised by a babysitter). In nearly three fourths of cases in

which the child had supervision (70%), the child was in the sight of the supervisor, and in two of the cases it had been hours since the supervisor had seen the child. The minimum number of hours listed since the supervisor had seen the child was one, and the maximum was 3. In more than half of cases where a child needed supervision, (60%), the supervisor was asleep at the time.

**Figure 3.14: 2008-2010 Supervisor Circumstances (2008 n=15, 2009 n=11, 2010 n=13, 2011 n=10)**



NOTE: Data in this table is only for those cases where the child needed supervision at the time of the incident

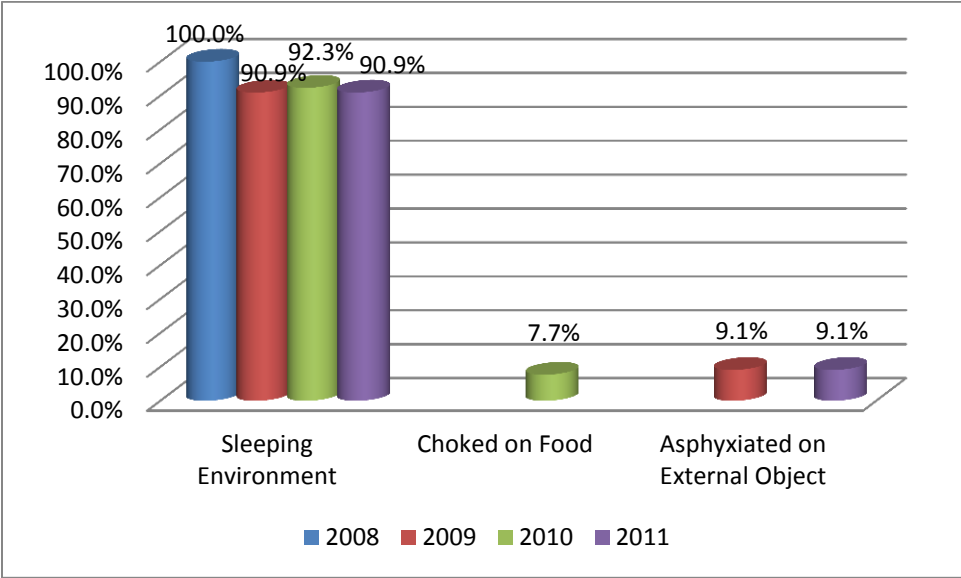
Supervisor Circumstances	2008	2009	2010	2011
<b>Asleep</b>	80.0% (12)	54.5 (6)	53.8% (7)	60% (6)
<b>Under age 22</b>	33.3% (5)	18.2% (2)	38.5% (5)	20% (2)
<b>Drug Impaired</b>	13.3% (2)	--	0% (0)	0% (0)
<b>Absent</b>	6.7% (1)	0% (0)	7.7% (1)	10% (1)
<b>Victim of Domestic Violence</b>	13.3% (2)	0% (0)	0% (0)	20% (2)
<b>Criminal History</b>	6.7% (1)	0% (0)	0% (0)	50% (5)

Nearly all incidents of accidental suffocation (90.9%) occurred in the child’s home, and the remaining death occurred at a friend’s home. 911 was called in all cases. CPS action was taken as a result of the death in 45.5% of cases; however, there was no pending prosecution at time of the case reviews.

Nearly one third (27.3%, n=3) of families experiencing an accidental suffocation had a prior child welfare history, which includes any history on the parent as a child victim. In two of the three cases, there was some CPS history regarding a sibling. In the remaining case the history was on the decedent’s parent as a child victim. None of the cases had an open child welfare case at the time of death.

The majority of accidental suffocation deaths involved children less than one year of age (n=10). All of the decedents under one year were in a sleeping environment at the time of their death. The remaining case was a child between 15 and 17 years of age and was not in a sleeping environment at the time of death.

**Figure 3.15: 2008-2011 Type of Accidental Suffocation (2008 n=15, 2009 n=11, 2010 n=13, 2011 n=11)**



Of those decedents who died in a sleeping environment, in nine of the cases the infant was sleeping on an adult mattress, couch, or the floor, while in the remaining case the child was sleeping in a car seat. In four of these cases where the child died in a sleeping environment this was a new sleep location for the child. In six of these cases, the infant was sleeping with a parent, other adult or another child. Thirty percent of all decedents were placed to sleep on either their stomach (20%) or sides (10%). One of the infants was found on their back (10%) and 70% (n=7) were found on their stomachs or sides and in the two remaining cases, decedents were found underneath another person. In 7 cases the child was suffocated by bedding (blankets, pillows, etc.), in two cases the child was suffocated due to overlay of another person and in the remaining case the child was found face down in the crib but there was no bedding over the head or face.

# 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.” More than three quarters (75.7%) of all accidental deaths of children in Clark County in 2011 were due to motor vehicle accidents, suffocation/strangulation, and drowning. By their nature, all accidental deaths are preventable and thus provide ample data to make recommendations aimed at preventing future child deaths.

**1. FOCUS ON CHANGING REGULATIONS TO BRING OLDER POOLS UP TO CURRENT STANDARDS FOR BARRIERS TO ACCESSING THE POOL INCLUDING, FENCES, GATES, ALARMS, ETC.**

Nearly all (71.4%) of drowning victims in 2011 were between the ages of one and four. Also 71.4% of drowning fatalities occurred in a pool or spa. In 2011 the majority of pool drowning incidents took place in older areas of Las Vegas, Henderson, North Las Vegas, and Boulder City which may account for the lack of appropriate barrier devices which are mandated by the County for newer pools. In addition, in 2011 6 of the 7 drowning fatalities involved Hispanic children. Prevention messaging should be designed to ensure that the information reaches the Hispanic community.

**2. IMPROVE/EXPAND CULTURALLY SENSITIVE OUTREACH AND EDUCATION EFFORTS REGARDING SAFE SLEEP ENVIRONMENTS FOR INFANTS.**

In 2011 nearly all cases of accidental suffocation were children less than one year of age (n=10 of 11) (one case was an older child involved in a choking incident) and all cases involving children less than one year occurred while the child was in a sleeping environment. A 2009 study in *Pediatrics* found that infant mortality rates attributable to accidental suffocation in bed have quadrupled since 1984 (Shapiro-Medoza, 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. In addition in 2011 more than three quarters of these cases involved a racial/ethnic minority (36.4% Hispanic, 18.2% Black, and 18.2% Pacific Islander), pointing to the need for more culturally specific outreach and education.

**3. SUPPORT INITIATIVES RELATED TO PREVENTING SUBSTANCE ABUSE IN CHILDREN AND YOUTH, ESPECIALLY THOSE RELATED TO LIMITING ACCESS TO PRESCRIPTION DRUGS.**

This year accidental overdose was the third leading cause of accidental death among children and youth in Clark County representing 21.6% (n=8) of all accidental deaths. There were more deaths due to accidental overdose than drowning in 2011. The majority of these cases were males (87.5%) between the ages of 15 and 17 years old (62.5%). In five of the eight cases the youth overdosed on prescription drugs, and in all five of those cases the drug was an opiate.

Prevention initiatives should focus on limiting access to prescription drugs in youth and help to educate youth and parents about the dangers of recreational prescription drug use.



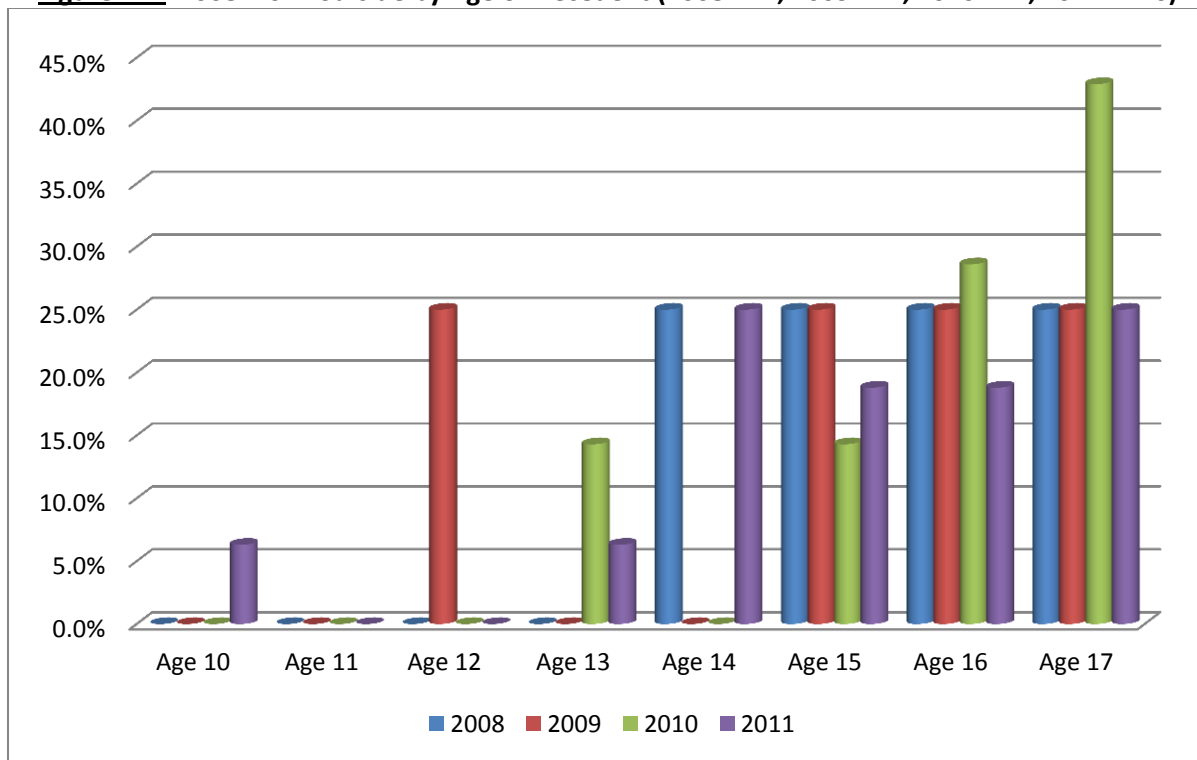
## SECTION IV: SUICIDE DEATHS

Suicide is defined as the willful termination of one’s own life. According to the Centers for Disease Control and Prevention’s fact sheet updated in 2012, suicide is the third leading cause of death among young people ages 15-24, just behind unintentional injury and homicide. In 2011 we saw a dramatic increase in the total number of youth suicides from 7 in 2010 to 16 in 2011. This is four times the number of suicide deaths in 2008 and 2009. This year the death rate for youth suicide in Clark County was calculated at 3.27 per 100,000, compared to the national youth suicide rate of 1.3 per 100,000. The percentages for sex, race and ethnicity for all 2008-2011 suicide cases are listed in the figures below. For 2011, eleven of the suicide cases were due to fatal firearm injuries, four were due to hanging, and one was due to prescription drug overdose. Only one of these cases had a family history of prior child welfare involvement.

*In 2011, the suicide rate for children under 18 in Clark County jumped to 3.27 per 100,000 compared to 1.3 per 100,000 nationally.*

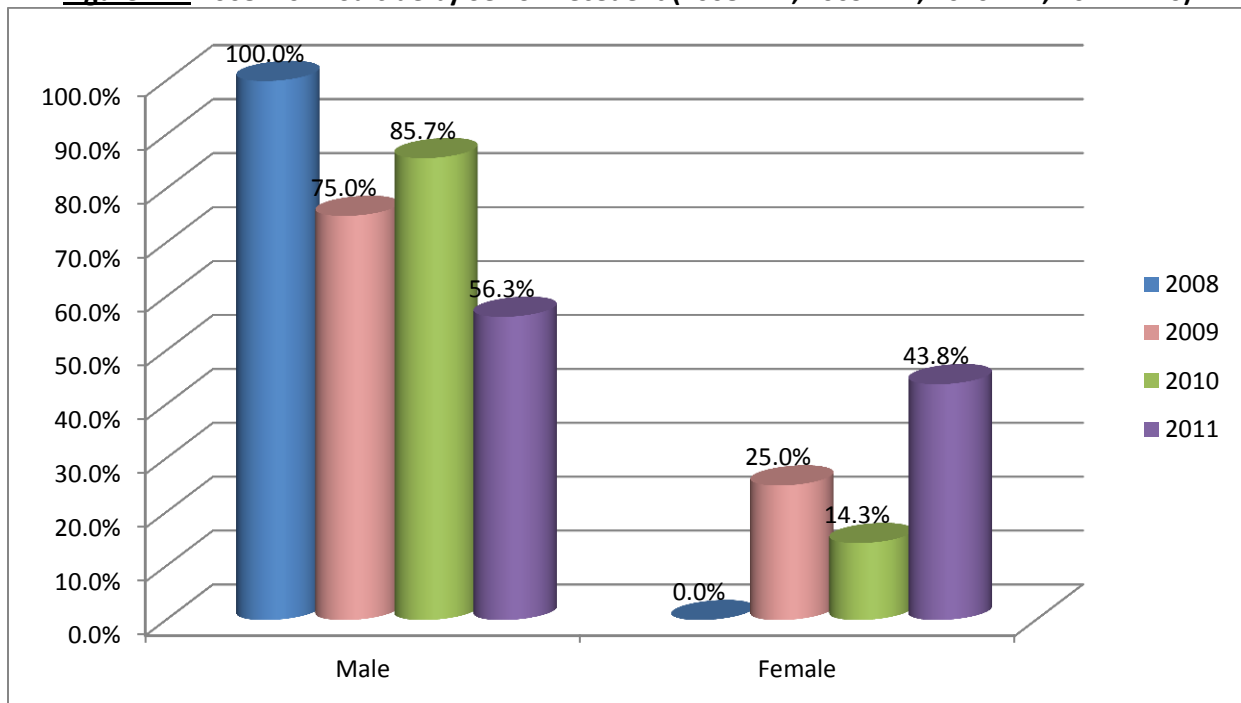
In 2011 the ages of youth who died from suicide ranged from 10 to 17 years, with the majority of cases being youth between 14 or 17 years old. The distribution of age among suicide deaths in 2011 is similar to that seen in previous years, however this is the first time the team has reviewed the suicide of a child as young as 10 years old. This is illustrated in Figure 4.1 below.

