

Summary of Findings from the 2012 Child Death Review Annual Report

The 2012 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 2012. Since 2008, the Child Death Review Team in Clark County has 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.

Overall 2012 Child Death Statistics

Manners of Death in 2012

- 222 cases reviewed in 2012 (28.6% decrease since 2008)
- 127 Natural (decrease of 37.44 % from 203 cases in 2008)
- 66 Accidents (increase of 1.5% from 65 cases in 2008 – first increase since seeing steady declines 2008-2011)
- 5 Suicide (decrease of 25% from 4 cases in 2008)
- 8 Homicide (a decrease of 61.9% from 21 cases in 2008- 2012 had the smallest number recorded since 2006)
- 16 Undetermined (a decrease of 11.1% from 18 cases in 2008)

Causes of Death in 2012

- Increase in motor vehicle incidents from 10 in 2011 to 19 in 2012
- SIDS stayed the same at 1 case in 2012
- Decrease in deaths caused by weapons from 30 in 2011 to 7 in 2012
- Increase in suffocation/strangulation deaths from 15 in 2011 to 23 in 2012
- Drowning up by one case from 8 in 2011 to 9 in 2012
- Poisoning/Overdose cases showed an increase from 9 in 2011 to 16 in 2012

2012 Child Deaths by Manner of Death – Additional Details and Recommendations for Prevention

Natural – There were 127 natural deaths reviewed in 2012. 44.9% of these deaths were due to complications of prematurity, followed by congenital defect (25.2%) and chronic illness (18.9%). 71.7% of natural deaths were children less than one year of age.

Recommendations:

- Continue to improve data collection and research on child deaths related to prematurity.
- Improve access and outreach for adequate family planning and prenatal care, particularly for young women (15-20 years of age).
- Improve parent education about proper management of common chronic illnesses in children such as asthma and diabetes.

Accident- Accidental deaths accounted for 29.7% (66 cases) of child deaths in 2012. The leading causes of accidental death included suffocation at 31.8% (n=21) followed by motor vehicle accidents (MVA) at 28.7% (n=19), complications of maternal drug use at 18.1% (n=12), drowning at 13.6% (n=9), and poisoning at 4.5% (n=3). For the third time in six years and the highest proportion in five years, the leading cause of accidental deaths cases were suffocations. In 2012 nearly all accidental suffocations (n=18) were children less than one year of age and all of those cases occurred in a sleeping environment. Motor vehicle accidents increased from 27% in 2011 to 28.7% in 2012 with half of the decedents (52.6%) between the ages of 15-17. Poisoning also showed an increase from 21.6% in 2011 to 22.6% in 2012, with 18.1% caused from complications of maternal drug use. In 2012 about half (n=5) of the drowning victims in Clark County were between the ages of one and four years and 55.6 % of all victims drowned in a pool or spa, while 44.4% (n=4) of drowning incidents occur in some kind of open water like a lake, river, or wash.

Recommendations:

- Improve/expand culturally sensitive outreach and education efforts regarding safe sleep environments for infants.
- Support campaigns for motor vehicle and pedestrian safety.
- Support initiatives related to preventing substance abuse in young adults as well as treatment and prenatal care for substance abusing pregnant women.
- Support existing initiatives like the Southern Nevada Child Drowning Prevention Coalition to continue to promote water safety in our community to prevent drowning incidents

The full report is available at the NICRP website <http://nic.unlv.edu>



Suicide – Suicide was the cause of 2.25% (5 cases) of child deaths in Clark County which represents a 68.8% decrease from 2011. All of the decedents attended school regularly, but two were experiencing school failure. None of the decedents had made a previous suicide attempt but 20% had made prior threats of suicide.

Recommendations:

- 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.
- 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.

Homicide- In 2012, 3.6% (8 cases) of child deaths were categorized as homicides. This is a decrease from 19 deaths in 2011, nearly half of what we have seen since 2008, and the smallest number recorded since 2006. In 2012, youth 10-14 years was the most frequent age group at 37.5%, followed by children ages 5-9 at 25%. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2012 there were far more non-firearm homicides (n=7) than firearm homicides (n=1). For non-firearm homicides (n=7), 85.7% were a result of child abuse or neglect (n=6). In four of those cases the perpetrator a parent’s partner (boyfriend/girlfriend or step parent) and two cases the perpetrator was the biological parent. In the remaining case the perpetrator was a stranger. More than half (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 youth (especially minority youth) through community based outreach and violence 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 be targeted toward parents as well as other adults living in the home that may be responsible for caregiving.

Undetermined – 7.20% (16 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. 8 of these 16 cases (50%) were infants less than 1 year of age. Among those children less than 1 year of age (n=8), 75% (n=6) died in a sleeping environment and in 4 of those 6 cases the child was sleeping with other adults.

Summary of Child Welfare History for all 2012 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.

- 53 of the 222 cases reviewed had some family history of involvement with DFS prior to the child’s death – an increase of 2 cases from 2011 (n=51).
- In 8 cases the child/family had an open case with DFS at the time of the child’s death (decrease of 2 cases from 2011)
- In 2 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 (4.1% of all child deaths in Clark County), three were homicides, four undetermined, and two accidental. In nearly half (n=4) of these cases the decedents’ and their family did not have any prior history with DFS.

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2012 CDR Team Prevention Activities

COMMUNITY COLLABORATION

There were four primary examples of community collaboration with the CDR team in 2012:

- In 2012 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.
- Following a recommendation from members of the local team, a representative from NICRP attended the Mental Health and Developmental Services Commission meeting in May 2012 to make a recommendation for improvement in residential mental health treatment for children. The local team proposed that the state consider recommending the implementation of a cross site peer review process for residential mental health treatment facilities so that they can each learn from one another to make improvements within their facilities to improve safety. This recommendation did not move forward in the 2013 legislative session but is being pursued by NICRP in 2013 through support from the Nevada Executive Committee for the Review of Child Deaths
- In August of 2012 NICRP worked with AAA's Henderson location to provide information on motor vehicle safety at their Summer Traffic Safety Event. NICRP attended and provided safety information to families attending the event, and coordinated with Nevada Highway Patrol to have one of their patrol officers attend the event and share safety information with attendees.
- Through collaboration with Prevent Child Abuse Nevada, safe sleep information is distributed to attendees at all community resource fairs they attend.

CHILD ABUSE AND NEGLECT PREVENTION

In 2012 a collaboration of members from the Clark County Child Death Review Team along with Prevent Child Abuse Nevada and NICRP worked together to continue the implementation of the "Choose Your Partner Carefully Campaign" through funding from the Executive Committee to Review the Death of Children. Again in 2012 the collaborative was able to distribute over 14,000 informational brochures and almost 300 posters in both English and Spanish. In addition there were bus stop signs posted throughout the community with the campaign information as well. Materials were distributed at a number of community resource fairs as well as partner agencies.

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, as well as several local events where information was distributed to attendees. In 2012 the coalition focused efforts on the Hispanic population due to disproportionate numbers of Hispanic children victims of both fatal and non-fatal drowning incidents.

SAFE SLEEP – SUFFOCATION PREVENTION

Unsafe sleep practices continue to claim the lives on infants in our community. In an effort to address this problem NICRP and the Southern Nevada Health District were awarded funding in 2011 from the Health Resource Support Administration (HRSA) Healthy Tomorrow's Program to support a hospital based safe sleep initiative in Clark County. The Clark County Child Death Review Team serves as the Advisory Board for this initiative, receiving regular updated throughout the year. Program implementation started in 2012 with the University Medical Center. An informational video on safe sleep geared toward parents and caregivers was produced, 200 UMC staff were trained, and more than 700 parents watched the informational video and completed a short survey. This project will continue over the next three and half years and will expand to all birthing hospitals in Southern Nevada.

The full report is available at the NICRP website <http://nic.unlv.edu>





2012 Annual Report of Child Deaths in Clark County, Nevada

A Report from the Child Death Review Team in Clark County

August 2013

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

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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 74% of the state's population under 18 years of age (US Census Bureau Quick Facts 2012 Estimates, Retrieved August 2012), 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 seven years, Clark County 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 2012. 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 of specific cases 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

Nevada child death review teams have adopted the following operating principles established by the National Center for Child Death Review:

- 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. 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 2012 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 reviews 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 agreement. 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. Only cases that have been officially assigned cause and manner of death by the Office of the Coroner/Medical Examiner or the attending physician signing the death certificate are placed on the monthly agenda. Cases from previous months' agendas that needed further review are listed first on the agenda. The next few pages of the agenda contain summary information for each manner of death year to date, and for previous years as a comparison. For example, the total number of accidental deaths the team has reviewed for that year, as well as the number for each of the previous years. This section allows the team to see any trends at first glance. The remaining pages of the agenda include new cases organized by manner of death and by cause of death within each manner. page of the agenda 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 2012 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 meeting, cases are reviewed in groups based on their cause of death. Agencies with additional information about a specific case are asked to present their case information during the review meeting. 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 state 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 2012

This year's report contains only data from 2008 to 2012. Data collected in 2006 and 2007 did not include all natural deaths, therefore annual comparisons made to 2006 and 2007 data can be easily misinterpreted. It is for this reason that data from 2006 and 2007 are not included in the 2012 report.



METHODOLOGY

In 2012, the team in Clark County continued to hold monthly review meetings and the Nevada Institute for Children’s Research and Policy (NICRP) continued 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. 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 team 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 2012 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. This is the fifth 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 2012. 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 an agency that is expected to have information about a case is unable to attend the meeting when the case will be reviewed, a request is made to the agency so that the data tool can be completed. If this information is unknown or unavailable at the time of the meeting, it is entered 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. The 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 indicating the pertinent facts of their involvement with the child and the family.

Data tools 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. During this phase 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 statistical significance. In addition to simple descriptive statistics, comparative data for 2008 - 2012 are presented in this report. The purpose of reporting annual comparative data is to track the major causes of child death, identify trends, and improve the ability of the team to design prevention strategies.

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.



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. The five standard manners include: 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 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, the manner would be suicide. If he was shot by someone else intentionally, the manner would be homicide. If he discharged a weapon while cleaning it and was hit, then the manner of death would be 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. Understanding the manner of death can provide reviewers a greater understanding of the circumstances surrounding the death, which increases the potential for preventing future child fatalities.

LIMITATIONS

As with any research there are limitations associated with this dataset. For example, over the past seven years, the data collection tool has been changed as well as some of the methods of data collection in effort to improve the accuracy with which data is presented.

As with years past, 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 may 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 and Accidental 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 addition there are three accidental deaths that are included in this report as their cases were reviewed by the team, but they were not processed through the Office of the Coroner/Medical Examiner. These three cases were fatal motor vehicle accidents of children who were residents of Clark County, Nevada but the injury and

death occurred out of state. Due to relationships with neighboring states, these cases were referred for review by the child death review team in the state where the fatal incident occurred.

In 2012, 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 2012 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 continue to be accessible in the



future as relationships for data sharing 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 2008-2012 where appropriate, as well as provide descriptive statistics regarding specific circumstances surrounding causes and manners of death to assist in generating data that driven prevention initiatives. This report does not represent all data collected regarding 2012 child fatalities, because some variables presented too few cases to provide information that is not identifiable.



FINDINGS

SECTION I: SUMMARY STATISTICS

In 2012, 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	2012
Count	311	283	251	237	222

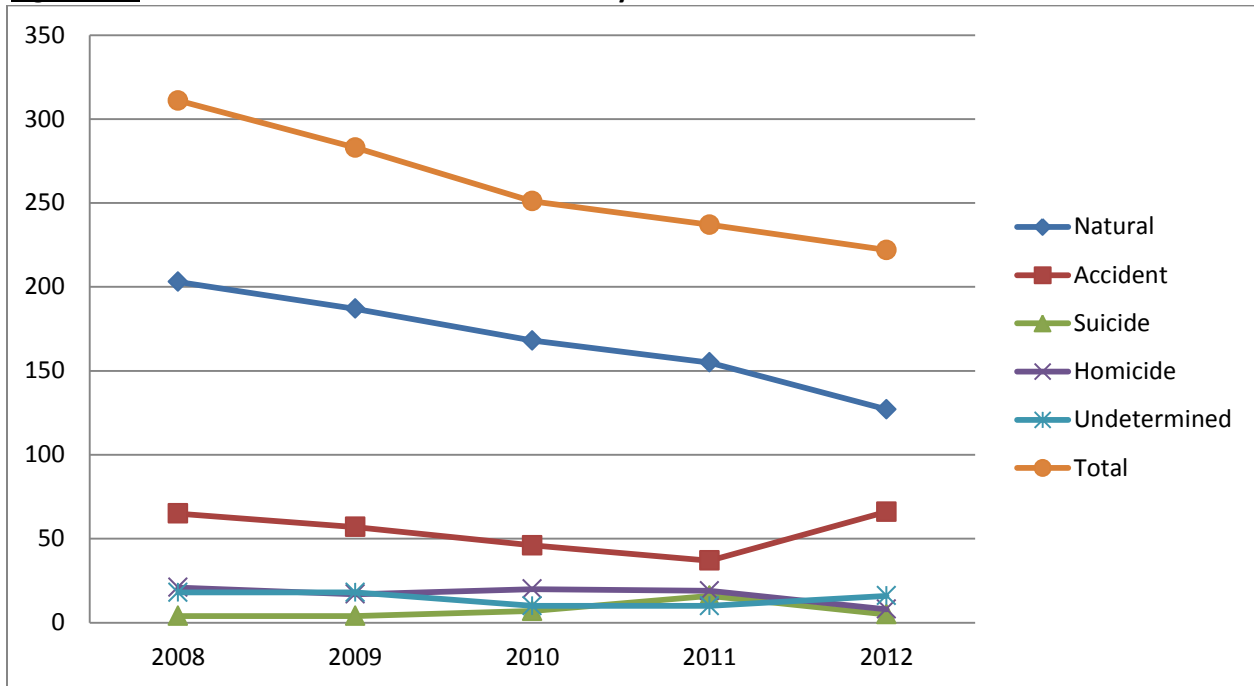
Beginning in 2008 all child deaths were reviewed by the team in Clark County and from that date forward we see a steady decline in the number of child fatalities in Clark County. The 222 cases in 2012 represent 100% of all child and fetal deaths referred to the team from the Clark County Office of the Coroner/Medical Examiner (Comparison to Clark County Office of the Coroner/Medical Examiner Data, June 2013). Because the same methodology was used to select cases for review since 2008 this represents a **28.6% decrease in Child Deaths in Clark County from 2008 to 2012.**

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 a case that the coroner/medical examiner's office investigates in order to assign manner 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 2012 57% of all deaths reviewed were natural (127 cases). The next most frequent category was accidental deaths at 29.7% or 66 cases. This is a marked increase in accidental deaths from 2011, and the highest number of accidental deaths reviewed in the last five years. As seen in Figure 1.1, there was a large increase in the number of suicides from 2010 (n = 7) to 2011 (n = 16), but this number dropped to a more consistent level in 2012, with only 5 reported youth suicides.

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 pages 14- 15).

MANNER OF DEATH

Figure 1.1: 2008-2012 Manner of Death Counts by Year



Manner	2008	2009	2010	2011	2012	% change 2011 to 2012
Natural	203	187	168	155	127	-18.1%
Accident	65	57	46	37	66	78.4%
Suicide	4	4	7	16	5	-68.8%
Homicide	21	17	20	19	8	-57.9%
Undetermined	18	18	10	10	16	60.0%
Total Cases Reviewed	311	283	251	237	222	-6.3%

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 - 2012. The leading medical cause of death for children in Clark County in 2012 was prematurity (n=57), second was congenital defects (n=32), and third was chronic illness (n=24).

Figure 1.2a: 2008-2012 Primary Medical Causes of Death (Counts)

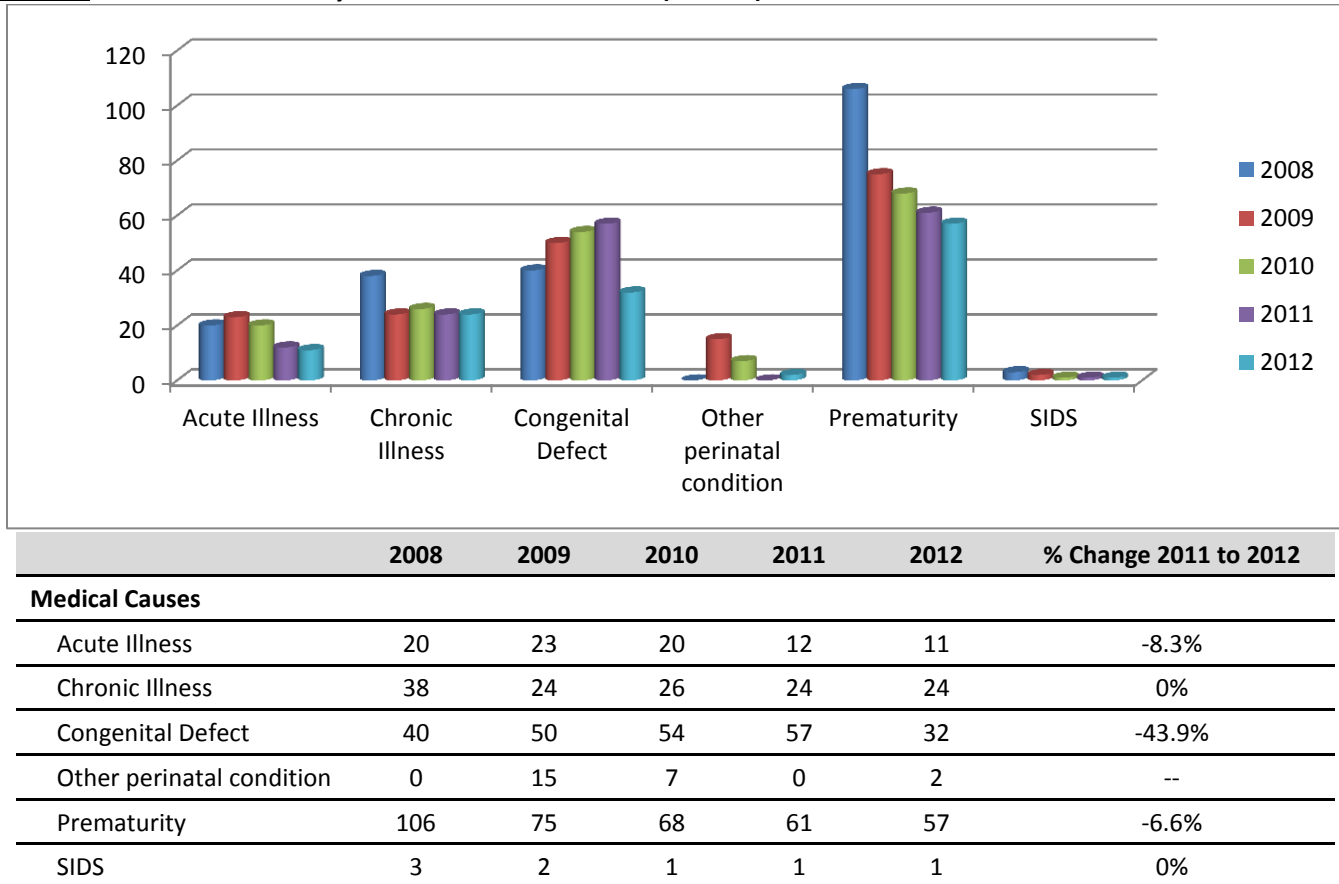
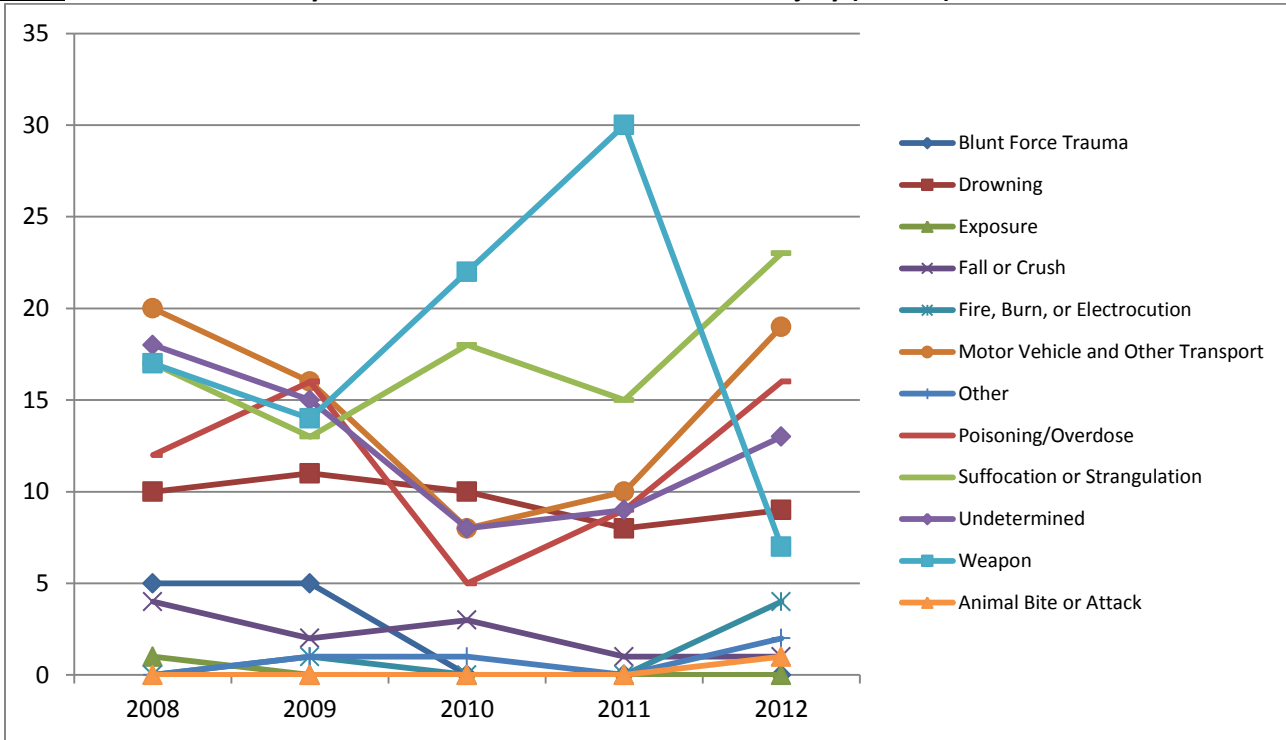


Figure 1.2b displays those cases from 2008 - 2012 where the primary cause of death was due to some type of external injury. This year suffocation/strangulation (n=23) is the leading cause of death due to external injury. Motor vehicle incidents are the second leading cause of child death due to external injury (n = 19), followed by poisoning/overdose (n = 16).

Top Three Causes of Child Deaths Related to External Injury:

- Suffocation/Strangulation (n=23)
- Motor Vehicle Incidents (n=19)
- Poisoning/Overdose (n=16)

Figure 1.2b: 2008-2012 Primary Causes of Death Related to External Injury (Counts)



Injury Causes	2008	2009	2010	2011	2012	% Change (2011 to 2012)
Drowning	10	11	10	8	9	12.5%
Exposure	1	0	0	0	0	0.0%
Fall or Crush	4	2	3	1	1	0.0%
Fire, Burn, or Electrocution	0	1	0	0	4	--
Motor Vehicle and Other Transport	20	16	8	10	19	90.0%
Other*	0	1	1	0	2	--
Poisoning/Overdose	12	16	5	9	16	77.8%
Suffocation or Strangulation	17	13	18	15	23	53.3%
Undetermined	18	15	8	9	13	44.4%
Weapon (including person's body part)	17	14	22	30	7	-76.7%

*"Other" causes included two cases that could not be categorized using one of the injury causes listed.

Figure 1.2c displays the crude death rates for children (ages 0-17 years) in Clark County for 2008 - 2012 as well as the change in the rates from 2008 to 2012. Causes of death with an overall increase in the rate from 2008 to 2012 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	2012	Change 2008-2011	% Change
Prematurity	20.53	14.66	13.23	12.49	11.63	-8.90	-43.4%
Congenital Defect	7.75	9.58	10.51	11.67	6.53	-1.22	-15.8%
Chronic Illness	7.36	4.89	5.06	4.91	4.90	-2.46	-33.5%
Acute Illness	3.87	4.5	3.89	2.87	2.24	-1.63	-42.0%
Other perinatal condition	0	2.93	1.36	0.00	0.41	0.41	n/a
External Injury	2008	2009	2010	2011	2012	Change 2008-2011	% Change
Motor Vehicle and Other Transport	3.87	3.13	1.56	2.05	3.88	0.01	0.2%
Poisoning/Overdose	2.32	3.13	0.97	1.84	3.26	0.94	40.7%
Undetermined	3.49	2.93	1.56	1.84	2.65	-0.84	-24.0%
Weapon	3.29	2.74	4.28	6.14	1.43	-1.86	-56.6%
Suffocation or Strangulation	3.29	2.54	3.50	2.66	4.69	1.40	42.6%
Drowning	1.94	2.15	1.95	1.64	1.84	-0.10	-5.4%
Fall or Crush	0.77	0.39	0.58	0.20	0.20	-0.57	-73.5%
SIDS	0.58	0.39	0.19	0.20	0.20	-0.38	-64.8%
Fire, Burn, or Electrocution	0	0.2	0.00	0.00	0.82	0.82	n/a
Exposure	0.19	0	0.00	0.00	0.00	-0.19	-100.0%
Total population of Clark County under 18*	516,398	511,619	513,184	488,553	490,186	-26,212	-5.1%

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

2010-2012 total population estimates come from the US Census Bureau Quickfacts (Retrieved Annually August 2011-2013)

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 rates are lower than the national and Nevada rates for 2012, with the exception of the unintentional injury rate (highlighted in pink), which is higher in 2012 than the Nevada or National rates.

Figure 1.2d: Overall Crude Child Death Rates 2008 to 2012 (per 100,000)

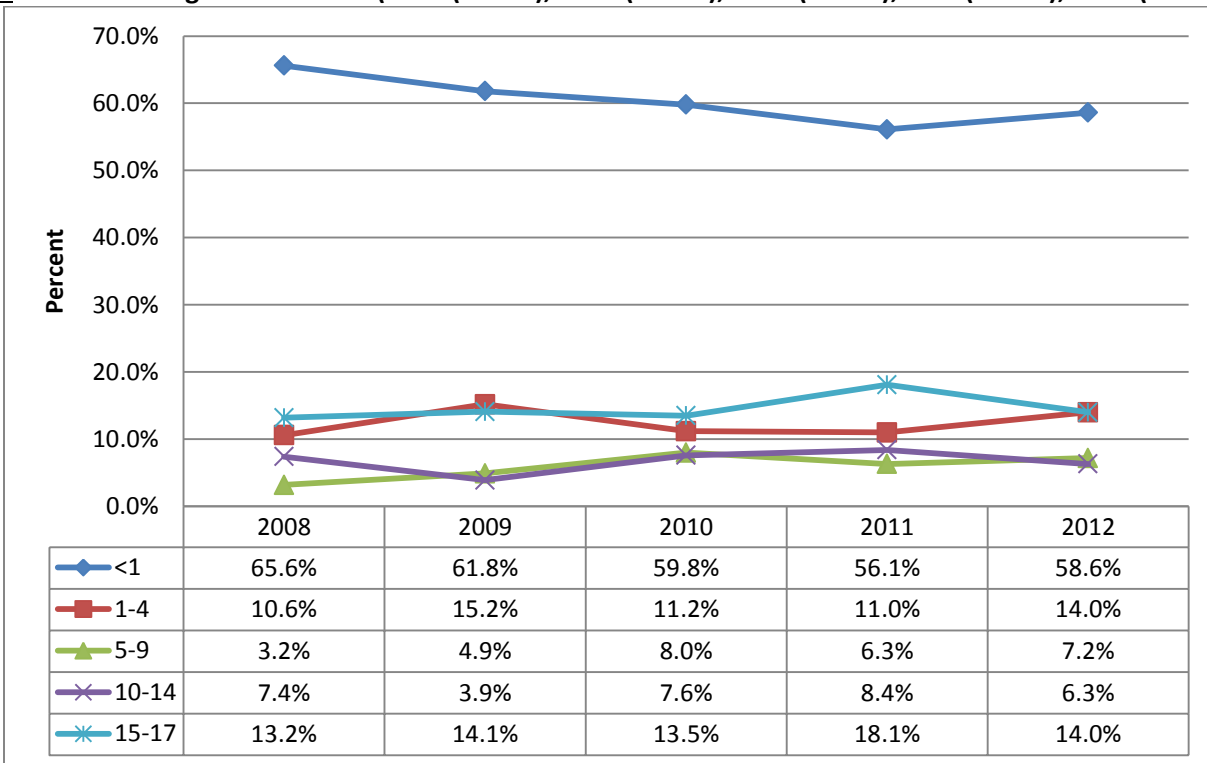
	2008	2009	2010	2011	2012	Change 2008-2012	National Rate*	Nevada Rate
All Deaths under 18	60.22	55.31	48.91	48.51	45.29	-14.93	55.9	54.5
All Unintentional Injuries (Accidents)	12.59	11.14	8.96	7.57	13.46	0.87	8.5	11.3
Suicide	0.77	0.78	1.36	3.27	1.02	0.25	1.4	2.3
Homicide	4.07	3.32	3.90	3.89	1.63	-2.44	2.4	2.3

*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)

OVERALL DEMOGRAPHICS

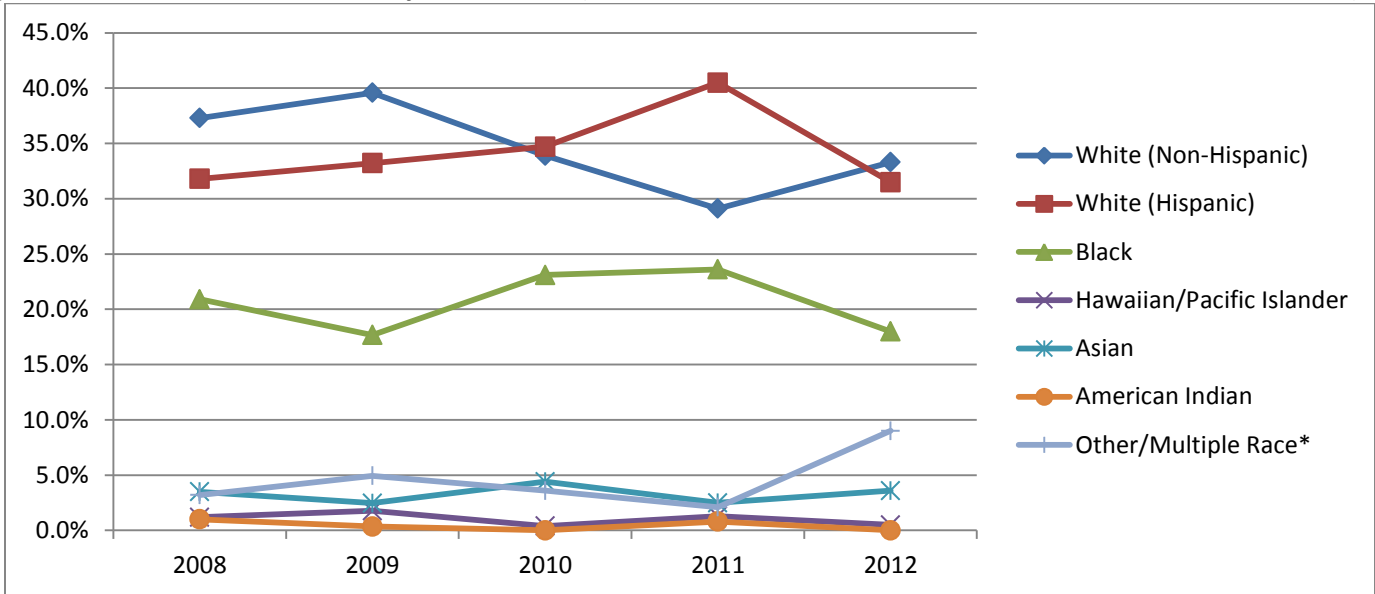
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2012 again the majority of deaths occurred in children less than one year of age (58.6%). The proportion of children in the other age categories has remained fairly consistent, with slightly fewer in the older age categories in 2012.

