

2010 Annual Report of Child Deaths in Clark County, Nevada

A Report from the Child Death Review Team in Clark County

August 2011



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

Nevada Institute For Children's Research & Policy

NICRP

UNLV
UNIVERSITY OF NEVADA LAS VEGAS

HEALTH SCIENCES
School of Community Health Sciences



This report was prepared by the Nevada Institute for Children's Research and Policy

NICRP Authors:

Tara Phebus, M.A.
Associate Director

Denise Tanata Ashby, J.D.
Executive Director

Special Thanks to:

The Child Death Review Team in Clark County

Marissa Marano – Research Assistant, NICRP

Amanda Haboush, M.A.
Senior Research Associate, NICRP

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>.

Nevada Institute for Children's Research and Policy
School of Community Health Sciences, UNLV
4505 S. Maryland Parkway, Box 453030, Las Vegas, NV 89154-3030
Phone: (702) 895-1040
Email: tara.phebus@unlv.edu
Web: <http://nic.unlv.edu>

TABLE OF CONTENTS

CHILD DEATH REVIEW IN CLARK COUNTY	4
METHODOLOGY	8
LIMITATIONS	10
CONFIDENTIALITY	11
FINDINGS	12
Section I: Summary Statistics	12
Overall Demographics	17
Child Welfare Involvement.....	20
Section II: Natural Deaths	24
Chronic Illness.....	28
Prematurity.....	30
Sudden Infant Death Syndrome (SIDS)	32
Natural Deaths: Recommendations for Prevention	33
Section III: Accidental Deaths	34
Motor Vehicle Accidents	36
Drowning.....	40
Suffocation.....	45
Accidental Deaths: Recommendations for Prevention	48
Section IV: Suicide Deaths	49
Situational Factors of Suicide	52
Method of Suicide	53
Circumstances of Suicide.....	54
Suicide Deaths: Recommendations for Prevention	57
Section V: Homicide Deaths	58
Firearm Homicide.....	61
Non-Firearm Homicides	65
Homicide Deaths: Recommendations for Prevention	70
Section VI: Undetermined Deaths	71
Undetermined Death – Less than One Year of Age	74
Undetermined Deaths – Over One Year of Age.....	75
LOCAL PREVENTION EFFORTS.....	76
2010 RECOMMENDATIONS TO THE STATE ADMINISTRATIVE TEAM	77
APPENDIX A: 2010 CDRT MEMBERSHIP LIST	79
APPENDIX B: NEVADA REVISED STATUTES RELATING TO CHILD DEATH REVIEW	80

CHILD DEATH REVIEW IN CLARK COUNTY

In an effort to identify risk factors and prevent future child deaths, in 1992 the State of Nevada joined many other states in mandating Child Death Review Teams. Since that time, both the law and the regional teams throughout Nevada have evolved to facilitate the growing need for collaborative efforts to identify interventions necessary to reduce the rate of child deaths in Nevada. While the primary legislative focus of Nevada Child Death Review Teams has been on addressing fatalities related to child maltreatment and/or involvement with the child welfare system, the teams have expanded their focus to address risk factors and preventability in a wide variety of cases. As the largest county in the State, containing approximately 73% of the state's population 19 years of age and younger (Nevada State Demographer 2010 Census Profiles, Retrieved August 2011), the Child Death Review team in Clark County has been, and will continue to be, a crucial part of identifying risk factors as well as recommending and implementing policies and procedures to minimize preventable child deaths in the State.

Starting in 2007 the Clark County Manger's Office has contracted with the Nevada Institute for Children's Research and Policy in the School of Community Health Sciences at the University of Nevada Las Vegas to collect case specific data from case reviews and compile an annual report of child deaths in Clark County including data on child deaths from 2006 to 2010. This report is a result of Clark County's commitment to make this information more visible and available to the public. While this report is commissioned by the Clark County Manger's Office, the Child Death Review Team serving Clark County is a multidisciplinary team that conducts independent reviews of cases of child deaths. This team does not report to any county official and the information found in this report is a result of those independent reviews.