**Figure 4.1: 2008–2011 Suicide by Age of Decedent (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



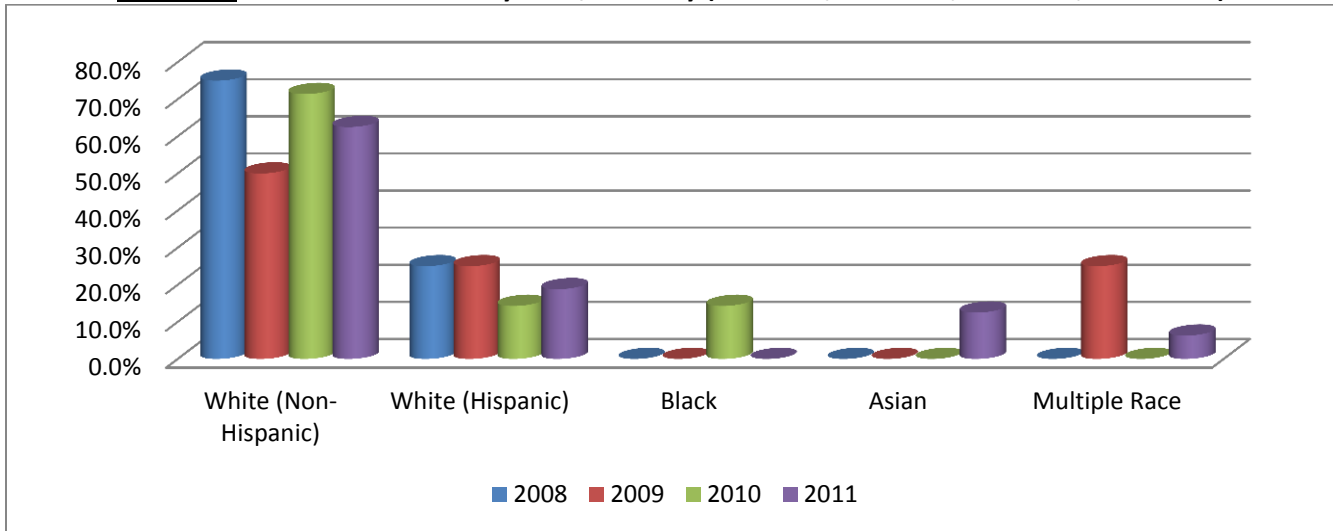
According to the National Center on Child Death Review, White males make up the greatest percentage of suicides among youth ages 15-24 years. In 2011 in Clark County, only slightly more than half of suicide victims were males (56.3%) between the ages of 10 and 17, and 62.5% of these were White Non-Hispanic. None of the youth who died from suicide in Clark County had a history with juvenile justice services and only one 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>. In 2011 the distribution between male and female suicide decedents is nearly equal, creating the highest proportion of female suicide deaths since the team started reporting data in 2006. This change in distribution by sex may be a result of the overall increase in suicides among youth in Clark County.

**Figure 4.2: 2008–2011 Suicide by Sex of Decedent (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



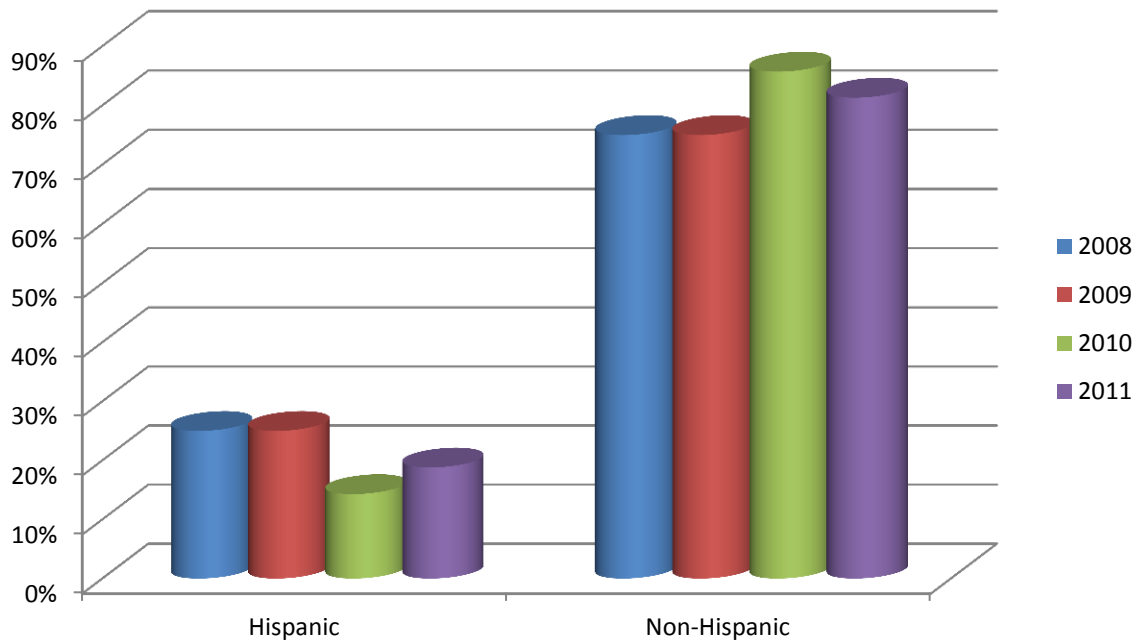
<sup>1</sup> Centers for Disease Control and Prevention (2004). Suicide Fact Sheet.

**Figure 4.3: 2008–2011 Suicide by Race/Ethnicity (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



Over the past four years there has been a decline in the number of Hispanic youth who complete suicide, in Clark County. Conversely, there has been an increase in Non-Hispanic youth completing suicide from 2008 to 2011 regardless of race (Figure 4.4). This is more in line with national statistics indicating that Non-Hispanic youth have the highest incidence of suicide completions.

**Figure 4.4: 2008–2011 Suicide by Ethnicity (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**

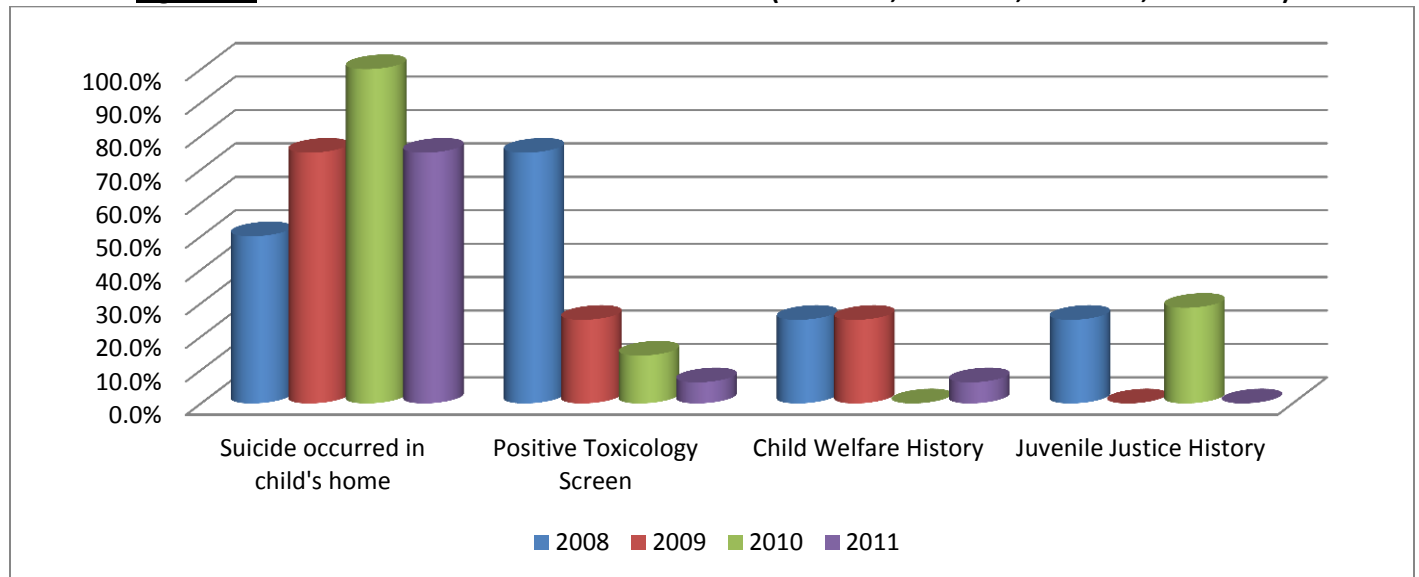


## SITUATIONAL FACTORS OF SUICIDE

In order to understand youth suicide in our community, the Child Death Review Team attempts to gather information about the child's background and involvement with other agencies. This information can help to guide recommendations for prevention and targeted outreach and education. These situational factors are presented in the section below.

In two of the suicide cases in 2011 the child had a history of substance abuse and none of the youth were involved in the juvenile justice system. Nearly one fifth (18.8%) of all suicide victims had been diagnosed with a mental illness, and in four cases (25%) a prior suicide attempt had been made. In 81.3% of all cases, the suicide occurred in the child's home. Other locations included a park, a friend's home, and a mental health facility. 911 was called in all cases. In all cases the child was attending school regularly at the time of death. However, in three cases the child was experiencing school failure (as evidenced by their school records) and in six cases a suicide note was left by the decedent.

**Figure 4.5: 2008–2011 Situational Factors of Suicide (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



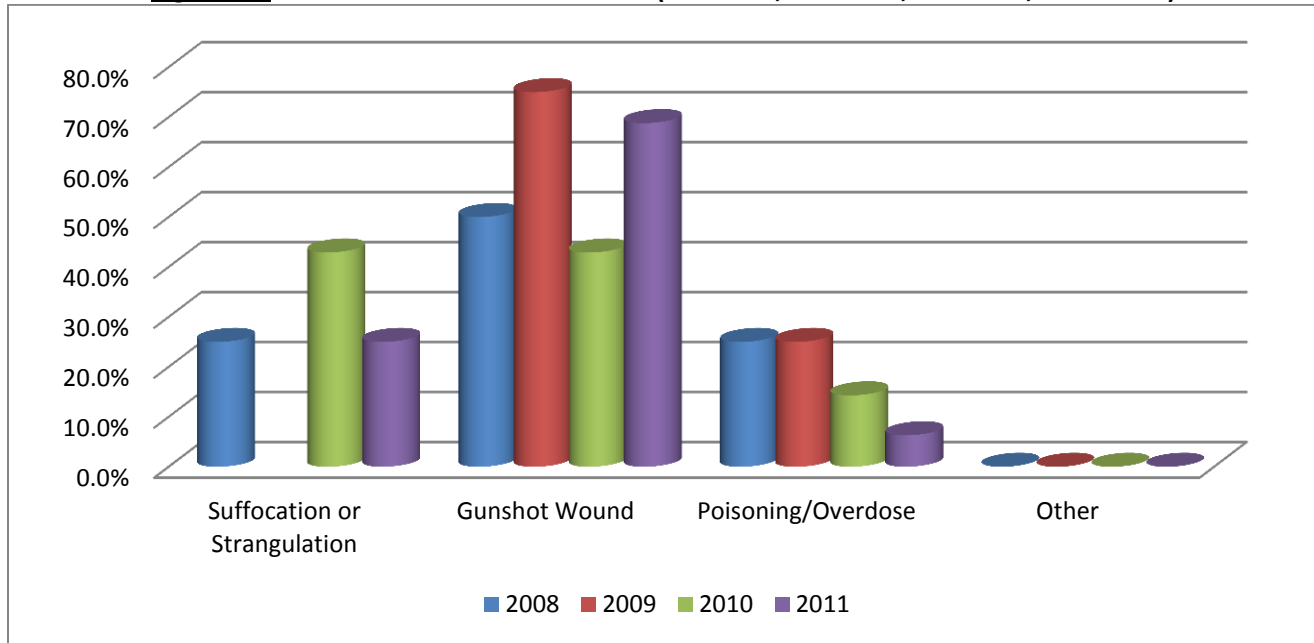
	2008	2009	2010	2011
<b>Suicide Occurred in Child's Home</b>	50.0% (2)	75% (3)	100% (7)	75% (12)
<b>Positive Toxicology Screen</b>	75.0%(3)	25% (1)	14.3% (1)	6.3% (1)
<b>Child Welfare History</b>	25.0%(1)	25% (1)	0% (0)	6.3% (1)
<b>Juvenile Justice History</b>	25.0%(1)	0% (0)	28.6% (2)	0% (0)

In 2011 a toxicology screen was conducted in only one of the suicide cases (an overdose), and an autopsy was conducted in eight cases. Sexual orientation was known in 15 of the cases and unknown in only one case. For those cases where sexual orientation was known, the majority were heterosexual, one was homosexual, and one was questioning.

## METHOD OF SUICIDE

A 2012 fact sheet authored by the National Center for the Prevention of Youth Suicide indicates that in 2009 45% of youth suicides are completed using a firearm, followed by suffocation at 40%<sup>2</sup>. This pattern is replicated in Clark County for 2008 through 2011. For Clark County teens in 2011, nearly 70% (n=11) used firearms as their method of suicide.

**Figure 4.6: 2008–2011 Method of Suicide (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



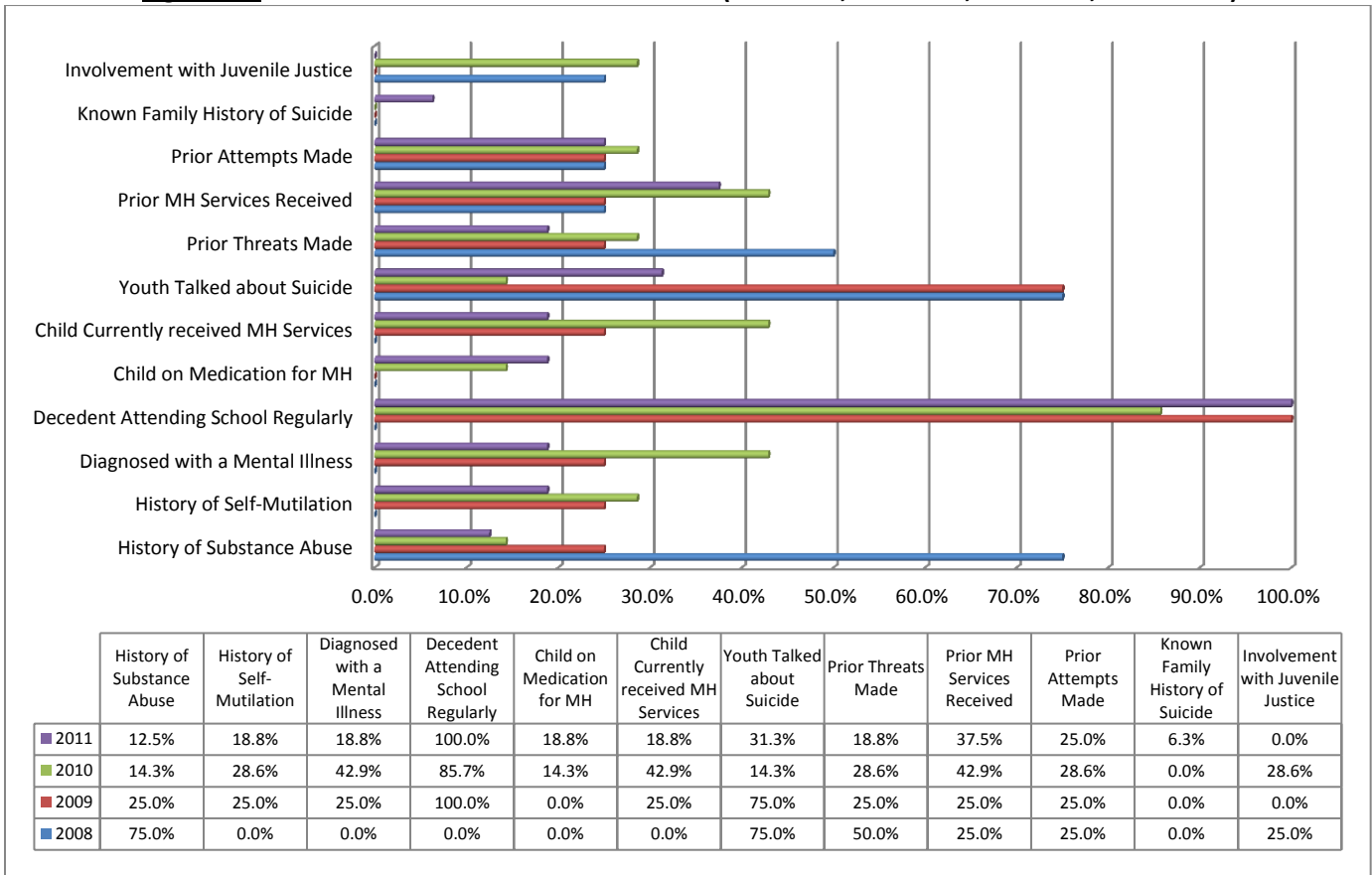
In eleven of the sixteen cases of suicide completion in 2011, the youth used a firearm, in four cases the method was hanging and the remaining case was an overdose of prescription medication. In nine of the eleven firearm suicides a handgun was used, a shot gun was used in the other two cases. In only one of these cases the firearm was stored in a locked cabinet, but the youth knew where the keys were stored. In 10 of the eleven firearm suicides the firearm was owned by a family member of the decedent, in the remaining case the firearm was owned by a friend of the decedent. Among all suicide deaths in 2011, four of the youth had made prior suicide attempts, and in six cases a note was left.