Figure 1.3: 2008-2012 Age of Decedent (2008 (n=311), 2009 (n=283), 2010 (n=251), 2011(n=237), 2012 (n=222))



Data regarding race and ethnicity are collected from the child's death certificate and are 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 was exceeded by White Hispanic children until this year when there were slightly fewer White Hispanic deaths than White Non-Hispanic. 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. However, in 2012 the proportion of Black children has declined again to 2009 numbers. These statistics are presented in Figure 1.4 below.

Figure 1.4: 2008-2012 Race/Ethnicity of Decedent (2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237, 2012 n=222)



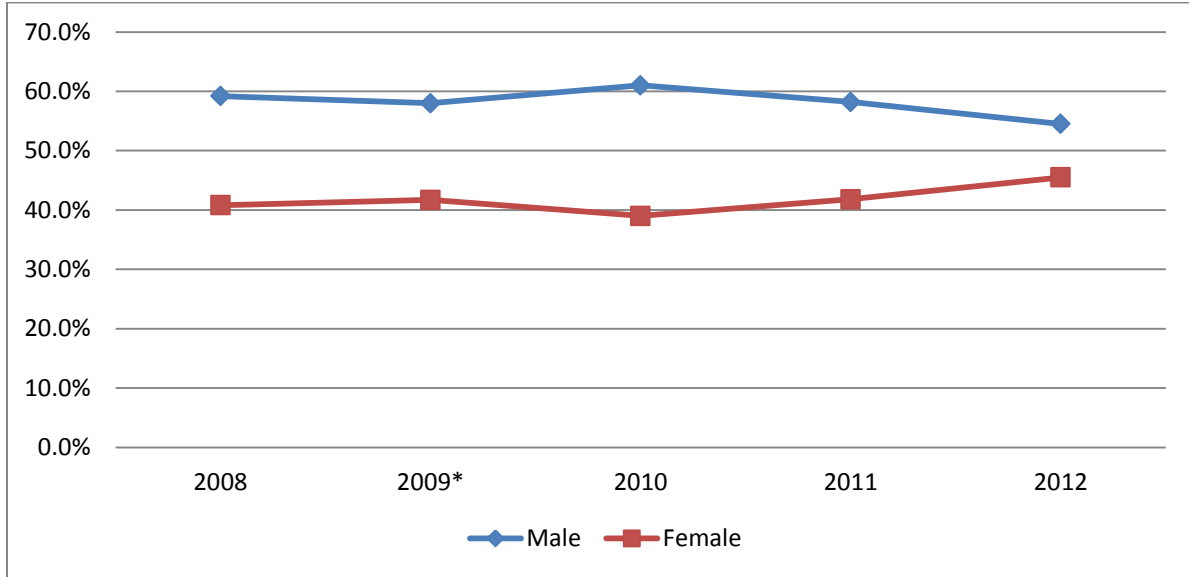
	White (Non-Hispanic)	White (Hispanic)	Black	Native Hawaiian/Pacific Islander	Asian	American Indian	Other/Multiple Race	Unknown
2008	37.3% (116)	31.8% (99)	20.9% (65)	1.2% (4)	3.5% (11)	1% (3)	3.2% (10)	1% (3)
2009	39.6% (112)	33.2% (94)	17.7% (50)	1.8% (5)	2.5% (7)	.4% (1)	4.9% (14)	--
2010	33.9% (85)	34.7% (87)	23.1% (58)	0.4% (1)	4.4% (11)	0	3.6% (9)	--
2011	29.1%(69)	40.5% (96)	23.6% (56)	1.3% (3)	2.5% (6)	0.8% (2)	21% (5)	--
2012	33.3% (74)	31.5% (70)	18% (40)	0.5% (1)	3.6% (8)	0	9% (20)	0.5% (1)

* 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 female decedents is very similar for all four years presented below. Each year there is a higher proportion of male as compared to female decedents. However, as seen in Figure 1.5 below, in 2012 there was an increase in the proportion of females and a corresponding decline in males approaching a more even distribution. In 2009 there was one case in which sex was unable to be determined at the time of death (fetal death); this case is listed as unknown in Figure 1.5 below.

Figure 1.5: 2008-2012 Sex of Decedent (2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237, 2012 n=222)



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

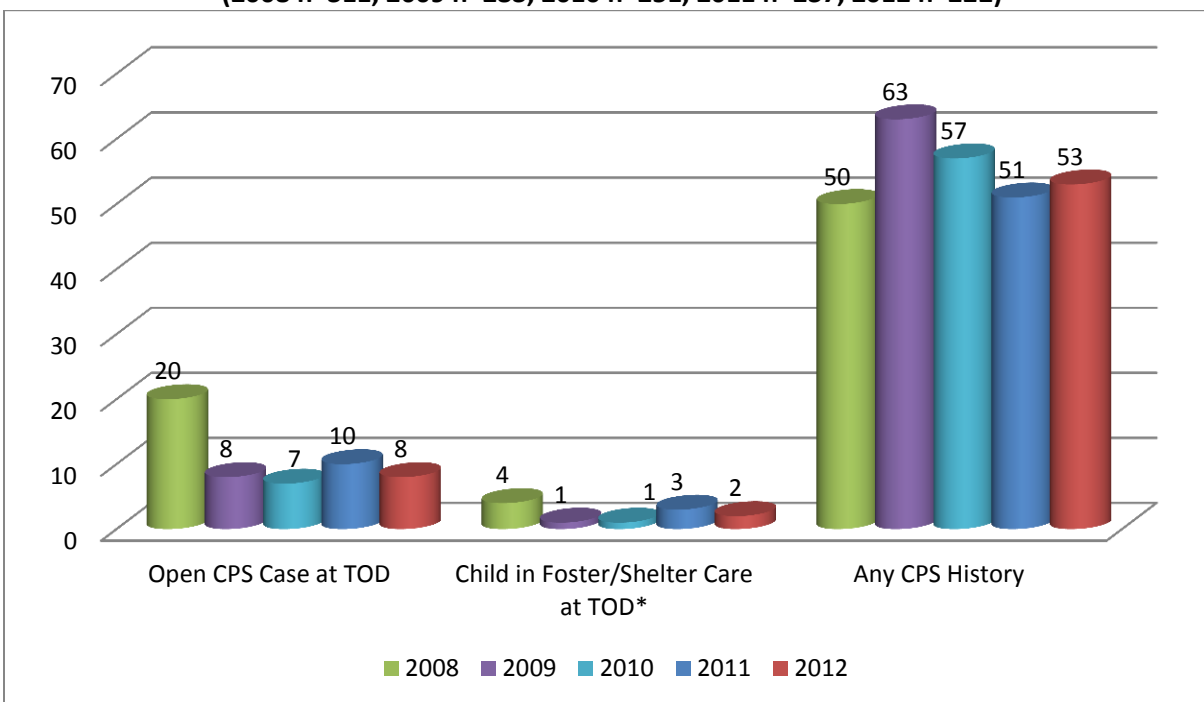
	2008	2009*	2010	2011	2012
Male	59.2% (184)	58% (164)	61% (153)	58.2% (138)	54.5% (121)
Female	40.8% (127)	41.7% (118)	39% (98)	41.8% (99)	45.5% (101)
Unknown	0	0.4% (1)	0	0	0

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 2008-2012 in which 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.

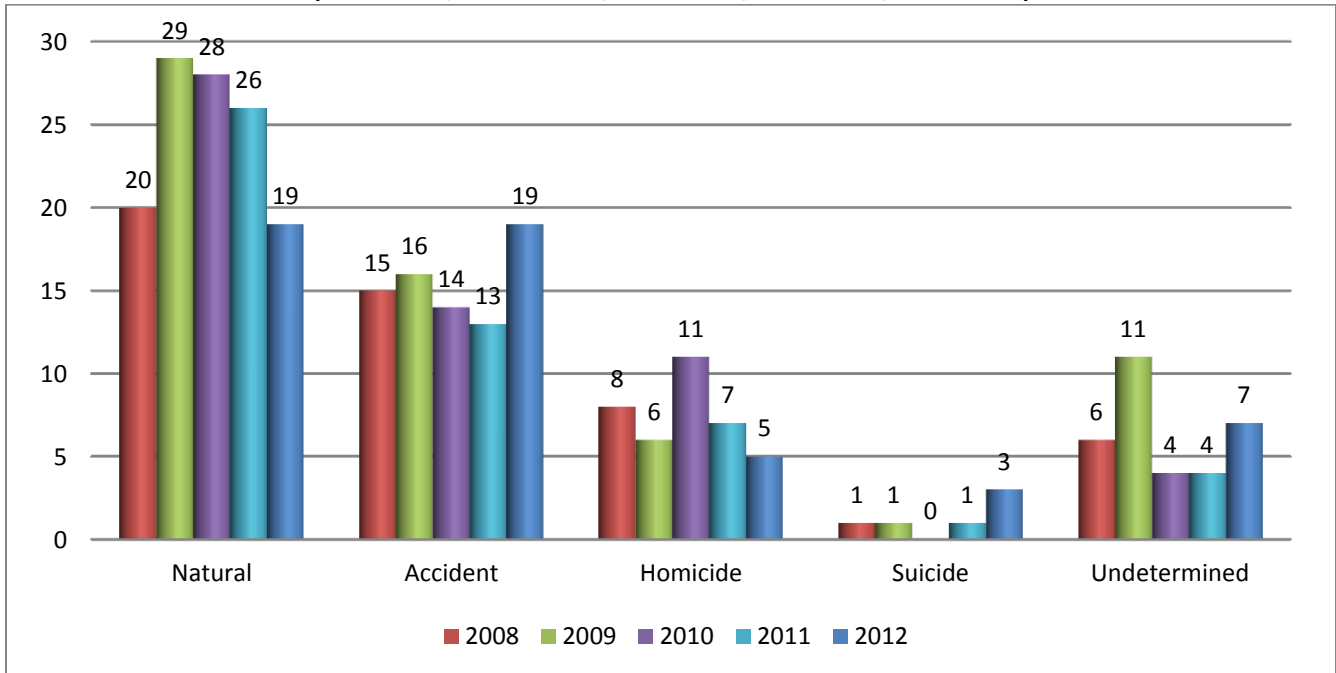
The numbers presented in Figure 1.6 below represent total counts in each of the categories.

Figure 1.6: 2008-2012 Type of Child Welfare Involvement
(2008 n=311, 2009 n=283, 2010 n=251, 2011 n=237, 2012 n=222)



*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: 2008-2012 Cases with Prior Child Welfare History by Manner of Death
 (2008 n=50, 2009 n=63*, 2010 n=57, 2011 n=51, 2012 n=53)



*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 2012 there were 222 child deaths and in 53 of those cases (23.7%) there was some family history of involvement with child welfare.

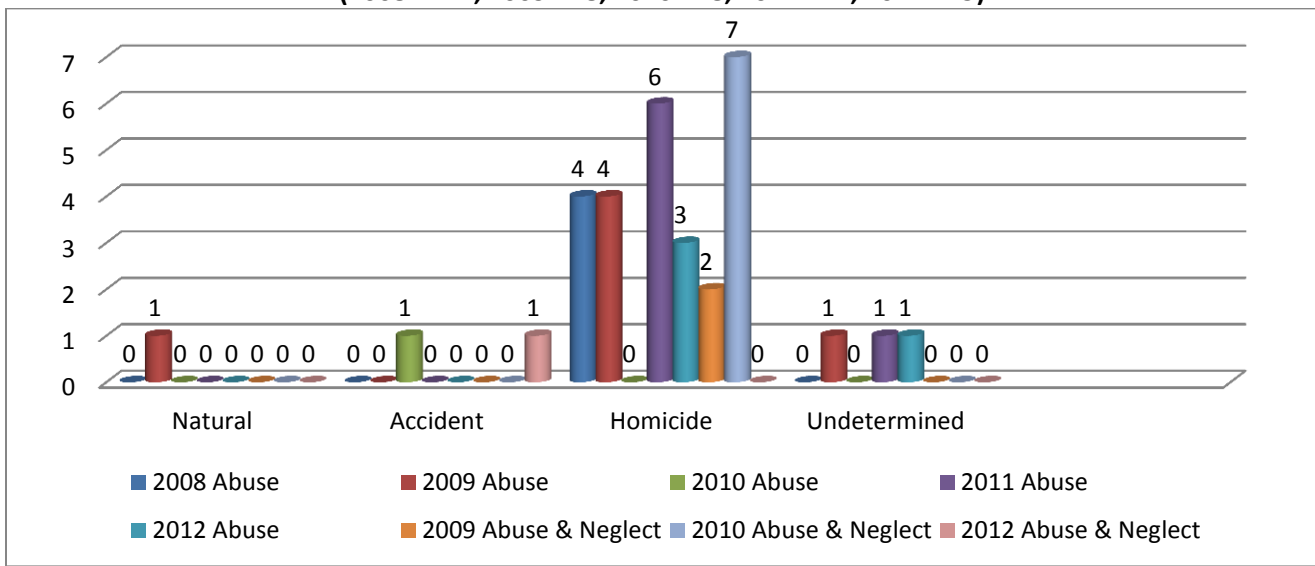
- For those deaths occurring in 2012 in which the family did have a history of involvement in child welfare, the most frequently occurring manners of death were Natural and Accident both at 35.8%
- Interestingly there has been a steady decline in Natural deaths with a family history with child welfare, while 2012 represents the year with the highest number of accidental deaths to children whose family has had some involvement with child welfare

For those deaths occurring in 2012 in which the family had no prior history of involvement with child welfare, Natural was the most frequently occurring category at 63.9%, followed by Accident at 27.8%, which is comparable to the findings in 2010 and 2011.

SUBSTANTIATED ABUSE/NEGLECT DEATHS

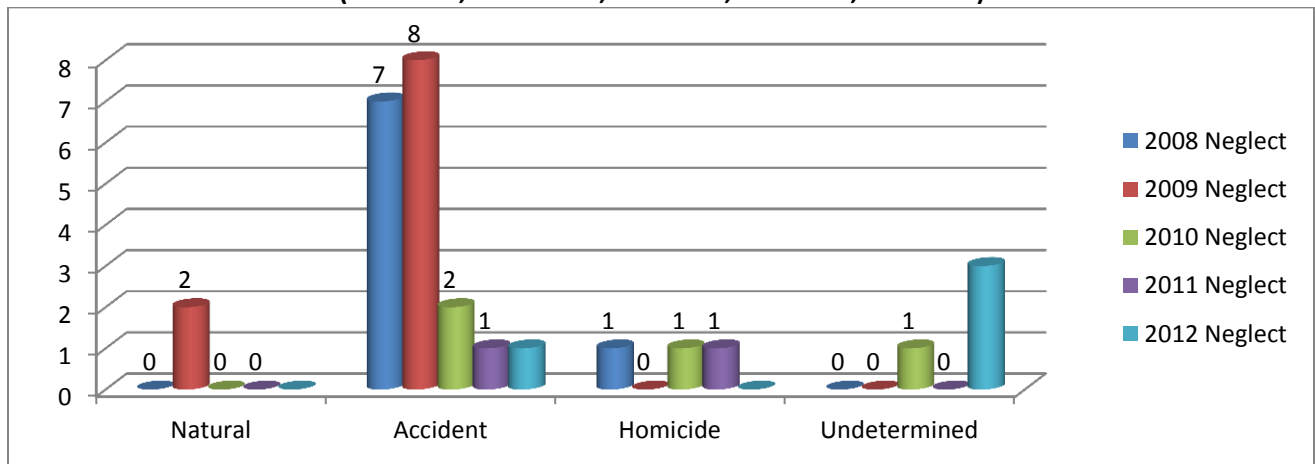
Starting with 2008 child deaths, the Clark County Department of Family Services (CCDFS) provides NICRP with statistics regarding child fatalities where their office received a death allegation of child abuse or neglect, and this allegation was substantiated. A report of abuse or neglect is “substantiated” 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 2012, there were 9 substantiated death allegations of child abuse or neglect; this represents 4.1% of all child deaths in 2012. In addition, there was one child fatality with substantiated child neglect due to a “significant contributing condition.” In this case the manner of death was ruled a homicide and was related to a lack of adequate care for a medical condition. Medical neglect was substantiated in this case, as the death was not expected based on the medical condition and a “significant” contributing condition listed on the death certificate was medical neglect. Additional information regarding the cases with substantiated death allegations (n=9) are presented in the figures below.

Figure 1.8a: 2008-2012 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, 2012 n=5)



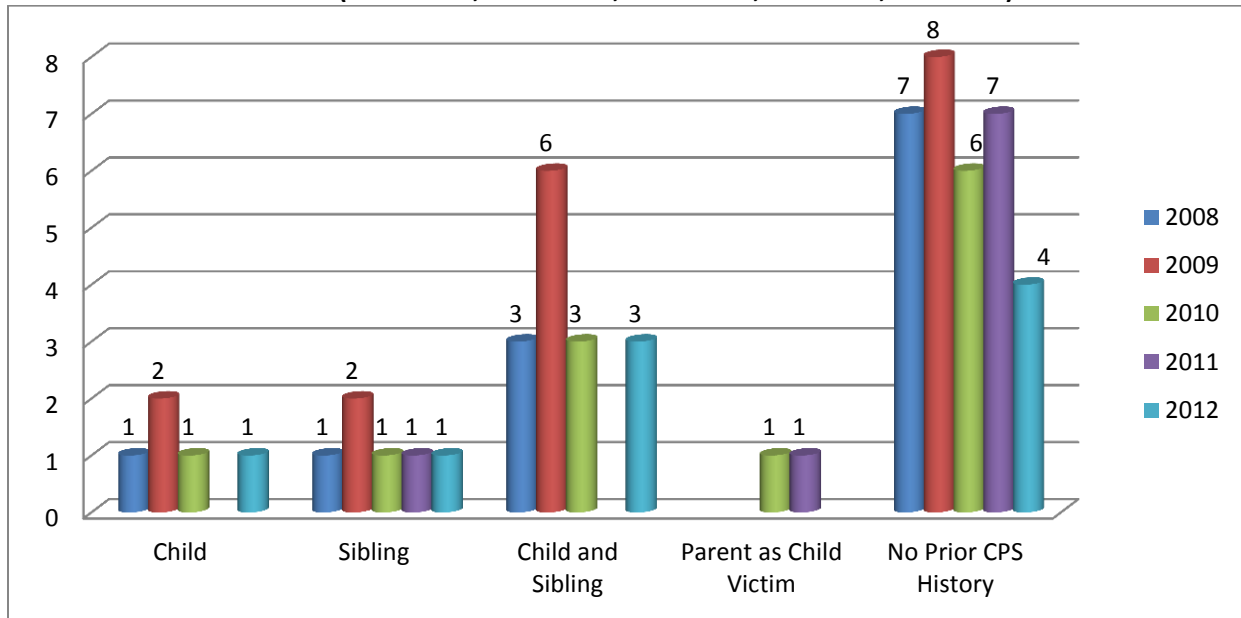
**In 2008 and 2011 there were no cases of substantiated abuse and neglect*

Figure 1.8b: 2008-2012 Manner of Death for Substantiated Death Allegations Neglect Only (2008 n=7, 2009 n=10, 2010 n=4, 2011 n=2, 2012 n=4)



In 2012 the substantiated allegations were split almost evenly between neglect only and abuse only, typically there are a greater number of abuse related cases. In addition most of the cases with substantiated abuse allegations are homicides, while most with neglect only are accidents or undetermined (see Figure 1.8a and 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, 2012 n=9)



With regard to the distribution of the number of types of prior family history with CPS, 2012 looks similar to prior years, however this is the smallest number of cases without a prior history with child welfare. In 2012, nearly half of the fatalities with a substantiated death allegation (4 of 9), the decedents' and their family did not have prior history with CPS. In three cases the history was regarding the decedent and his/her siblings, and in the other two cases history was related to the decedent or their sibling but not both.

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 death 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 2012 the majority of natural deaths (71.7%) were among children less than one year old, which is about the same as in 2010 and 2011.

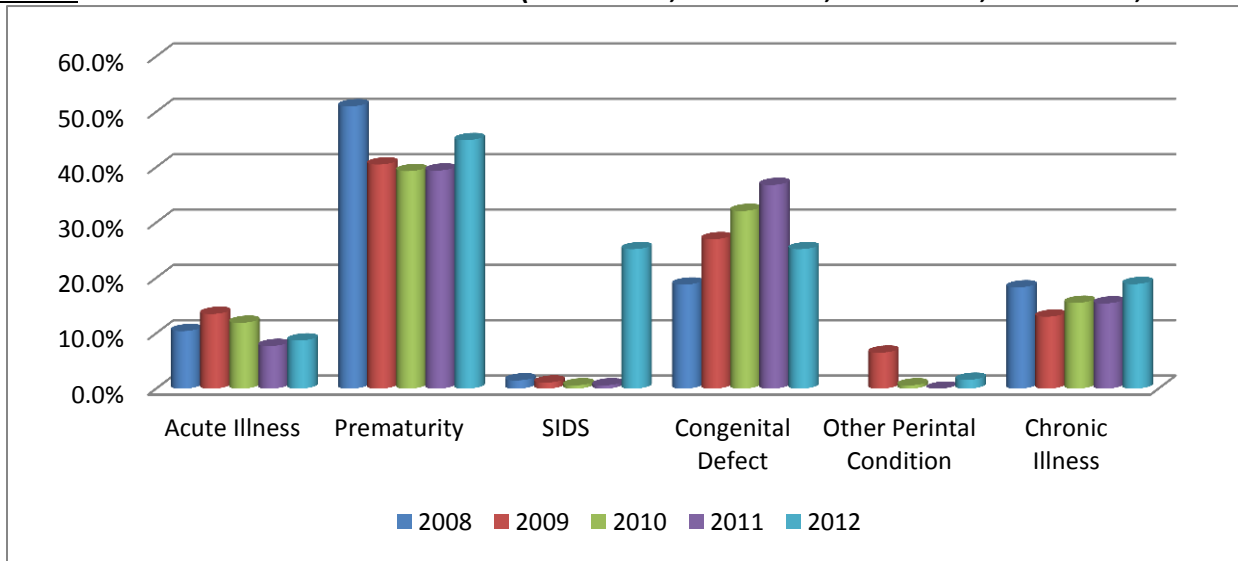
The leading causes of natural deaths (n=127) reviewed included:

- Prematurity (n=57)
- Congenital Anomalies (n=32)
- Chronic Illness (n=24)
- Acute Illness (n=11)

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. From 2010 to 2012 there has only been 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.

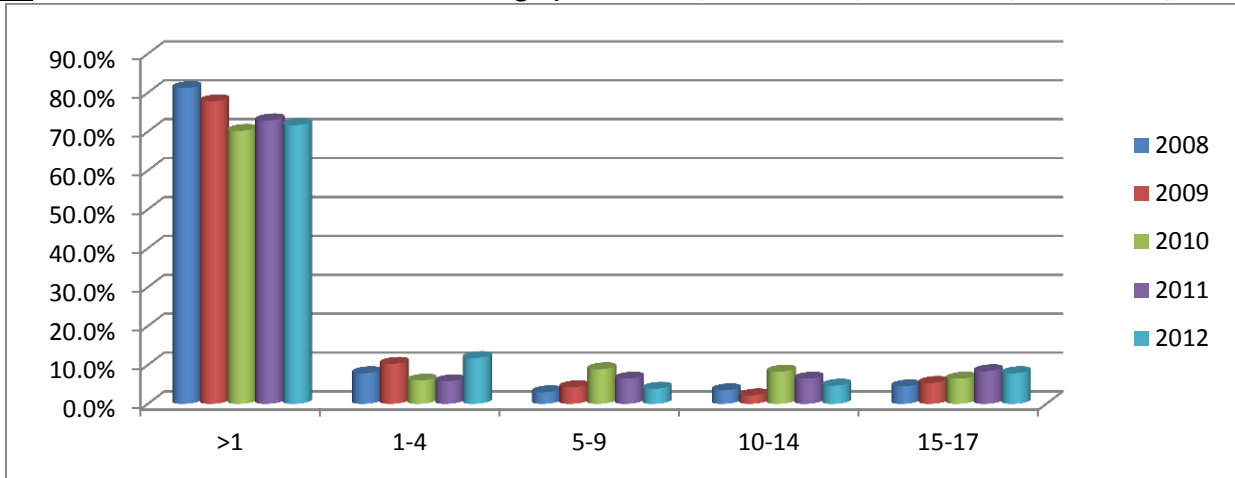
The following graph (Figure 2.1) presents all of the causes of natural deaths among cases reviewed from 2008 to 2012. As illustrated, the category “Prematurity” is again the leading cause of natural death in children at 44.9% which is a decrease compared to the 51% in 2008, but very similar to the numbers in 2009-2011.

Figure 2.1: 2008-2012 Natural Causes of Death (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155, 2012 n=127)



Cause	2008	2009	2010	2011	2012
Acute Illness	10.4%(21)	11.9%(22)	11.9% (20)	7.7% (12)	8.7% (11)
Prematurity	51%(103)	40.5% (75)	39.3% (66)	39.4% (61)	44.9 (57)
SIDS	1.5%(3)	1.1% (2)	0.6% (1)	0.6% (1)	0.8% (1)
Congenital Defect	18.8%(38)	27% (50)	32.1% (54)	36.8% (57)	25.2%(32)
Other Perinatal Condition	--	6.5% (12)	0.6% (1)	--	--
Chronic Illness	18.3%(37)	13% (24)	15.5% (26)	15.4% (24)	18.9% (24)

Figure 2.2: 2008-2011 Natural Death Decedent Age (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155, 2012 n=127)

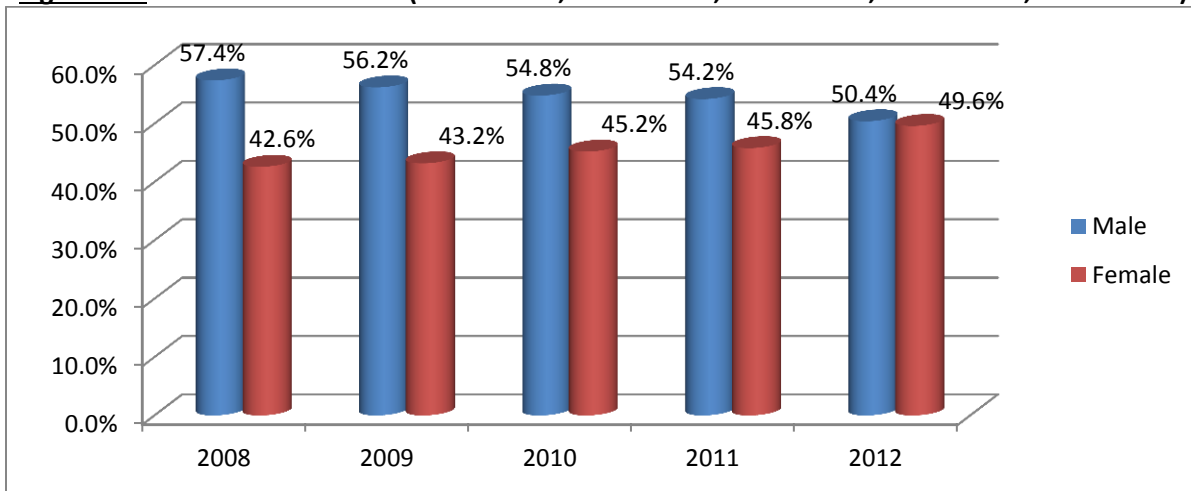


	2008	2009	2010	2011	2012
<1 year	81.2%(164)	77.8% (144)	70.2% (118)	72.9% (113)	71.7% (91)
1-4 years	7.9%(16)	10.3% (19)	6.0% (10)	5.8% (9)	11.8 (15)
5-9 years	3.0%(6)	4.3% (8)	8.9% (15)	6.5% (10)	3.9% (5)
10-14 years	3.5%(7)	2.2% (4)	8.3% (14)	6.5% (10)	4.7% (6)
15-17 years	4.5%(9)	5.4% (10)	6.5% (11)	8.4% (13)	7.9% (10)

The graph in Figure 2.2 above illustrates decedent age for all natural deaths from 2008 to 2012. The majority of natural deaths are among children less than one year of age from 2008 through 2012. However, we do see a decrease in the number of natural deaths of children under one year of age from 2008 to 2012 (81.2% in 2008 compared to 71.7% in 2012). At the same time, there is a slight increase in the number of natural deaths among children in older age groups.

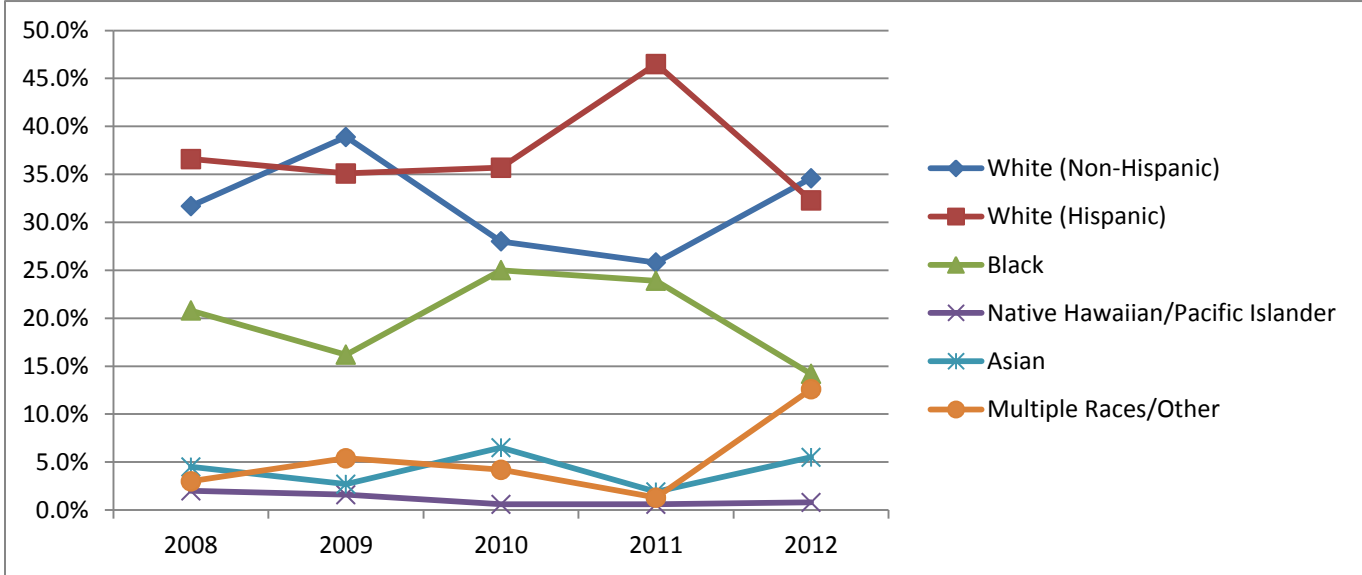
Figure 2.3 below consistently demonstrates that more males than females die from natural causes with the distribution being very similar from year to year, but becoming more equal in 2012.