Goals & Purpose for Teams

The primary goal of all Child Death Review Teams is to prevent future child deaths. The child death review process enables jurisdictions to come together in a collaborative, multidisciplinary forum to openly discuss detailed circumstances in an effort to gain a better

understanding of child deaths. The team provides a venue for representatives from a variety of both public and private agencies as well as community organizations to share information in a confidential and non-threatening environment. The National Center for Child Death Review (hereinafter, National Center), which is supported by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, has developed a "Program Manual for Child Death Review" (hereinafter, Program Manual) to assist States in developing and conducting Child Death Review Teams. Many of the recommendations provided in that document have been adopted by both the State and local Child Death Review Teams in Nevada.



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

National Center for Child Death Review

The Purpose

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

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

The Operating Principles of Child Death Review

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

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

The Objectives

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

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.

Each regional child death review team should:

Composition of Child Death Review Teams

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

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

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

The Child Death Review Team in Clark County includes members representing all of the mandatory categories, as well as additional members from other public and private organizations including the Clark County Department of Juvenile Justice, Local Fire Departments, Safe Kids Coalition, the Office of Suicide Prevention and many others.

A complete list of local Child Death Review Team members for 2010 is located in Appendix A.

The Review Process

Regional child death review teams are charged with the periodic review of child deaths which occur in the area represented by the team. Regional teams may review the death of any child who either resides in or died in the State of Nevada, within their respective regions. The Child Death Review Team for Clark County meets once a month at the Office of the Coroner/Medical Examiner for a period of three hours to conduct reviews. The team reviewed an average of 20 new cases per month.

At the beginning of each meeting, the chairs of the team remind members of the confidential nature of the review process and ask any new members to sign a confidentiality statement. All attendees in the meeting are required to sign an annual confidentiality agreement stating that all information shared in the meetings may not be discussed or shared outside of the child death review meeting (see page 10 for a full description of measures taken to preserve the confidentiality of information shared during meetings).



The monthly agenda is organized first according to status and all cases that were brought back from the previous month are listed first. After that all cases are organized by manner of death and by cause of death within each manner. Only cases that have been officially assigned cause and manner of death by the Office of the Coroner/Medical Examiner or attending physician are placed on the monthly agenda. The first few pages of the agenda contain summary information for all cases that month organized by cause and manner of death. This section allows the team to see any trends at first glance. In addition the front page of the agenda contains summary information for each manner of death year to date. For example, this section displays the total number of accidental deaths the team has reviewed for that year. For each individual case, a summary sheet is created that contains basic demographic information about the child and also a short description regarding the circumstances of the child's death. This full agenda with all information is provided to the team to review one week prior to the meeting. In 2010 all team members were sent the agenda one week prior to the meeting and expected to

print and bring their own agenda to the meeting. During the review meeting cases are reviewed in groups based on their cause of death. Agencies with additional information are asked to present their case information. All team members are then given the opportunity to ask questions regarding the case. After the case review, team members have the opportunity to make and discuss recommendations for improvements to laws, policies and practices which will support the safety of children and prevent future child deaths. Each quarter, the Child Death Review Team for Clark County submits a report to the Nevada Division of Child and Family Services, on behalf of the Administrative Team, which identifies statistical information regarding the cases that were reviewed in that quarter and recommendations made based on those reviews.

Team Changes in 2010

In 2010 the team worked to solidify existing team protocols and procedures. The team consistently received the ages of parents through an agreement with the Southern Nevada Health District to screen birth records for decedents and provide the ages of the parents when the birth certificate was issued in Nevada. In addition, the local fire departments participated in review meetings. The team now has representation from the Henderson Fire Department and the North Las Vegas Fire Department. Additionally the team has taken extra care to discuss the contribution of child abuse or neglect in each case. For each case reviewed the team makes a determination about whether they feel that child abuse or neglect either caused or contributed to the child's death. This information is not based solely on any one agency's regulations or policies but rather the determination of the team as a multidisciplinary group.



METHODOLOGY

In 2010, Clark County continued to collect and maintain a county-level database to manage the review information on child fatalities. The Nevada Institute for Children's Research and Policy (NICRP) continues to collect the data and maintain a database of information as well as produce the annual report. The data were collected using a form that was modeled after the collection tool developed by the National Center for Child Death Review. The data collection tool is used to collect as much information as possible through specific questions about the demographics of the child, the supervisor, caregiver, and the family. The tool is also used to capture detailed information regarding the circumstances surrounding the child's death. In addition, this tool is constantly reviewed to ensure that it is effective in capturing information most pertinent for the prevention of future child deaths.