<sup>2</sup> [http://dhhs.nv.gov/Suicide/DOCS/StatisticsResearch/AAS\\_YouthFactSheet\\_2009.pdf](http://dhhs.nv.gov/Suicide/DOCS/StatisticsResearch/AAS_YouthFactSheet_2009.pdf)

# CIRCUMSTANCES OF SUICIDE

There are several factors that have been identified as risk factors for suicide. The circumstances that were present in the 16 cases reviewed in 2011 are listed in Figure 4.7 below.

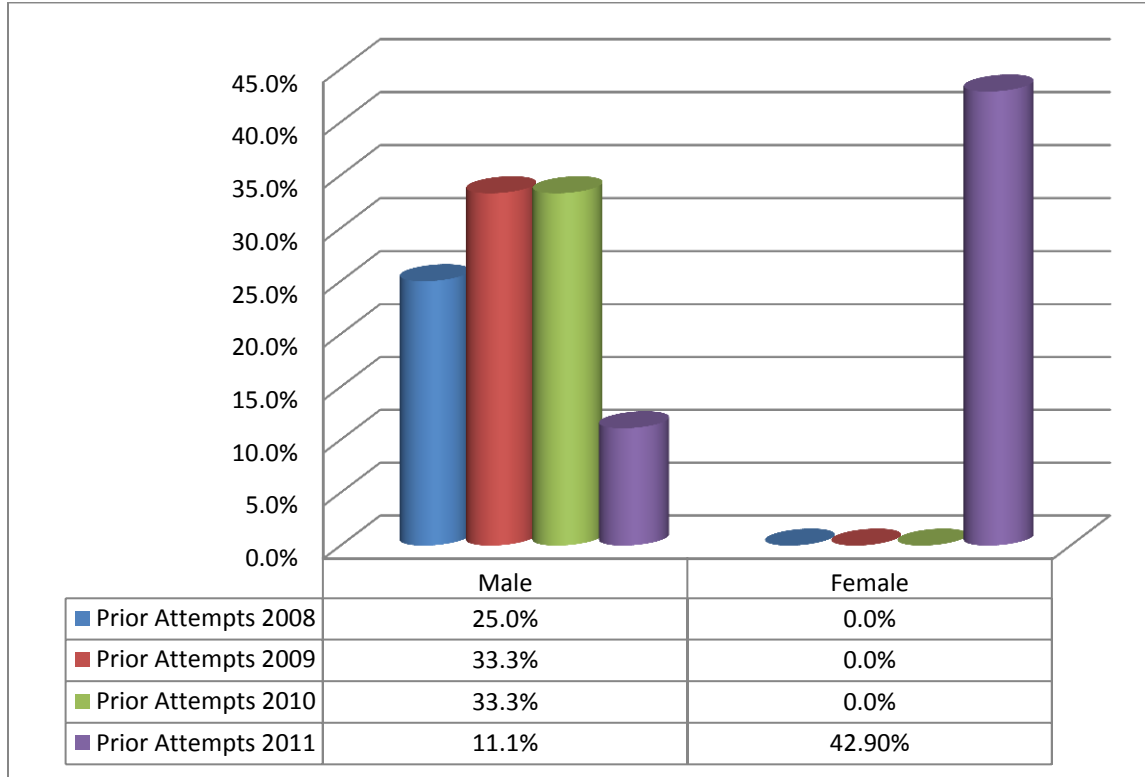
**Figure 4.7: 2008-2011 Circumstances of Suicide (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



In the 2011 cases, all youth were attending school regularly, and more than one third (37.5%) had previously received mental health services. In addition, in 25% of cases the youth had made a prior attempt and 18.8% of decedents had made prior threats of suicide.

According to the literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide<sup>3</sup>. In 2011, one quarter (25%) of decedents had made a known prior suicide attempt. National literature clearly shows that adolescent males of all races are four times more likely to complete suicide than females, but adolescent females are twice as likely as adolescent males to attempt suicide. Among suicide fatalities in Clark County in 2011, 42.9% of female decedents had made a prior attempt while in the previous three years only male decedents had a history of prior attempts (Figure 4.8).

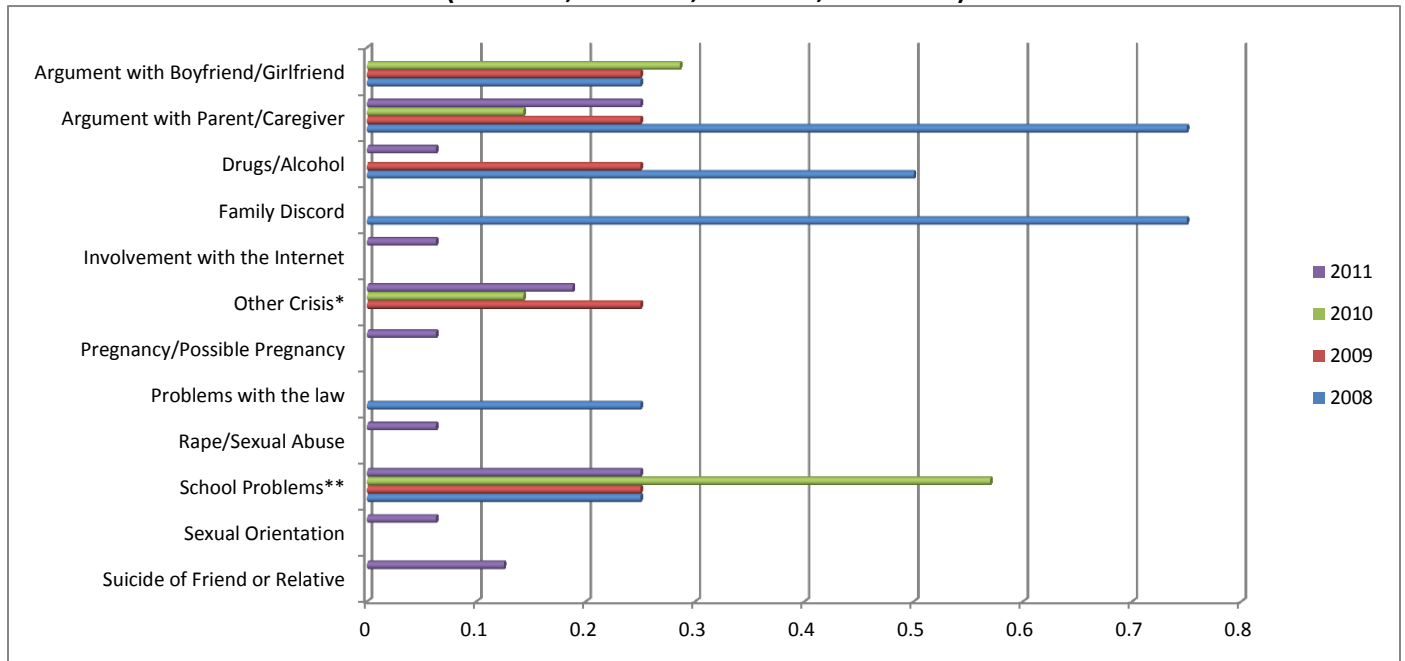
**Figure 4.8: 2008–2011 Prior Attempts Made by Sex (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)**



<sup>3</sup> www.KidsHealth.org, Retrieved August 25, 2012

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. Four of the victims had recently had a fight with their parent and four were experiencing school problems (See Figure 4.9).

**Figure 4.9: 2008–2011 History of Acute or Cumulative Crisis**  
(2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16)



\* Other Crisis includes alleged sexual abuse, and anger management issues

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

	2008	2009	2010	2011
<b>Argument with Boyfriend/Girlfriend</b>	25% (1)	25% (1)	28.6% (2)	0.0%
<b>Argument with Parent/Caregiver</b>	75.0%(3)	25% (1)	14.3% (1)	25% (4)
<b>Family Discord</b>	75.0% (3)	0.0%	0.0%	0.0%
<b>School Problems**</b>	25.0% (1)	25% (1)	57.1% (4)	25% (4)
<b>Involvement with the Internet</b>	0.0%	0.0%	0.0%	6.3% (1)
<b>Argument with Boyfriend/Girlfriend</b>	25.0% (1)	0.0%	28.6% (2)	12.5% (2)
<b>Drugs/Alcohol</b>	50.0% (2)	25% (1)	0.0%	6.3% (1)
<b>Other Crisis*</b>	0.0%	25% (1)	0.0%	18.8% (3)
<b>Suicide of Friend or Relative</b>	0.0%	0.0%	0.0%	12.5% (2)
<b>Rape/Sexual Abuse</b>	0.0%	0.0%	0.0%	6.3% (1)
<b>Pregnancy/Possible Pregnancy</b>	0.0%	0.0%	0.0%	6.3% (1)
<b>Problems with the law</b>	25.0% (1)	0.0%	0.0%	0.0%
<b>Sexual Orientation</b>	0.0%	0.0%	0.0%	6.3% (1)



# SUICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

2011 saw an alarming number of youth suicides in Clark County, in fact the total number of youth suicides in 2011 was more than twice the total number for 2008, 2009 and 2010 combined. 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 elementary school through high school. However, there are particular areas in which targeted efforts may be needed.

**1. EXPAND SUICIDE PREVENTION EFFORTS IN ELEMENTARY SCHOOLS TO AND CONTINUE EDUCATION TO TEACHER, PARENTS AND OTHERS ABOUT SUICIDE PREVENTION.**

In 2011 there were 16 youth suicide deaths. All deaths were among youth ages 10 to 17 years of age indicating that middle and high schools are still the most appropriate place to target prevention interventions. However, 2011 there was one case of a suicide death of a child as young as 10 years old, therefore we may want to increase efforts in elementary schools as well. It is essential that mental health screenings occur in children that are school aged, and that teachers and other non-family members are educated about the signs and risk factors for suicide. Like most educational efforts if the information is provided early and consistently it may have a greater impact.

**2. EXPAND EXISTING FIREARM SAFETY CAMPAIGNS TO INCLUDE SPECIFIC MESSAGES ABOUT PREVENTING MEANS FOR SUICIDE, ESPECIALLY IF CHILDREN HAVE A HISTORY OF MENTAL HEALTH ISSUES, OR PRIOR ATTEMPTS.**

In 2011 70% of all suicide victims used firearms. This is one of the means of suicide that should be most difficult for children and youth to get a hold of. Families that choose to have firearms in their homes must be especially careful about ensuring that they are store in a locked secured location where children and youth do not have access, especially if that child has a history of mental health issues or substance abuse.

**3. EXPAND AND PROMOTE GATEKEEPER TRAINING FOR ANYONE WORKING WITH YOUTH TO RECOGNIZE SIGNS OF SUICIDE AS WELL AS TECHNIQUES FOR HOW TO INTERVENE IF SUICIDAL IDEATION IS SUSPECTED.**

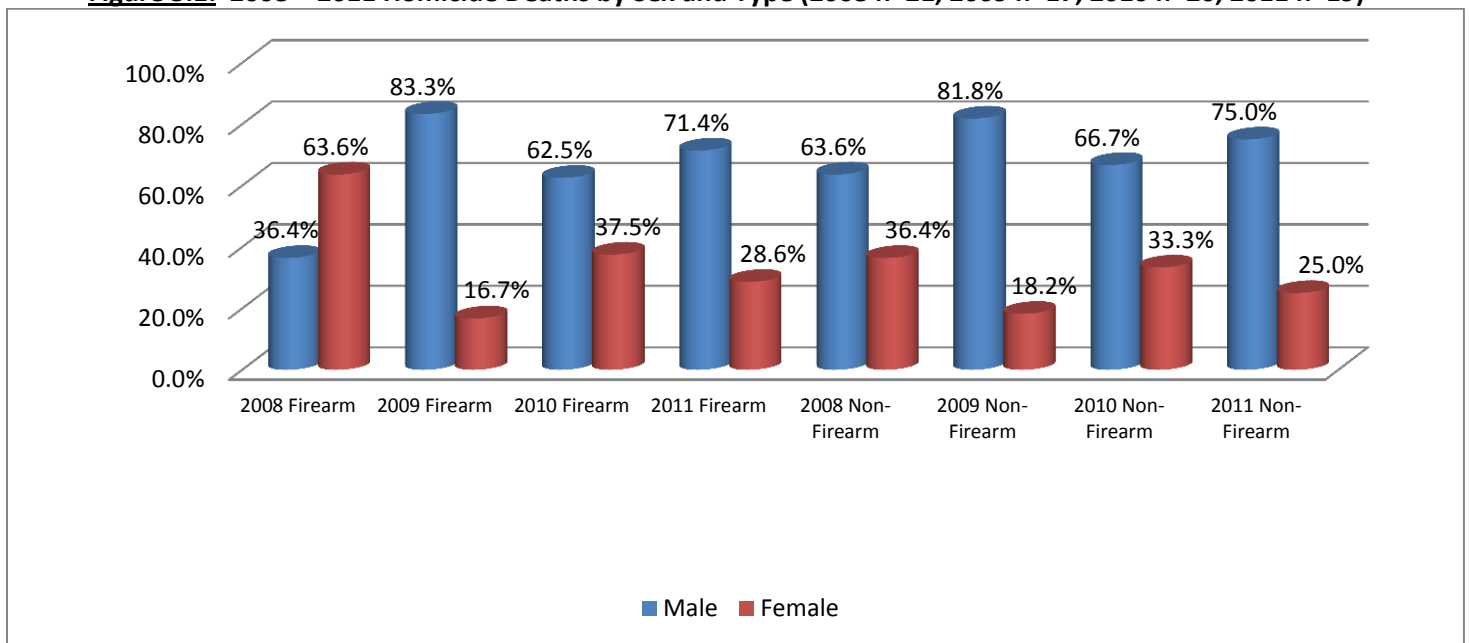
In 37.3% of youth suicides in 2011 the child had previously received mental health services and in 31.3% of cases the youth had talked about suicide and in 25% youth had made prior suicide attempts. Verbalizing suicidal ideation should always be taken seriously. However many parents, teachers, friends, 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. In 2008, the Centers for Disease Control and Prevention lists youth homicide as the second leading cause of death for the 10-24 age group<sup>4</sup>, and states that “among 10-24 year olds, 86% of homicide victims were male, and 82% were killed with a firearm.”<sup>5</sup> Furthermore, “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>6</sup>

In 2011, there were 19 homicides of children and youth in Clark County, which is fairly consistent with the previous three years. The 2011 homicides fell into two categories – those that were committed using a firearm (36.8%) and those that were committed without a firearm (63.2%). Overall, victims were about three times as likely to be male (73.7%) than female (26.3%, See Figure 5.1). This year we saw a large proportion of homicide victims less than four years of age (52.6%), which is similar to 2009 and 2010.