Figure 2.3: Natural Deaths - Sex (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155, 2012 n=127)



The graph in Figure 2.4 below shows the racial and ethnic breakdown of the natural deaths for 2008-2012. In 2012, about one third of natural deaths were among White Non-Hispanic children (34.6%), followed by White Hispanic children at 32.3%, and then 14.2% Black children.

Figure 2.4: Natural Deaths – Race/Ethnicity (2008 n=202, 2009 n=185, 2010 n=168, 2011 n=155, 2012 n=127)



	2008*	2009	2010	2011	2012
White (Non-Hispanic)	31.7% (64)	38.9% (72)	28.0% (47)	25.8% (40)	34.6% (44)
White (Hispanic)	36.6% (74)	35.1% (65)	35.7% (60)	46.5% (72)	32.3% (41)
Black	20.8% (42)	16.2% (30)	25.0% (42)	23.9 (37)	14.2% (18)
Native Hawaiian/Pacific Islander	2.0% (4)	1.6% (3)	0.6% (1)	0.6% (1)	0.8% (1)
Asian	4.5%(9)	2.7% (5)	6.5% (11)	1.9% (3)	5.5% (7)
Multiple Races/Other	3.0% (6)	5.4% (10)	4.2% (7)	1.3% (2)	12.6% (16)

*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

Just over one sixth (18.9%) 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 2012 more males (54.2%) as compared to females (45.8%) died from complications associated with chronic illness. The most frequent age category for chronic illness was 15 to 17 years (29.2%) followed by 10 to 14 years and 1 to 4 years (25% for both age groups). See Figure 2.5 below.

Figure 2.5: 2008-2012 Natural Deaths - Chronic Illness – Age in Years
(2008 n=37, 2009 n=24, 2010 n=26, 2011 n=24, 2012 n=24)

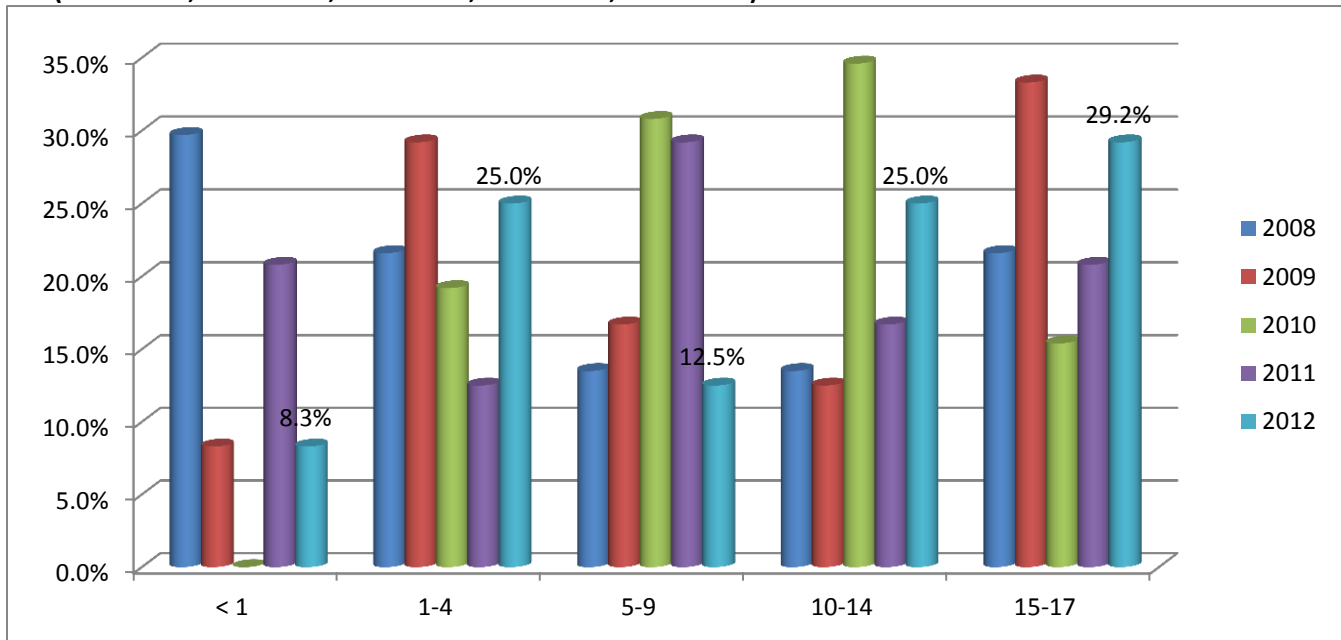
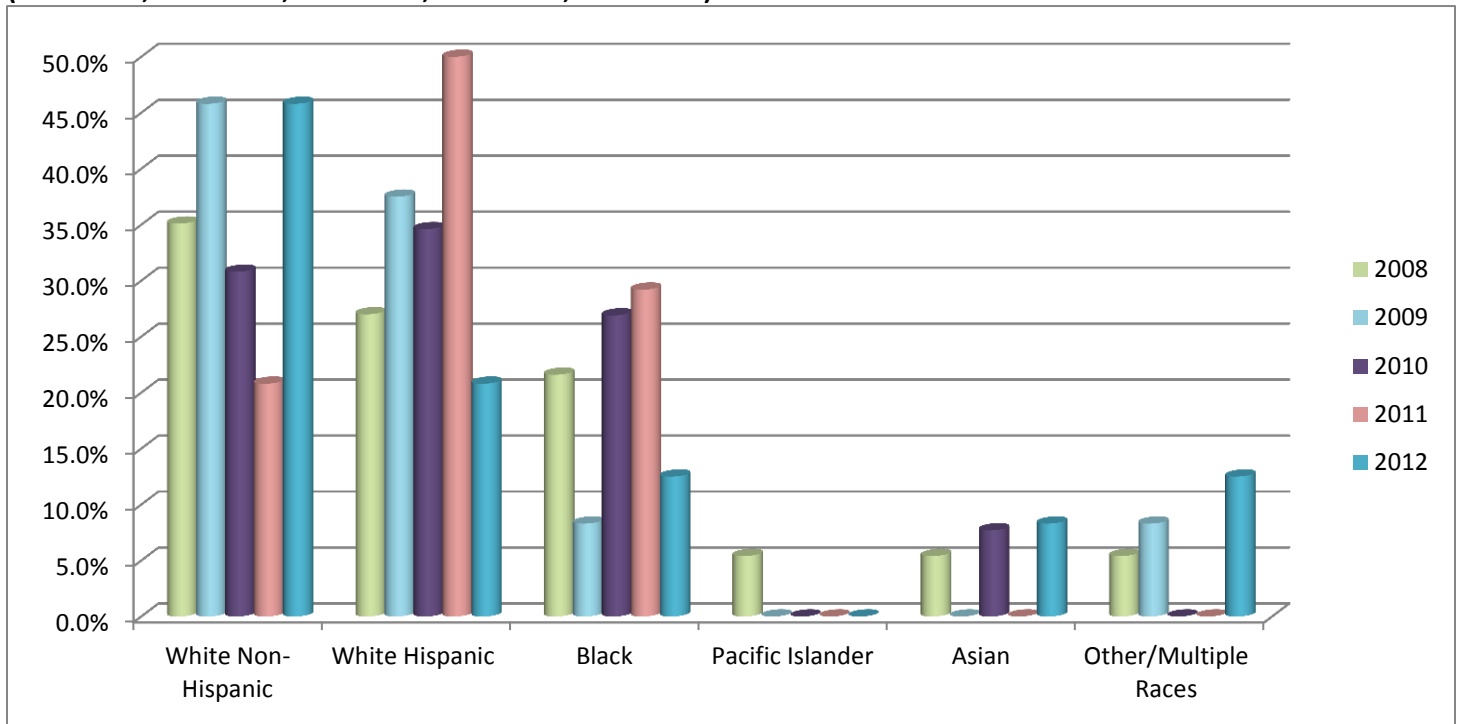


Figure 2.6 displays the racial and ethnic breakdown for deaths associated with chronic illnesses in 2008-2012. In 2012 Nearly half (45.8%) of the cases in 2012 were White Non-Hispanic Children, which is the same as in 2009.

Figure 2.6: 2012 Natural Deaths – Chronic Illness Race/Ethnicity
 (2008 n=37, 2009 n=24, 2010 n=26, 2011 n=24, 2012 n=24)



In nearly one third of the cases of chronic illness this year (29.2%) the child had the condition since birth, while another 20.8% 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 70.8% of the cases, the decedent was receiving medical care for the chronic condition at the time of death and in the majority of cases, the families receiving medical care were following the doctors' prescribed care plan (82.3%).

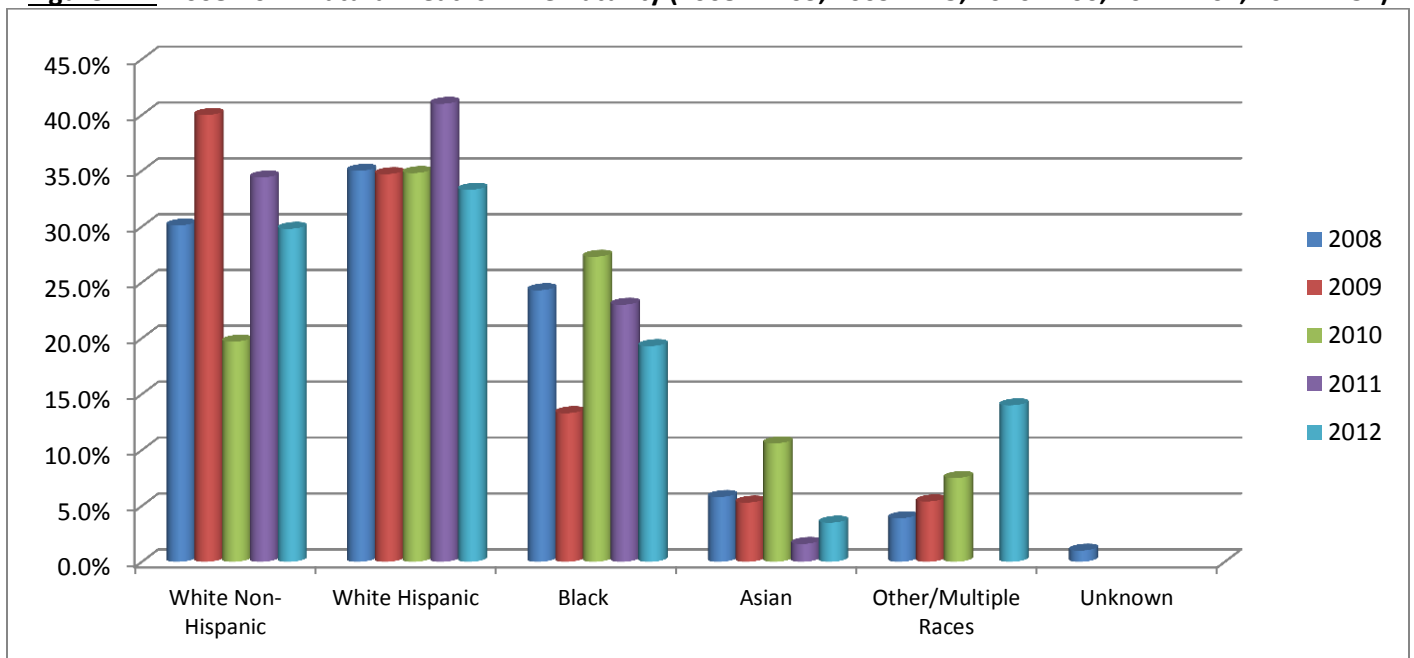
PREMATURITY

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.

Nearly half (44.9%) of all natural deaths in Clark County reviewed in 2012 were caused by complications of prematurity, about the same as prior years. As expected, all of the children in this category were less than one year of age at the time of their death. In 2012 there were nearly the same number of males (49.1%) and females (50.1%) in the category, which is similar to prior years.

In 2012, premature deaths occurred most frequently among White Hispanics (33.3%), followed by White Non-Hispanics (29.8%). This year there was a continued decrease in the percentage of Black premature decedents, from 27.3% in 2010 to 19.3% in 2012. This is similar to national statistics that indicate that Hispanic infants are more likely than White infants to be born premature (Centers for Disease Control and Prevention, 2012).

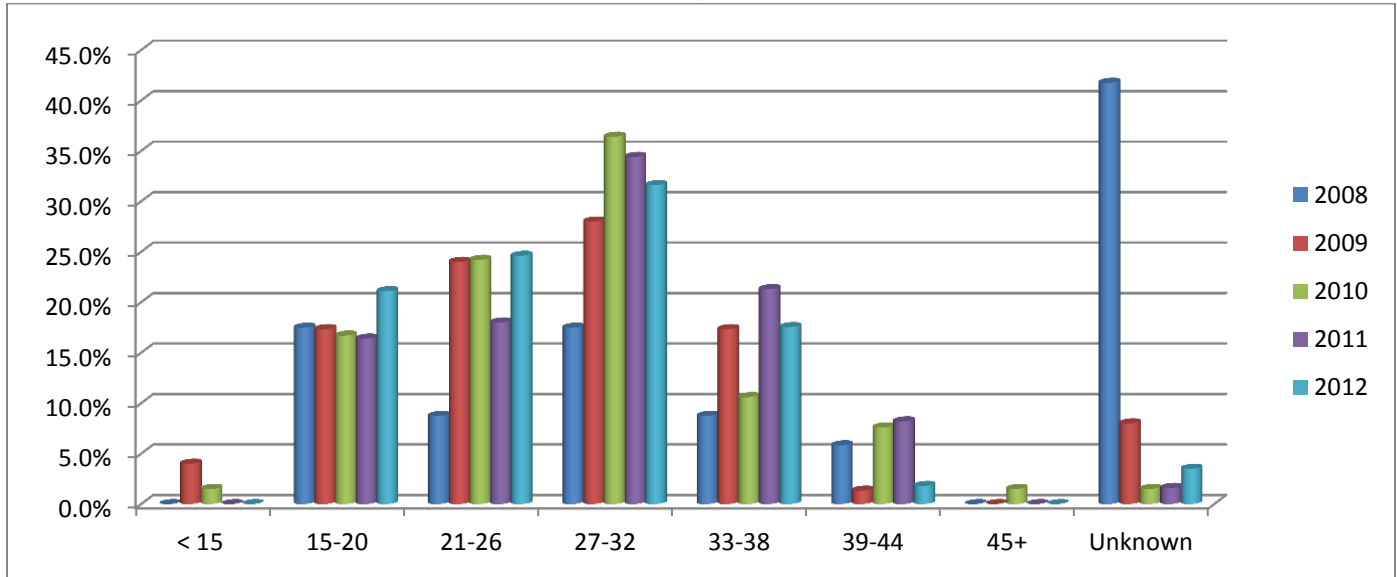
Figure 2.7: 2008-2012 Natural Deaths – Prematurity (2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61, 2012 n=57)



In 2012 cases where the cause of death was listed as prematurity, gestational age was known in 85.9% of cases (n=49) and ranged from 20 to 37 weeks. In 71.9% (n=41) of cases, it was indicated that the mother received prenatal care, which is nearly twice as many as in 2011 (39.3%). In 98.2% (n=56) of the cases the mother had known medical complications or infections.

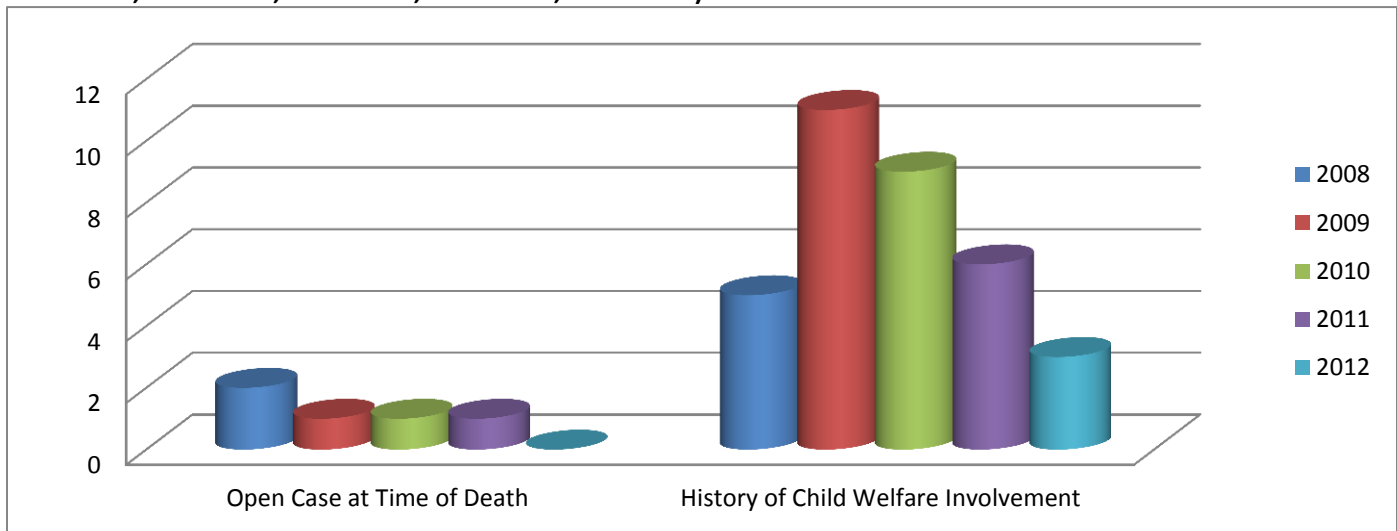
In 2012 the age of the mother was known in 96.4% of cases (n=55), and ranged from 17 to 39 years. Since maternal age is a factor that influences the likelihood of complications and premature birth, this is an important variable to track. The graph below illustrates the age categories of mothers of infants who died from complications associated with prematurity in 2008-2012. 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 from 2010-2012 it was known in all but two cases.

Figure 2.8: 2008-2012 Natural Deaths – Prematurity – Mother’s Age in Years
 (2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61, 2012 n=57)



Of all natural deaths due to prematurity in 2012, 5.3% (compared to 9.8% in 2011) had any family history of involvement with child welfare (this could be siblings, or the parent as a child victim), and none of these decedents had an open case with child welfare at the time of their death.

Figure 2.9: 2008-2012 Prematurity – Child Welfare Involvement
 (2008 n=103, 2009 n=75, 2010 n=66, 2011 n=61, 2012 n=57)



	2008		2009		2010		2011		2012	
	Count	%	Count	%	Count	%	Count	%	Count	%
Open Case at Time of Death	2	1.9%	1	1.3%	1	1.5%	1	1.6%	0	0%
History of Child Welfare Involvement	5	4.9%	11	14.7%	9	13.6%	6	9.8%	3	5.3%

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. From 2010 to 2012 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 of SIDS in 2012, 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 2012 the majority (58.6%) of natural deaths occurred among children less than one year of age. Again this year there were a high proportion of deaths attributed to complications of prematurity (44.9%) 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 FAMILY PLANNING AND 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 96% (n=55) cases in 2012. In 2012 45.7% of mothers were 25 years of age or younger, and at 21.1% 2012 represents the highest proportion of mothers ages 15 to 20 years. 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 continuation 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 first time mothers in Southern Nevada.

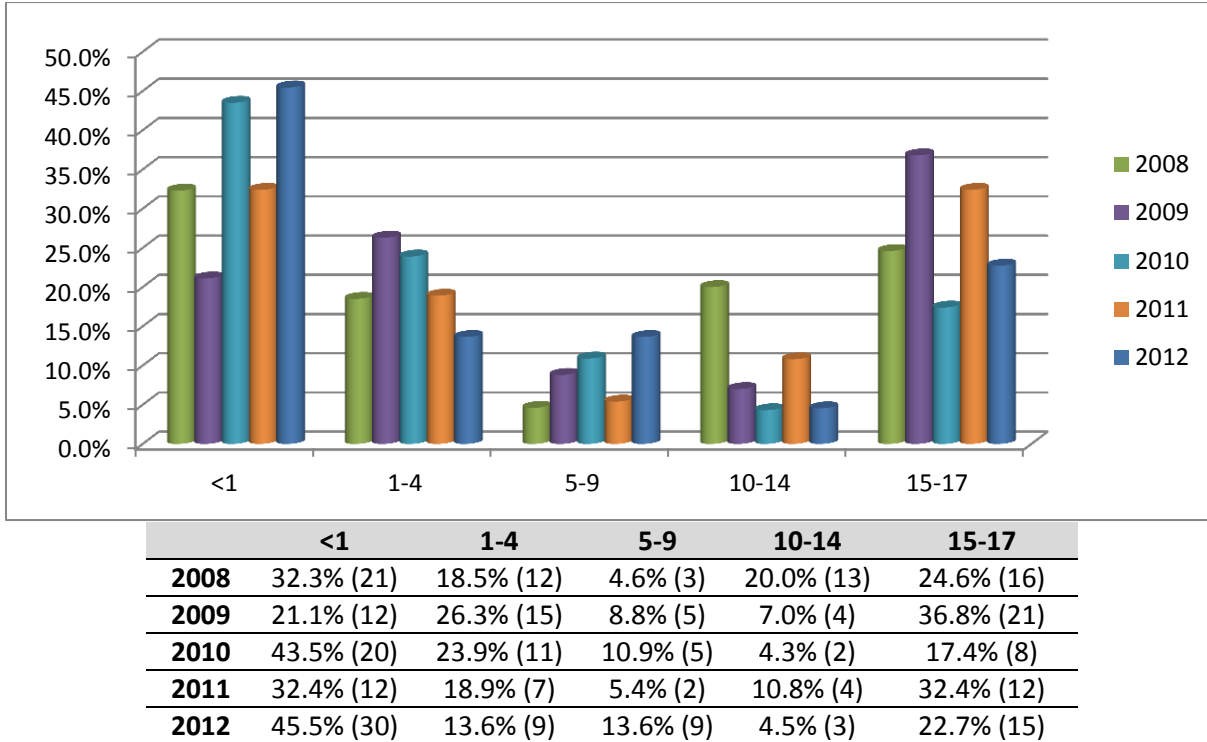
3. IMPROVE PARENT EDUCATION ABOUT PROPER MANAGEMENT OF COMMON CHRONIC ILLNESSES IN CHILDREN.

This year one of the leading causes of natural deaths was chronic illness (18.9%). 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. In 2012 nearly one third (29.2%) of these deaths were children between 15 and 17 years of age. Parents of teens with a chronic illness experience special challenges as they try to navigate their teens need for increased independence with the need to carefully monitor their condition.

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 2012, 66 child deaths in Clark County were ruled as accidental, showing a marked increase from 2011. All of the 66 cases were investigated by the coroner/medical examiner’s office. Of those 66 cases, 62.1% were male and 37.9% were female. More than half (59.1%) of the cases were children ages zero to 4 years of age.

Figure 3.1: 2008-2012 Percent of Children by Age category for All Accidental Deaths
(2008 n=65, 2009 n=57, 2010 n=46, 2011 n=37, 2012 n=66)



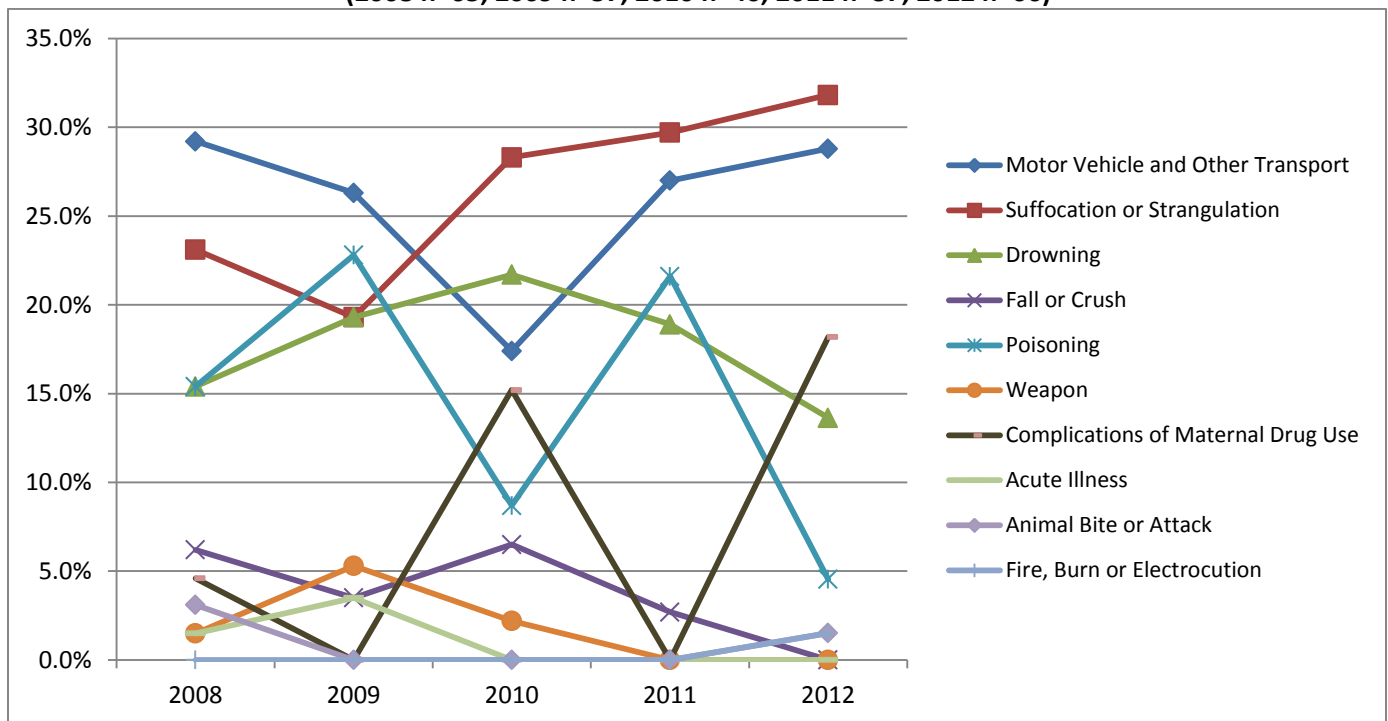
About one third of all accident victims were White Non-Hispanic (31.8%), another third were White Hispanic (36.4%), 13.6% were Black, and the remaining cases were children who were Asian, Pacific Islander or multiracial. This distribution is more in line with previous years, as the largest group is White Hispanic, followed by White Non-Hispanic.

In less than one third (28.8%) of accidental child deaths, the child’s family had some history with the child welfare system, making these cases mandatory reviews. In 47.4% of all accidents with prior child welfare history, the history was regarding the decedent. In 3% of all accidents, there was a child welfare case open with the family at the time of the child’s death. In 59% (n=39) of cases the team determined that the decedents needed supervision, but in 7.6% 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 71.8% of cases 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 23% of accidents reviewed where a supervisor was present, the supervisor was less than 25 years of age. The majority of accidental deaths in 2012 occurred either in the child’s home (45.5%), or in a roadway, driveway or sidewalk (27.3%). Additionally, there were three accidental deaths where children from out of state died while in Clark County. These children were all from California.

For the third time in five years, the leading cause of accidental death was suffocation (31.8%) and not motor vehicle accidents (MVA) as it has been from 2008-2009. 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. However, in 2012 we see a sharp increase in the number of these deaths in Clark County, nearly doubling from the 10 cases in 2011 to 19 cases in 2012.

The third leading cause of death was complications of maternal drug use at 17.9%, and drowning was fourth which accounts for 13.4% 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 2012, as well as all causes of accidental deaths in a table is displayed in Figure 3.2 below.

Figure 3.2: 2008-2012 Percent of Accidental Injury Deaths by Cause
(2008 n=65, 2009 n=57, 2010 n=46, 2011 n=37, 2012 n=66)



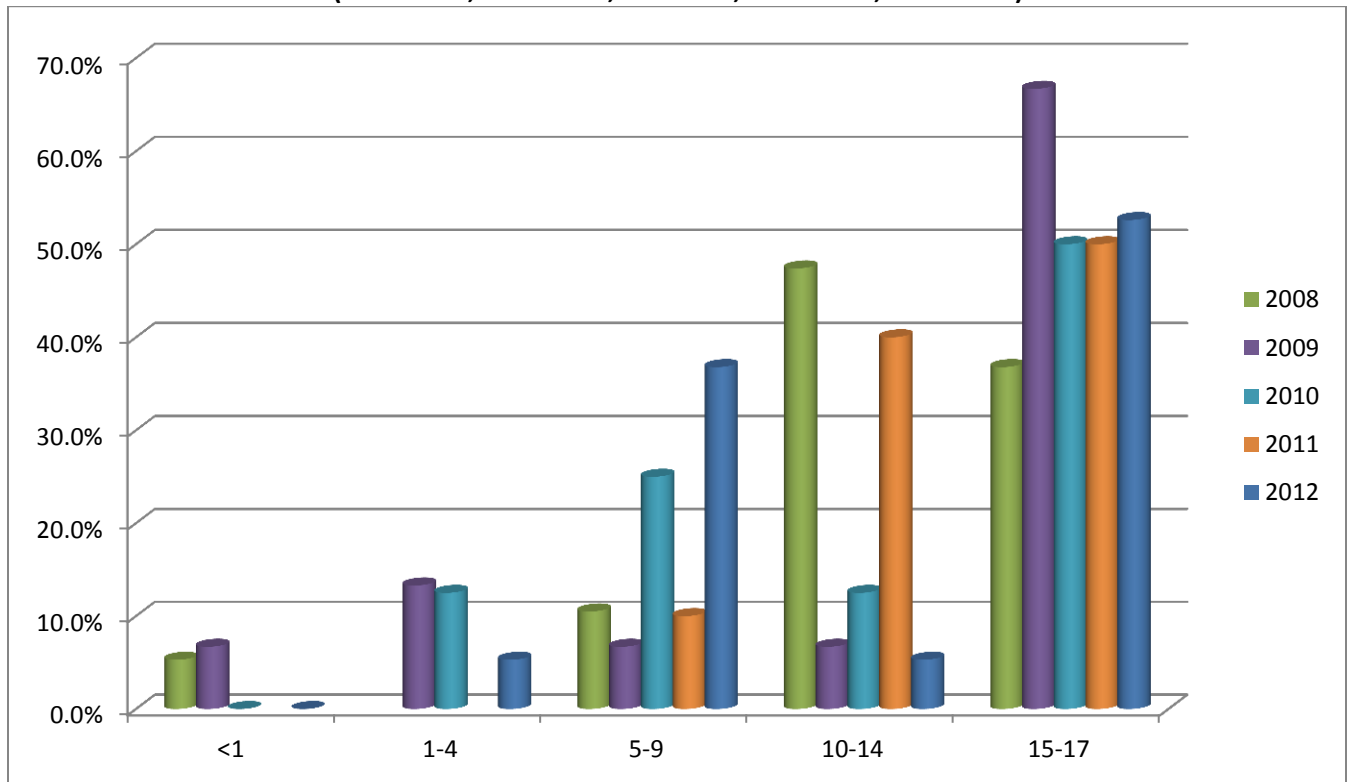
	2008	2009	2010	2011	2012
Motor Vehicle and Other Transport	29.2% (19)	26.3% (15)	17.4% (8)	27% (10)	28.7% (19)
Suffocation or Strangulation	23.1% (15)	19.3% (11)	28.3% (13)	29.7% (11)	31.8% (21)
Drowning	15.4% (10)	19.3% (11)	21.7% (10)	18.9% (7)	13.6% (9)
Fall or Crush	6.2% (4)	3.5% (2)	6.5% (3)	2.7% (1)	0%
Poisoning	15.4% (10)	22.8% (13)	8.7% (4)	21.6% (8)	4.5% (3)
Weapon	1.5% (1)	5.3% (3)	2.2% (1)	0%	0%
Complications of Maternal Drug Use	4.6% (3)	0%	15.2% (7)	0%	18.1% (12)
Acute Illness*	1.5% (1)	3.5% (2)	0%	0%	0%
Animal Bite or Attack	3.1% (2)	0%	0%	0%	1.5% (1)
Fire, Burn or Electrocutation	0%	0%	0%	0%	1.5% (1)

*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.