Data presented in this report is drawn from information gathered at each of the monthly child death review meetings. The Clark County Office of the Coroner/Medical Examiner forwards information for all fetal and child deaths to NICRP for review by the child death review team on a monthly basis. In 2010 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 if a fetal death certificate is issued. Although fetal death certificates do not indicate a manner of death, for the purposes of child death review and this report, these cases were classified based on the manner reported by the coroner/medical examiner's office. 2010 is the third 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 will allow the team to monitor trends in all fetal and child deaths, including those due to Natural causes.

It is important to note this change when reviewing the total number of child deaths starting in 2008, which due to the change in methodology looks substantially larger than 2006 and 2007. This is because the team reviewed ALL deaths and not just a selection of the natural deaths. Because the methodology is the same it is more representative to compare 2008-2010 data when reviewing natural deaths.

During the review meeting representatives from various agencies provide information on the case that is then used to complete the data tool. If agencies are unable to attend the meetings requests are made to the agency for the pertinent information on the case. Information that was unavailable at the meeting or unknown by agencies at the meeting is listed as "unknown" in the database. The Clark County Office of the Coroner/Medical Examiner provides copies of death certificates as well as investigation summaries for each case for data collection purposes when it is available to them. Clark County Department of Family Services also screens each case for prior history with the child welfare agency and if there is history, then that agency completes a form containing the pertinent facts of their involvement with the child and the family.

Data forms were completed by NICRP staff, numerically coded and then entered into a statistical data analysis software package. The data was cleaned, or checked for errors using a process of generating frequencies and identifying outliers, then verifying their accuracy. At this time no additional case information was requested, if the information did not exist in the file, it was simply listed as "unknown". This dataset was then used to produce the statistics that appear in this report. Descriptive statistics are used in this report to present summary information about all cases as well as the leading causes under each manner of death. Frequencies and cross-tabulations were used, however

due to the small sample size, tests for statistical significance were not completed. In many cases the subset of cases being discussed is too small to make accurate statements about a number's statistical significance. In addition to simple descriptive statistics, comparative data for 2006 - 2010 are also presented in this report. The goal is to be able to track the major causes of child death to identify trends and improve the ability to design prevention strategies in Clark County.

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

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, that would be suicide. If he was shot by someone else on purpose, that is homicide. If he discharged a weapon while cleaning it and was hit, that is an accident (although it is important to note that this scenario also presents an element of neglect which the team may identify at review). It is important to pay attention not only to cause of death, but manner as well, because understanding the manner of death can provide reviewers a greater understanding of the circumstances surrounding the death, which increases the potential for preventing future child fatalities.



The cause of death is indicated by the actual physiological event that caused the person to die and is generally determined through autopsy. Manner is a ruling about intent and is determined by the investigation and circumstances surrounding the death. Therefore, the exact same physiological cause of death could have five possible manners of death. There are five standard manners used: 1) Natural, 2) Accidental, 3) Suicide, 4) Homicide, and 5) Undetermined. The

LIMITATIONS

As with any research there are limitations associated with this dataset. Since we are in the fifth year of data collection there have been changes made to the data collection tool as well as some of the methods for collection to improve the accuracy of data presented in this report. However, certain limitations could not be avoided.

Again this year not all information could be gathered regarding every case reviewed. This missing information is due to a variety of circumstances including differences in the focus of various investigating agencies. The information that is important for tracking and prevention may not be pertinent to a medical examiner or law enforcement investigation and is therefore not available in their reports. In other instances a child may not be a resident of this state and therefore the team did not have access to all of the family's background information. This limits the level of detail provided for several cases in this report. Additionally, there are many sections where the total number of cases discussed is so small that statistical generalizations cannot be made.

Finally, to ensure consistency in data reporting, the Child Death Review Team's database was compared with records from the Clark County Office of the Coroner/Medical Examiner. The number of cases in each manner of death matched with only two exceptions. The largest difference was among fetal 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. The other category was accidental deaths. In this category the Clark County Office of the Coroner/Medical Examiner reports two more deaths than were reviewed by the team. Both of these deaths were residents of another Nevada county and therefore referred to those local teams for review. Therefore the total number of accidental deaths reviewed by the Clark County CDR team and thus presented in this report

were 46, while the coroner/medical examiner's database lists 48 accidental child deaths.