**Figure 5.1: 2008 – 2011 Homicide Deaths by Sex and Type (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19)**



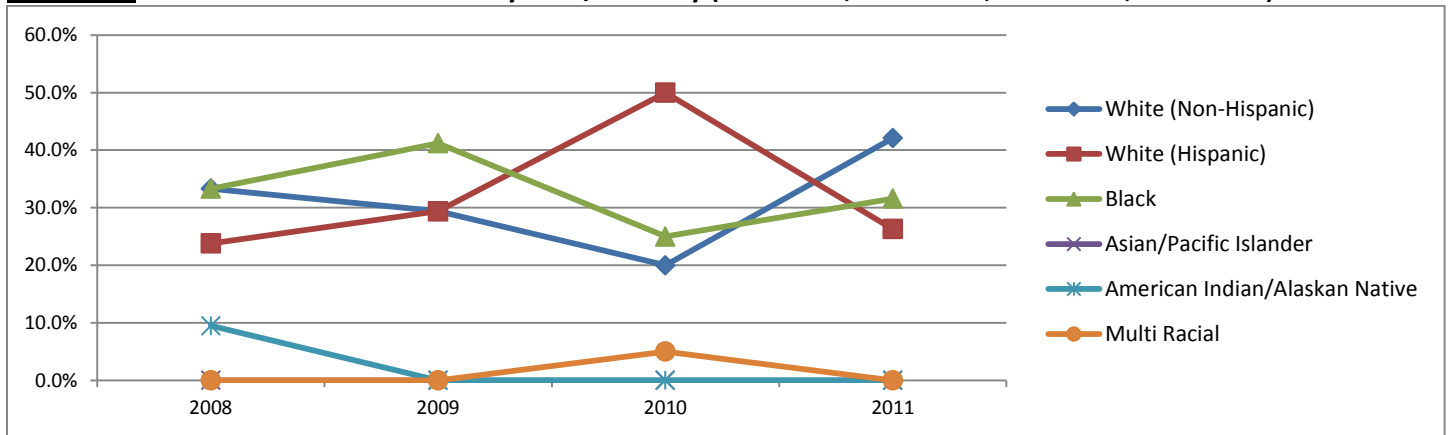
<sup>4</sup> <http://www.cdc.gov/ncipc/pub-res/YVFactSheet.pdf>

<sup>5</sup> [http://www.cdc.gov/ncipc/dvp/YV\\_DataSheet.pdf](http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf)

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

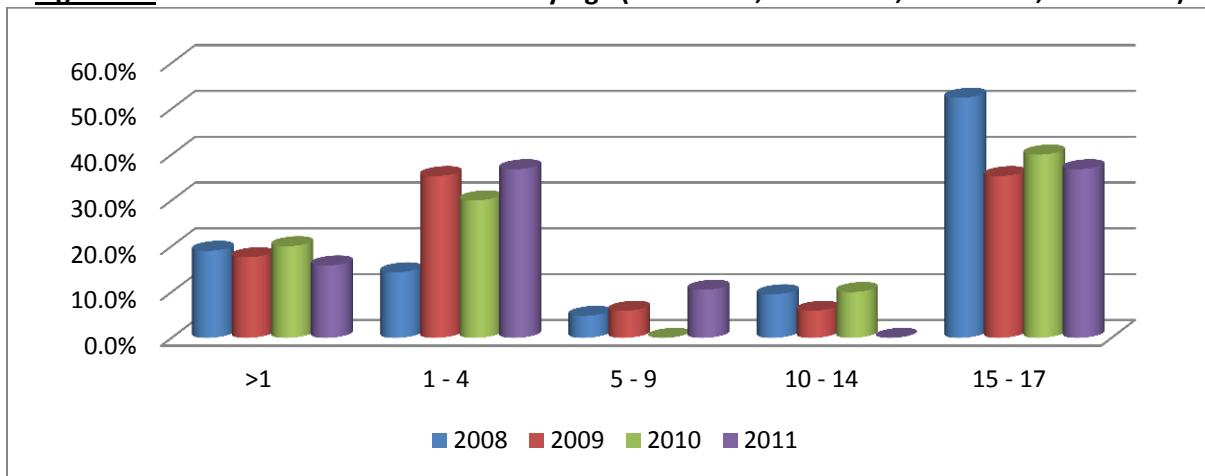
Nearly half (42.1%) of all child homicides in Clark County in 2011 were White Non-Hispanic children. Black children (31.6%) were the second most frequent racial/ethnic group in this manner of death. The remaining 26.3% of cases (n=5) were White Hispanic children.. These data indicate that Black and Hispanic teens are disproportionately victimized by homicide. (Figure 5.2).

**Figure 5.2: 2008-2011 Homicide Deaths by Race/Ethnicity (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19)**



It is also interesting to note the bimodality of the age distribution in 2008 through 2011. The oldest group (ages 15-17) and the youngest group (infants <1 year, and children ages 1 to 4 years) demonstrated the highest percentages of victims in all four years.

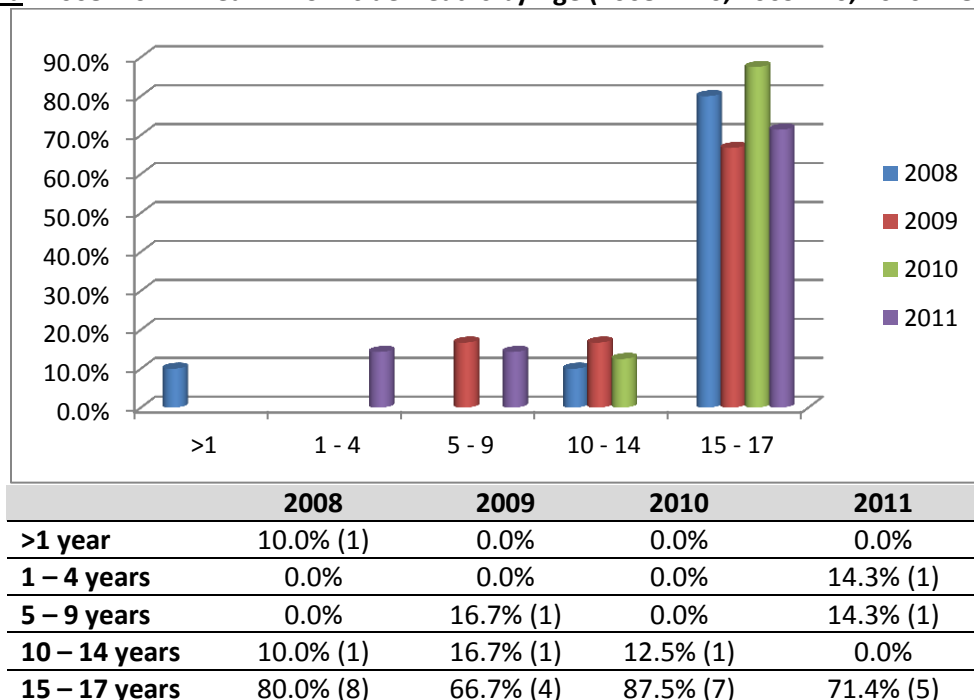
**Figure 5.3: 2008–2011 Homicide Deaths by Age (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19)**



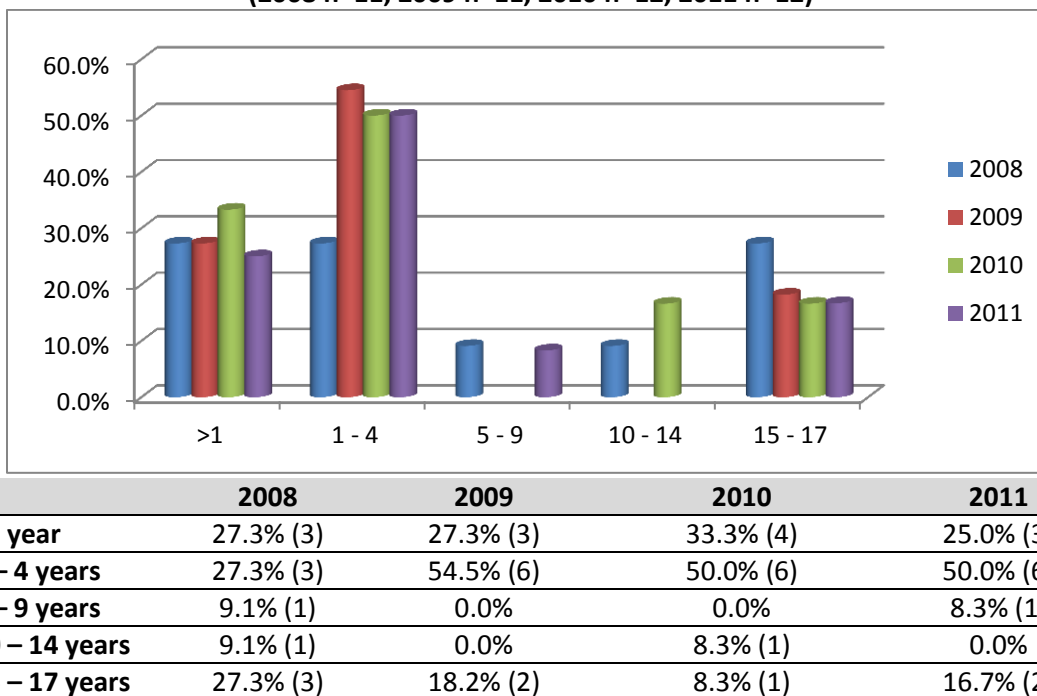
	2008	2009	2010	2011
<b>Less than 1 year</b>	19.0% (4)	17.6% (3)	20.0% (4)	15.8% (3)
<b>1 – 4 years</b>	14.3% (3)	35.3% (6)	30.0% (6)	36.8% (7)
<b>5 – 9 years</b>	4.8% (1)	5.9% (1)	0%	10.5% (2)
<b>10 – 14 years</b>	9.5% (2)	5.9% (1)	10.0 (2)%	0%
<b>15 – 17 years</b>	52.4% (11)	35.3% (6)	40.0% (8)	36.8% (7)

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 (Figures 5.4a and 5.4b).

**Figure 5.4a: 2008–2011 Firearm Homicide Deaths by Age (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7)**



**Figure 5.4b: 2008–2011 Non-Firearm Homicide Deaths by Age (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12)**



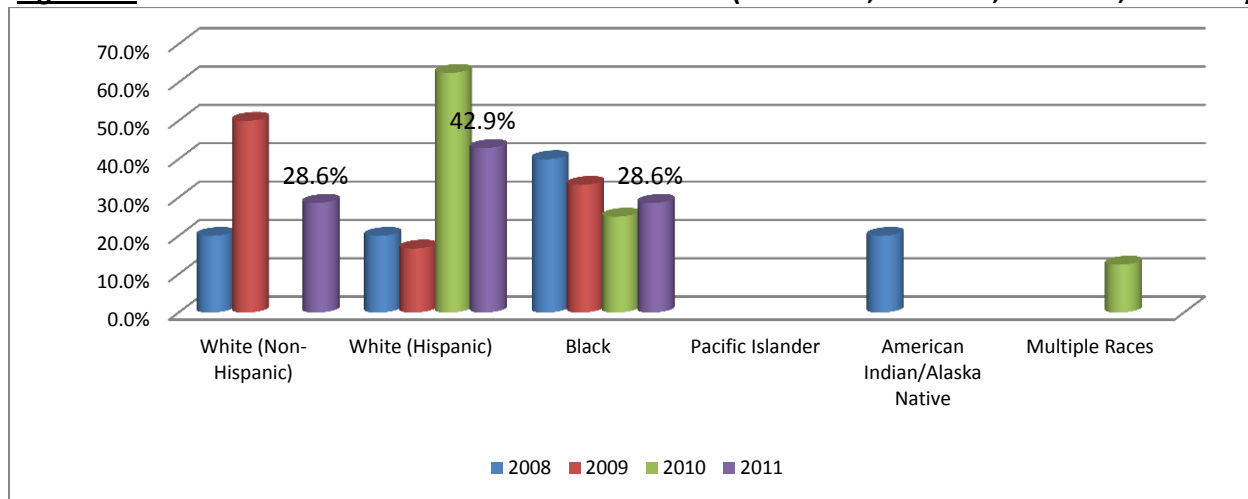
# FIREARM HOMICIDE

Nationally, youth homicides represent the greatest proportion of all firearm deaths<sup>7</sup>. According to the Centers for Disease Control and Prevention in 2010, 84% of homicide victims ages 10 to 24 years of age were killed using a firearm. 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>8</sup> Clark County’s data in 2011 once again exemplifies?? 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 are almost always committed using inexpensive and easily acquired handguns.”<sup>9</sup>

Starting in 2010 there were more non firearm homicides than firearm homicides, where previously these numbers were evenly split. In 2011 firearm homicides represent 36.8% (n=7) while non-firearm homicides represent 63.2% (n=12) of all homicides. This likely explains the higher proportion of younger victims of homicide in 2011 and 2010 as younger children are more likely to be victims of non-firearm homicide (see Figure 5.4b). In 2011 71.4% of firearm homicide victims were male.

In 2011, nearly half of victims were White Hispanic (42.9%) and the remaining victims were either Black (28.6%) or White Non-Hispanic (28.6%). Again this year, the percentage of Black victims of firearm homicide is disproportionate to the population distribution in Southern Nevada and represents a clear area for intervention and prevention.

**Figure 5.5: 2008–2011 Race of Victim in Firearm Homicide (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7)**



Nearly all child victims of firearm homicide (87.5%) were regularly attending school at the time of their death. None of the victims had a chronic illness or disability; however in one case the victim had a known history of substance abuse and had not received any substance abuse treatment. None of the victims tested positive for drugs at the time of their death. In two of these cases, prosecution was pending at the time of the review.