MOTOR VEHICLE ACCIDENTS

There were 19 accidental child fatalities due to motor vehicle accidents (MVAs) in Clark County in 2012, a nearly 50% increase from 2011 when there were 10 cases. In 2012, 57.9% of these MVA cases involved male victims, which is similar to previous years where there have been more male victims than female. The majority (57.9% or n=11) of decedents were White Hispanic and the remaining 42.1% were White Non-Hispanic (n=4), Black (n=3), and Polynesian (n=1). This year three of the victim's families had a prior history with the child welfare system and three of the decedents had a juvenile justice history. Half of the decedents (52.6%) were between the ages of 15-17, and 94.7% were over the age of 5 years. In 2012 there was one death due to a MVA in which the child was between the ages of 1 and 4 years.

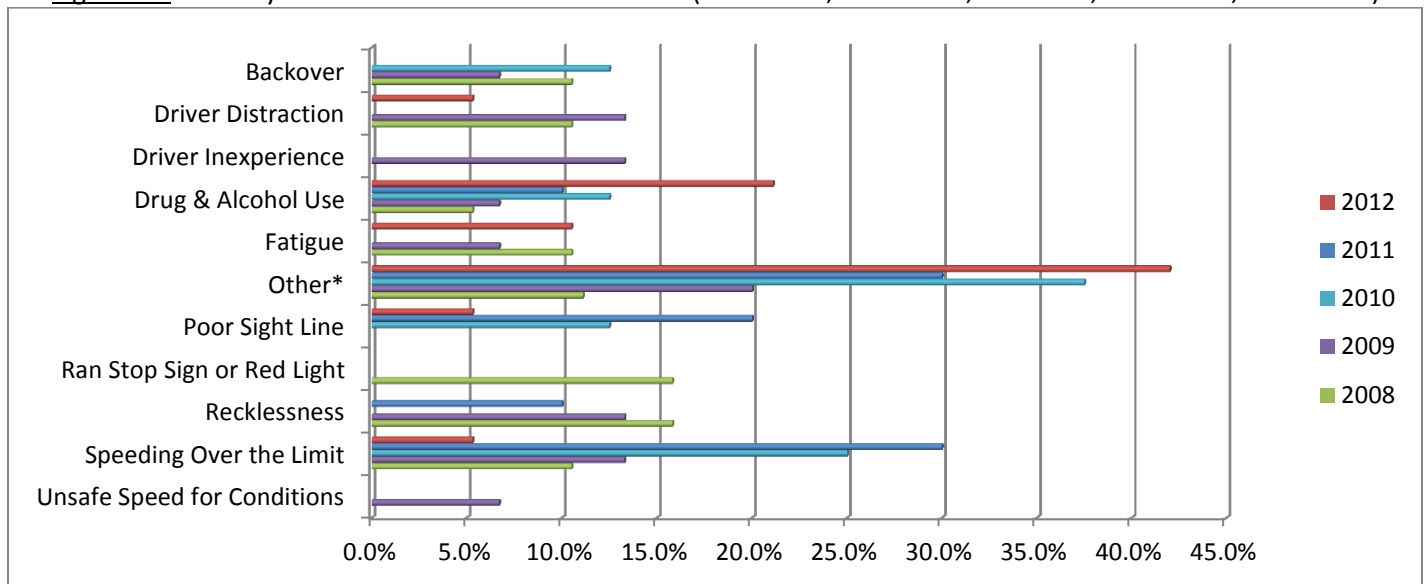
Figure 3.3: 2008-2012 Percent of Motor Vehicle Accident Victims by Age Category
(2008 n=19, 2009 n=15, 2010 n=8, 2011 n=10, 2012 n=19)



	<1 year	1-4 years	5-9 years	10-14 years	15-17 years
2008	5.3% (1)	0.0% (0)	10.5% (2)	47.4% (9)	36.8% (7)
2009	6.7% (1)	13.3% (2)	6.7% (1)	6.7% (1)	66.7% (10)
2010	0.0% (0)	12.5% (1)	25.0% (2)	12.5% (1)	50.0% (4)
2011	0.0% (0)	0.0% (0)	10% (1)	40% (4)	50% (5)
2012	0.0% (0)	5.3% (1)	36.8% (7)	5.3% (1)	52.6% (10)

In all child fatalities involving motor vehicles in 2012, 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 (n=13). Nearly half of all motor vehicle accidents occurred on a residential or city street (47.4%) which is similar to 2008 and 2011. Primary causes of accidents included drug or alcohol use (21.1%), and fatigue (10.5%). At the time of the accident, 21.1% (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, 2012 n=19)



	2008	2009	2010	2011	2012
Back Over	10.5% (2)	6.7% (1)	12.5% (1)	0% (0)	0% (0)
Driver Distraction	10.5% (2)	13.3% (2)	0% (0)	0% (0)	5.3% (1)
Driver Inexperience	0% (0)	13.3% (2)	0% (0)	0% (0)	0% (0)
Drug & Alcohol Use	5.3% (1)	6.7% (1)	12.5% (1)	10% (1)	21.1% (4)
Fatigue	10.5% (2)	6.7% (1)	0% (0)	0% (0)	10.5% (2)
Other*	11.1% (4)	20% (3)	37.5% (3)	30% (3)	42.1% (8)
Poor Sight Line	0% (0)	0% (0)	12.5% (1)	20% (2)	5.3% (1)
Ran Stop Sign or Red Light	15.8% (3)	0% (0)	0% (0)	0% (0)	0% (0)
Recklessness	15.8% (3)	13.3% (2)	0% (0)	10% (1)	0% (0)
Speeding Over the Limit	10.5% (2)	13.3% (2)	25% (2)	30% (3)	0% (0)
Unsafe Speed for Conditions	0% (0)	6.7% (1)	0% (0)	0% (0)	0% (0)

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

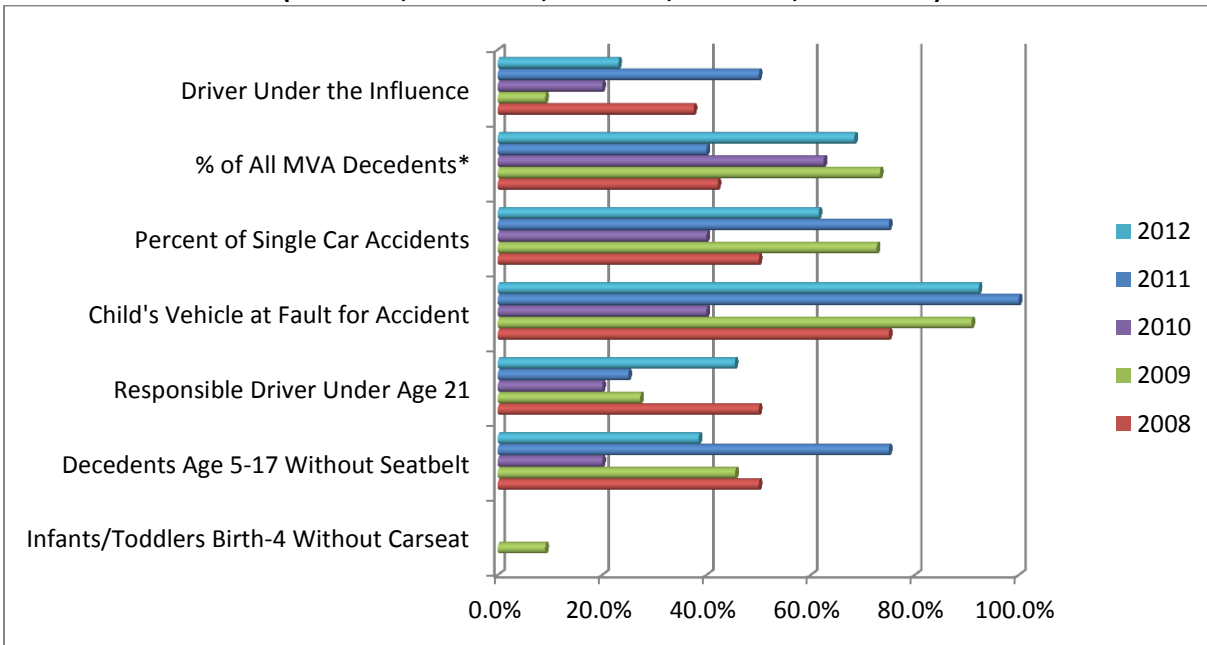
In 73.7% of cases, the child was in a car, van, SUV, or truck, in 21% of cases the child was a pedestrian or on a bicycle, and in the remaining case the child was on a motorcycle. In 73.3% of cases, the vehicle the decedent was in at the time was at fault for the incident.

In two cases, the decedent was the driver of the vehicle involved in the accident (one was a car, the other a motorcycle). In both of these cases the decedent did have a valid driver's license.

More than half of decedents involved in MVAs (68.4%, n=13) were passengers in vehicles. Of those passengers killed, 46.2% were between 10 and 14 years old, 46.2% were between the ages of 15-17 and there was one decedent who was between the age of 1 and 4 years old. In the passenger fatalities, 61.5% of these accidents were single car accidents, and the other 38.5% were two-car accidents. In 92.3% 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 three of these cases, the driver responsible was over age 24, 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 2012 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: 2008-2012 Circumstances of MVA Passenger Fatalities
(2008 n=8, 2009 n=11, 2010 n=5, 2011 n=4, 2012 n=13)



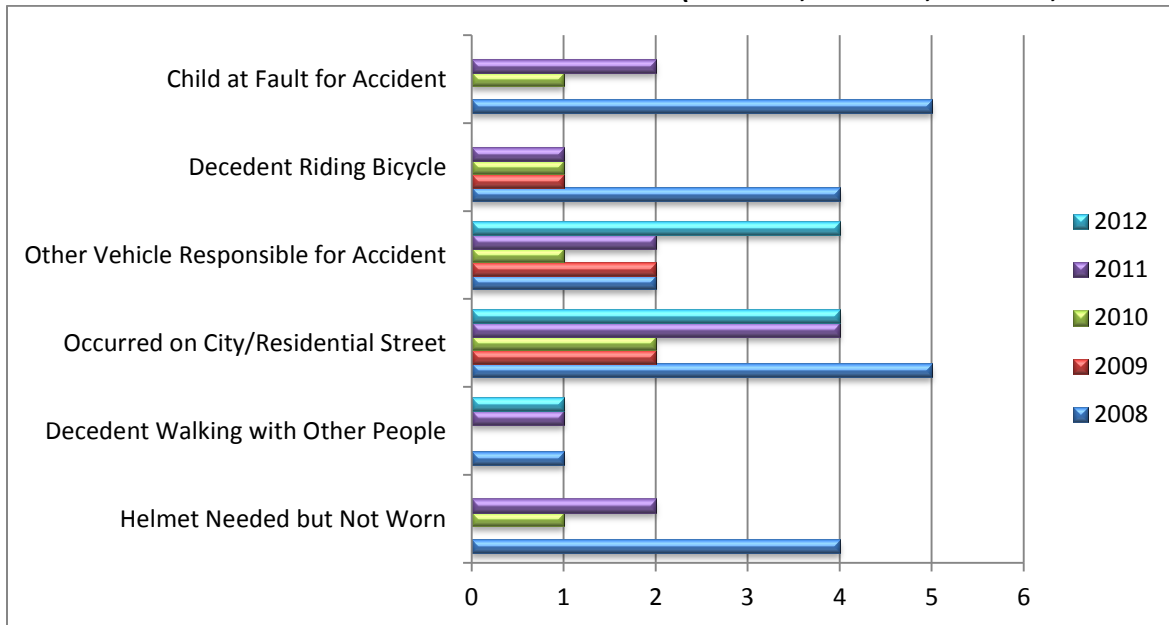
	2008	2009	2010	2011	2012
Infants/Toddlers Birth-4 Without Car seat	0%	9.1% (1)	0%	0%	0%
Decedents Age 5-17 Without Seatbelt	50.0% (4)	45.5% (5)	20% (1)	75% (3)	38.5% (5)
Responsible Driver Under Age 21	50.0% (4)	27.3% (3)	20% (1)	25% (1)	15.4% (2)
Child's Vehicle at Fault for Accident	75.0% (6)	90.9% (10)	40% (2)	100% (4)	92.3% (12)
Percent of Single Car Accidents	50.0% (4)	72.7% (8)	40% (2)	75% (3)	61.5% (8)
% of all MVA Decedents*	42.1%(8)	73.3%(11)	62.5% (5)	40% (4)	68.4% (13)
Driver Under the Influence	37.5% (3)	9.1% (1)	20% (1)	50% (2)	23.1% (3)

NOTE: Categories are not mutually exclusive and percentages are calculated out of the total number of passenger fatalities.

* This percentage represents the total number of all MVA fatalities (n=13 of 19 in 2012) 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 11 and 8 years old. In two cases the decedent was hit while a vehicle was turning, and in the other two the decedent was hit by oncoming traffic. None of the decedents were in a crosswalk at the time of their fatal injuries.

Figure 3.6: 2008-2012 Circumstances of MVA Pedestrian Fatalities (2008 n=7, 2009 n=2, 2010 n=2, 2011 n=4, 2012 n=4)



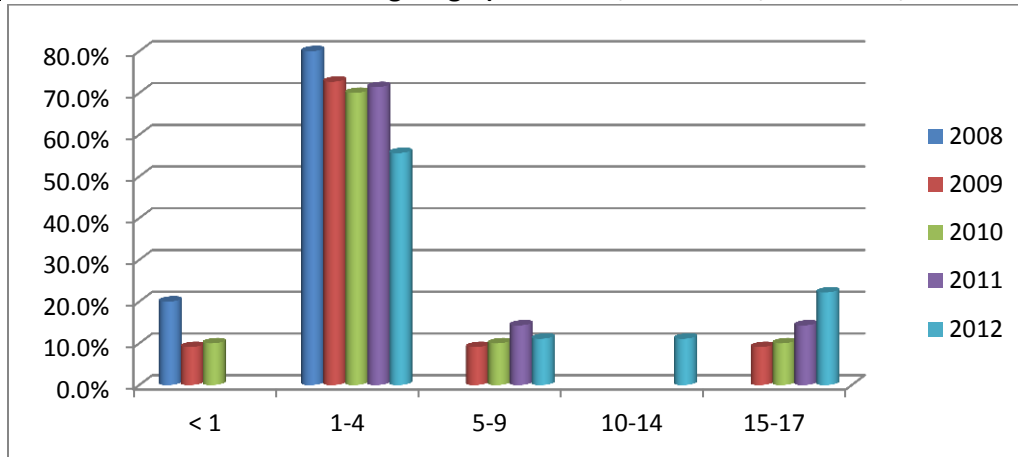
	2008	2009	2010	2011	2012
Helmet Needed but Not Worn	4	0	1	2	0
Decedent Walking with Other People	1	0	0	1	1
Occurred on City/Residential Street	5	1	2	4	4
Other Vehicle Responsible for Accident	2	2	1	2	4
Decedent Riding Bicycle	4	1	1	1	0
Child at fault for Accident	5	0	1	2	0

DROWNING

According to the data collected by the Southern Nevada Health District, there were 54 submersion incidents in Clark County among children aged 0-14 years of age. The majority of these incidents (n=44) occurred in swimming pools.

In 2012, drowning was the fourth leading cause of accidental death among children in Clark County, with 9 deaths in this category. In 2012, we saw a slight increase in the number of drowning fatalities up two cases since 2011. Again this year, the majority of fatal drowning victims (55.6%) were between the ages of 1 and 4 years, indicating that prevention efforts should focus on those children under 5 years of age.

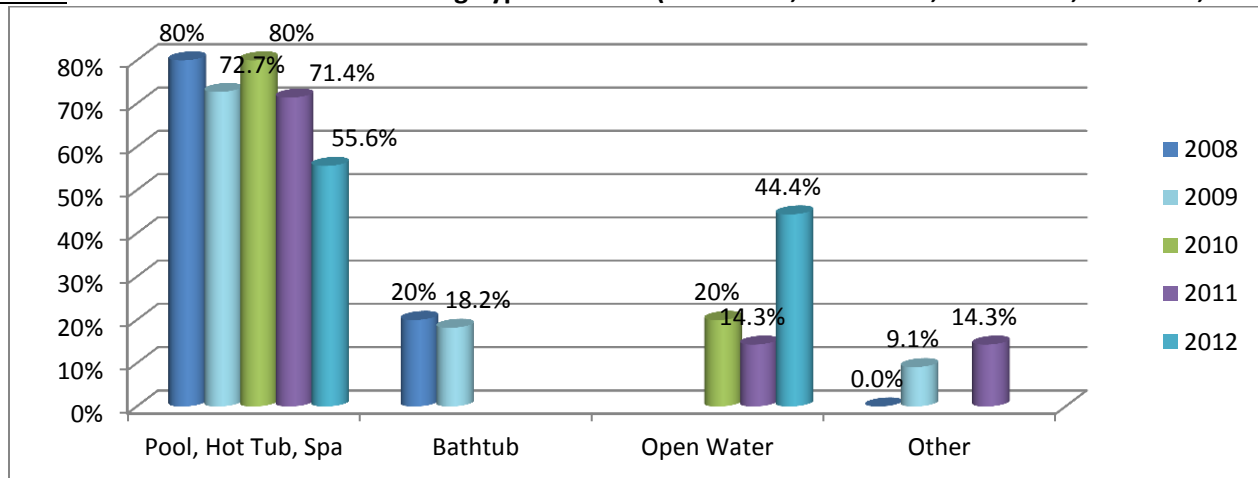
Figure 3.7: 2008-2012 Accidental Drowning – Age (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)



	2008	2009	2010	2011	2012
< 1 year	20.0% (2)	9.1% (1)	10% (1)	0.0%	0.0%
1-4 years	80.0% (8)	72.7% (8)	70% (7)	71.4% (5)	55.6% (5)
5-9 years	0.0%	9.1% (1)	10% (1)	14.3% (1)	11.1% (1)
10-14 years	0.0%	0.0%	0.0%	0.0%	11.1% (1)
15-17 years	0.0%	9.1% (1)	10% (1)	14.3 (1)	22.2% (2)

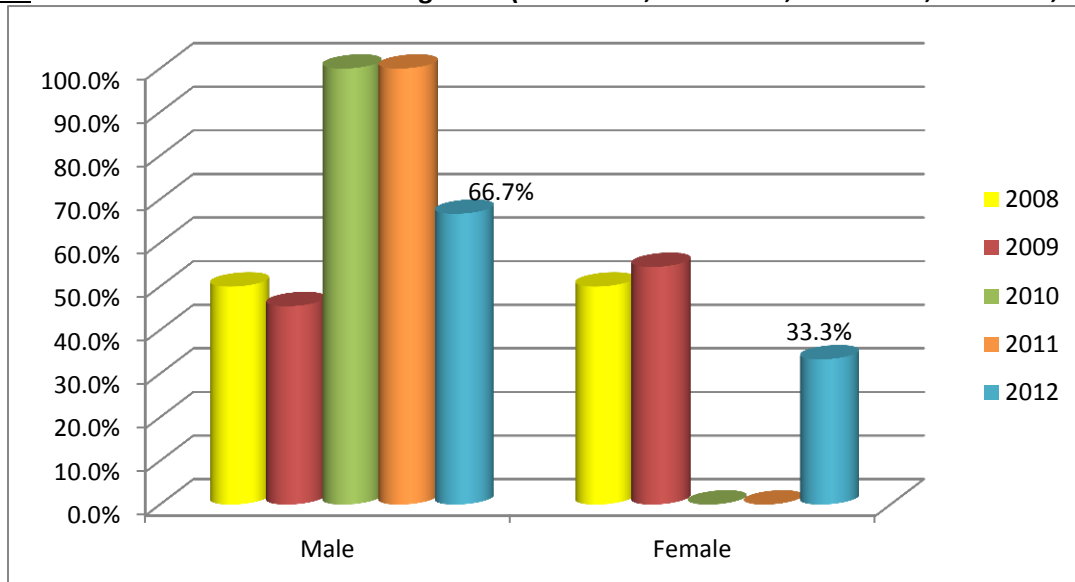
Similar to previous years, in 2012 most drowning cases occurred in a pool, hot tub or spa (55.6%). However in 2012 nearly half of the fatal drowning incidents (44.4%) occurred in some kind of open water like a lake, river or wash.

Figure 3.8: 2008-2012 Accidental Drowning Type of Water (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)



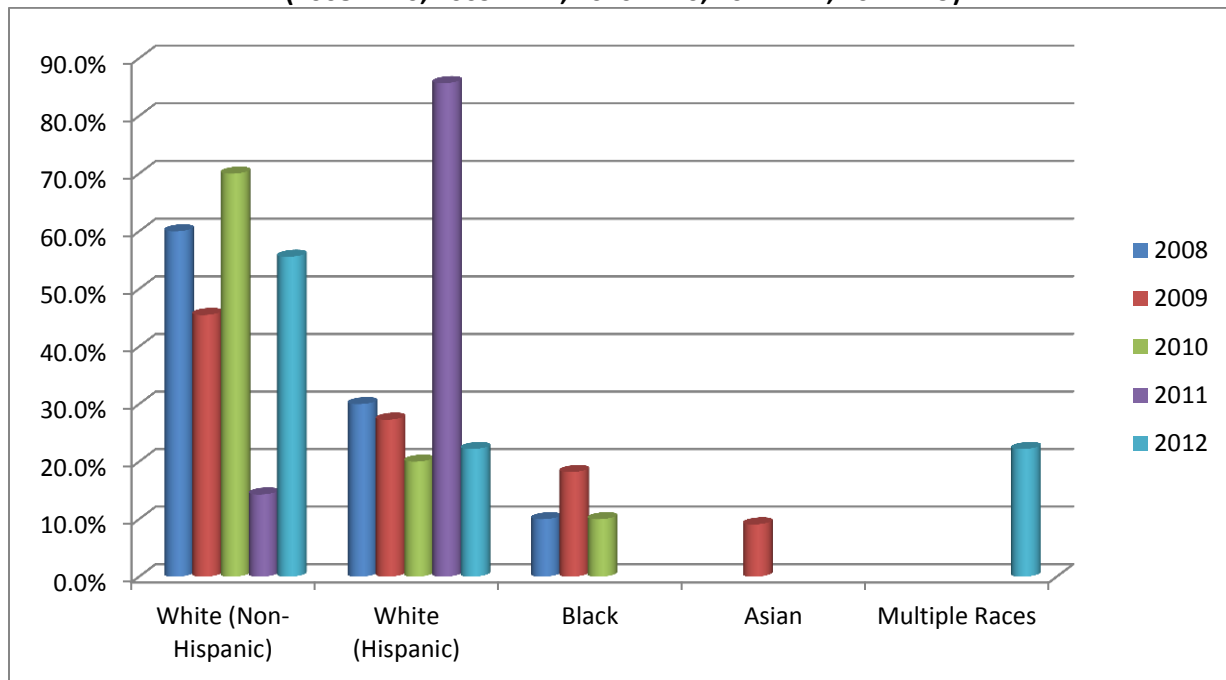
In 2012 66.7% of all fatal drowning incident victims were male. This is the first time in three years that we have female victims.

Figure 3.9: 2008-2012 Accidental Drowning – Sex (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)



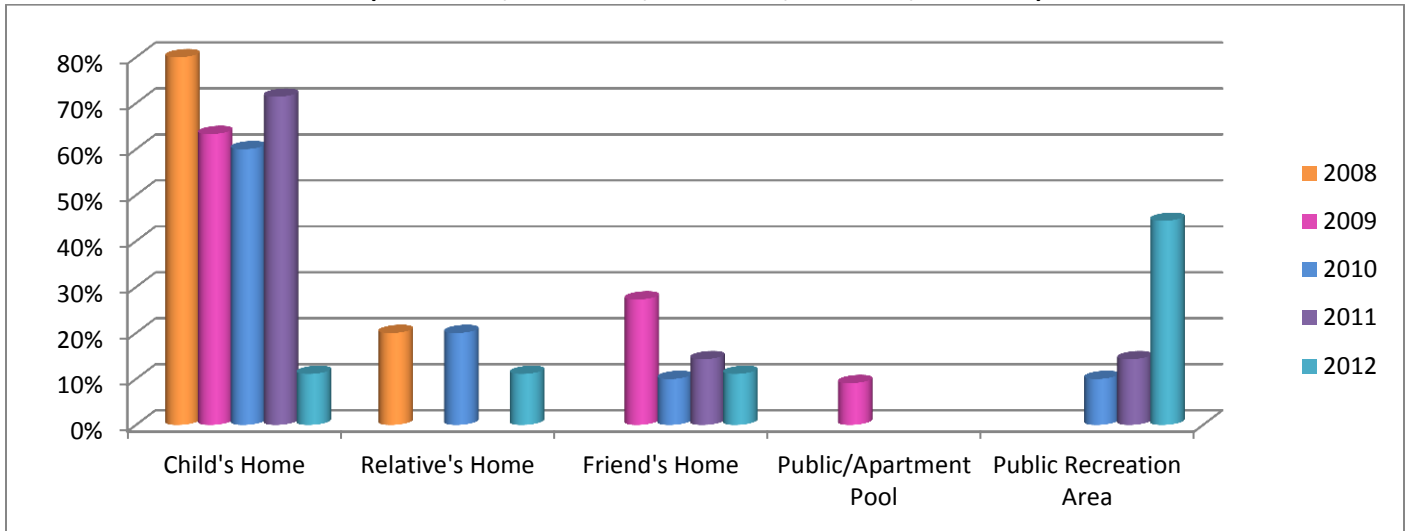
The race/ethnicity data for drowning victims in 2012 is more similar to 2008-2010 with a greater proportion of Non-Hispanic children. This distribution is displayed in Figure 3.10.

Figure 3.10: 2008-2012 Accidental Drowning – Race/Ethnicity (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)



In 2012 the majority (88.9%, n=8) of drowning cases occurred outside of the child’s home at a friend or family member’s home or local park or recreation area. The remaining drowning fatality occurred at the child’s home.

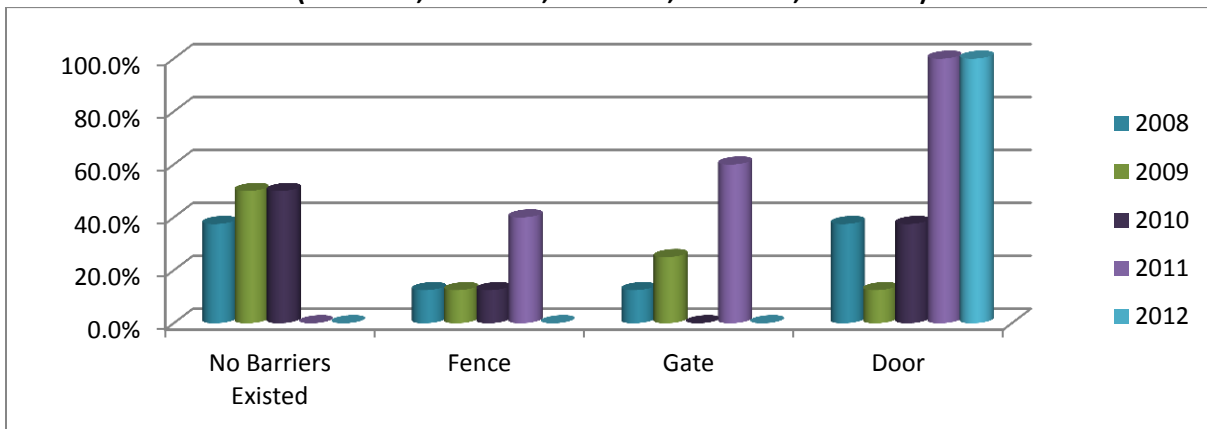
Figure 3.11: 2008-2012 Accidental Drowning – Drowning Location
(2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)



For those cases where the team determined the child needed supervision, most frequently (60%) the biological parent was the supervisor at the time of the incident, followed by some other relative at 11.1%. In 60% of cases where supervision was needed, the child was last seen in the house and was subsequently left unsupervised between three and twenty minutes. In two cases the child was wearing a floatation device and in two cases there was a gathering or event going on at the same time as the incident.

Figure 3.12 below shows whether or not barriers existed to accessing the pool or spa and if so, what they were. For 2012, in all cases the home had a locked door blocking the entrance to the pool or spa but none of the pools had a fence or gate to provide a secondary barrier to the pool.

Figure 3.12: 2008-2012 Accidental Drowning – Barriers to Pool/Spa*
(2008 n=8, 2009 n=8, 2010 n=8, 2011 n=5, 2012 n=5)

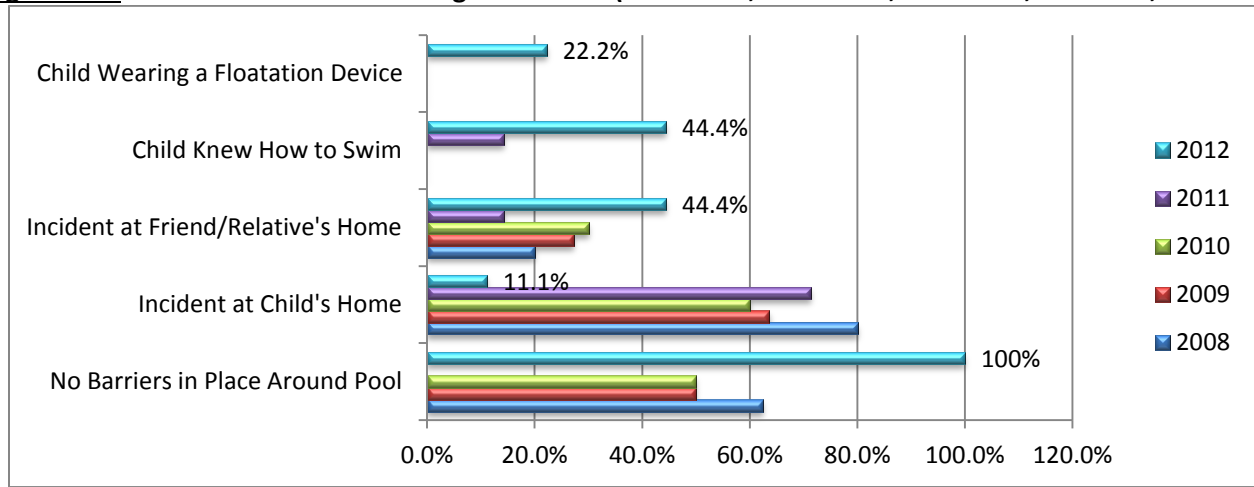


*This table represents only those cases where the drowning occurred in a pool/spa

	2008	2009	2010	2011	2012
No Barriers Existed	37.5% (3)	50% (4)	50% (4)	0%	0%
Fence	12.5% (1)	12.5% (1)	12.5% (1)	40% (2)	0%
Gate	12.5% (1)	25% (2)	0% (0)	60% (3)	0%
Door	37.5% (3)	12.5% (1)	37.5% (3)	100% (5)	100% (5)

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 cases involving older children, they could open all gates and fences on their own. None of the families of the drowning victims had a history of involvement in the child welfare system.