In 2010, data collection processes have become even more consistent. This year the child death review team was able to gain access to more pieces of information including hospital records, school records, and police investigation reports. Additionally, the ages of the parents were more readily available in 2010 as a system of information sharing was developed with the Southern Nevada Health District. This information was used to complete the review and later the data collection tool.

Agencies have become more familiar with the team and its purpose and, upon request, are sharing the information for these purposes. The team anticipates that information will be even more accessible in the future as relationships for data sharing are processes and protocols are developed between the team and the relevant agencies.



CONFIDENTIALITY

All cases reviewed by the Child Death Review Team are kept completely confidential. Information shared in the meetings is protected under NRS 432B.407 and cannot be shared with anyone outside the meeting. 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 2006-2010 where appropriate, as well as provide descriptive statistics regarding specific circumstances surrounding causes and manners of death to assist in generating data driven prevention initiatives. This report does not represent all data collected regarding 2010 child fatalities, because some variables presented too few cases to provide information that is not identifiable.



FINDINGS

SECTION I: SUMMARY STATISTICS

Again in 2010, the Child Death Review Team in Clark County reviewed ALL child deaths and all fetal deaths over 20 weeks gestation. This resulted in the large difference in the total number of cases reviewed starting in 2008 as this was the first year that the team reviewed all child and fetal deaths (See Table 1 below).

Table 1: Total Child Deaths Reviewed by Year

Year	2006	2007	2008	2009	2010
Count	148*	155*	311	283	251

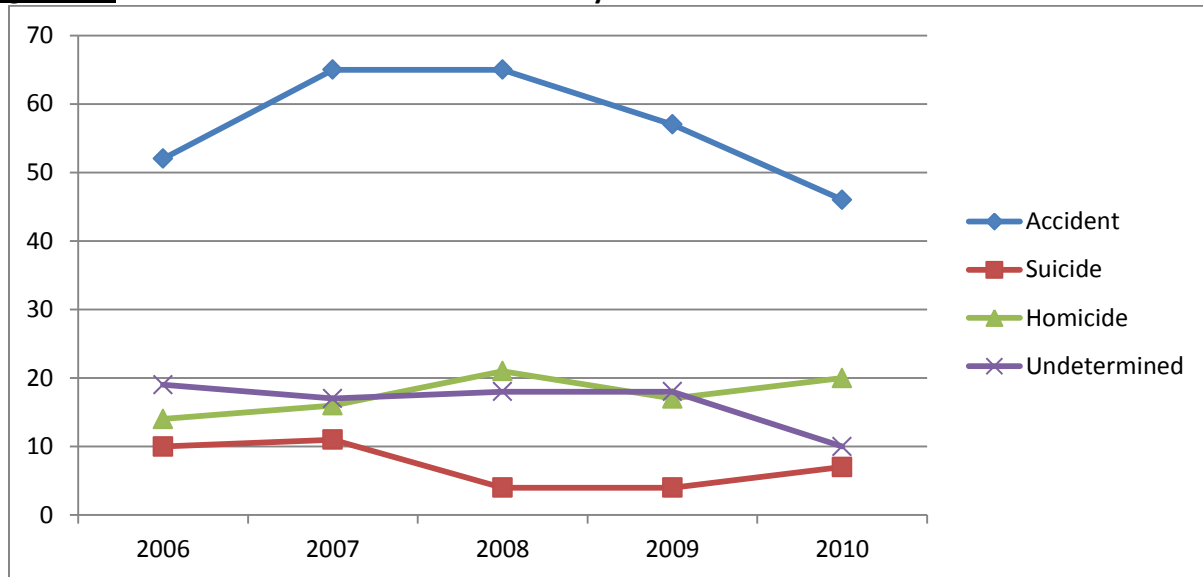
**Totals in 2006 and 2007 are not comparable to data in 2008-2010 because in 2006 and 2007 all child deaths were NOT reviewed (see explanation below).*

The table indicates an increase from 2007 to 2008, but this is due to the change in the methodology starting in 2008 when all cases of child and fetal deaths (over 20 weeks gestation) were reviewed by the team, not a drastic increase in the number of children that died in 2008, 2009 and 2010 compared to 2006 and 2007. The 251 cases in 2010 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 2011). Because the same methodology was used to select cases for review since 2008 this represents a **19.3% decrease in Child Deaths in Clark County from 2008 to 2010.**