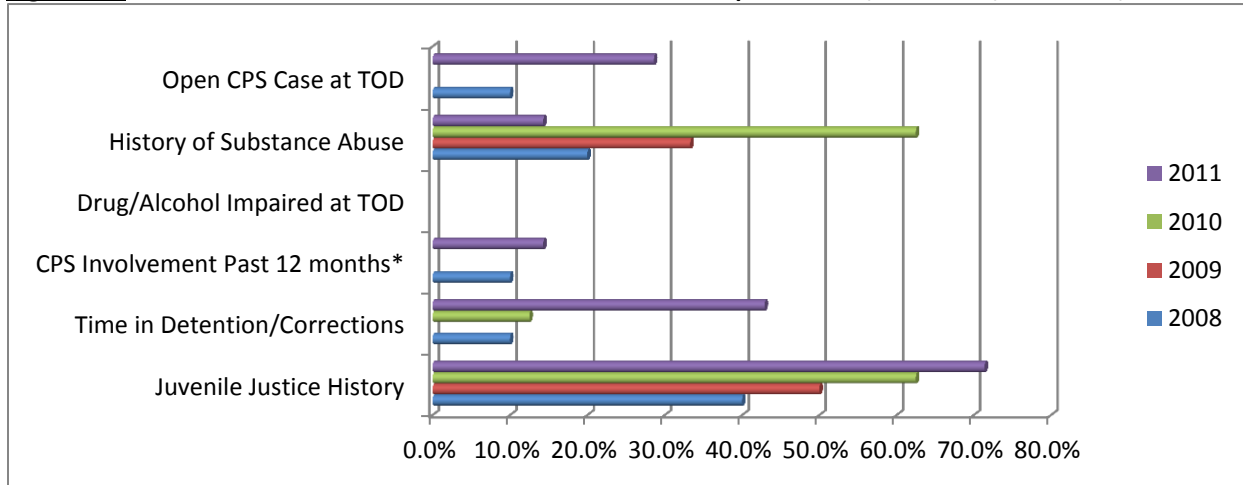
<sup>7</sup> www.childdeathreview.org (2007)

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

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

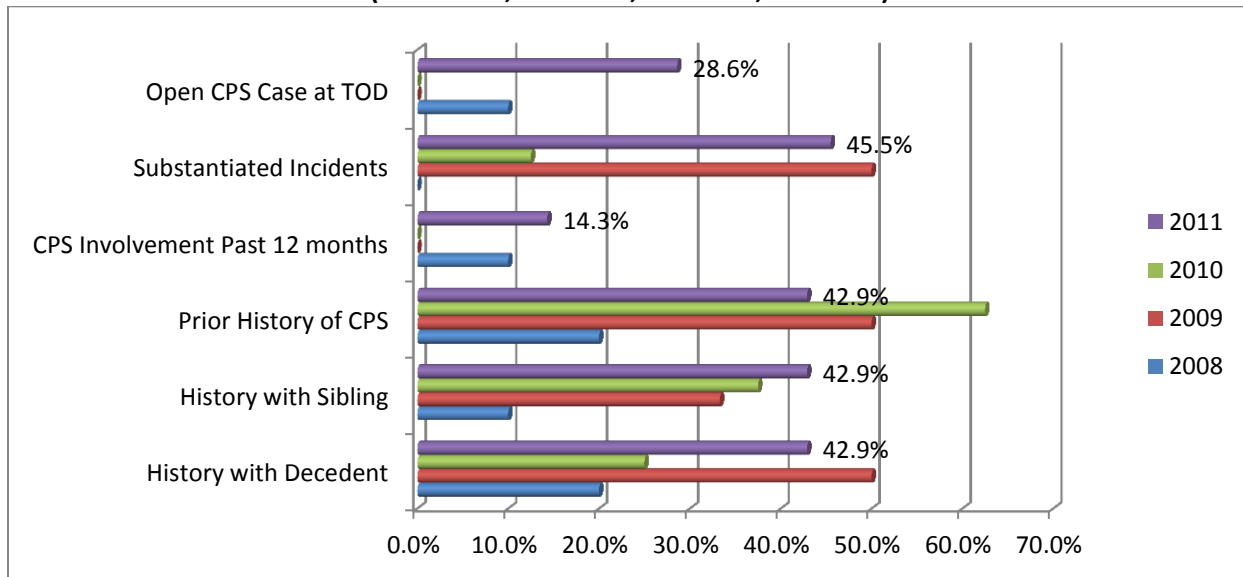
More than half of firearm homicide victims (71.4%) had a known juvenile justice history, demonstrating an increasing trend from 2008 to 2011. In 2011 42.9% of the youth had been incarcerated in a juvenile correctional facility prior to death.

**Figure 5.6: 2008–2011 Characteristics of Firearm Homicides (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7)**

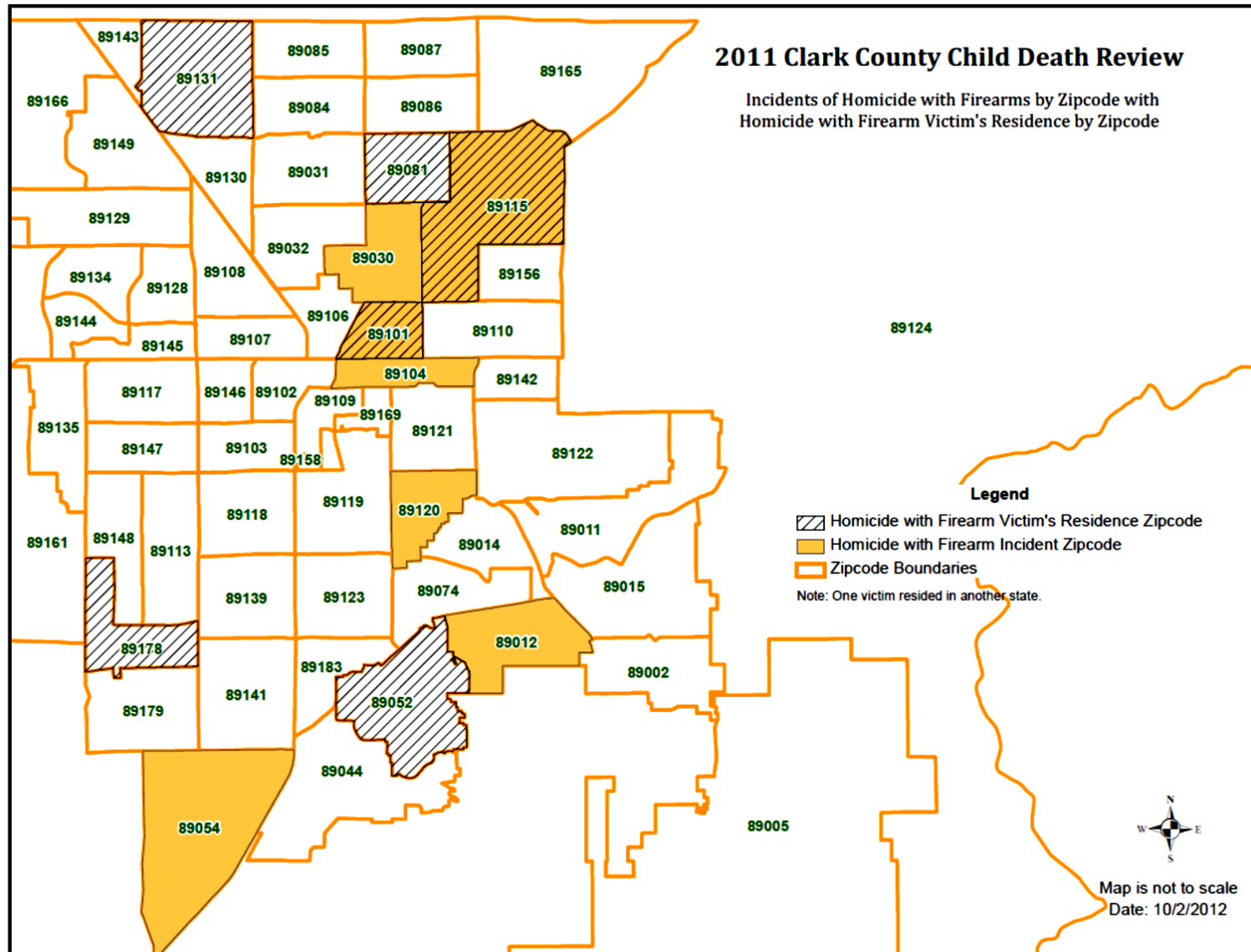


Of the firearm homicide cases in 2011, 42.9% of the families of the decedent had a history with the child welfare system (Figure 5.7). CPS action was taken as a result of the death in four cases. The circumstances surrounding these fatalities varied widely. In one case there was some kind of argument that preceded the homicide, in one case the victim was showing the firearm to a friend, in another case the firearm was mistaken for a toy, and in three cases gang involvement was either known or suspected.

**Figure 5.7: 2008–2011 Child Welfare Involvement for Firearm Homicide Victims (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7)**



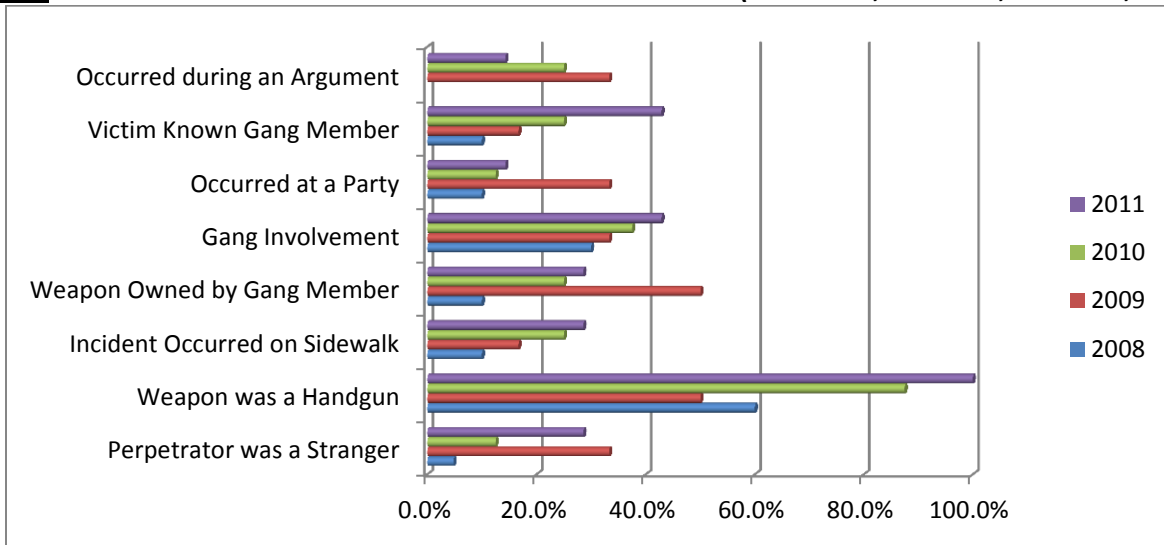
The map below illustrates the incident location as well as the location of the child's residence by zip code. The majority of incidents occurred on the east side of the county and incidents are concentrated in the northeastern zip codes.



In 85.7% of cases (n=6) the incident occurred on a sidewalk, parking lot or other open area. All of the firearm incidents involved a handgun. In the majority of cases, the firearms were not owned by family or friends of the decedent. In two cases the firearm was owned by a gang member, in one case the firearm was owned by a stranger, and in three cases the owner could not be determined.

There was known or suspected gang involvement in nearly half of the cases of firearm homicide (42.9%) which is the highest proportion since 2006. This may be a product of better data collection methods and not necessarily an increase in gang involved youth homicides. In all three of these cases, both the victim and the perpetrator were known or suspected to be in a gang. One incident was a drive by shooting and in two of these incidents the victim was a bystander.

**Figure 5.8: 2008–2011 Incident Information for Firearm Homicides (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7)**

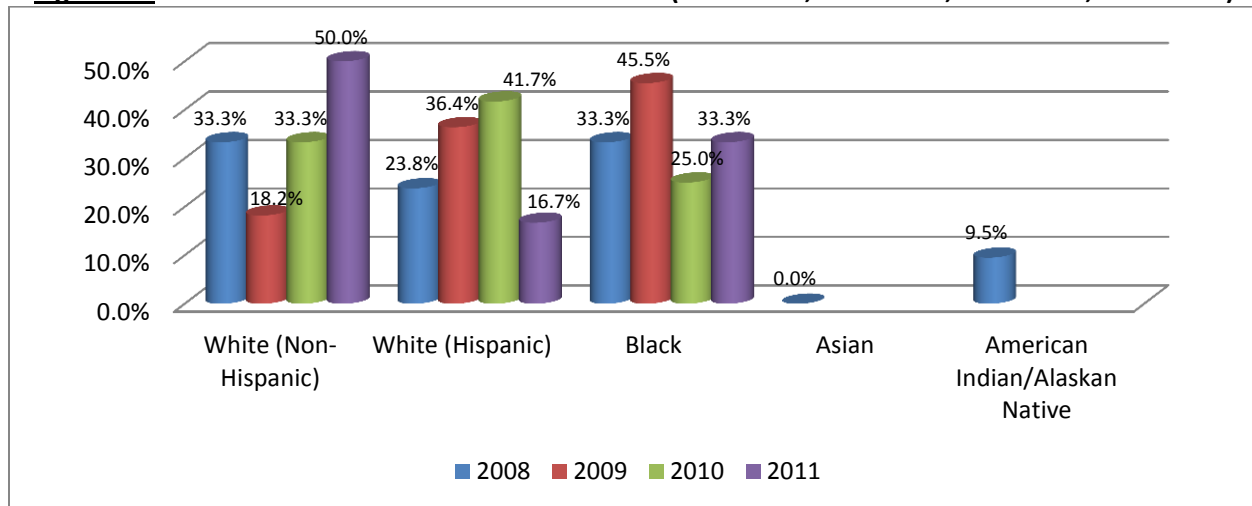




# NON-FIREARM HOMICIDES

In 2011 there were 12 non-firearm homicides. These cases display an entirely different set of characteristics than the firearm homicides. This year 75% (n=9) of non-firearm homicide victims were between the ages of 0 and 4 years, 25% (n=3) were less than one year of age, 8.3% (n=1) were between 5 and 9 years of age, and the remaining 16.7% (n=2) were between 15 and 17 years of age. This year Black children were disproportionately represented in non-firearm homicides (Figure 5.9). Fifty percent (n=6) of victims were White Non-Hispanic, 33.3% (n=4) were Black, and the remaining 16.7% (n=2) were White Hispanic. The majority of non-firearm homicide victims were male (75%) and none of these children had a disability, but one did suffer from seizure disorder.

**Figure 5.9: 2008–2011 Race of Non-Firearm Victims (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12)**

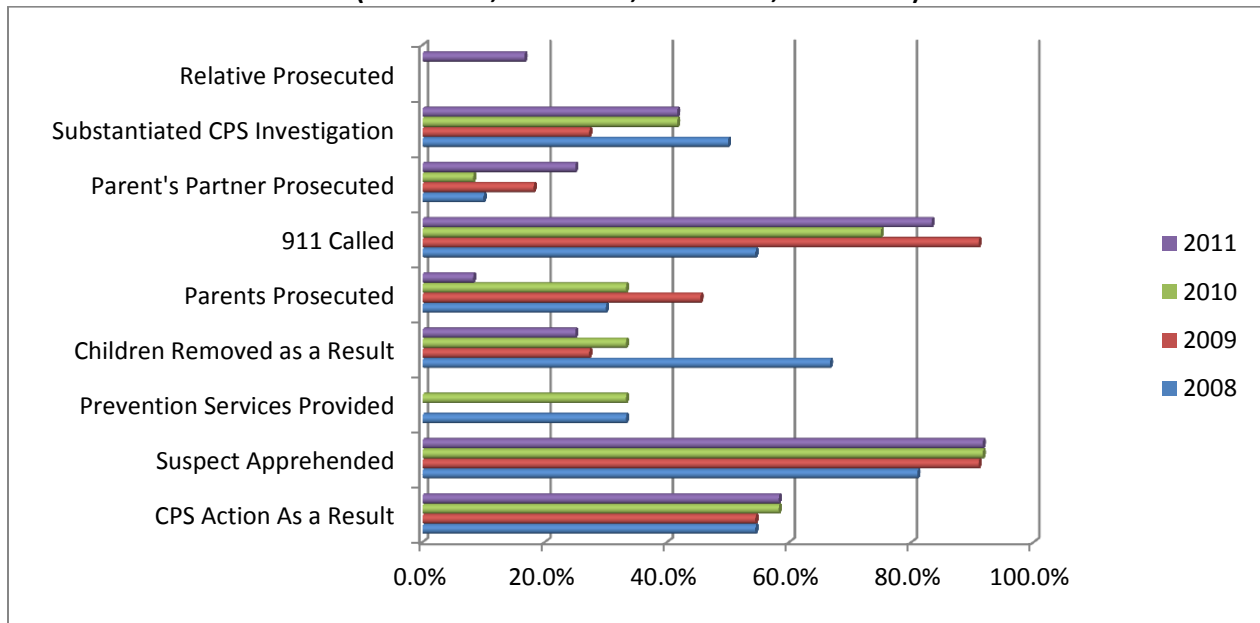


There were three non-firearm homicide victims in 2011 that were school aged and all three were attending school regularly at the time of their death. In 25% of cases (n=3) the victim’s primary supervisor at the time of the incident was a biological parent, in another 25% of cases (n=3) the supervisor was the victim’s mother’s boyfriend. In the other cases the supervisor was a grandparent or other relative, babysitter or family friend. None of the parents of these children had experienced any prior child deaths; in one case the decedent’s biological parent had a history of substance abuse.