Figure 3.13: Items Relative to Drowning Prevention (2008 n=10, 2009 n=11, 2010 n=10, 2011 n=7, 2012 n=9)

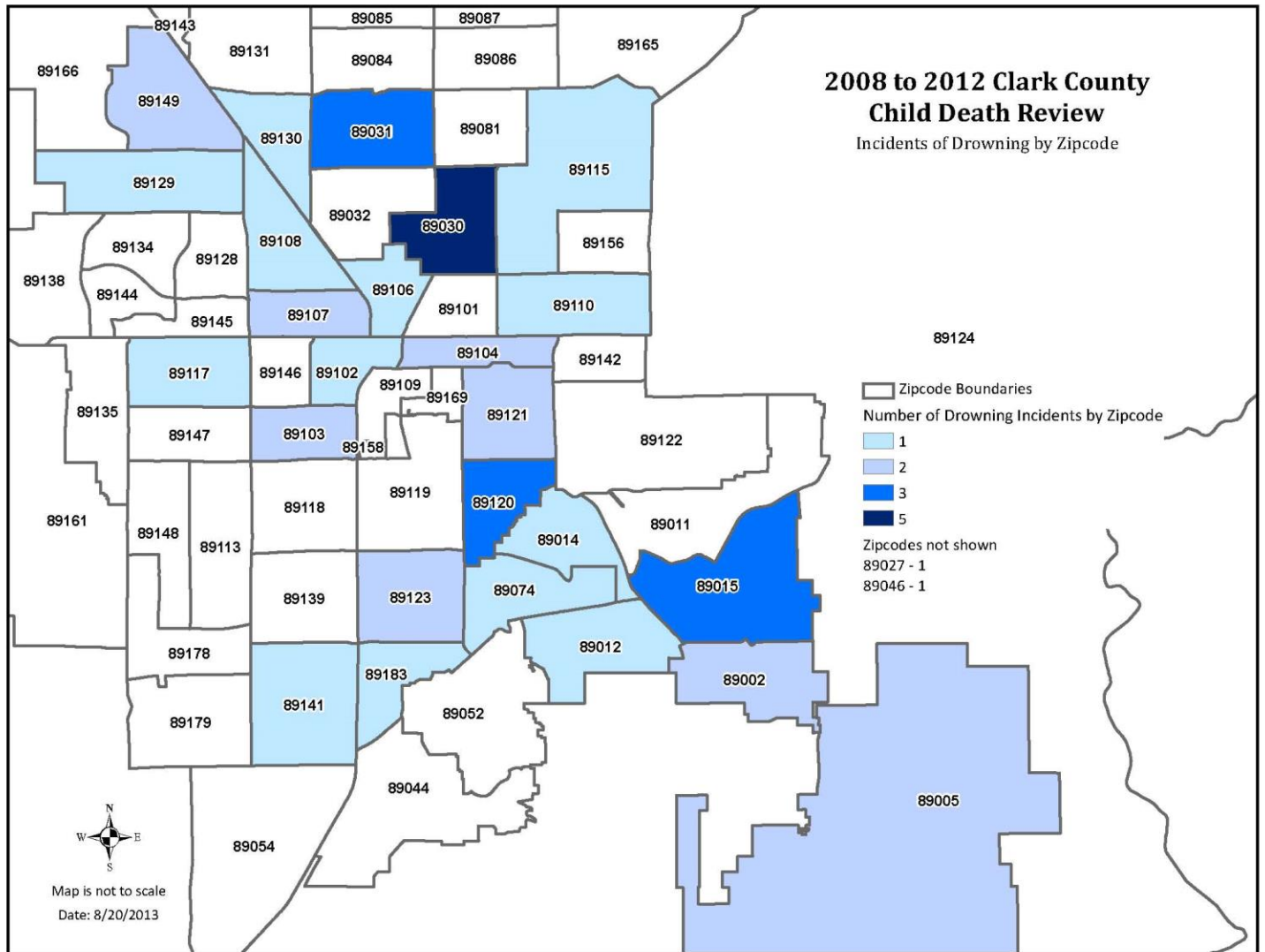


	2008	2009	2010	2011	2012
No Barriers in Place Around Pool*	62.5% (5)	50% (4)	50% (4)	0.0%	100% (5)
Incident at Child's Home	80.0% (8)	63.6% (7)	60% (6)	71.4% (5)	11.1% (1)
Incident at Friend/Relative's Home	20.0% (2)	27.3% (3)	30% (3)	14.3% (1)	44.4% (4)
Child Knew How to Swim	0.0%	0.0%	0.0%	14.3% (1)	44.4% (4)
Child Wearing a Floatation Device	0.0%	0.0%	0.0%	0.0%	22.2% (2)

**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 2012 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.

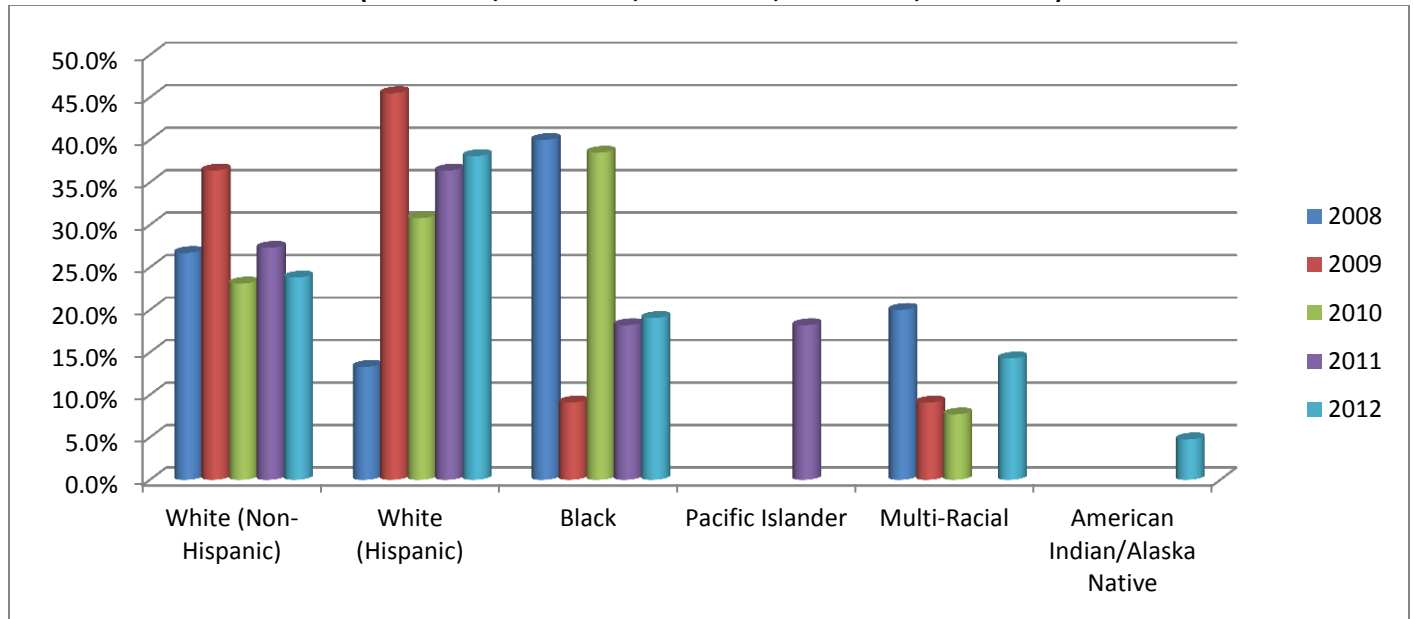
The following map displays the zip code location for drowning fatalities over the past five years. Those zip codes with darker shades of blue have higher incidents of drowning. The map shows that fatal incidents have occurred in many zip codes, but have been most concentrated in 89030, 89120, and 89015.



SUFFOCATION

In 2012, there were 21 accidental suffocations in Clark County, which is that largest number we have seen in the past five years. All but three of the cases involved infants less than one year old. One third of the decedents (38.1%) were female, and 61.9% were male. More than one third (38.1%) of decedents were White Hispanic, and 23.8% 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 19% in 2012.

Figure 3.13: Percentage of Accidental Suffocations by Race/Ethnicity
(2008 n=15, 2009 n=11, 2010 n=13, 2011 n=11, 2012 n=21)



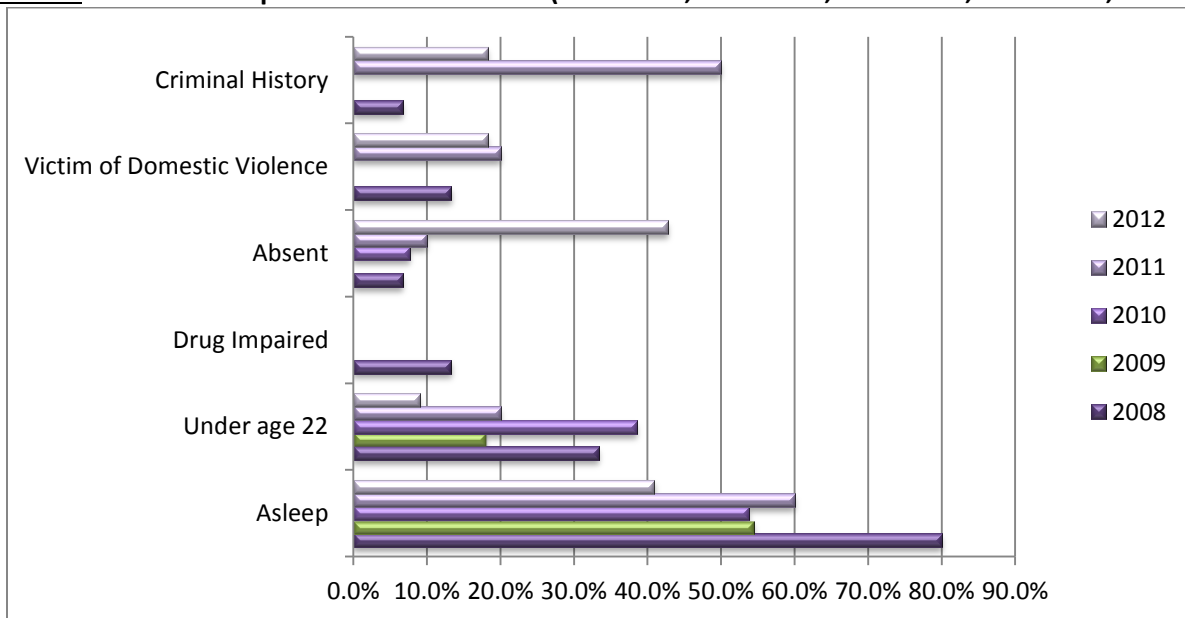
	2008	2009	2010	2011	2012
White (Non-Hispanic)	26.7% (4)	36.4%(4)	23.1% (3)	27.3% (3)	23.8% (5)
White (Hispanic)	13.3% (2)	45.5%(5)	30.8% (4)	36.4% (4)	38.1% (8)
Black	40.0% (6)	9.1% (1)	38.5% (5)	18.2% (2)	19.0% (4)
Pacific Islander	0%	0%	0%	18.2% (2)	0%
Multi-Racial	20% (3)	9.1% (1)	7.7% (1)	0%	14.3% (3)
American Indian/Alaska Native	0%	0%	0%	0%	4.8% (1)

Three of the decedents of accidental suffocation in 2012 suffered from a disability or had a chronic illness and four were acutely ill in the two weeks preceding their death. In 95.2% of cases, the primary caregiver at the time of the incident was a parent. In all cases the primary caregiver had experienced no prior child deaths. Mothers' ages ranged between 18 and 46 years, with the average age being 27 years. Fathers ranged in age from 18 to 53 years and the average age was 34 years. In 6 of these cases one of the child's parents had a known history of substance abuse.

In four cases involving infants, the infant was born prematurely and in 48% of cases involving infants, the mother was known to have received prenatal care. In two of the cases involving an infant the decedent's mother had a history of using illicit drugs during her pregnancy and in six cases the mother reported medical complications during her pregnancy.

In all cases where supervision was necessary the children had supervision at the time of their deaths, and all were supervised by their biological parent, foster parent, grandparent or other relative. In 40.9% of cases where the child was supervised, the child was in the sight of the supervisor at the time of the incident and in 30% 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 12. In 40% of cases where a child needed supervision, the supervisor was asleep at the time of the incident.

Figure 3.14: 2008-2012 Supervisor Circumstances (2008 n=15, 2009 n=11, 2010 n=13, 2011 n=10, 2012 n=21)



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

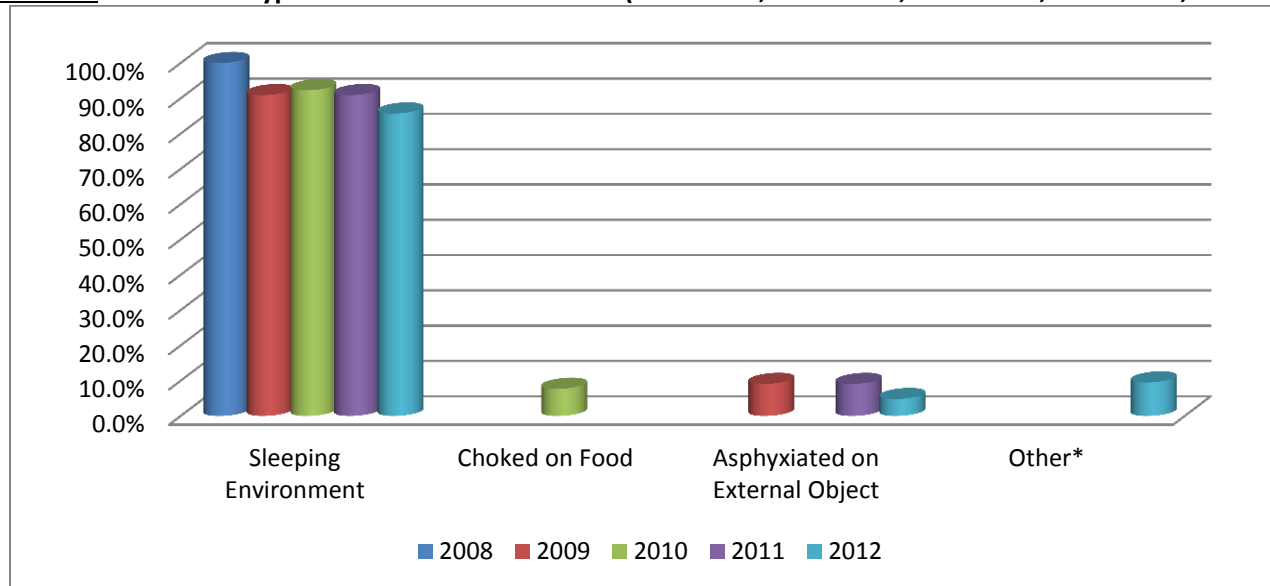
Supervisor Circumstances	2008	2009	2010	2011	2012
Asleep	80.0% (12)	54.5 (6)	53.8% (7)	60% (6)	40.9% (9)
Under age 22	33.3% (5)	18.2% (2)	38.5% (5)	20% (2)	9.0% (2)
Drug Impaired	13.3% (2)	--	0% (0)	0% (0)	0% (0)
Absent	6.7% (1)	0% (0)	7.7% (1)	10% (1)	42.8% (9)
Victim of Domestic Violence	13.3% (2)	0% (0)	0% (0)	20% (2)	18.2% (4)
Criminal History	6.7% (1)	0% (0)	0% (0)	50% (5)	18.2 (4)

Nearly all incidents of accidental suffocation (90.5%) occurred in the child's home, and the remaining deaths occurred at a friend or relative's home. 911 was called in all cases. Some form of action by the Department of Family Services was taken as a result of the death in 38% of cases.

Nearly half (47.6%, n=10) of families experiencing an accidental suffocation had a prior child welfare history, which includes any history on the parent as a child victim. In eight of the ten cases, there was some CPS history regarding a sibling. In the remaining cases the history was on the decedent. Two 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=18). All of the decedents under one year were in a sleeping environment at the time of their death. The remaining cases involved children between 1 and 9 years. In one case the child choked on a small object, one was an accidental suffocation by a dog leash, and the remaining case involved a ventilator tube that became dislodged.

Figure 3.15: 2008-2012 Type of Accidental Suffocation (2008 n=15, 2009 n=11, 2010 n=13, 2011 n=11, 2012 n=21)



**Other includes an accidental strangulation and dislodged at home ventilator tube*

Of those decedents who died in a sleeping environment (n=18), in eleven of the cases the infant was sleeping on an adult mattress or couch while in the remaining seven cases the child was sleeping in a crib, bassinette or playpen. In six of these cases where the child died in a sleeping environment this was a new sleep location for the child. In seven of these cases, the infant was sleeping with a parent, other adult or another child.

44.4% of all decedents were placed to sleep on either their stomach (5.6%) or sides (38.9%). Three of the infants were found on their back (16.7%) and 77.8% (n=14) were found on their stomachs or sides and in the remaining case the position was unknown. In 7 cases the child was suffocated by bedding (blankets, pillows, etc.), in one case a plastic bag was covering the decedents face, in four cases the child was suffocated due to overlay of another person and in the remaining cases the child was found face down in the crib or bed but there was no bedding found over the head or face.

POISONING/DRUG OVERDOSE

In 2012 the Child Death Review team in Clark County reviewed a total of 15 deaths due to poisoning or drug overdose – representing nearly 23% of all accidental deaths. The majority of these cases (n=12) were infant/fetal deaths due to maternal substance abuse, while the remaining three cases were youth between the ages of 15 and 17 years who died from an alcohol or drug overdose. Each of these distinct categories is discussed separately below.

Complications of Maternal Substance Abuse

This year the team reviewed 12 cases of accidental fetal or infant deaths due to maternal substance abuse. The age of the mother was known in all but one case and ranged from 19 to 38 years with an average of 29 years of age. Causes of death for these infants included intrauterine asphyxiation, placental abruption, and intrauterine fetal demise due to maternal substance use. In 58% of these fatalities, methamphetamine is listed as the substance used, in the remaining cases the substance was cocaine, heroin, or other opiates.

Regarding prenatal care, only 25%(n=3) of mothers received prenatal care and for those that did not receive prenatal care, the reasons listed included that they did not know they were pregnant or how far along they were. Others indicated that they did not get prenatal care because they were unemployed and did not have insurance, they could not afford care, or that they planned to terminate the pregnancy.

Three of these mothers had other children living with them at the time of the fetal/infant death, while another two women had other children, but they were not living with them at the time of this incident. Two of these mothers each had one prior child who had died, and none of these cases were pending prosecution at the time of the review.

Overdose

The remaining three cases in this category were youth between 15 and 17 years that accidentally overdosed on drugs or alcohol. Some basic characteristics of these fatalities are listed below.

- All three decedents were male
- Two were White Non-Hispanic, and one was White Hispanic
- All three had a prior history of substance abuse (alcohol, prescription drugs and marijuana)
- One had received substance abuse treatment in the past
- One had a prior history with juvenile justice services
- One had received mental health treatment in the past
- Two were attending school regularly (this was unknown in the other case)

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.” Nearly one third (31.8%) of all accidental deaths of children in Clark County in 2012 were due to, suffocation/strangulation, followed by 28.7% due to motor vehicle accidents, and 18.1% due to complications of maternal substance abuse. These three causes account for 78.6% of all accidental deaths. By their nature, all accidental deaths are preventable and thus provide ample data to make recommendations aimed at preventing future child deaths.

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

2012 marks the highest number of accidental suffocations reviewed by the team since 2006 at 21 cases or 31.8% of all accidental deaths. Nearly all cases of accidental suffocation were children less than one year of age (n=18 of 21) (the remaining three incidents involved over children in choking or strangulation incidents) 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-Medozza, et.al, 2009). In addition, we also know that among Undetermined deaths in 2012, half of those (n=8) were infants less than one year in unsafe sleep environments.

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 2012 more than three quarters of these cases involved a racial/ethnic minority (38.1% Hispanic, 19% Black, and 14.3% Multiracial), pointing to the need for more culturally specific outreach and education. Several organizations including the Southern Nevada Health District (SNHD) and NICRP are working to provide outreach and education about the importance of safe sleep practices. In 2013 SNHD and NICRP implemented a hospital based safe sleep program designed to educate hospital personnel in modeling appropriate behavior as well as training parents through an instructional video.

2. SUPPORT CAMPAIGNS FOR MOTOR VEHICLE AND PEDESTRIAN SAFETY

In 2012 motor vehicle accidents were the second leading cause of accidental death accounting for 28.7% (n=19) of all accidental deaths. This is following a decline in these types of deaths from 2008 to 2011. More than half of these decedents are between 15 and 17 years of age and most 68.4% were passengers in vehicles during these fatal accidents. The Department of Public Safety has implemented its “Zero Fatalities” campaign and we hope to see a decline in these statistics in 2013.

3. SUPPORT INITIATIVES RELATED TO PREVENTING SUBSTANCE ABUSE IN YOUNG ADULTS AS WELL TREATMENT AND PRENATAL CARE FOR SUBSTANCE ABUSING PREGNANT WOMEN

This year fetal and infant deaths due to complications of maternal substance abuse were the third leading cause of death at 18.1% of all accidents (n=12). This is the highest number of these types of fatalities since NICRP started creating this report in 2006. The average age of these mothers was 29 years old, and 58% of them were using methamphetamines and this caused the death of their child. Many of the women reported not receiving prenatal care either because they did not know they were pregnant or did not have insurance or the economic means to pay for healthcare.

Substance abuse prevention programs targeted at youth could include a family planning component to ensure that women of child bearing age consider the impact of substance use on an unplanned pregnancy.

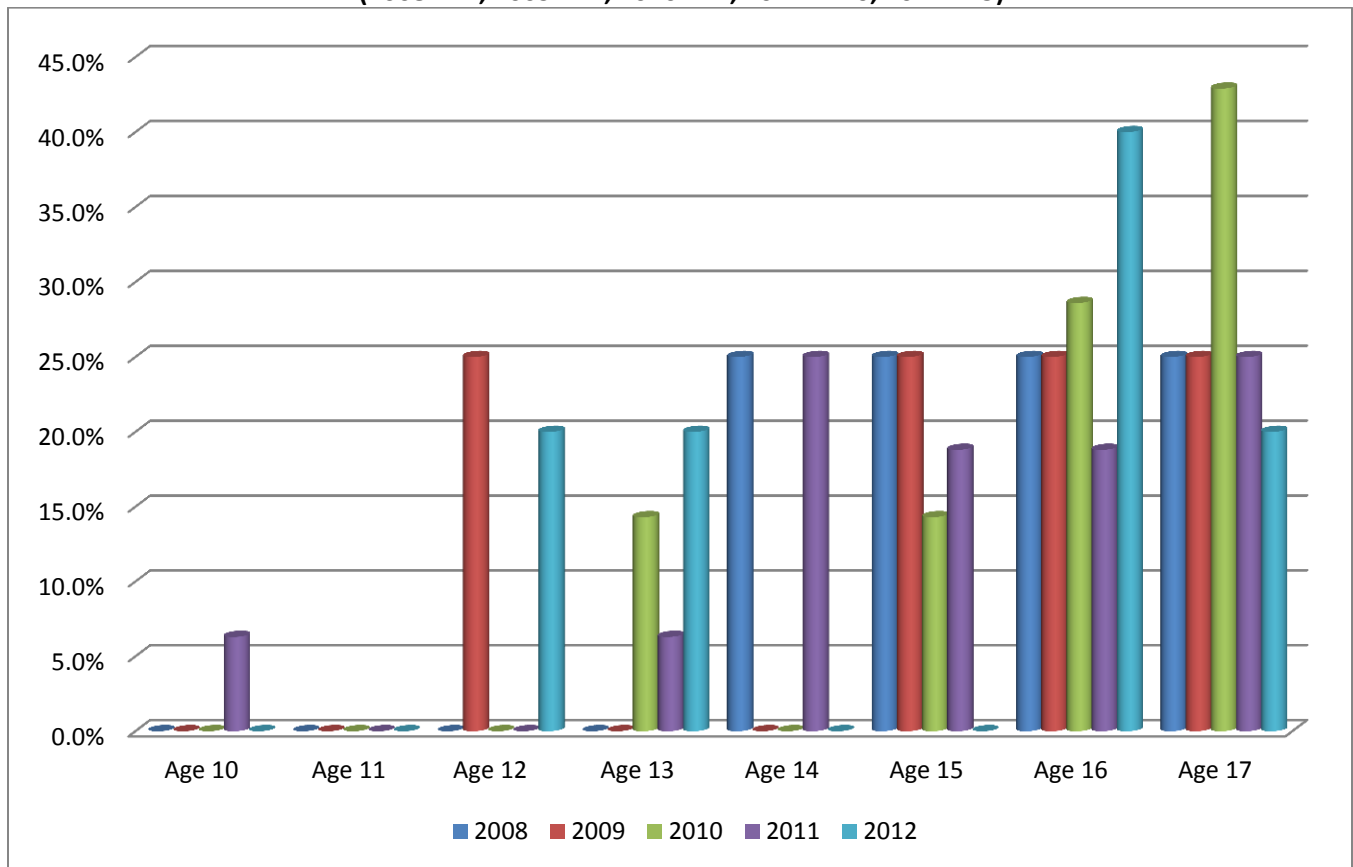
SECTION IV: SUICIDE DEATHS

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 respectively. In 2011 we saw a dramatic increase in the total number of youth suicides from 7 in 2010 to 16 in 2011, but this number dropped to 5 in 2012. This year the death rate for youth suicide in Clark County was calculated at 1.02 per 100,000, compared to the national youth suicide rate of 1.3 per 100,000. This represents a sharp decline from 2011 when the rate spiked up to 3.27, as well as an overall increase from 2008 of 0.25 deaths per 100,000. The percentage of suicides by sex, race and ethnicity for all 2008-2012 are listed in the figures below. For 2012, one of the suicide cases was due to fatal firearm injuries, two were due to hanging, and one was due to prescription drug overdose. In three of these cases there was a family history of prior child welfare involvement.

In 2012, the suicide rate for children under 18 in Clark County was 1.02 per 100,000 compared to 1.3 per 100,000 nationally.

In 2012 the ages of youth who died from suicide ranged from 10 to 17 years, with most decedents being between 16-17 years old. The distribution of age among suicide deaths in 2012 is similar to that seen in previous years. This is illustrated in Figure 4.1 below.

Figure 4.1: 2008–2012 Percentage of Suicides by Age of Decedent
(2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



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 2012 in Clark County, only slightly more than half of suicide victims were males (60%) between the ages of 10 and 17, and 60% of these were White Non-Hispanic males. None of the youth who died from suicide in Clark County had a history with juvenile justice services but three had a history of involvement with the child welfare system. In 2012 the distribution between male and female suicide decedents is nearly equal, and similar to the distribution in 2011.