Deaths are categorized based on the official manner of death and can be placed in one of five categories: natural, accidental, suicide, homicide, or undetermined. These classifications are determined by the coroner/medical examiner's office during an investigation or by a physician signing the death certificate in the hospital, if it is not a coroner's case. "Coroner's Case" refers to the cases that the coroner/medical examiner's office investigates in order to assign manners of death and sign the death certificate. If hospital physicians sign the death certificate, it is because they do not feel the death needs to be investigated. Since all deaths were reviewed in 2010 it is not surprising that the majority of all deaths reviewed were natural deaths at 67% (168 cases). The next most frequent category was accidental deaths at 18.3% or 46 cases. This is the smallest number of accidental deaths since NICRP began creating this report with 2006 deaths, and the fewest natural deaths since the team started reviewing all natural deaths in 2008. There was an increase in the number of suicides in 2010 at seven cases compared to only four cases in 2008 and 2009. We also saw an increase in the number of homicide cases from 2009 to 2010, but still one fewer than in 2008.

These overall counts are important to understanding the general trends in child deaths in Clark County. As expected there are far more Natural deaths reported in 2008-2010 when compared to previous years. This is due to the fact that starting in 2008 all deaths were reviewed, while in previous years natural deaths were screened for review and only selected cases were reviewed by the team. This is important to remember when comparing percentages of all deaths over the past five years. This is especially clear when looking at the overall causes of death. The majority are Natural causes where in the past the majority of these causes have been Accidental. This is due to the fact that all deaths (including fetal deaths over 20 weeks gestation) were reviewed and Natural deaths are the most frequently occurring among children less than one year of age, which is also the most frequently occurring age category. To further illustrate this, overall statistics regarding cause of death have been broken out to display those that are due to medical causes and those that are due to external injuries (see page 13).

Figure 1.1: 2006-2010 Manner of Death Counts by Year



Manner	2006	2007	2008	2009	2010	% Change 2009 to 2010
Natural*	48	43	202***	185	168	-9.2%
Accident	53	66	65	57	46	-19.3%
Suicide	9	12	4	4	7	75%
Homicide	20	15	21	17	20	17.6%
Undetermined	18	17	18	18	10	-44.4%
Not Applicable**	--	2	1	2	0	n/a
Total Cases Reviewed	148	155	311	283	251	-11.3%

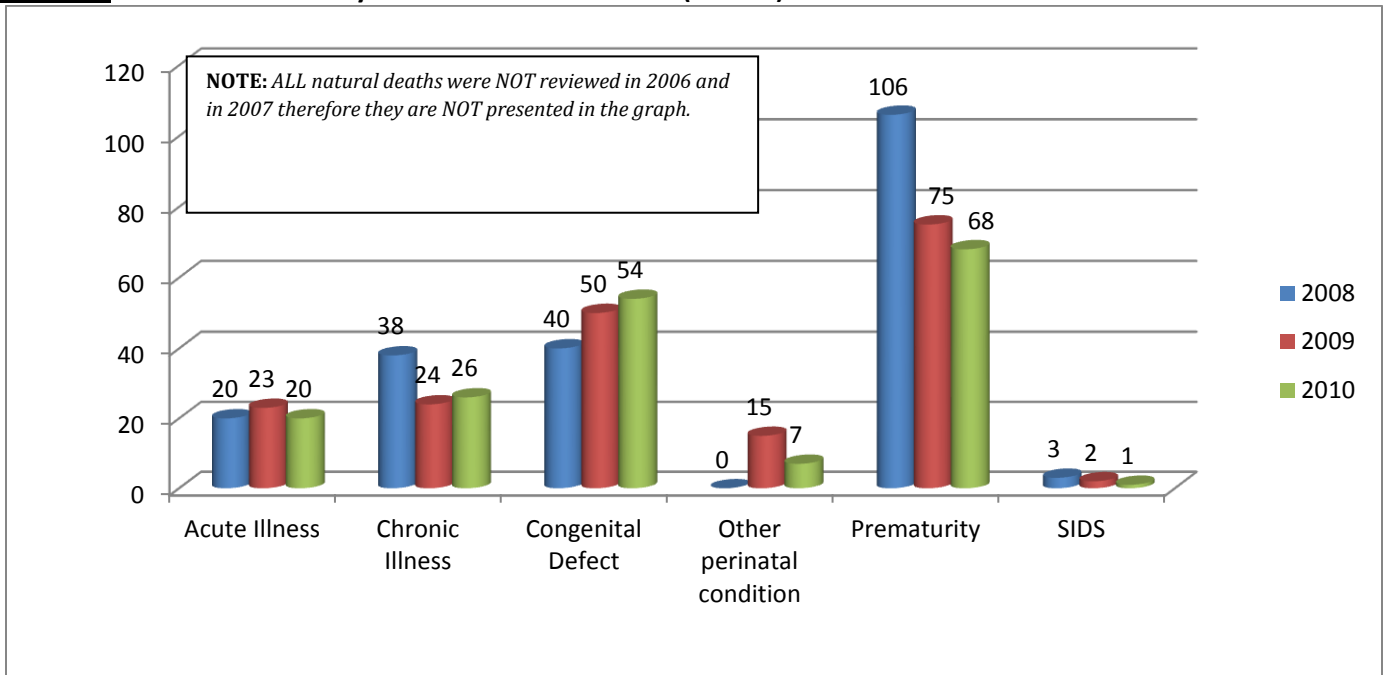
*Natural deaths are not represented on the graph due to the change in methodology starting in 2008 (see methodology section on page 7 for further information.)