In 2011, 83.3% of non-firearm homicides (n=10) were the result of child abuse or neglect. In three of these cases the perpetrator was the decedent’s biological mother’s boyfriend, in four of the cases the perpetrator was a relative (grandparent, uncle, etc.) and in the remaining three cases the perpetrator was a family friend or other caregiver. Circumstances include the child being beaten or shaken (n=8), in one case the child was left unattended and drown, in another case the child was stabbed. The remaining two cases were related to an assault by a stranger or rival gang member and was not child abuse.

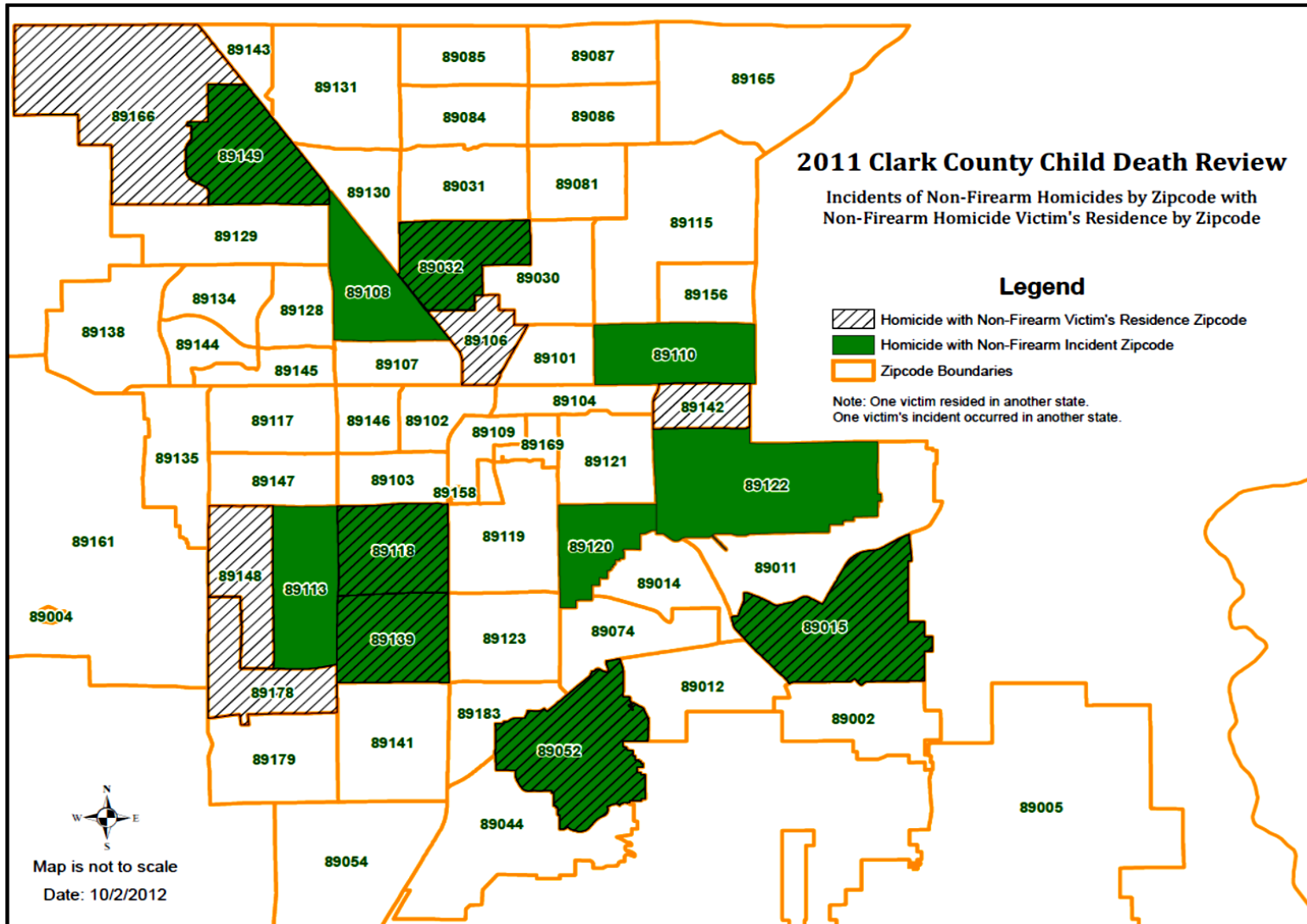
In 83.3% of cases (n=10) prosecution was pending at the time of the review, this information was unknown in one case.

**Figure 5.10: 2008–2011 Incident Information for Non-Firearm Homicides  
(2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12)**



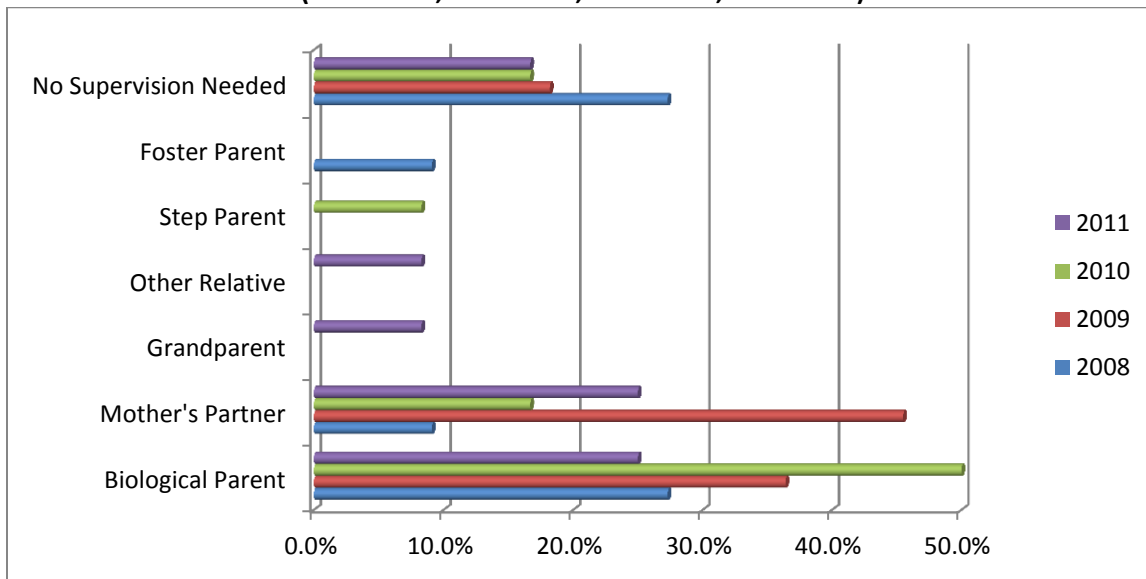
In ten of the twelve cases 911 was called. CPS action was taken as a result of the death in 58.3% (n=7) of cases. Action for these seven cases included removal of remaining children and additional services provided by the Department of Family Services (DFS). In 41.7% (n=5) of cases the allegations were substantiated by DFS. In the other five cases DFS did not take action for a variety of reasons. Primarily DFS 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 2011 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. This map illustrates that non-firearm homicides are distributed across the county and not isolated to one region.



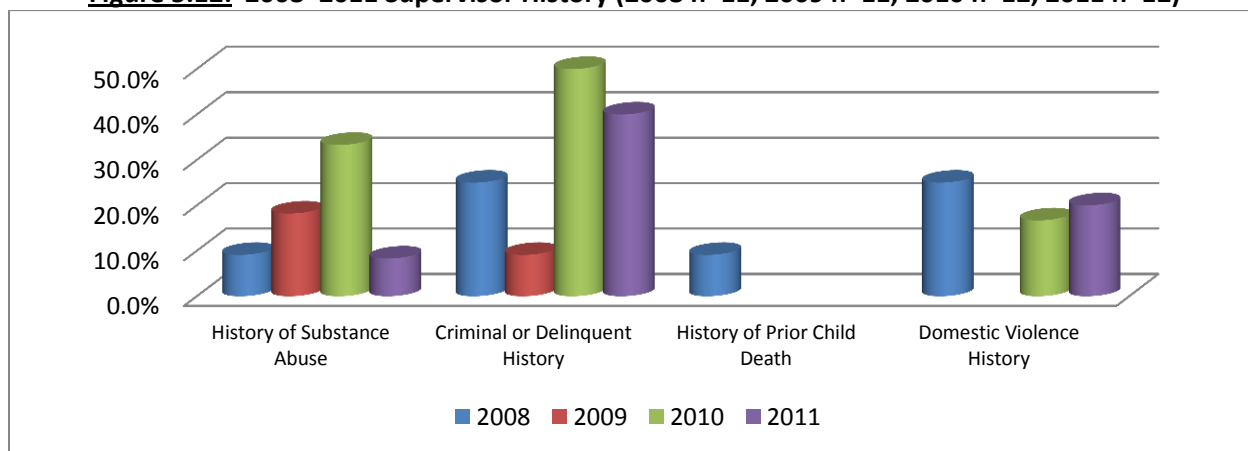
In nearly all cases the team determined that the decedent had proper supervision at the time of death 75% (n=9), one child required direct supervision due to their age but did not receive it and the remaining two victims were of an age that they did not need direct supervision. In 83.3% (n=10) of cases the supervisor was also responsible for inflicting fatal injuries. In the remaining two cases, the perpetrator was a stranger and the child was of an age that they did not need a supervisor. Figures 5.11 and 5.12 provide additional information about the child's supervision at the time of the incident.

**Figure 5.11: 2008–2011 Primary Supervisor at Time of Incident**  
(2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12)



In 2011, for those cases where the child required supervision (n=10) 20% (n=2) of supervisors had a known history of substance abuse. None of the supervisors were drug or alcohol-impaired at the time of the incident. In addition, 40% (n=4) of supervisors had a delinquent or criminal history, but none had a history of prior child deaths (See Figure 5.12).

**Figure 5.12: 2008–2011 Supervisor History** (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12)



About one third (n=4) of the cases had a prior family history of involvement in child welfare. Regarding those cases with a previous child welfare history, 16.7% of those cases (n=2) involved both the decedent and his/her siblings. At the time of the child's death, none of these families had open child welfare cases.

The majority of non-firearm homicides (83.3%, n=10) were caused by child abuse or neglect and all but one of these cases were due to abusive head trauma. In 9 cases that the team reviewed, it was determined that child abuse caused the child's death and in one case it was determined that child neglect contributed to the child's death. There were two non-firearm homicide cases that involved assault, and not child abuse or neglect.

When abusive injuries are inflicted upon a child by someone other than a family member it is considered to be assault, and not child abuse. In the remaining two cases assault was determined to be the causal factor in the child's death. Both cases involved adolescents and the fatal injuries were inflicted by a rival gang member and the perpetrator was a stranger (someone not known to the child or their family) the other case.

# HOMICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

Homicide, by definition, is the intentional killing of another human being. Nineteen children and youth were the victims of homicide in Clark County in 2011. 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. FOCUS ON ADDRESSING THE NEEDS OF MINORITY YOUTH THROUGH COMMUNITY BASED OUTREACH AND GANG PREVENTION ACTIVITIES.**

In 2011 firearm homicides occurred primarily among youth ages 10-17, and nearly all were 15-17 year olds (71.4%), and 71.4% of victims were male. The data in 2011 indicate that nearly three fourths of all victims were minorities, split between White Hispanic (42.9%), Black (28.6%) youth. Again the percentage of both White Hispanic and Black victims are disproportionate to the population distribution in Southern Nevada and identifies a specific target population for intervention efforts. The data also shows that 71.5% of the victims had a prior juvenile justice history, and that approximately 42% 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.

*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](http://www.childdeathreview.org), 2007

## ***NON-FIREARM HOMICIDES:***

### **1. DEVELOP AND PROMOTE NETWORKS OF SERVICES TO HELP FAMILIES MOST AT RISK TO PREVENT INCIDENTS BEFORE THEY START. PARENTING/STRESS MANAGEMENT TRAINING SHOULD ALSO BE TARGETED TOWARD ADULTS LIVING IN THE HOME WITH CHILDREN WHO ARE NOT THEIR BIOLOGICAL PARENTS, BUT ARE RESPONSIBLE FOR CARE GIVING.**

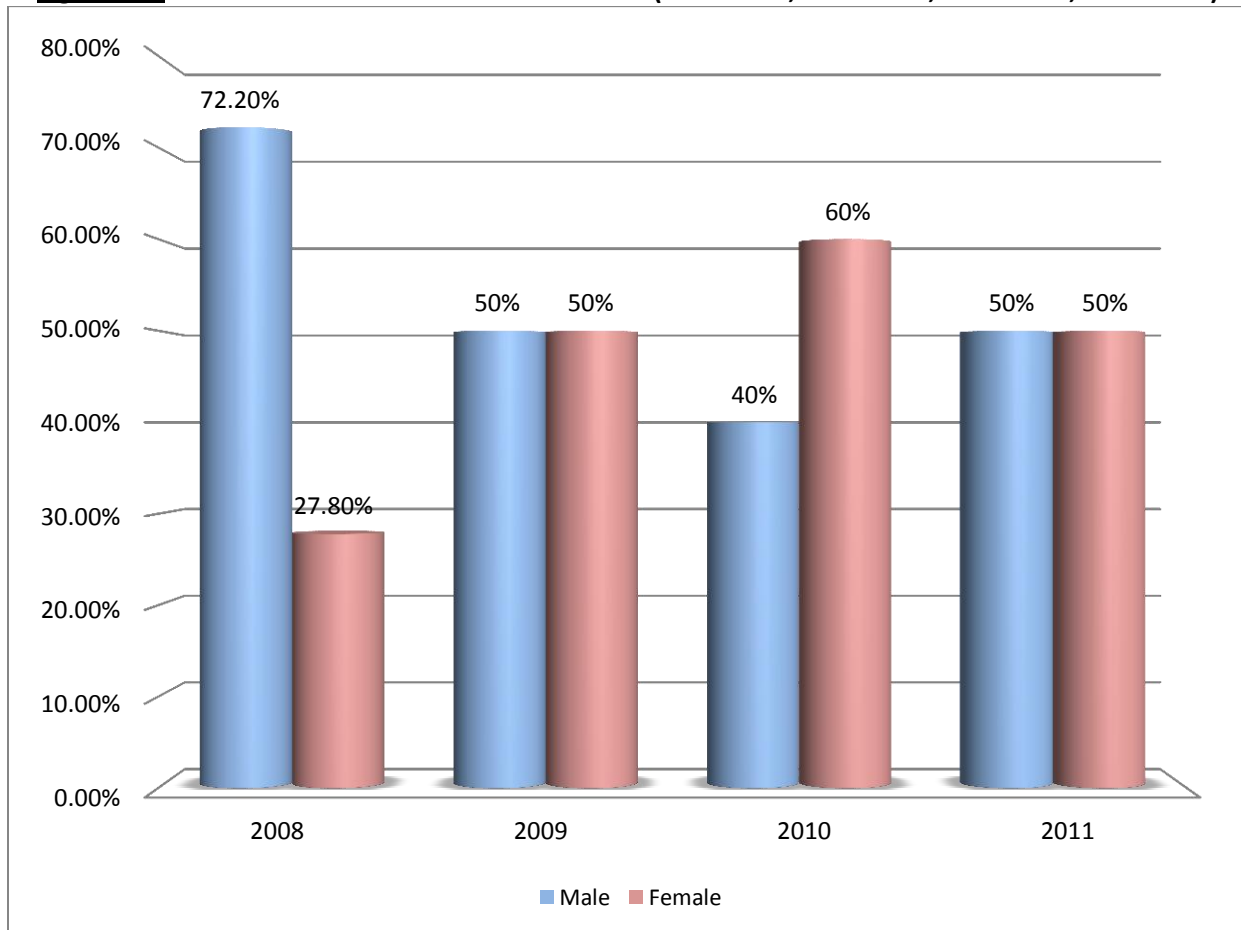
In 2011 non-firearm homicides represented over half (63%) of all youth homicides. The majority of non-firearm homicide victims were less than four years of age (n=9), the remaining victims were distributed throughout all other age groups. In 2011, 83.3% of non-firearm homicides were a result of child abuse (n=10). In 3 cases the perpetrator was the mother's boyfriend, in four cases it was a relative (grandparent, uncle, etc.), and in the remaining three cases the perpetrator was a friend or other caregiver. 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.