Figure 4.2: 2008–2012 Percentage of Suicides by Sex of Decedent

(2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)

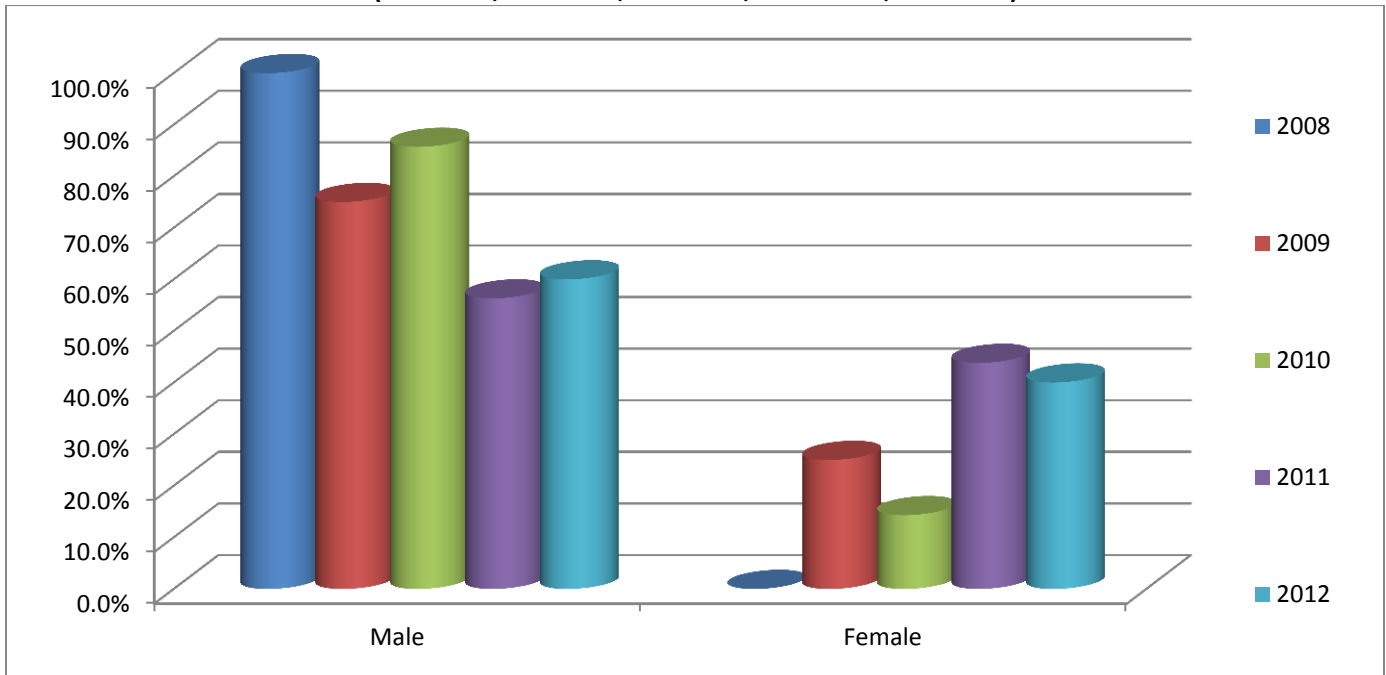
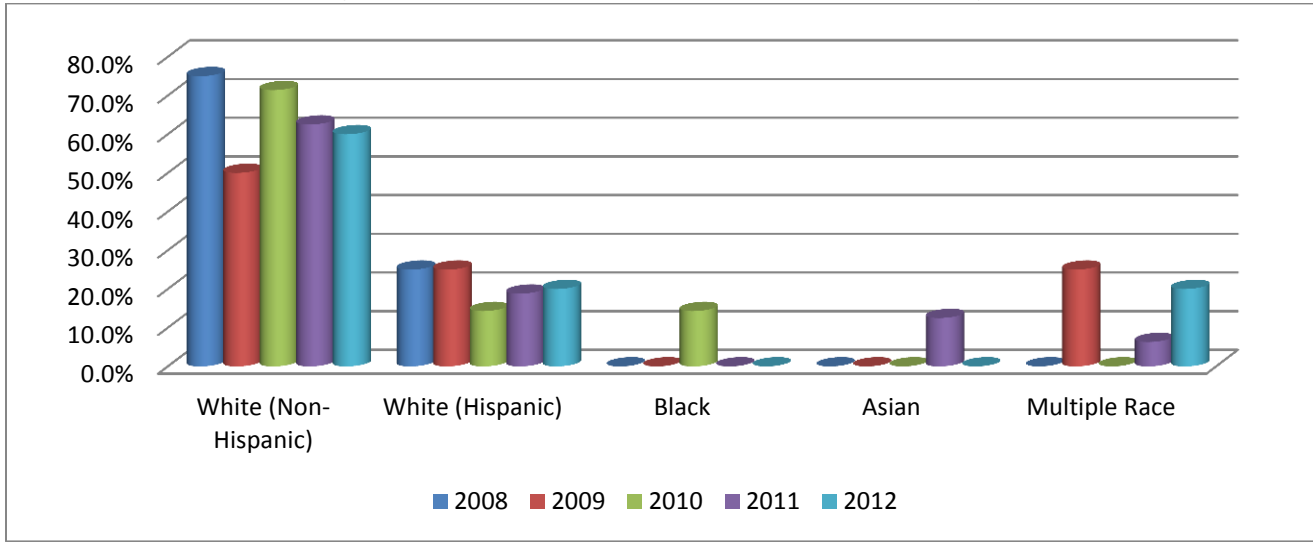
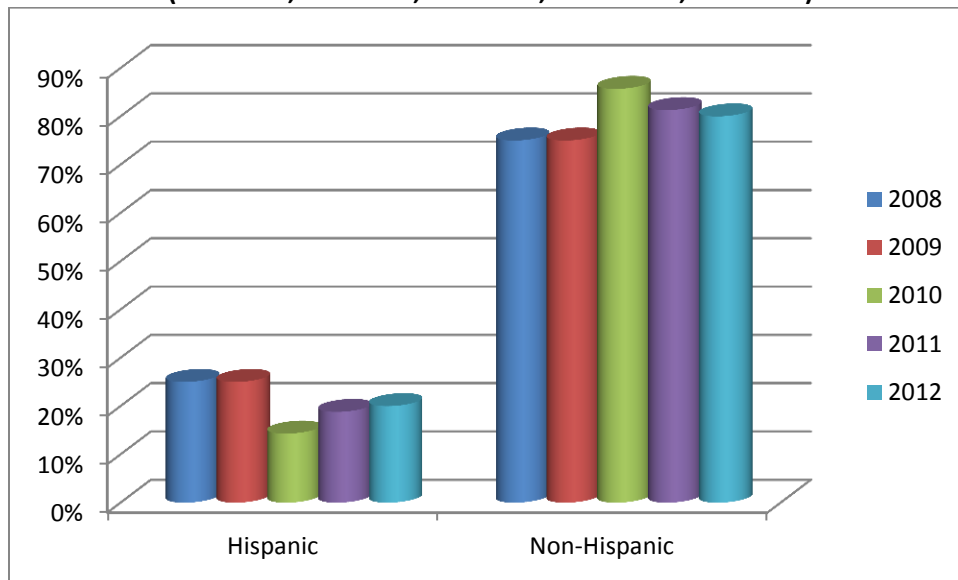


Figure 4.3: 2008–2012 Percentage of Suicides by Race/Ethnicity of Decedent
 (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



Over the past five 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 2012 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: 2008–2012 Percentage of Suicides by Ethnicity of Decedent
 (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



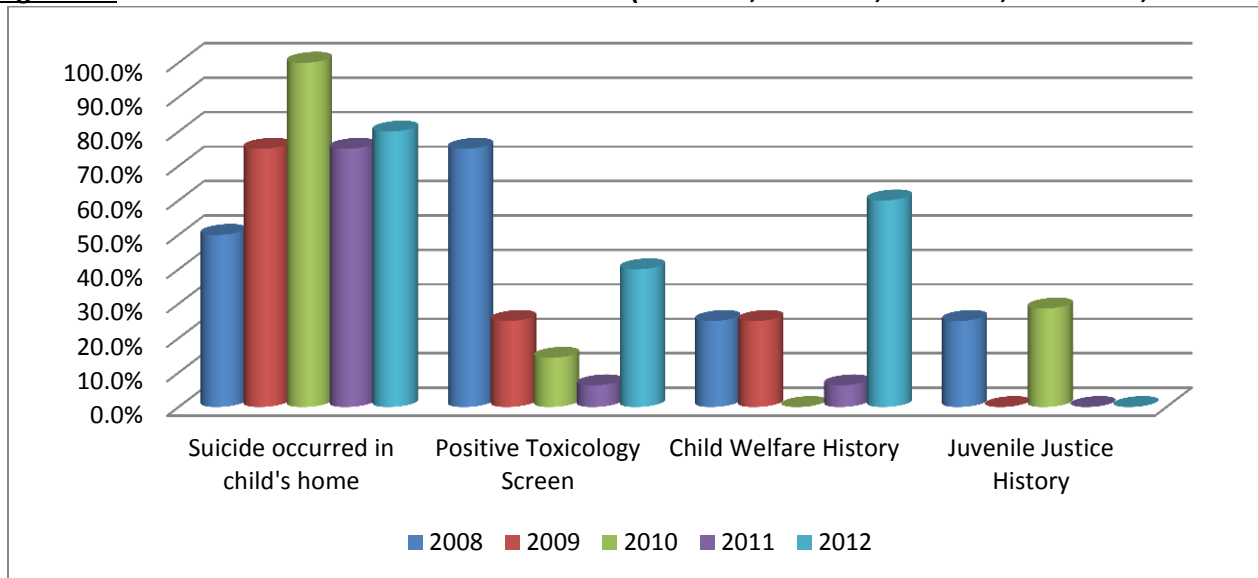
SITUATIONAL FACTORS OF SUICIDE

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 identify target populations for outreach and education. The situational factors historically tracked by the team include: location of the suicide, toxicology reports, child welfare history, and juvenile justice history.

Figure 4.5 below displays the situational factors of youth suicide by year for 2008-2012. This year none of the decedents had been involved with the juvenile justice system, but two of them did have a history of substance abuse and two had a positive toxicology screen at their autopsy. Nearly all incidents occurred in the decedent's home (n=4) and the remaining incident occurred on a roadway. Additional factors are listed below.

- All five attended school regularly – but two were experiencing school failure
- None of the decedents left a suicide note
- One had been diagnosed with a mental illness (depression) but none had any known prior suicide attempts

Figure 4.5: 2008–2012 Situational Factors of Suicide (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)

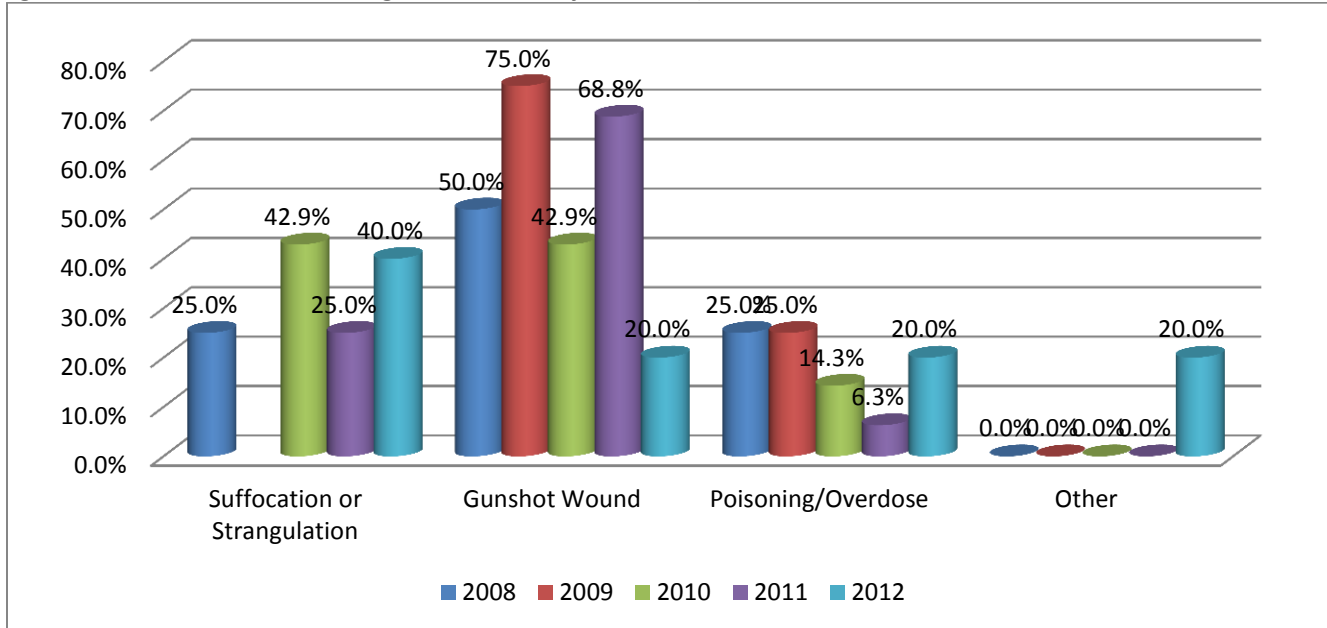


	2008	2009	2010	2011	2012
Suicide Occurred in Child's Home	50.0% (2)	75% (3)	100% (7)	75% (12)	80% (4)
Positive Toxicology Screen	75.0%(3)	25% (1)	14.3% (1)	6.3% (1)	40% (2)
Child Welfare History	25.0%(1)	25% (1)	0% (0)	6.3% (1)	60% (3)
Juvenile Justice History	25.0%(1)	0% (0)	28.6% (2)	0% (0)	0% (0)

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 were completed using a firearm, followed by suffocation at 40%¹. This pattern was replicated in Clark County for 2008 through 2011. However, in 2012 this pattern was reversed: 40% (n =2) of suicides were completed through suffocation and 20% (n = 1) were completed with a firearm.

Figure 4.6: 2008–2012 Percentage of Suicides by Method (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



As seen in Figure 4.6, in 2012, the most common method of suicide was suffocation/strangulation (n=2), followed by gunshot wounds (n=1), poisoning (n=1), and “other” (n=1). In the one case categorized as “other”, the decedent jumped from a moving bus.

¹ 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 cases reviewed 2008-2012 are listed in Table 4.7 below.

Table 4.7: 2008-2012 Circumstances of Suicide

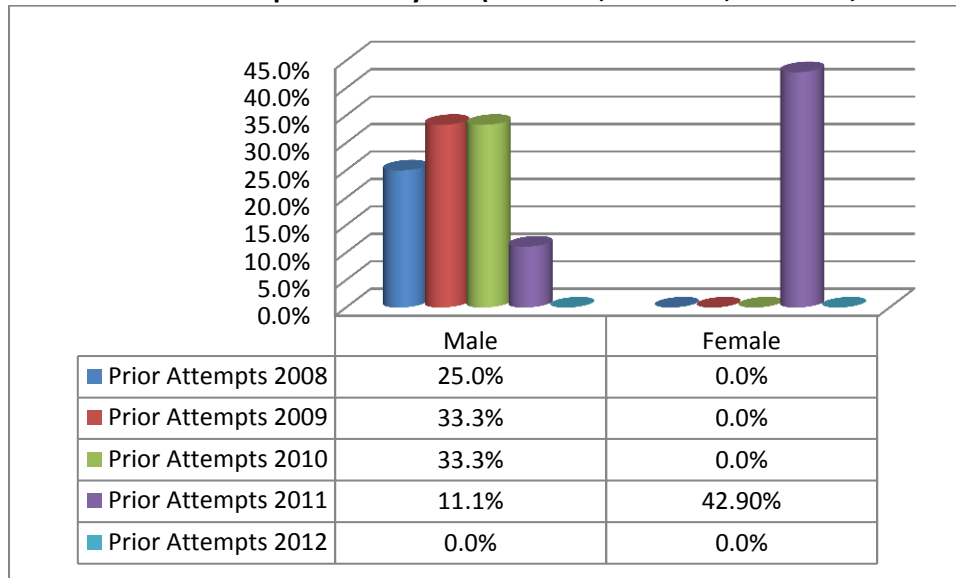
	2008 (n=4)	2009 (n=4)	2010 (n=7)	2011 (n=16)	2012 (n=5)
History of Substance Abuse	75.0%	25.0%	14.3%	12.5%	20.0%
History of Self-Mutilation	-	25.0%	28.6%	18.8%	20.0%
Diagnosed with a Mental Illness	-	25.0%	42.9%	18.8%	20.0%
Decedent Attending School Regularly	-	100.0%	85.7%	100.0%	80.0%
Child on Medication for MH	-	-	14.3%	18.8%	20.0%
Child Currently received MH Services	-	25.0%	42.9%	18.8%	-
Youth Talked about Suicide	75.0%	75.0%	14.3%	31.3%	60.0%
Prior Threats Made	50.0%	25.0%	28.6%	18.8%	20.0%
Prior MH Services Received	25.0%	25.0%	42.9%	37.5%	-
Prior Attempts Made	25.0%	25.0%	28.6%	25.0%	-
Known Family History of Suicide	-	-	-	6.3%	20.0%
Involvement with Juvenile Justice	25.0%	-	28.6%	-	-

NOTE: dashes indicate that there were zero cases in that category for that year.

In the 2012 cases, 80% of youth were attending school regularly and none had previously received mental health services. In addition, in 20% of cases the youth had made prior threats of suicide, although none were known to have made any prior attempts.

According to the literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide². In 2012 none of the decedents had made a known prior suicide attempt, although in one case the decedent had made suicide threats in the past. 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. Figure 4.8 illustrates prior attempts of suicide by sex for 2008-2012.

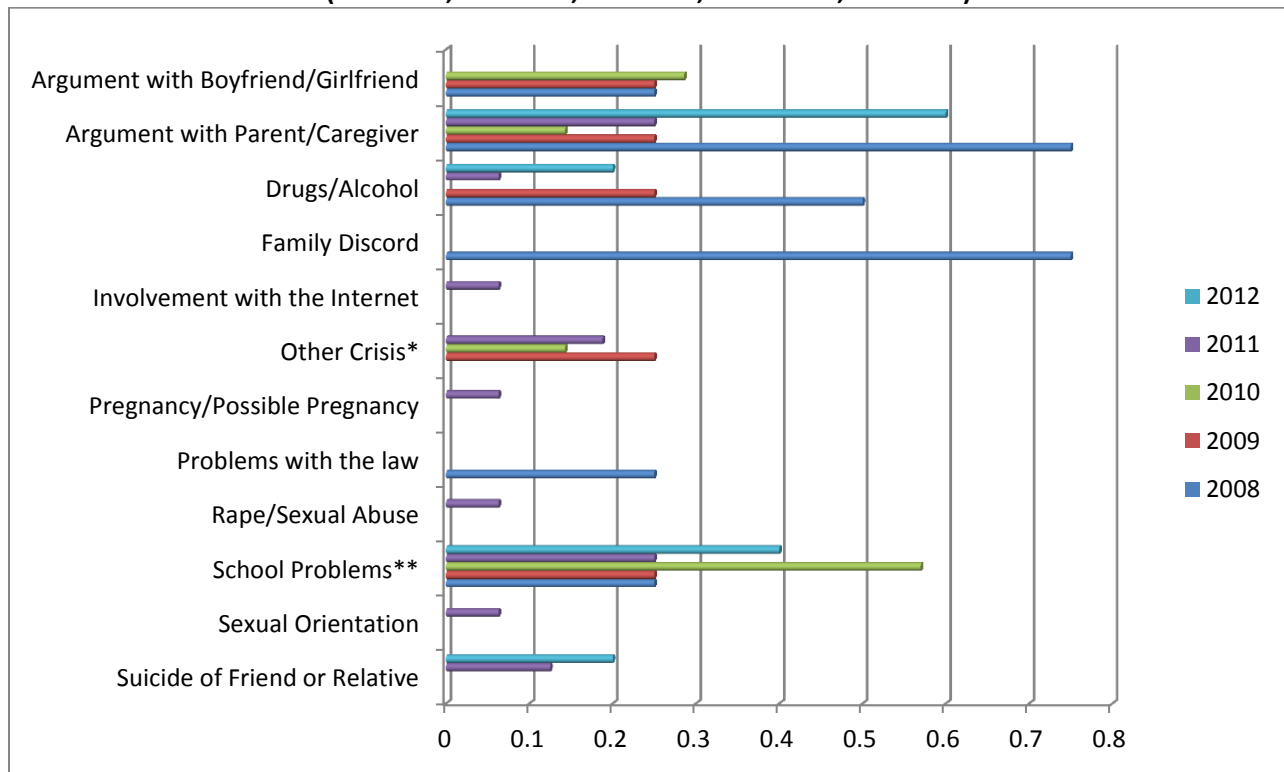
Figure 4.8: 2008–2012 Prior Attempts Made by Sex (2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



² www.KidsHealth.org, Retrieved August 25, 2012

A review of the decedents' history of acute or cumulative crisis indicates that arguments with parent/caregiver, school problems, or drugs/alcohol were present in all of the suicide cases in 2012. Specifically, three of the victims had recently had a fight with a parent, two were experiencing school problems, and one had a history of substance abuse (See Figure 4.9).

Figure 4.9: 2008–2012 History of Acute or Cumulative Crisis
(2008 n=4, 2009 n=4, 2010 n=7, 2011 n=16, 2012 n=5)



* 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	2012
Argument with Boyfriend/Girlfriend	25.0% (1)	25.0% (1)	28.6% (2)	0.0%	0.0%
Argument with Parent/Caregiver	75.0% (3)	25.0% (1)	14.3% (1)	25.0% (4)	60.0% (3)
Family Discord	75.0% (3)	0.0%	0.0%	0.0%	0.0%
School Problems**	25.0% (1)	25.0% (1)	57.1% (4)	25.0% (4)	40.0% (2)
Involvement with the Internet	0.0%	0.0%	0.0%	6.3% (1)	0.0%
Argument with Boyfriend/Girlfriend	25.0% (1)	0.0%	28.6% (2)	12.5% (2)	0.0%
Drugs/Alcohol	50.0% (2)	25.0% (1)	0.0%	6.3% (1)	20.0% (1)
Other Crisis*	0.0%	25.0% (1)	0.0%	18.8% (3)	0.0%
Suicide of Friend or Relative	0.0%	0.0%	0.0%	12.5% (2)	20.0% (1)
Rape/Sexual Abuse	0.0%	0.0%	0.0%	6.3% (1)	0.0%
Pregnancy/Possible Pregnancy	0.0%	0.0%	0.0%	6.3% (1)	0.0%
Problems with the law	25.0% (1)	0.0%	0.0%	0.0%	0.0%
Sexual Orientation	0.0%	0.0%	0.0%	6.3% (1)	0.0%

SUICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

It appears that 2011 was an anomaly in the high number of suicide deaths (n=16), as 2012 returns to much lower numbers at five suicide deaths this year. While this decline is encouraging, five incidents is still one more than in both 2008 and 2009 when there were four cases each year. 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 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.

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.

2. 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.

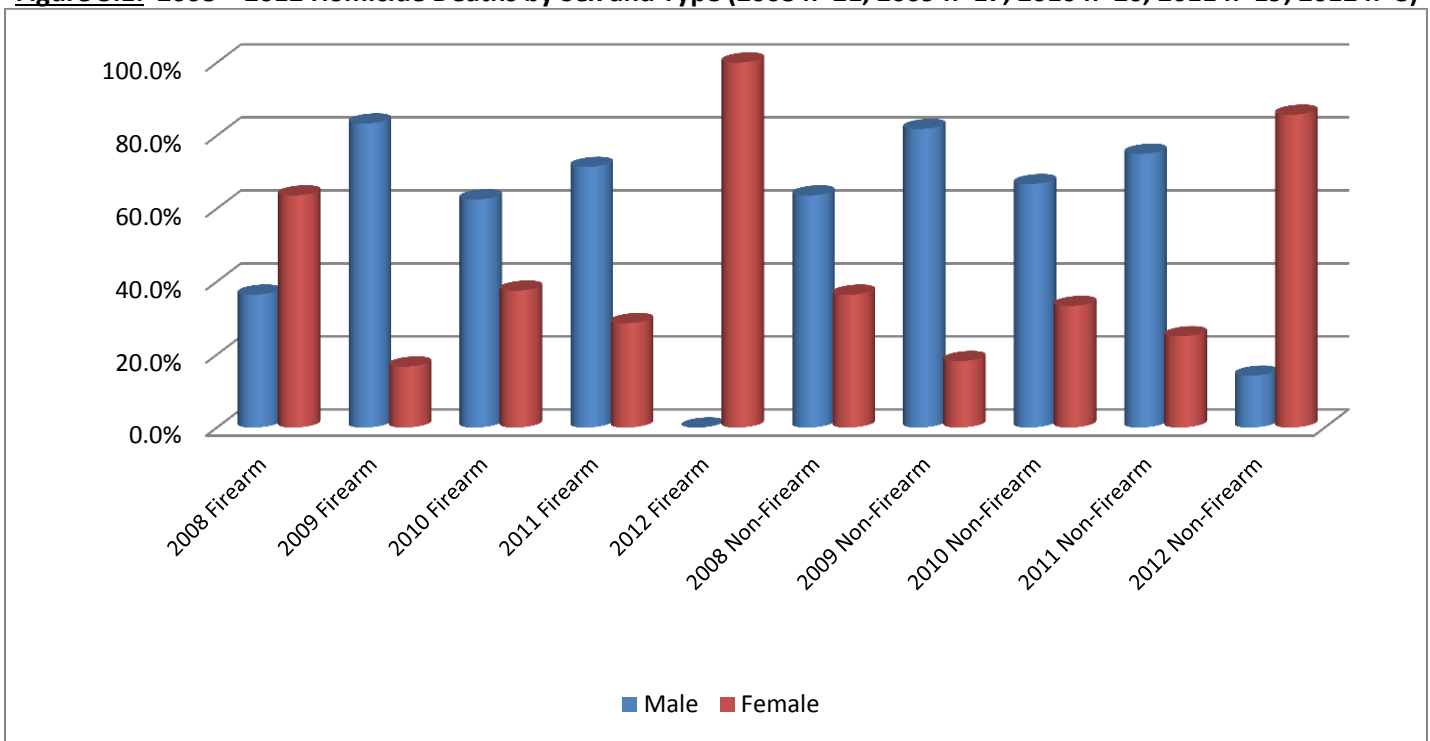
Over the past five years, the majority of victims (55.6%) used firearms at their method of suicide. This is one of the means of suicide that should be most difficult for children and youth to get a hold of. Families that choose to have firearms in their homes must be especially careful about ensuring 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.

SECTION V: HOMICIDE DEATHS

Homicide is legally defined as the killing of one human being by another human being. In July 2013 the CDC released a report that 2010 demonstrated a 30 year low in youth homicides among the 10-24 year old age group³, and that from 2000-2010 the rate declined by about 1 percent each year. However, “among 10 to 24 year-olds, homicide is still 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.”⁴

In 2012, there were 8 homicides of children and youth in Clark County, which is nearly half of what we have seen in the previous four years, and the smallest number of homicides recorded since 2006. The 2012 homicides fell into two categories – those that were committed using a firearm (n=1) and those that were committed without a firearm (n=7). This is the first time there has only been one firearm related homicide since data collection started in 2006. In 2012 the majority of victims were female (n=6) and only two victims were male. This may be due to the fact that only one of the homicides in 2012 involved the use of a firearm (See Figure 5.1).

Figure 5.1: 2008 – 2012 Homicide Deaths by Sex and Type (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19, 2012 n=8)

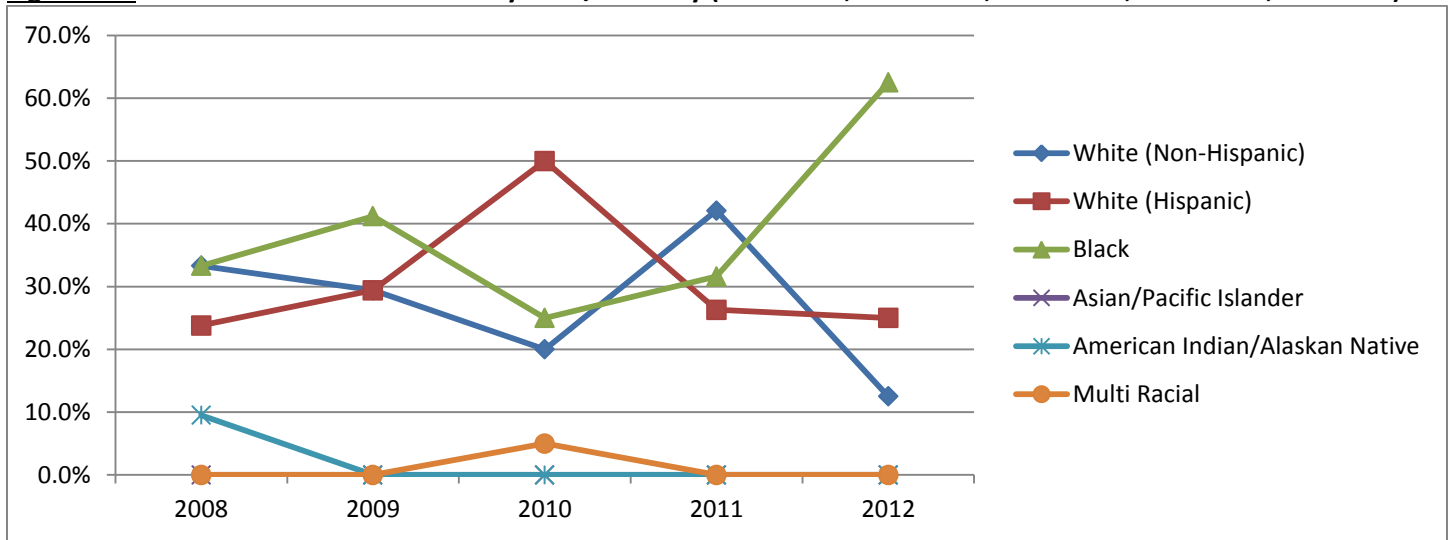


³ <http://www.cdc.gov/media/releases/2013/p0711-homicide-rates.html>

⁴ http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf

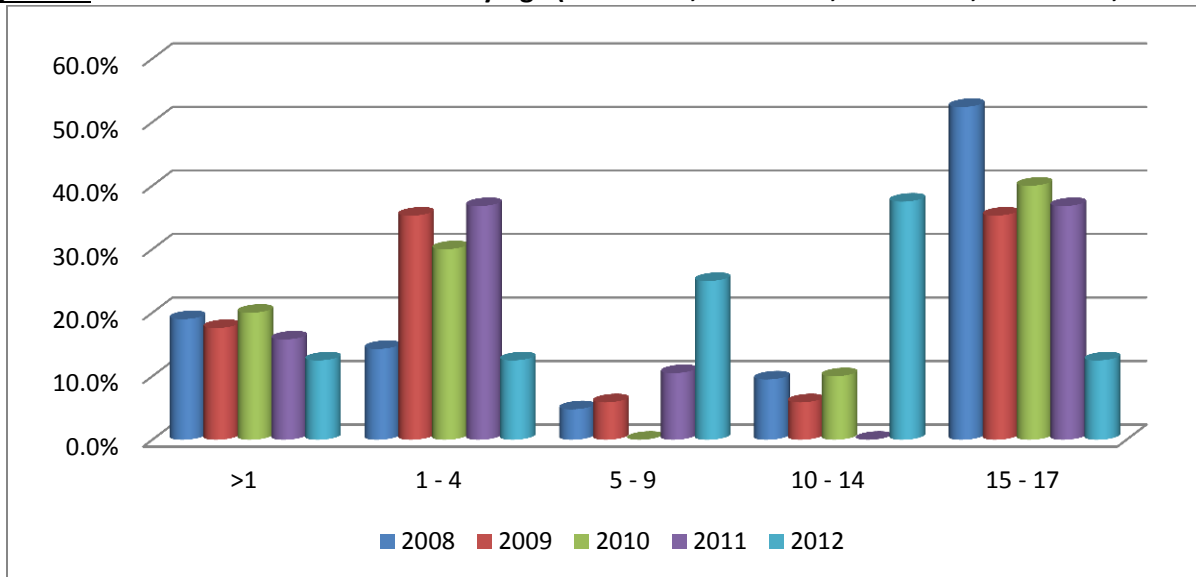
For the first time in three years, the majority of all child homicides in Clark County in 2012 were Black children. White Hispanic children (25%) were the second most frequent racial/ethnic group in this manner of death. The remaining 12.5% of cases (n=1) were White Non-Hispanic children.. These data indicate that Black and Hispanic teens are disproportionately victimized by homicide. (Figure 5.2).

Figure 5.2: 2008-2012 Homicide Deaths by Race/Ethnicity (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19, 2012 n=8)



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 five years.