**Manner is not recorded on fetal death certificates; therefore in cases of fetal deaths in 2007 no manner was recorded. In 2008 and 2009 all deaths were reviewed including fetal deaths over 20 weeks gestation. Therefore those fetal deaths with natural causes were categorized as natural deaths although they were not issued a death certificate. However in cases where the circumstances of the death were not natural, if no manner of death was assigned the coroner/medical examiner's office then NICRP also did not assign a manner and these are listed as "Not Applicable" (See methodology section on page 7 for further explanation).

***This change starting in 2008 reflects the increase in the number of cases reviewed, NOT an increase in total natural deaths

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 2007 - 2010. The leading medical cause of death for children in Clark County in 2010 was prematurity (n=68), second was congenital defects (n=54), and third was chronic illness (n=26).

Figure 1.2a: 2008-2010 Primary Medical Causes of Death (Counts)



	2007*	2008	2009	2010
Medical Causes				
Acute Illness	15	20	23	20
Chronic Illness	4	38	24	26
Congenital Defect	5	40	50	54
Other perinatal condition	0	0	15	7
Prematurity	13	106	75	68
SIDS	6	3	2	1

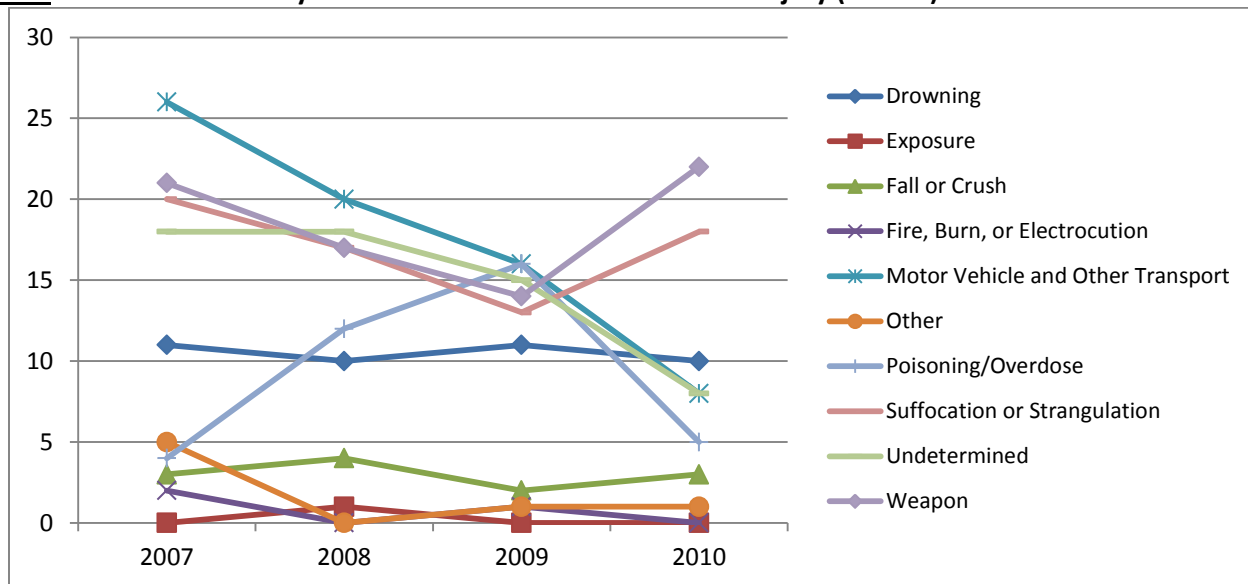
*Data for 2006 are not presented in the table or graph because of changes in classification categories from 2006 to 2007. 2007 are not presented in the graph above because data on all natural deaths were not collected until 2008.