## SECTION VI: UNDETERMINED DEATHS

In 2011, Clark County reviewed 10 cases where the death was ruled “undetermined.” This ruling is used by the Office of the Coroner/Medical Examiner 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/medical examiner may rule a death “undetermined” when sufficient evidence or information cannot be obtained to assign another manner of death.

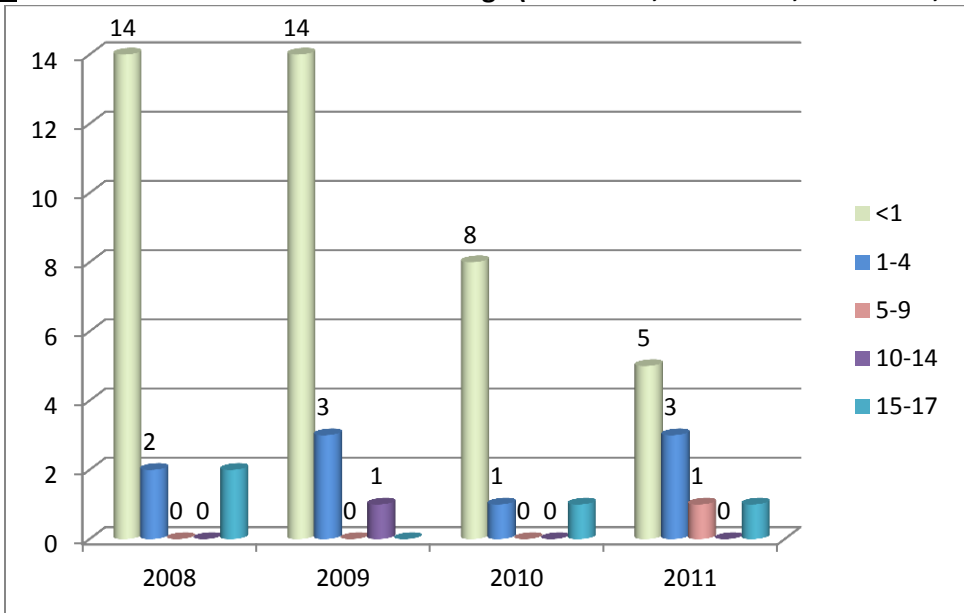
In nine of the 10 cases, the cause was also listed as “undetermined.” For the remaining case the cause listed on the death certificate was “contact, perforating gunshot wound of the head.” The following tables represent the descriptive statistics regarding undetermined deaths reviewed by the Clark County Team from 2008 to 2011. Figure 6.1 provides information about the sex of these decedents.

**Figure 6.1: 2008-2011 Undetermined Deaths: Sex (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10)**



Again in 2010 the majority of undetermined child deaths were those less than one year of age (50% or 5 cases, See Figure 6.2). However there are far fewer undetermined cases than in 2008 and 2009.

**Figure 6.2: 2008-2011 Undetermined Deaths: Age (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10)**



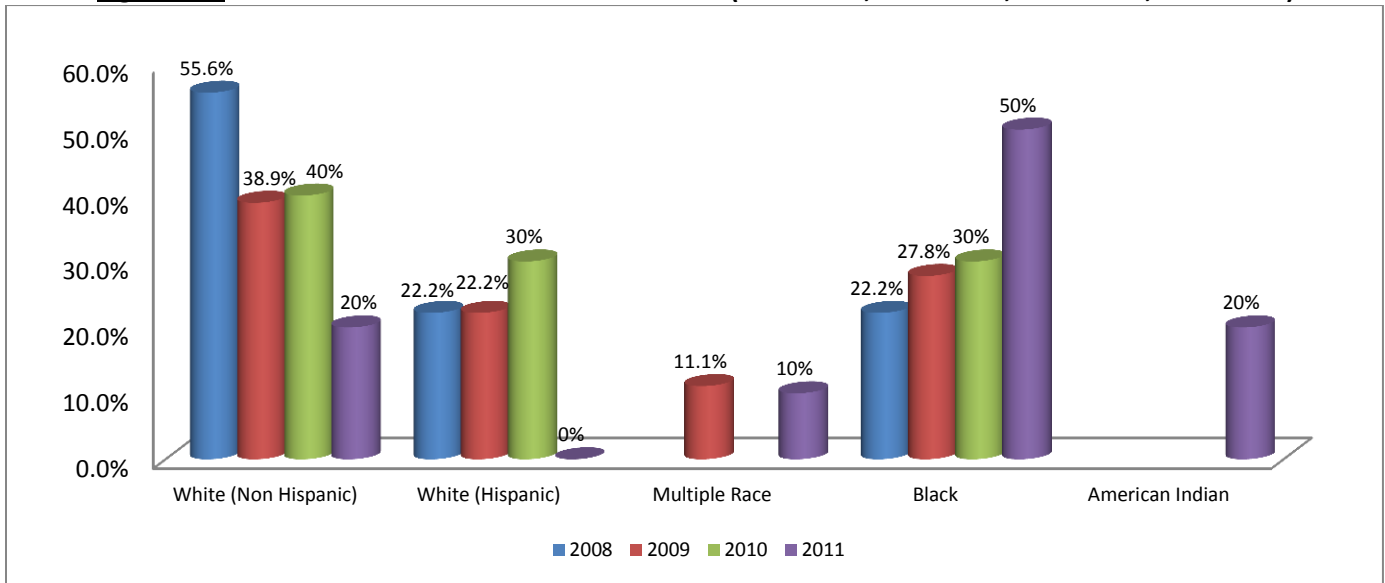
	Less than 1 year	1 to 4 years	5-9 years	10-14 years	15 to 17 years
<b>2008</b>	77.8% (14)	11.1% (2)	0%	0%	11.1% (2)
<b>2009</b>	77.8% (14)	16.7% (3)	0%	5.6% (1)	0%
<b>2010</b>	80.0% (8)	10.0% (1)	0%	0%	10.0% (1)
<b>2011</b>	50% (5)	30% (3)	10% (1)	0%	10% (1)



In 2011, half of undetermined child deaths were black, and for the first time there were no Hispanic children in this category. In addition, in 2011 there were two deaths that involved American Indian children (Figure 6.3).

None of these children had a disability, but one did have a chronic illness, and in seven of the ten cases the child died while in a sleep environment. Among undetermined deaths, nearly half of families had prior history with child protective services, 40% (4 cases) had a history of child welfare involvement. In all cases where there was a history of child welfare involvement the cases did not involve the decedent, only his or her siblings. Additionally, there were no cases where the child was in foster care at the time of death.

**Figure 6.3: 2008-2011 Undetermined Deaths: Race (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10)**



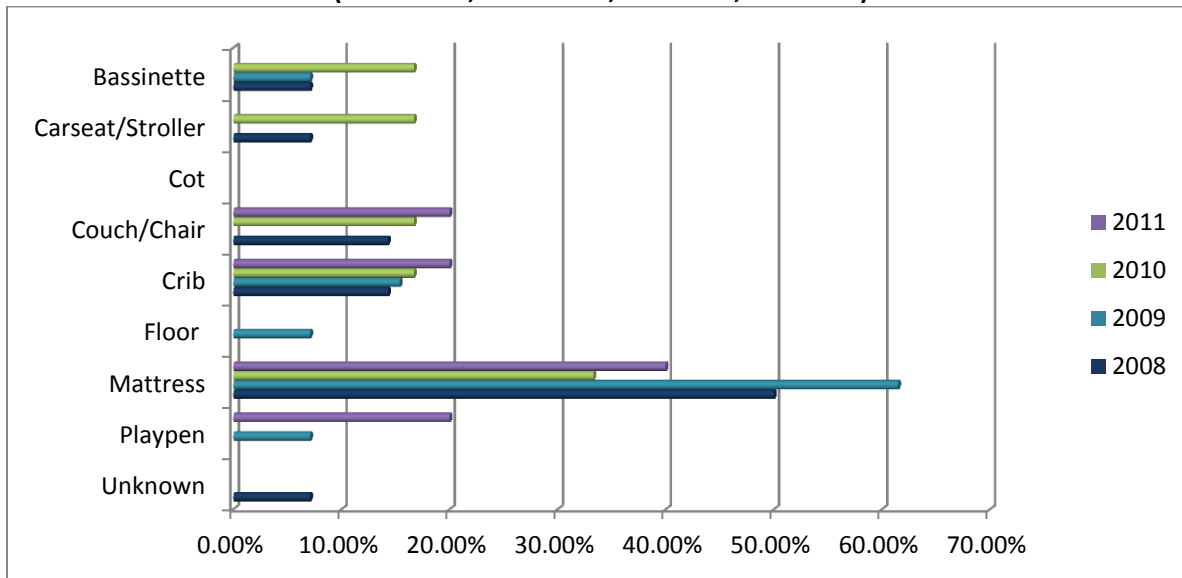
	White (Non-Hispanic)	White (Hispanic)	Multiple Race	Black	American Indian
<b>2008</b>	55.6% (10)	22.2% (4)	0%	22.2% (4)	0%
<b>2009</b>	38.9% (7)	22.2 (4)	11.1% (2)	27.8% (5)	0%
<b>2010</b>	40% (4)	30% (3)	0%	30% (3)	0%
<b>2011</b>	20% (2)	0%	10% (1)	50% (5)	20%

# UNDETERMINED DEATH – LESS THAN ONE YEAR OF AGE

Half all of undetermined deaths in 2011 were children under one year of age (50% or 5 cases). In all of those cases, the child’s death occurred while the child was in a sleeping environment. In 60% of these cases (3 of the 5 children found in sleeping environments) the child was sleeping on a mattress, or couch at the time of their death. In one case the child was sleeping with other adults and children.

Figure 6.4 illustrates the various sleep locations for these children. We see an increase in 2011 in children less than one year of age sleeping on adult mattresses, but still not as many compared to 2008 and 2009.

**Figure 6.4: 2008-2011 Children <1 year old: Sleep Location**  
(2008 n=13, 2009 n=13, 2010 n=6, 2011 n=5)



Incident Sleep Place	2008 (n=13)	2009 (n=13)	2010 (n=6)	2011 (n=5)
<b>Unknown</b>	7.7% (1)	0.0%	0.0%	0.0%
<b>Cot</b>	0.0%	0.0%	0.0%	0.0%
<b>Floor</b>	0.0%	7.1% (1)	0.0%	0.0%
<b>Playpen</b>	0.0%	7.1% (1)	0.0%	20.0% (1)
<b>Car seat/Stroller</b>	7.7% (1)	0.0%	16.7% (1)	0.0%
<b>Couch/Chair</b>	15.4% (2)	0.0%	16.7% (1)	20.0% (1)
<b>Mattress</b>	53.8% (7)	61.5% (8)	33.3% (2)	40.0% (2)
<b>Bassinette</b>	7.7% (1)	7.1% (1)	16.7% (1)	0.0%
<b>Crib</b>	7.7% (1)	15.4% (2)	16.7% (1)	20.0% (1)

Among the deaths of children less than one year of age that were in sleeping environments, 60% (3 cases) of these children were placed to sleep on their stomach, while in the other 40% (2 cases), the child was placed to sleep on his/her back. When found, most children were on their stomach or side (80%, n=4), in the remaining case the child was found on his/her back.

In addition, decedents were found in a variety of sleep environments, 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.

## **UNDETERMINED DEATHS – OVER ONE YEAR OF AGE**

2011 was slightly unusual in that half of all undetermined deaths involved children over one year of age. This year there was one 15 year old, one 6 year old, a 2 year old, and two 1 year olds. In these cases it seems that there are two possible manners of death, however there is not enough information to assign either one, and so a determination of Undetermined was used.

# LOCAL PREVENTION EFFORTS

The Child Death Review Team in Clark County makes an effort to act locally to prevent child deaths. There were several activities completed in 2011 and they are 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 Review meetings. 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 AND DATA COLLECTION

In 2011 the team added members from the Clark County School District Police – Threat Assessment Team. Given the large spike in youth suicides in 2011, partnership with this team was crucial to understanding the circumstances of these fatalities. In addition, the team developed a new process for obtaining school records that allows for members from the school district to help facilitate the receipt of complete records for the purpose of the review.

## COMMUNITY COLLABORATION

In 2011 the team continued to support efforts related to safe sleep by serving as the local point of contact for distribution of safe sleep brochures printed by the Nevada Executive Committee for the Review of Child Deaths.

Dr. Sandra Cetyl, one of the pediatricians on the team, organized a meeting with Sunrise Hospital Staff, local law enforcement, district attorneys, and the coroner's office to discuss common issues associated with child death investigations when a child dies at the hospital. In this meeting each agency used the time to explain their process and understand the motivations for other agency positions. The meeting was successful in helping to make simple changes to processes to ensure that all agency needs are met and expectations are clarified.

## CHILD ABUSE AND NEGLECT PREVENTION

In 2011 a collaboration of members from the Clark County Child Death Review Team worked together to generate a proposal to the Executive Committee for Child Death Review to receive funding to support a "Choose Your Partner Carefully Campaign." The collaboration was awarded funding and NICRP as Prevent Child Abuse Nevada worked to organize the group to create print materials (brochures and posters) as well as post bus stop signs throughout the Las Vegas area. The campaign also held a press conference during child abuse prevention month and several of the members of the collaboration were interviewed about the campaign on both television and radio. The group was able to print and distribute more than 25,000 brochures and there were 15 bus stop signs around the Las Vegas area with 5 stops displaying both an English and a Spanish version of the poster.

## DROWNING PREVENTION

Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. The Southern Nevada Drowning Prevention Coalition continues to coordinate efforts, and ensure consistent prevention messaging related to water safety and drowning prevention. There are three members of the Clark County CDRT that continue to serve on this coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County. This year the collaboration celebrated April Pools Day with a joint press conference.