Figure 5.3: 2008–2012 Homicide Deaths by Age (2008 n=21, 2009 n=17, 2010 n=20, 2011 n=19, 2012 n=8)



	2008	2009	2010	2011	2012
Less than 1 year	19.0% (4)	17.6% (3)	20.0% (4)	15.8% (3)	12.5% (1)
1 – 4 years	14.3% (3)	35.3% (6)	30.0% (6)	36.8% (7)	12.5% (1)
5 – 9 years	4.8% (1)	5.9% (1)	0%	10.5% (2)	25% (2)
10 – 14 years	9.5% (2)	5.9% (1)	10.0% (2)	0%	37.5% (3)
15 – 17 years	52.4% (11)	35.3% (6)	40.0% (8)	36.8% (7)	12.5% (1)

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: 2008–2012 Firearm Homicide Deaths by Age (2008 n=10, 2009 n=6, 2010 n=8, 2011 n=7, 2012 n=1)

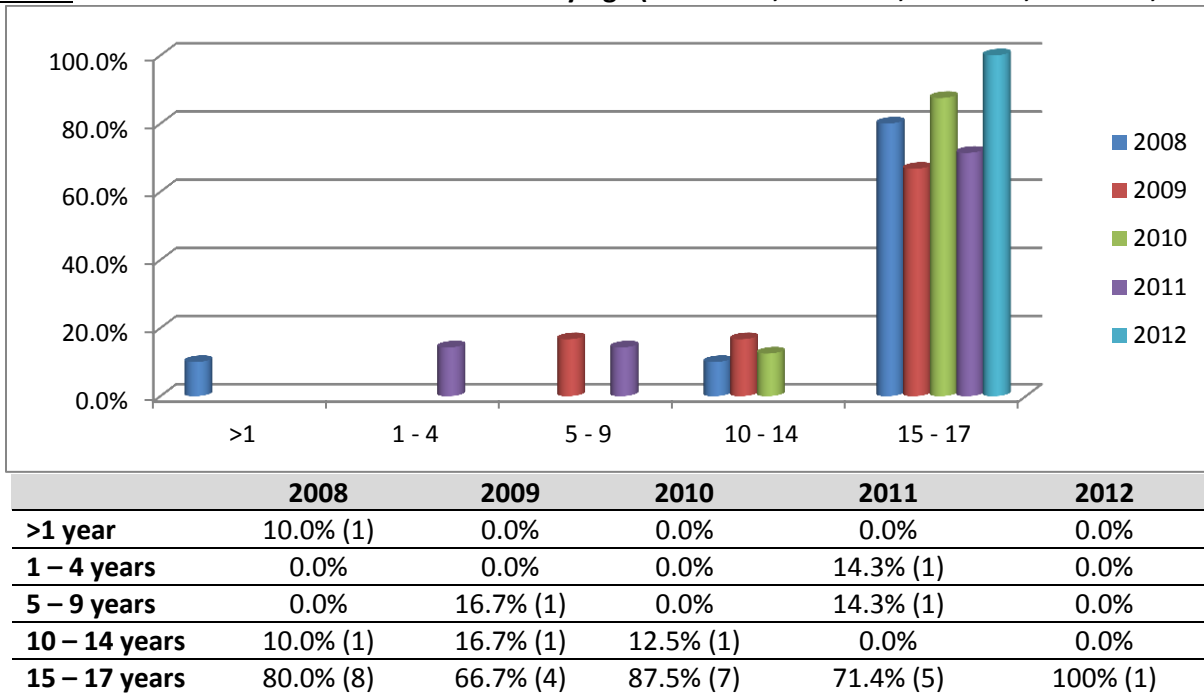
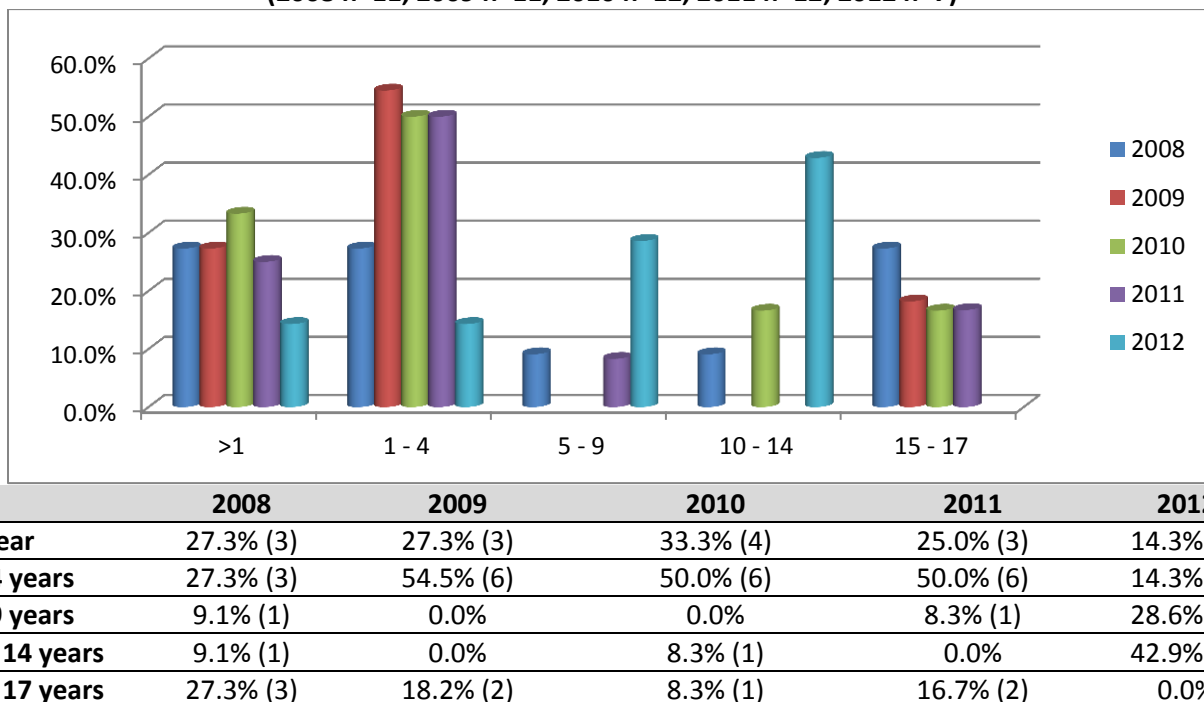


Figure 5.4b: 2008–2012 Non-Firearm Homicide Deaths by Age (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12, 2012 n=7)



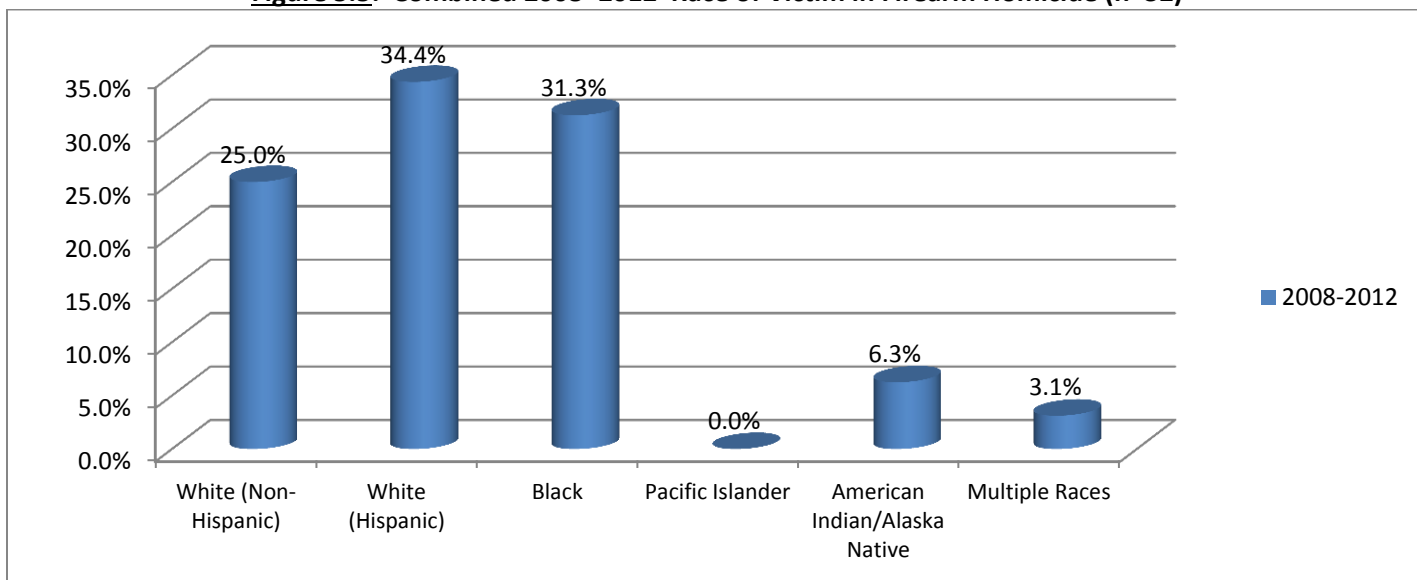
FIREARM HOMICIDE

Nationally, youth homicides represent the greatest proportion of all firearm deaths⁵. 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.”⁶ Clark County’s child death review data has historically mirrored these national risk factors. However in 2012 there was only one firearm related homicide.

Starting in 2010 there were more non firearm homicides than firearm homicides, where previously these numbers were evenly split. This year, homicides of all types are down and especially firearm homicides dropped to only one incident in 2012. This one incident occurred at a party and it appears that the decedent was not the target, but rather an innocent bystander in the wrong place at the wrong time. This decedent was attending school regularly; the family had no prior history with child welfare and did not exhibit any of the red flags or other characteristics common in previous years. Because there is only one case of firearm homicide in 2012, details for this case will not be provided in the figures and text below. Rather, a five year (2008-2012) total is presented for each of the figures.

Figure 5.5 below outlines the racial/ethnic distribution of firearm homicides from 2008-2012. Minorities have been consistently over represented in this manner of death over the past five years.

Figure 5.5: Combined 2008–2012 Race of Victim in Firearm Homicide (n=32)

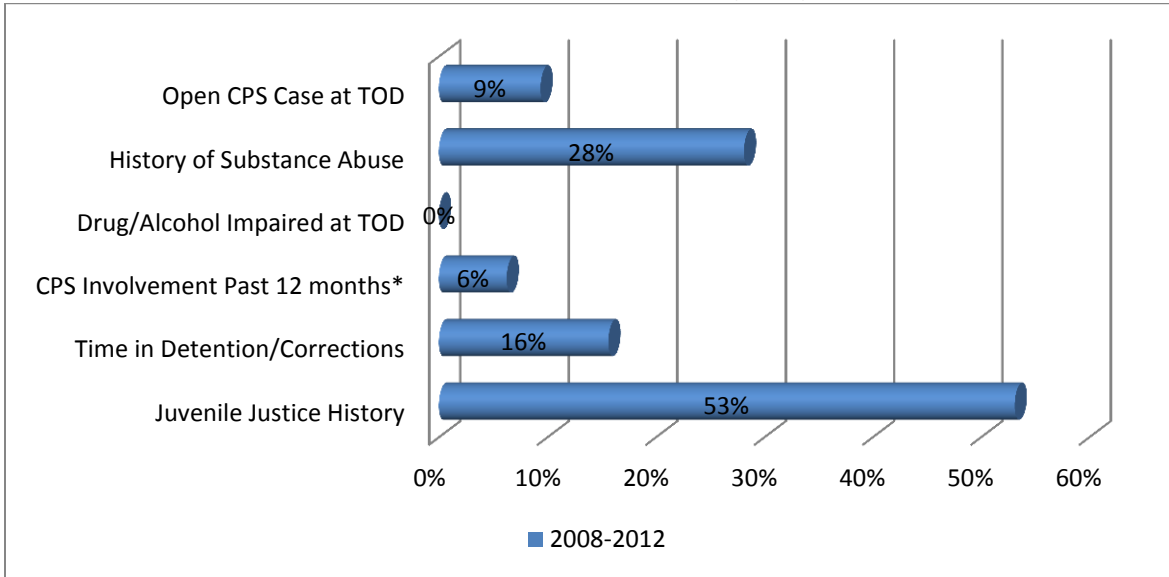


⁵ www.childdeathreview.org (2007)

⁶ www.childdeathreview.org (2007)

Over the past five years about half of firearm homicide victims (53%) had a known juvenile justice history, but only 16% have spent time detention or corrections.

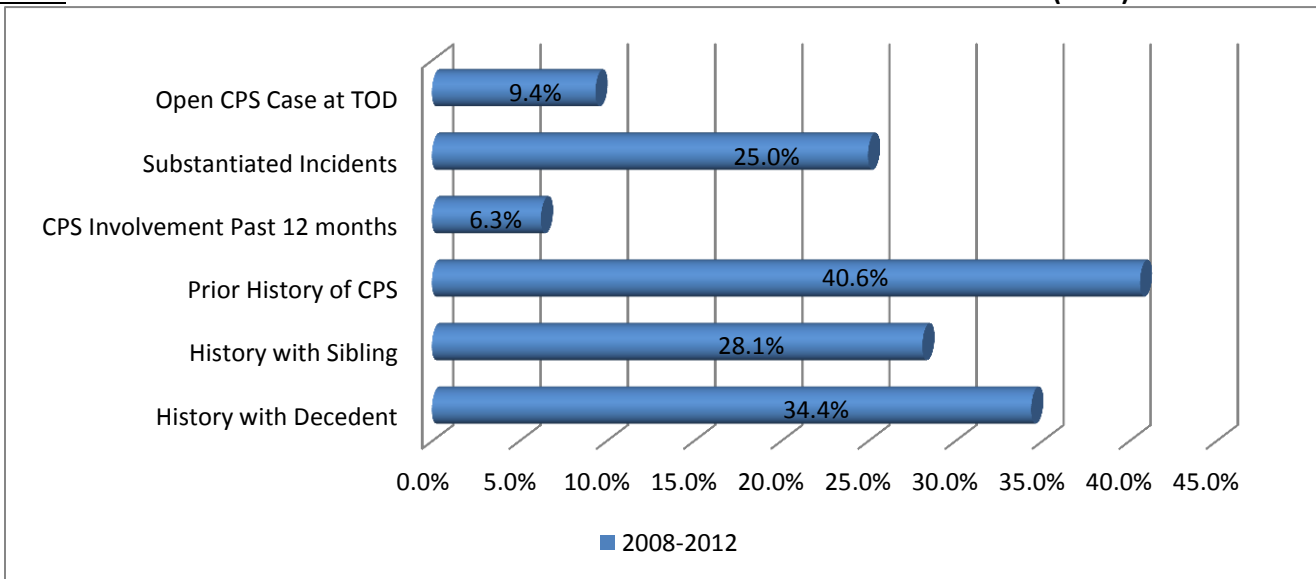
Figure 5.6: Combined 2008–2012 Characteristics of Firearm Homicides (n=32)



NOTE: Categories are not mutually exclusive.

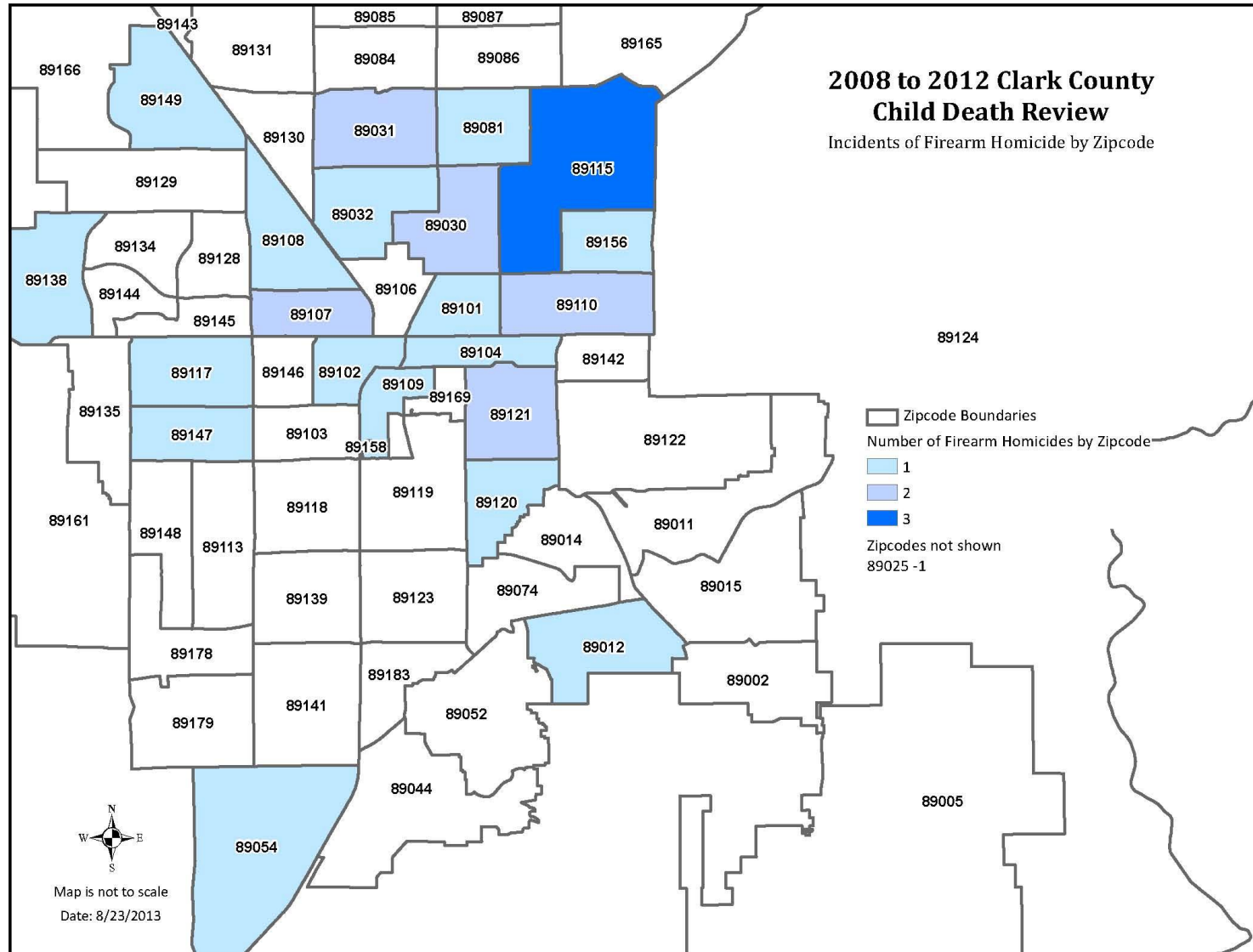
Of the firearm homicide cases over the past five years, 40.6% of the families of the decedent had a history with the child welfare system, and in 34.4% of all firearm fatalities the history with child welfare involved the decedent (Figure 5.7).

Figure 5.7: Combined 2008–2012 Child Welfare Involvement for Firearm Homicide Victims (n=32)



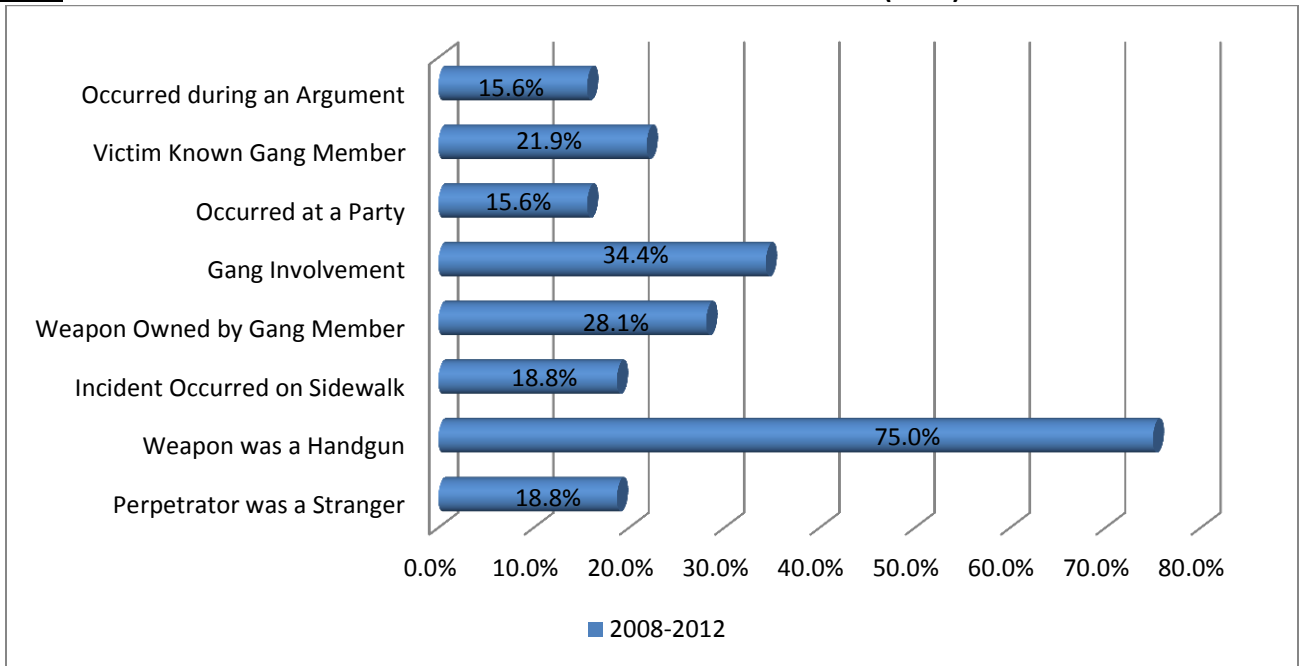
NOTE: Categories are not mutually exclusive.

The map below illustrates the incident location for firearm homicides from 2008-2012 by zip code. The darker the zip code is shaded the higher the number of incidents in that zip code. While the incidents are widely distributed, they are concentrated in the north east portion of the county and particularly in 89115.



From 2008-2012, 75% of firearm homicides have involved a handgun and 34.4% of incidents involved gang activity, but only 21.9% of victims were gang members themselves (see Figure 5.8 below).

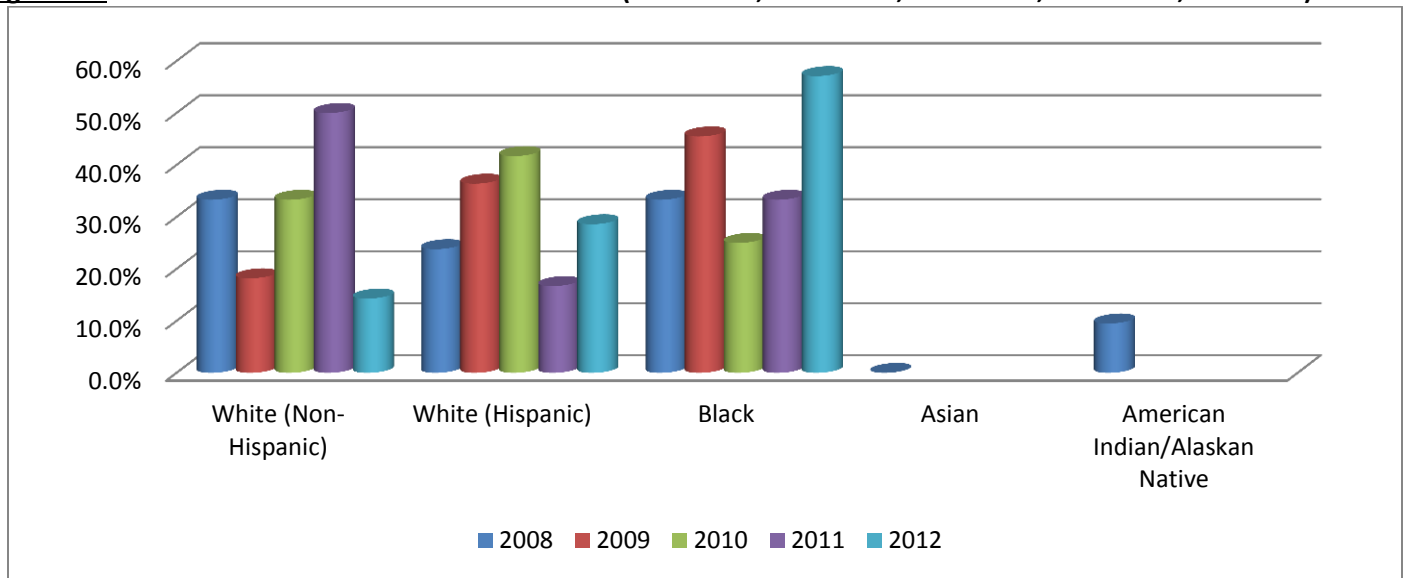
Figure 5.8: Combined 2008–2012 Incident Information for Firearm Homicides (n=32)



NON-FIREARM HOMICIDES

In 2012 there were 7 non-firearm homicides. These cases display an entirely different set of characteristics than the firearm homicides. This year 28.6% (n=2) of non-firearm homicide victims were between the ages of 0 and 4 years, 14.3% (n=1) were less than one year of age, 28.6% (n=2) were between 5 and 9 years of age, and the remaining 42.9% (n=3) were between 10 and 14 years of age. Again this year Black children were disproportionately represented in non-firearm homicides (Figure 5.9). More than half (57.1% n=4) were Black, followed by White Hispanic (28.6%) and then White Non-Hispanic at 14.3%. This year the majority of non-firearm homicide victims were female (71.4%) and one of these children had a genetic disability, and one did suffer from asthma.

Figure 5.9: 2008–2012 Race of Non-Firearm Victims (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12, 2012 n=7)

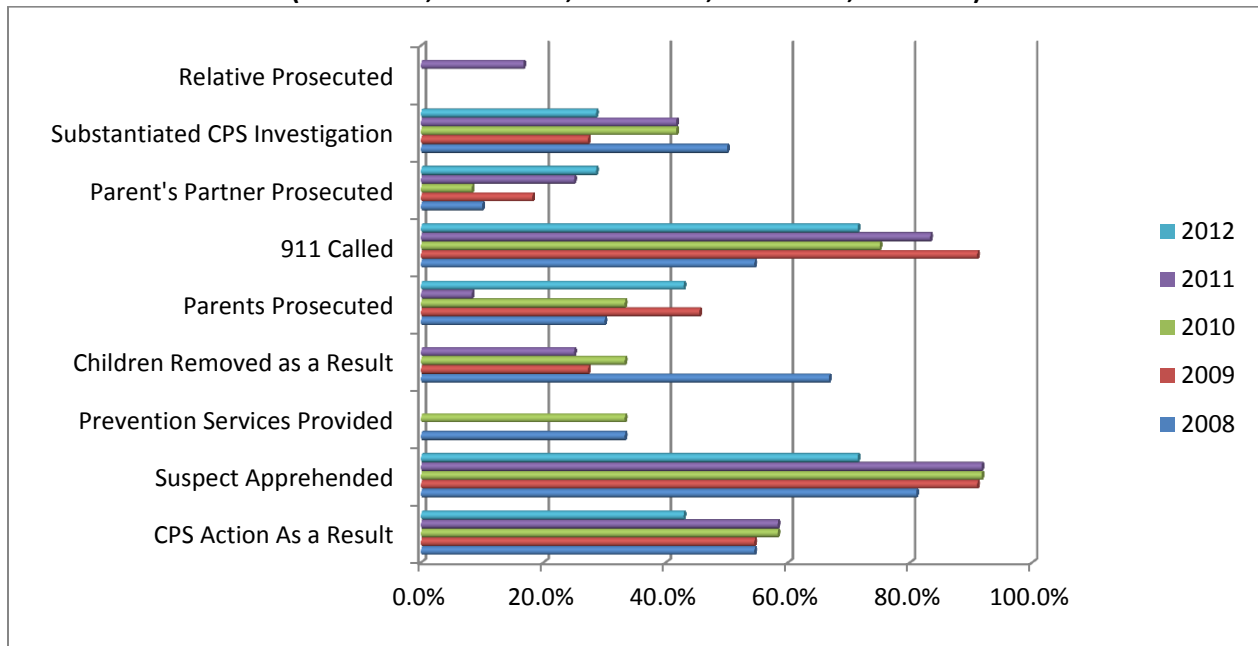


There were five non-firearm homicide victims in 2012 that were school aged and all five were attending school regularly at the time of their death. In 25% of cases (n=3) the victim’s primary supervisor at the time of the incident was a biological parent, in another 25% of cases (n=3) the supervisor was 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 2012, 71.4% of non-firearm homicides (n=5) were determined by the team to be the result of child abuse or neglect. Five of these four cases also involved a CPS investigation in Clark County, while the remaining case involved a Nevada resident who died in another state’s jurisdiction. Among all seven non-firearm homicides, four of the perpetrators were a parent's partner (parent's girlfriend/boyfriend or step-parent), two were actually the child's biological parent and in one case the perpetrator was a stranger. Circumstances include the child being beaten or shaken (n=4), in one case the child did not receive timely medical attention and suffered a burst appendix, and in two cases the child was stabbed. The remaining non-firearm homicide was a random assault on a child and her parents resulting in their deaths.

Prosecution of either the parent or the parent’s partner was pending at the time of review for six of the seven cases. For the remaining case the assault was random and law enforcement was looking for the perpetrator.

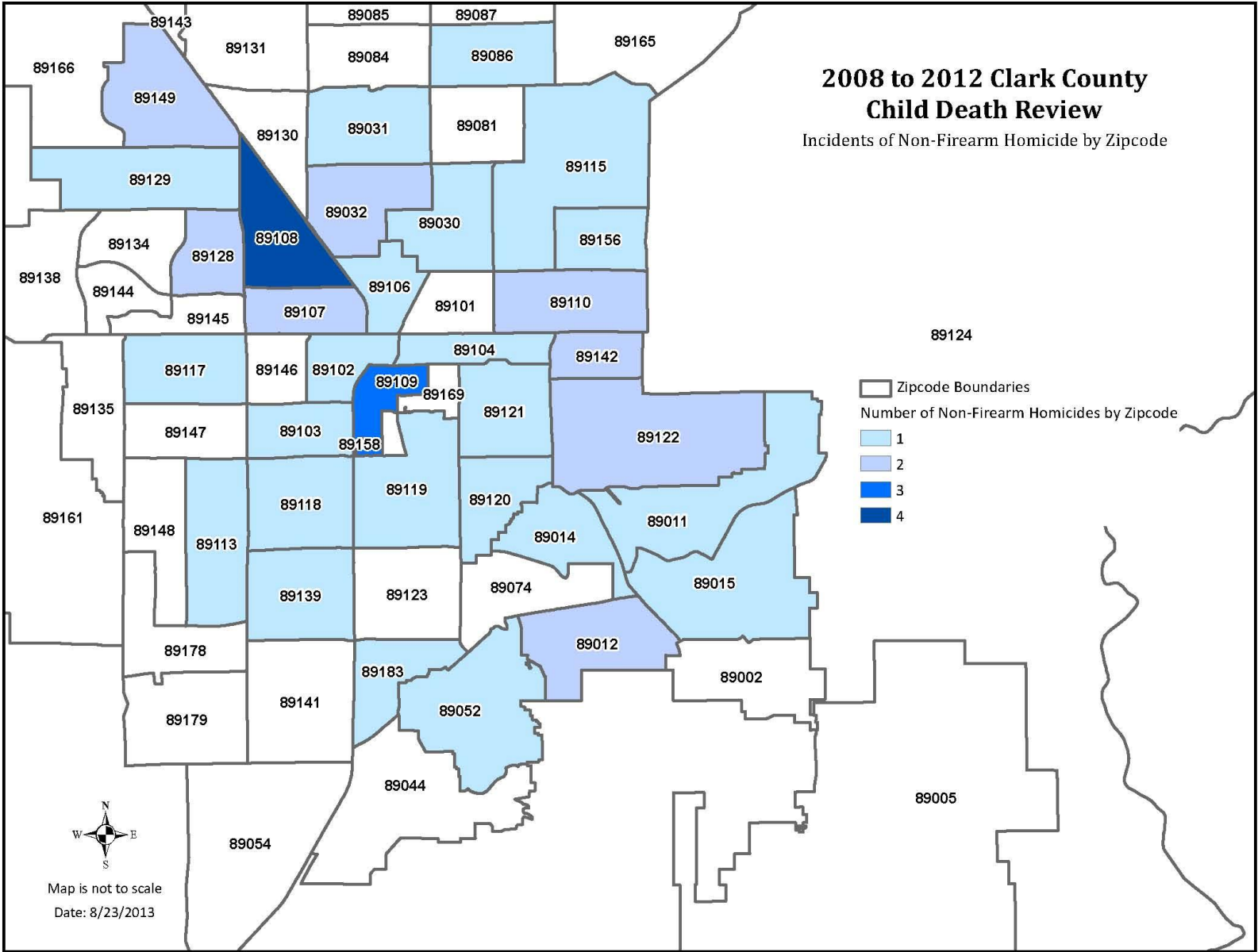
Figure 5.10: 2008–2012 Incident Information for Non-Firearm Homicides
 (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12, 2012 n=7)



In five of the seven non-firearm cases 911 was called. The Department of Family Services (DFS) was contacted and took action in 57.1% (n=4) of the seven cases in the form of a CPS investigation, with all four cases being found substantiated. In two of these four cases, action also included a request for court intervention pursuant to NRS 432B, and the provision of appropriate child welfare services for relevant members of the deceased child's surviving family members. No additional action was taken in the other two cases as the deceased child was the only child in the family and/or household.

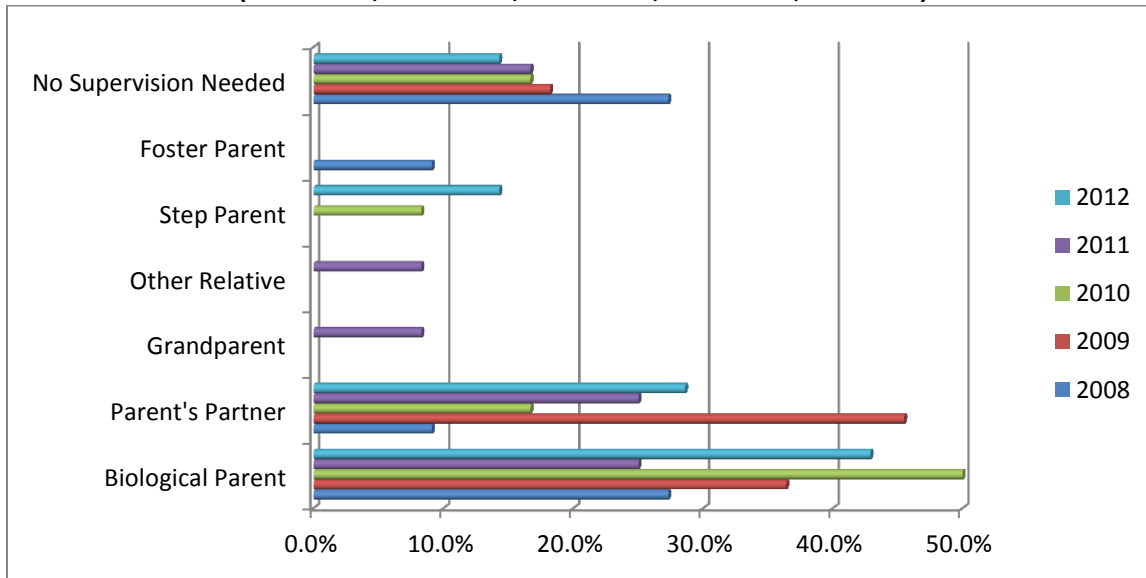
In the remaining three non-firearm homicides in 2012, DFS did not take action due to lack of jurisdiction and/or because the child death was the result of an injury inflicted by someone who did not meet the statutory criteria of an eligible perpetrator under NRS 432B.

The map below illustrates the zip code locations for all non-firearm homicides in Clark County from 2008-2012. The map is shaded such that those zip codes shaded in a darker blue have had more incidents of non-firearm homicides. As you can see these incidents have occurred in nearly every zip code over the past five years, however 89108 has had the greatest number, followed by 89109.



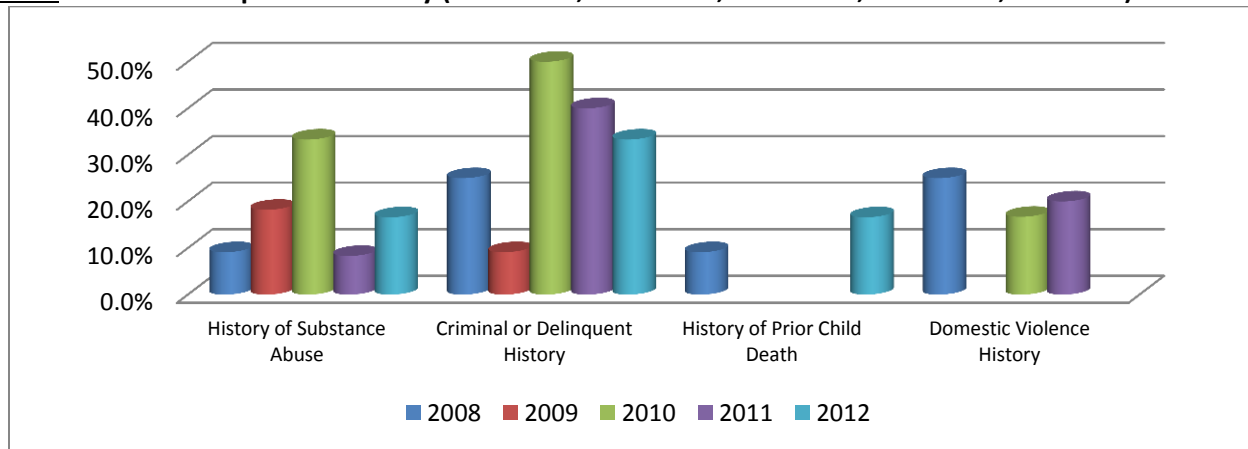
In nearly all cases the team determined that the decedent had proper supervision at the time of death 85.7% (n=6), the remaining victim was of an age that she did not need direct supervision. In 85.7% (n=6) of cases the supervisor was also responsible for inflicting fatal injuries. In the remaining case, 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: 2008–2012 Primary Supervisor at Time of Incident
(2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12, 2012 n=7)



In 2012, for those cases where the child required supervision (n=6) 16.6% (n=1) 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, 33.3% (n=2) of supervisors had a delinquent or criminal history, and one had a history of prior child deaths (See Figure 5.12).

Figure 5.12: 2008–2012 Supervisor History (2008 n=11, 2009 n=11, 2010 n=12, 2011 n=12, 2012 n=7)



More than half (n=4) of the cases had a prior family history of involvement in child welfare. Regarding those cases with a previous child welfare history, 28.6% of those cases (n=2) involved both the decedent and his/her siblings. At the time of the child’s death, two of these families had open child welfare cases.

The majority of non-firearm homicides (85.7%, n=6) were caused by child abuse or neglect and all but three of these cases were due to abusive head trauma. In 5 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 caused the child's death. There was one non-firearm homicide that involved assault, and not child abuse or neglect.

HOMICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

Homicide, by definition, is the intentional killing of another human being. Eight children and youth were the victims of homicide in Clark County in 2012, which is the smallest number since data collection began in 2006. The data separates into two distinct categories for child homicides: firearm related and non-firearm related, and each category has a distinct pattern of circumstances.

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 2012 non-firearm homicides represented all but one case of all homicides for the year. In 2011, 71.4% of non-firearm homicides were a result of child abuse or neglect (n=5). In 3 cases the perpetrator was the parent's partner (boyfriend/girlfriend), in three cases it was a relative (grandparent, uncle, etc.), and in the remaining the perpetrator was a stranger. Prevention efforts should continue to 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.

Major Risk Factors for Child Maltreatment

- Younger children, especially under the age of five.
- Parents or caregivers who are under the age of 30.
- Low income, single-parent families experiencing major stresses.
- Children left with male caregivers who lack emotional attachment to the child.
- Children with emotional and health problems.
- Lack of suitable childcare.
- Substance abuse among caregivers.
- Parents and caregivers with unrealistic expectations of child development and behavior.

<http://www.childdeathreview.org/causescan.htm>,
2013

FIREARM HOMICIDES:

1. FOCUS ON ADDRESSING THE NEEDS OF MINORITY YOUTH THROUGH COMMUNITY BASED OUTREACH AND VIOLENCE PREVENTION EFFORTS

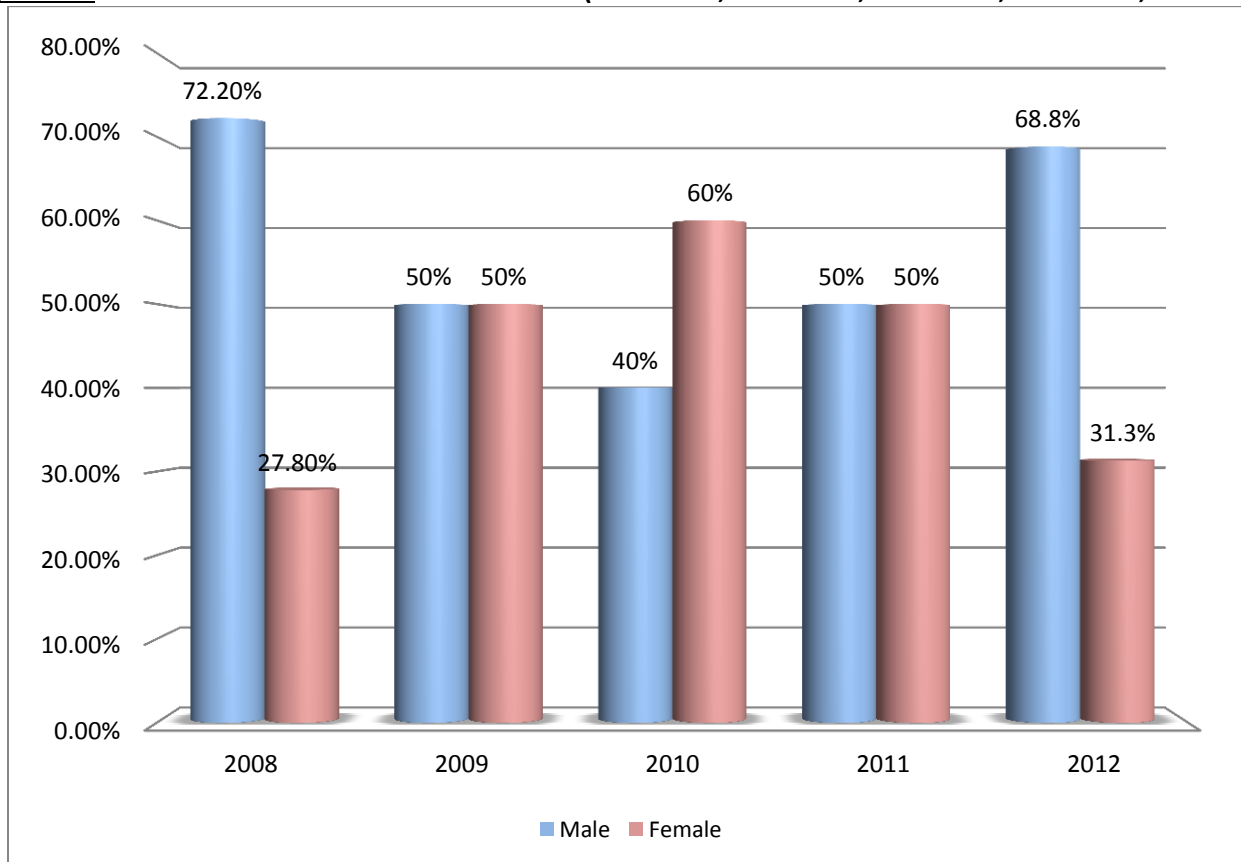
In 2012 there was only one firearm related homicide reviewed by the Clark County team. This is the first time there was only one case and is encouraging to see this reduction in 2012. Over the past five years we can see some trends in the characteristics of these fatalities. One is that over the five year period of 2008 to 2012 65.7% of firearm homicide victims were either White Hispanic (34.4%) or Black (31.3%). Another is that more than half of all victims in the past five years have had some history with juvenile justice services and that 75% of all incidents involved the use of a handgun.. 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.

SECTION VI: UNDETERMINED DEATHS

In 2012, Clark County reviewed 16 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.

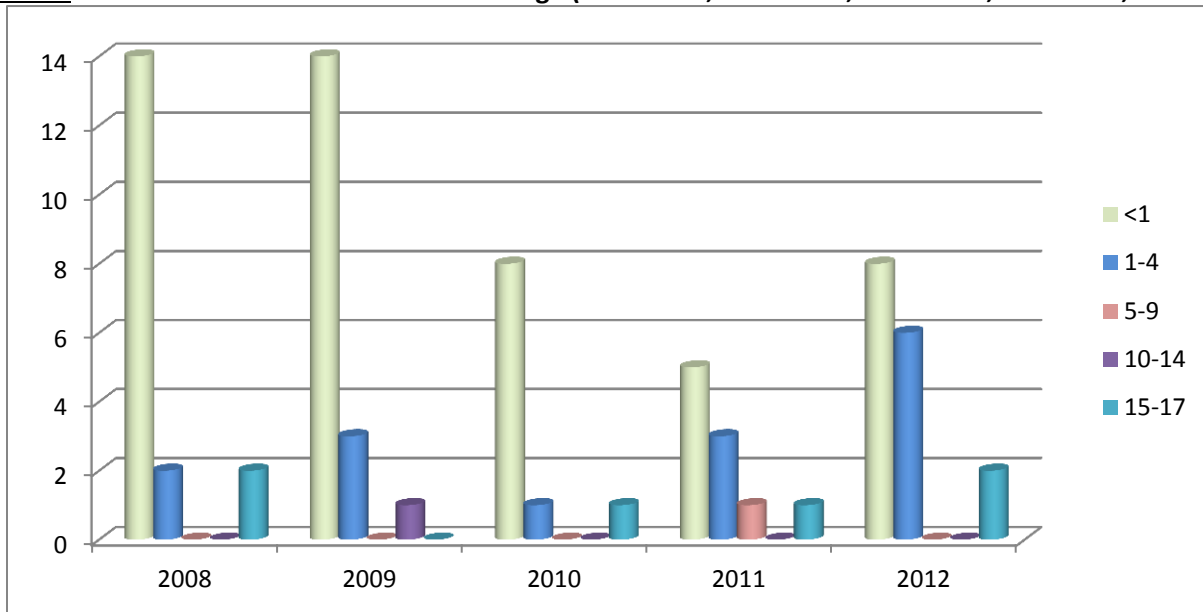
In 13 of the 16 cases, the cause was also listed as “undetermined.” For the remaining 3 cases the cause listed on the death certificate was “inhalation of products of combustion due to house fire.” The following tables represent the descriptive statistics regarding undetermined deaths reviewed by the Clark County Team from 2008 to 2012. Figure 6.1 provides information about the sex of these decedents.

Figure 6.1: 2008-2012 Undetermined Deaths: Sex (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10, 2012 n=16)



Again in 2012, the majority of undetermined child deaths were those less than one year of age (50% or 8 cases, See Figure 6.2). However, in 2012 there were more undetermined deaths than in 2010 and 2011, but fewer than 2008 and 2009.

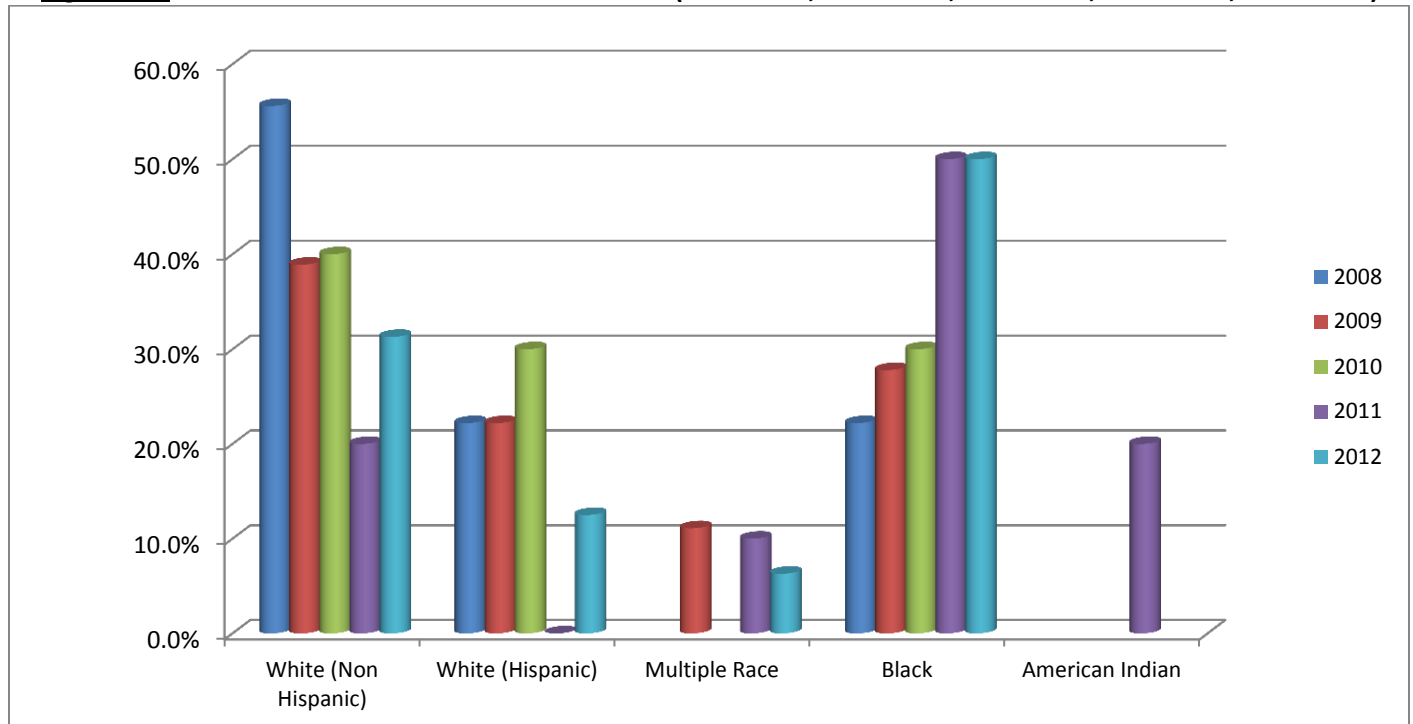
Figure 6.2: 2008-2012 Undetermined Deaths: Age (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10, 2012 n=16)



	Less than 1 year	1 to 4 years	5-9 years	10-14 years	15 to 17 years
2008	77.8% (14)	11.1% (2)	0%	0%	11.1% (2)
2009	77.8% (14)	16.7% (3)	0%	5.6% (1)	0%
2010	80.0% (8)	10.0% (1)	0%	0%	10.0% (1)
2011	50% (5)	30% (3)	10% (1)	0%	10% (1)
2012	50% (8)	37.5% (6)	0%	0%	12.5% (2)

In 2012, again half of undetermined child deaths were black and 31.3% were White Non-Hispanic children (Figure 6.3). None of these children had a disability, but two did have a chronic illness, and in 12 of the 16 cases the child died while in a sleep environment. Among undetermined deaths, nearly half (43.8% or 7 cases) of families had prior history with child protective services and the history may have involved the child, their siblings, or the child's parents as child victims. Additionally, there were no cases where the child was in foster care at the time of death.

Figure 6.3: 2008-2012 Undetermined Deaths: Race (2008 n=18, 2009 n=18, 2010 n=10, 2011 n=10, 2012 n=16)



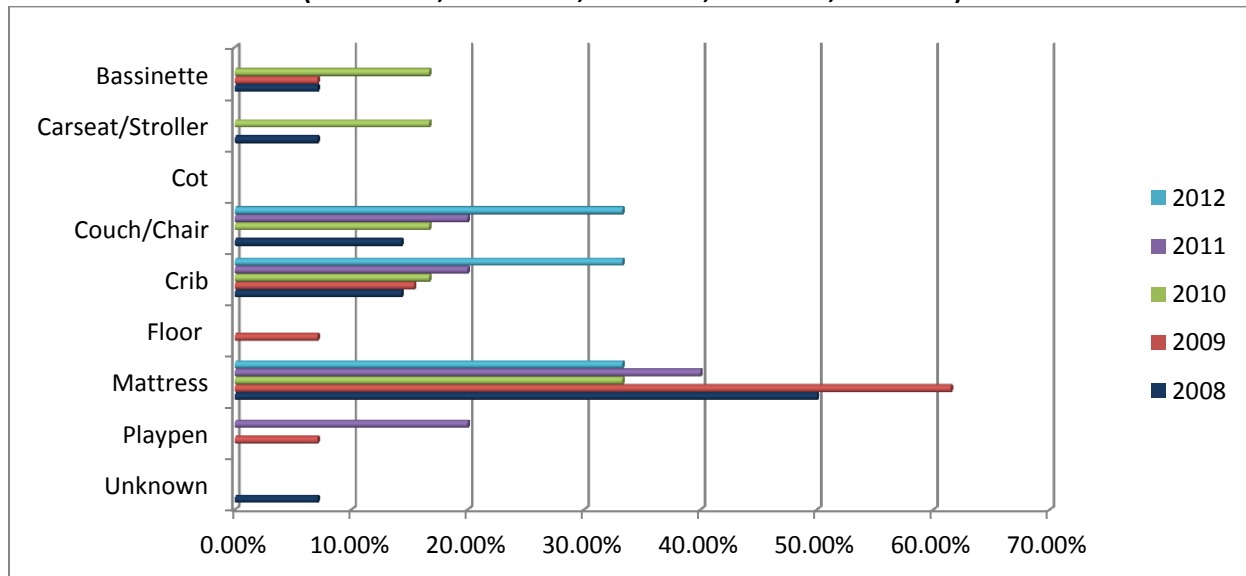
	White (Non-Hispanic)	White (Hispanic)	Multiple Race	Black	American Indian
2008	55.6% (10)	22.2% (4)	0%	22.2% (4)	0%
2009	38.9% (7)	22.2% (4)	11.1% (2)	27.8% (5)	0%
2010	40% (4)	30% (3)	0%	30% (3)	0%
2011	20% (2)	0%	10% (1)	50% (5)	20%
2012	31.3% (5)	12.5% (2)	6.3% (1)	50% (8)	0%

UNDETERMINED DEATH – LESS THAN ONE YEAR OF AGE

Half all of undetermined deaths in 2012 were children under one year of age (50% or 8 cases). In 75% (n=6) of those cases, the child’s death occurred while the child was in a sleeping environment. In 83% of these cases (5 of the 6 children found in sleeping environments) the child was sleeping on a mattress or couch at the time of their death. In four cases, the child was sleeping with other adults.

Figure 6.4 illustrates the various sleep locations for these children. We see an increase in 2012 in children less than one year of age sleeping on couches/chairs so this may need to be a focus of future safe sleep messaging.

Figure 6.4: 2008-2012 Children <1 year old: Sleep Location
(2008 n=13, 2009 n=13, 2010 n=6, 2011 n=5, 2012 n=6)



Incident Sleep Place	2008 (n=13)	2009 (n=13)	2010 (n=6)	2011 (n=5)	2012 (n=6)
Unknown	7.7% (1)	0.0%	0.0%	0.0%	0.0%
Cot	0.0%	0.0%	0.0%	0.0%	0.0%
Floor	0.0%	7.1% (1)	0.0%	0.0%	0.0%
Playpen	0.0%	7.1% (1)	0.0%	20.0% (1)	0.0%
Car seat/Stroller	7.7% (1)	0.0%	16.7% (1)	0.0%	0.0%
Couch/Chair	15.4% (2)	0.0%	16.7% (1)	20.0% (1)	33.3% (2)
Mattress	53.8% (7)	61.5% (8)	33.3% (2)	40.0% (2)	33.3% (2)
Bassinette	7.7% (1)	7.1% (1)	16.7% (1)	0.0%	0.0%
Crib	7.7% (1)	15.4% (2)	16.7% (1)	20.0% (1)	33.3% (2)

Among the deaths of children less than one year of age that were in sleeping environments, 16.7% (1 case) of these children were placed to sleep on their stomach, while in the other 66.6% (4 cases), the child was placed to sleep on his/her back and in one case the position was unknown. When found, one third of children were on their stomach or side, in the remaining cases the infants were 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

Again in 2012, half of all undetermined deaths (N=8) involved children over one year of age. This year there was six children between the ages of one and four years, and another two children between 15 and 17 years of age. In these cases it seems that there may be two possible manners of death, however there is not enough information to assign either one, and so a determination of undetermined was used.

In most of these cases (n=5) the cause of death was also listed as undetermined, but for three of the cases the cause of death was listed as smoke inhalation due to a house fire. For the cases where undetermined was listed as the cause of death, in one case there was suspected child abuse, one case was possibly related to the decedent's drug use, and in another case the decedent was pregnant and died during childbirth. In the remaining two cases, investigators found nothing to help explain the cause of the child's death and therefore it was ruled undetermined.

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 2012 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.

COMMUNITY COLLABORATION

In 2012 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.

Following a recommendation from members of the local team, a representative from NICRP attended the Mental Health and Developmental Services Commission meeting in May 2012 to make a recommendation for improvement in residential mental health treatment for children. The local team proposed that the state consider recommending the implementation of a cross site peer review process for residential mental health treatment facilities so that they can each learn from one another to make improvements within their facilities to improve safety.

In August of 2012 NICRP worked with AAA's Henderson location to provide information on motor vehicle safety at their Summer Traffic Safety Event. NICRP attended and provided safety information to families attending the event, and coordinated with Nevada Highway Patrol to have one of their patrol officers attend the event and share safety information with attendees.

In addition through collaboration with Prevent Child Abuse Nevada, safe sleep information is distributed to attendees at all community resource fairs they attend.

CHILD ABUSE AND NEGLECT PREVENTION

In 2012 a collaboration of members from the Clark County Child Death Review Team along with Prevent Child Abuse Nevada and NICRP worked together to continue the implementation of the "Choose Your Partner Carefully Campaign" through funding from the Executive Committee to Review the Death of Children. Again in 2012 the collaborative was able to distribute over 14,000 informational brochures and almost 300 posters in both English and Spanish. In addition there were bus stop signs posted throughout the community with the campaign information as well. Materials were distributed at a number of community resource fairs as well as partner agencies.

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, as well as several local events where information was distributed to attendees. In 2012 the coalition focused efforts on the Hispanic population due to disproportionate numbers of Hispanic children victims of both fatal and non-fatal drowning incidents.

SAFE SLEEP – SUFFOCATION PREVENTION

Unsafe sleep practices continue to claim the lives on infants in our community. In an effort to address this problem NICRP and the Southern Nevada Health District were awarded funding in 2011 from the Health Resource Support Administration (HRSA) Healthy Tomorrow’s Program to support a hospital based safe sleep initiative in Clark County. The Clark County Child Death Review Team serves as the Advisory Board for this initiative, receiving regular updates throughout the year. Program implementation started in 2012 with the University Medical Center. An informational video on safe sleep geared toward parents and caregivers was produced, 200 UMC staff were trained, and more than 700 parents watched the informational video and completed a short survey. This project will continue over the next three and half years and will expand to all birthing hospitals in Southern Nevada.

2012 RECOMMENDATIONS TO THE STATE ADMINISTRATIVE TEAM

Summary of Recommendations Reported to the State Administrative Team for 2012 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 2012. "Action" listed under each recommendation represents the response from the Administrative Team.

2012-01: *Work with Nevada DMV to include additional questions about pedestrian safety on Nevada Driver's License exam as well as work with law enforcement to emphasize the importance of enforcing existing laws designed for pedestrian safety including those regulations for motorists as well as pedestrians.*

Action: It was determined by the group that adding questions to a Driver's License exam may not address the issue as this would only target new drivers. Therefore the Office of Traffic Safety presented at the team meeting on their "Zero Fatalities" campaign which includes messaging about pedestrian safety.

2012-02: *Create a program or policy that requires parents to be trained in CPR during a prenatal visit or prior to leaving the hospital with an infant.*

Action: Staff to the Administrative Team reached out to hospital staff to ask about requirements for CPR training for new parents. A survey was created and those that responded indicated that parents are offered CPR classes at their location, but that it is not required.

2012-03: *Recommend that agencies who provide in-home services for families with infants tour the entire home to talk about safety and not only where the parents say the child sleeps.*

Action: A letter from the Administrative Team was sent to stakeholder agencies regarding in-home assessments in July/August 2013.

2012-04: *In the next revision of safe sleep materials, specifically include a "boppy" (round fluffy piece of bedding designed for infants) as an unsafe sleep environment.*

Action: Referred to Public Awareness Subcommittee to review during update and review of existing safe sleep materials.

2012-05: *Work with local jurisdictions to include warning signs and/or barriers in areas where irrigation channels cause strong currents and increase the risk of drowning.*

Action: Administrative Team staff contacted Southern Nevada Child Drowning Prevention Coalition members from "Stay Away Don't Play", a local organization aimed at keeping people safe around open water to ensure that these issues were being addressed.

2012-06: *Work with high-risk OBGYNs to focus safe sleep efforts on mothers expecting twins as the risks for unsafe sleep environments may be higher with them.*

Action: A letter from the Administrative Team indicating the importance of promoting safe sleep messaging and offering print materials for their office was sent to high risk OBGYN offices statewide in July/August 2013.

2012-07: *Work with existing motor vehicle safety programs to emphasize the importance of pedestrian safety.*

Action: The team will monitor progress of this recommendation (12-01) with an earlier recommendation as that recommendation included the DMV and Office of Traffic Safety.

2012-08: *Increase awareness of flood wash systems through public education informing the community on the safety tips and possible dangers, as well as connecting with local flood control districts to ensure that washes are properly marked and signed.*

Action: Update from a member of the Southern Nevada Child Drowning Prevention Coalition on activities of “Stay Away Don’t Play”, a group focused on safety around local washes.

2012-09: *Review foster parent training statewide and ensure that “safe sleep training” is a part of that curriculum.*

Action: Foster parent training curricula statewide were reviewed and for those that did not include safe sleep as a component, it was added to the training and has been incorporated in the curriculum.

2012-10: *Support efforts to promote Nevada’s Safe Haven law to the public and ensure that professionals working in settings where infants may be surrendered are trained in how to appropriately deal with that situation.*

Action: A Work Group was created in 2011 to work on improving internal infrastructure and training and expanding outreach and education regarding Nevada’s Safe Haven law. The workgroup has been meeting several times a year and has ensured coordinated internal policies for child welfare agencies regarding safe haven surrenders, developed sample policies for safe haven locations, as well as compiled a list of training coordinators for safe haven locations to ensure they are up to date on the latest information. This workgroup provides regular updates at Executive Committee and Administrative Team meetings.

APPENDIX A: 2012 CDRT MEMBERSHIP LIST

2012 Core Members

Dr. Sandra Cetl	Sunrise Hospital/Children's Assessment Center (2012 Team Chair)	Sally Jost	Clark County School District
Ricky Crosby	Clark County Department of Juvenile Justice Services	Dave McKenna	Henderson Police Department
Margarita DeSantos	Southern Nevada Health District	Dr. Alane Olson	Clark County Office of the Coroner/Medical Examiner
Dr. Andrew Eisen	Touro University	Darren Reimer	Nevada Dept. of Public Safety/NV Highway Patrol
Paula Hammack	Clark County Department of Family Services	Michael Staudaher	Clark County District Attorney's Office
Mark Hoyt	North Las Vegas Police Department		

2012 At Large Members

Troy Armstrong	Clark County Department of Family Services	Paula Haynes-Green	Clark County Department of Family Services
Marion Biron	Clark County Department of Family Services	Kathryn Hooper	Henderson Fire Department
Mary Ellen Britt	Southern Nevada Health District	Mark Hoyt	North Las Vegas Police Department
Annette Darr	Las Vegas Metropolitan Police	Tracy Kingera	Clark County Department of Juvenile Justice Services
Gil Diaz	Clark County School District Police – Threat Assessment Team	Jill Marano	Nevada Division of Child and Family Services
Tiffany Driscoll	Boulder City Police	Mary Martinat	University Medical Center – Trauma Services
Brigid Duffy	Clark County District Attorney's Office- Child Welfare	Dr. Neha Mehta	Sunrise Hospital- Forensic Pediatrician
Michelle Edwards	Clark County District Attorney's Office- Child Welfare	Tricia Mendiola-Sarabs	Nevada Institute for Children's Research and Policy
Linda Flatt	Nevada Office of Suicide Prevention	Tara Phebus	Nevada Institute for Children's Research and Policy
Deborah Flowers	Nevada Department of Child and Family Services	Terri Remer	Clark County Office of the Coroner
Jen Ford	Boulder City Police	Lynn Row	Clark County School District
Dr. Tony Fredrick	Southern Nevada Health District	Peggy Rowe	Clark County Department of Family Services
Marion Hancock	Sunrise Hospital	Rosemary Virtuoso	Clark County School District
Janne Hanrahan	Clark County District Attorney's Office – Child Welfare	James Weiskopf	Las Vegas Metropolitan Police Department

APPENDIX B: NEVADA REVISED STATUTES RELATING TO CHILD DEATH REVIEW (2012)

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)

NOTE: Under Assembly Bill 154 in the 2013 Nevada Legislative Session, changes were made to this section of the NRS. These changes included the combining of the state level Executive Committee and Administrative teams as well as explicitly allowing for the use of aggregate de-identified data for research and prevention programs. The detailed changes in Assembly Bill 154 can be found at: <http://www.leg.state.nv.us/Session/77th2013/Bills/AB/AB154.pdf>.