## SAFE SLEEP – SUFFOCATION PREVENTION

Unsafe sleep practices continue to claim the lives on infants in our community. In an effort to address this problem, in 2011, NICRP and the Southern Nevada Health District were awarded funding from the Health Resource Support Administration (HRSA) Healthy Tomorrow's Program to support a hospital based safe sleep initiative in Clark County. This program will work with local birthing hospitals to ensure that there is a hospital policy on sleep positioning, that staff are trained in safe sleep practices, and that new parents watch a short informational video on how to safely place their baby to sleep. This program has grant support for five years, and during that period, we hope to implement the program in all birthing hospitals in the Las Vegas Valley.

# 2011 RECOMMENDATIONS TO THE STATE ADMINISTRATIVE TEAM

*Summary of Recommendations Reported to the State Administrative Team for 2011 Child Deaths*

Every quarter the Child Death Review Team in Clark County 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 Child Death Review Team in Clark County to the Administrative Team to Review the Death of Children in 2011. "Action" listed under each recommendation represents the response from the Administrative Team.

**2011-01:** *Create a requirement for continuing education on mandatory reporting of child abuse and neglect for all licensed child care workers as a part of the Nevada Registry. In addition create a multi-year project targeting different audiences for training on mandatory reporting. These could include; teachers, principals, parks and recreation staff, child care centers, pediatricians, etc.*

**Action:** Presentation scheduled for Department of Family and Child Services child care licensing staff.

**2011-02:** *Provide and widely advertise and incentivize training for parents on complete airway obstruction and the Heimlich Maneuver.*

**Action:** Pending outcome.

**2011-03:** *Implement a campaign to alert single parents to the importance of choosing a responsible partner to ensure the safety of their children.*

**Action:** The Executive Committee funded the implementation of the "Choose Your Partner Carefully" campaign in Southern Nevada.

**2011-04:** *Develop a forum for mental health facilities to get together to hold closed peer reviews to identify opportunities for all facilities to improve environments, policy, and practice.*

**Action:** Presentation delivered to Mental Health and Disabilities Services.

**2011-05:** *Work with hospitals, rehabilitation facilities, and support groups (like Narcotics Anonymous) to provide information to family members about signs and symptoms of a drug overdose and increased risks for overdose when a person comes out of a treatment facility.*

**Action:** Referral to Public Awareness Subcommittee.

**2011-06:** *Use actual scene photos of what "unsafe" sleep environments look like for training parents and other caregivers about safe sleep. These could be used to facilitate an activity where participants can point out what's wrong in the picture and why.*

**Action:** Pending outcome.

**2011-07:** *Education and awareness campaigns should also encourage homeowners with a pool to know CPR, have an accessible telephone, and have someone in the home that knows how to swim.*

**Action:** Referral to Public Awareness Subcommittee.

**2011-08:** *Create an educational campaign to provide information to parents and family members to recognize signs of child abuse, as well as strategies to prevent and report child abuse.*

**Action:** Prevention activities in the community for the month of April and information distributed.

**2011-09:** *Provide education for parents about firearm safety and the importance of storing weapons in a locked secure location and also not allowing any minors to know the combination or have access to keys.*

**Action:** Referral to Public Awareness Subcommittee.

**2011-10:** *Support interagency communication and help develop a process by which if youth in the juvenile justice system are seen in the Emergency Room for overdose or substance abuse DJJS is notified of this incident so appropriate services can be provided.*

**Action:** Updated contact information with Nevada Association of Juvenile Justice Administrators (NAJJA) and Juvenile Justice Commission (JJC). Child Death Review summary developed for meeting packets.

# APPENDIX A: 2011 CDRT MEMBERSHIP LIST

## 2011 Core Members

Dr. Andrew Eisen	Touro University	Vicki Monroe	Clark County District Attorney's Office
Gwen Osburn	Southern Nevada Health District	Dr. Alane Olson	Clark County Office of the Coroner/Medical Examiner
Sally Jost	Clark County School District	Mark Reeping	Mesquite Police Department
Dave McKenna	Henderson Police Department	Joseph Smith	Nevada Highway Patrol/Department of Public Safety
<b>Ricky Crosby</b>	<b>Clark County Department of Juvenile Justice Services (2011 Team Chair)</b>	Robert Sullivan	North Las Vegas Police Department
Tom Morton	Clark County Department of Family Services	Lisa Teele	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail
<b>Dr. Sandra Cetl</b>	<b>Sunrise Hospital/Children's Assessment Center (2011 Team Vice Chair)</b>		

## 2011 At Large Members

Troy Armstrong	Clark County Department of Family Services	Paula Haynes-Green	Clark County Department of Family Services
Sue Battaglia	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail	Kathryn Hooper	Henderson Fire Department
Marion Biron	Clark County Department of Family Services	Mark Hoyt	North Las Vegas Police Department
Mary Ellen Britt	Southern Nevada Health District	Tracy Kingera	Clark County Department of Juvenile Justice Services
Julie Bolton	Clark County School District	Natasha Koch	Nevada Highway Patrol
Mary Brown	Clark County District Attorney's Office	Jill Marano	Nevada Division of Child and Family Services
Kristine Buist	Las Vegas Metropolitan Police	Mary Martinat	University Medical Center – Trauma Services
Toni Castillo	Clark County Office of the Coroner/Medical Examiner	Dr. Neha Mehta	Sunrise Hospital
Annette Darr	Las Vegas Metropolitan Police	Tara Phebus	Nevada Institute for Children's Research and Policy
Gil Diaz	Clark County School District Police – Threat Assessment Team	Darren Reimer	Nevada Dept. of Public Safety/NV Highway Patrol
Linda Flatt	Nevada Office of Suicide Prevention	Lynn Row	Clark County School District
Deborah Flowers	Nevada Department of Child and Family Services	Peggy Rowe	Clark County Department of Family Services
Dr. Tony Fredrick	Southern Nevada Health District	Gregory Schultz	Las Vegas Metropolitan Police Department
John Fudenberg	Clark County Office of the Coroner/Medical Examiner	Bruce Swanson	Henderson Police Department
Paula Hammack	Clark County Department of Family Services	Denise Tanata Ashby	Nevada Institute for Children's Research and Policy
Marion Hancock	Sunrise Hospital	Kamil Taylor-Diggs	Nevada Institute for Children's Research and Policy
Janne Hanrahan	Clark County District Attorney's Office – Child Welfare	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)

# Summary of Findings from the 2011 Child Death Review Annual Report

The 2011 Annual Report of Child Deaths in Clark County, Nevada provides data regarding all infant, child, and fetal (over 20 weeks gestation) deaths occurring in Clark County in 2011. This represents the fourth year that the Child Death Review Team in Clark County reviewed 100% of the child deaths referred to the team by the Clark County Office of the Coroner/Medical Examiner; this includes all natural deaths, as well as all accidents, homicides, suicides, and undetermined cases. The team also reviewed all fetal deaths over 20 weeks gestation.

## Overall 2011 Child Death Statistics

### Manners of Death in 2011

- 237 cases reviewed in 2011 (23.8% decrease since 2008)
- 155 Natural (decrease of 7.7 % from 168 in 2010)
- 37 Accidents (decrease of 19.6% from 46 cases in 2010)
- 16 Suicide (128.6% increase from 2010 – more incidents in 2011 than 2008-2010 combined)
- 19 Homicide (one more case than in 2010)
- 10 Undetermined (same number as in 2010, but a 44.4% decrease from 2009 (n=18))

### Causes of Death in 2011

- Increase in motor vehicle incidents from 8 in 2010 to 10 in 2011
- SIDS stayed the same at 1 cases in 2011
- Increase in deaths caused by weapons from 22 in 2010 to 30 in 2011
- Decrease in suffocation/strangulation deaths from 18 in 2010 to 15 in 2011.
- Drowning down by two cases from 10 in 2010 to 8 in 2011.
- Poisoning/Overdose cases showed an increase from 5 in 2010 to 9 in 2011.

## 2011 Child Deaths by Manner of Death – Additional Details and Recommendations for Prevention

**Natural** – There were 155 natural deaths reviewed in 2011. 39.4% of these deaths were due to complications of prematurity, followed by congenital defect (36.8%) and chronic illness (15.4%). 72.9% of natural deaths were children less than one year of age. We continued to see a decrease in the number of SIDS deaths in 2011 from 2 in 2009 to 1 in 2010, and 1 in 2011.

### Recommendations:

- Continue to improve data collection and research on child deaths related to prematurity.
- Improve access and outreach for adequate prenatal care, particularly for young women.
- Improve parent education about proper management of common chronic illnesses in children.

**Accident-** Accidental deaths accounted for 15.6% (37 cases) of child deaths in 2011. The leading causes of accidental death included suffocation at 29.7% followed by motor vehicle accidents (MVA) at 27%, poisoning at 21.6%, and drowning at 18.9%. For the second time in six years the leading cause of accidental deaths were suffocations. In 2011 nearly all accidental suffocations (n=11) were children less than one year of age and nearly all of those cases (n=10) occurred in a sleeping environment. Motor vehicle accidents increased from 17.45 % in 2010 to 27% in 2011 with half of the decedents (50%) between the ages of 15-17. Poisoning also showed an increase from 8.7% in 2010 to 21.6% in 2011. Similar to 2010, in 2011, nearly all (n=5) of the drowning victims in Clark County were between the ages of one and four years and 71.4 % of all victims drowned in a pool or spa. In 2011, we also see the lowest number of child drowning incidents since data collection in 2006.

### Recommendations:

- Focus on changing regulations to bring older pools up to current standards for barriers to accessing the pool including, fences, gates, alarms, etc.
- Improve/expand culturally sensitive outreach and education efforts regarding safe sleep environments for infants.
- Support initiatives related to preventing substance abuse in children and youth, especially those related to limiting access to prescription drugs.

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**Homicide-** In 2011, 8% (19 cases) of child deaths were categorized as homicides. This is an increase from 17 deaths in 2009 but a decrease from 20 deaths in 2010. In 2011 children ages 1-4 years and youth 15-17 years were the most frequent age groups both at 36.8% respectively. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2011 there were more non-firearm homicides (n=12) than firearm homicides (n=7). For firearm homicides (n=7) the data show that 71.4 % of the victims had a prior juvenile justice history, and in 3 of these incidents gang affiliation was known or suspected. For non-firearm homicides (n=12), 83.3% were a result of child abuse or neglect (n=10). In three of those cases the perpetrator was the mother’s boyfriend and in the remaining cases the perpetrator was a relative or family friend. One third (n=4) of the decedents’ families had a history of involvement with the child welfare system.

Recommendations:

- Firearm Homicides: Focus on addressing the needs of minority youth through community based outreach and gang prevention activities.
- Non-Firearm Homicides: Develop and promote networks of services to help families most at risk to prevent incidents before they start. Parenting/stress management training should also be targeted toward adults living in the home with children who are not their biological parents, but are responsible for care giving.

**Suicide** – Suicide was the cause of 6.8% (16 cases) of child deaths in Clark County which represents a 128.6% increase from 2010 and represents more cases than 2008-2010 combined. All of the decedents attended school regularly, 25% of the decedents (n=4) made a previous attempt, and 18.8% of decedents had made prior threats of suicide.

Recommendations:

- Expand suicide prevention efforts in elementary schools and continue education to teachers, parents, and others about suicide prevention.
- Expand existing firearm safety campaigns to include specific messages about preventing access to lethal means for suicide, especially if children have a history of mental health issues or prior attempts.
- Expand and promote gatekeeper training for anyone working with youth to recognize signs of suicide as well as techniques for how to intervene if suicidal ideation is suspected.

**Undetermined** – 4% (10 cases) of child deaths were ruled undetermined, which is a decrease from 2008 (n=18). This ruling is used by the Office of the Coroner/Medical Examiner when information regarding the circumstances of the death makes it difficult for the medical examiner to make a distinct determination about the manner of the death. 5 of these 10 cases (50%) were infants less than 1 year of age. 2011 showed a slight increase in undetermined deaths for African American children rising to 50% of all undetermined deaths from 30% in 2010. Among children less than 1 year of age (n=5), all died in a sleeping environment and in 1 of the 5 cases the child was sleeping with another person (parent, sibling or both).

### Summary of Child Welfare History for all 2011 Child Deaths

The team records whether a child or their family has ever had any involvement with the Department of Family Services (DFS). Prior history is recorded regardless of the cause of the child’s death and often the cause of the child’s death is unrelated to any previous history of involvement with DFS.

- 51 of the 237 cases reviewed had some family history of involvement with DFS prior to the child’s death – a decrease from 2010 (n=57).
- In 10 cases the child/family had an open case with DFS at the time of the child’s death
- In 3 cases the child was in foster/shelter care at the time of their death (an increase from 2010).
- In 2012 there were 9 substantiated death allegations of abuse or neglect.
- Of the 9 substantiated death allegations (3.4% of all child deaths in Clark County), 1 was ruled an accident, while 8 were ruled homicides. In more than 75% (n=7) of these cases the decedents’ and their family did not have any prior history with DFS.

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## 2011 CDR Team Prevention Activities

- In 2011 the team added members from the Clark County School District Police-Threat Assessment Team. Given the large spike in youth suicides in 2011, partnership with this team was crucial to understanding the circumstances of these fatalities. In addition, the team developed a new process for obtaining school records that allows for members from the school district to help facilitate the receipt of complete records for the purpose of the review.
- In 2011 the team continued to support efforts related to safe sleep by serving as the local point of contact for distribution of safe sleep brochures printed by the Nevada Executive Committee for the Review of Child Deaths. Dr. Sandra Cetl, one of the pediatricians on the team, organized a meeting with Sunrise Hospital Staff, local law enforcement, district attorneys, and the coroner's office to discuss common issues associated with child death investigations when a child dies at the hospital. In this meeting each agency used the time to explain their process and understand the motivations for other agency positions. The meeting was successful in helping to make simple changes to processes to ensure that all agency needs are met and expectations are clarified.
- In 2011 a collaboration of members from the Clark County Child Death Review Team worked together to generate a proposal to the Executive Committee for Child Death Review to receive funding to support a "Choose Your Partner Carefully Campaign." The collaboration was awarded funding and NICRP as Prevent Child Abuse Nevada worked to organize the group to create print materials (brochures and posters) as well as post bus stop signs throughout the Las Vegas area. The campaign also held a press conference during child abuse prevention month and several of the members of the collaboration were interviewed about the campaign on both television and radio. The group was able to print and distribute more than 25,000 brochures and there were 15 bus stop signs around the Las Vegas area with 5 stops displaying both English and Spanish versions of the poster.
- Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. The Southern Nevada Drowning Prevention Coalition continues to coordinate efforts, and ensure consistent prevention messaging related to water safety and drowning prevention. There are three members of the Clark County CDRT that continue to serve on the coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County. This year the collaboration celebrated April Pools Day with a joint press conference.
- Unsafe sleep practices continue to claim the lives of infants in our community. In an effort to address this problem, in 2011, NICRP and the Southern Nevada Health District were awarded funding from the Health Resource Support Administration (HRSA) Healthy Tomorrow's Program to support a hospital based safe sleep initiative in Clark County. This program will work with local birthing hospitals to ensure that there is a hospital policy on sleep positioning, that staff are trained in safe sleep practices, and that new parents watch a short informational video on how to safely place their baby to sleep. This program has grant support for five years, and during that period, we hope to implement the program in all birthing hospitals in the Las Vegas Valley.

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