Figure 1.2b displays those cases 2007 - 2010 where the primary cause of death was due to some type of external injury. For the first time since this report has been published, weapons (n=22) are the leading cause of death due to external injury. These cases include abuse related deaths where the weapon used was actually a person's body part (hand, fist, foot, etc.). Suffocation/strangulation is the second leading cause of child death due to external injury at 18 cases, with drowning in third place at 10 cases. For the first time motor vehicle accidents are not in the top three leading causes of child deaths due to external injury and this Figure also displays the sharp declines in deaths due to motor vehicle incidents from 16 cases in 2009 to only 8 cases in 2010, also those related to overdose or poisoning have declined from 16 cases in 2009 to only 5 cases in 2010.

Top Three Causes of Child Deaths Related to External Injury:

- Weapons (including a person's body part) (n=22)
- Suffocation/Strangulation (n=18)
- Drowning (n=10)

Figure 1.2b: 2007-2010 Primary Causes of Death Related to External Injury (Counts)



	2007	2008	2009	2010
Injury Causes				
Drowning	11	10	11	10
Exposure	0	1	0	0
Fall or Crush	3	4	2	3
Fire, Burn, or Electrocutation	2	0	1	0
Motor Vehicle and Other Transport	26	20	16	8
Other	5	0	1	1
Poisoning/Overdose	4	12	16	5
Suffocation or Strangulation	20	17	13	18
Undetermined	18	18	15	8
Weapon (including person's body part)	21	17	14	22

**Due to differences in methodology for data collection data from 2006 is not included in this graph.*

Figure 1.2c displays the crude death rates for children (ages 0-17 years) in Clark County for 2008 - 2010 as well as the change in the rates from 2008 to 2010. Causes of death with an increase in the rate 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	Change 2008-2010	% Change
Prematurity	20.53	14.66	13.23	-7.30	-35.5%
Congenital Defect	7.75	9.58	10.51	2.76	35.6%
Chronic Illness	7.36	4.89	5.06	-2.30	-31.2%
Acute Illness	3.87	4.5	3.89	0.02	0.6%
Other perinatal condition	0	2.93	1.36	-1.57	n/a
External Injury	2008	2009	2010	Change	% Change
Motor Vehicle and Other Transport	3.87	3.13	1.56	-2.31	-59.8%
Poisoning/Overdose	2.32	3.13	0.97	-1.35	-58.1%
Undetermined	3.49	2.93	1.56	-1.93	-55.4%
Weapon (including person's body part)	3.29	2.74	4.28	0.99	30.1%
Suffocation or Strangulation	3.29	2.54	3.50	0.21	6.5%
Drowning	1.94	2.15	1.95	0.01	0.3%
Fall or Crush	0.77	0.39	0.58	-0.19	-24.2%
SIDS	0.58	0.39	0.19	-0.39	-66.4%
Fire, Burn, or Electrocution	0	0.2	0.00	0.00	n/a
Exposure	0.19	0	0.00	-0.19	-100.0%
Total population of Clark County under 18*	516398	511619	513184	-3214	-0.6%

*Total population estimates for Clark County for 2008 and 2009 come from the Las Vegas Perspective 2009, 2010. 2010 total population estimates come from the US Census Bureau Quickfacts (Retrieved August 2011)

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 2005-2007. In Clark County, our overall death rate and unintentional injury rate is lower than the Nevada and national rates, but the homicide and suicide rates for Clark County in 2010 are higher than the national rate.

Figure 1.2d: Overall Crude Child Death Rates 2008 to 2010 (per 100,000)

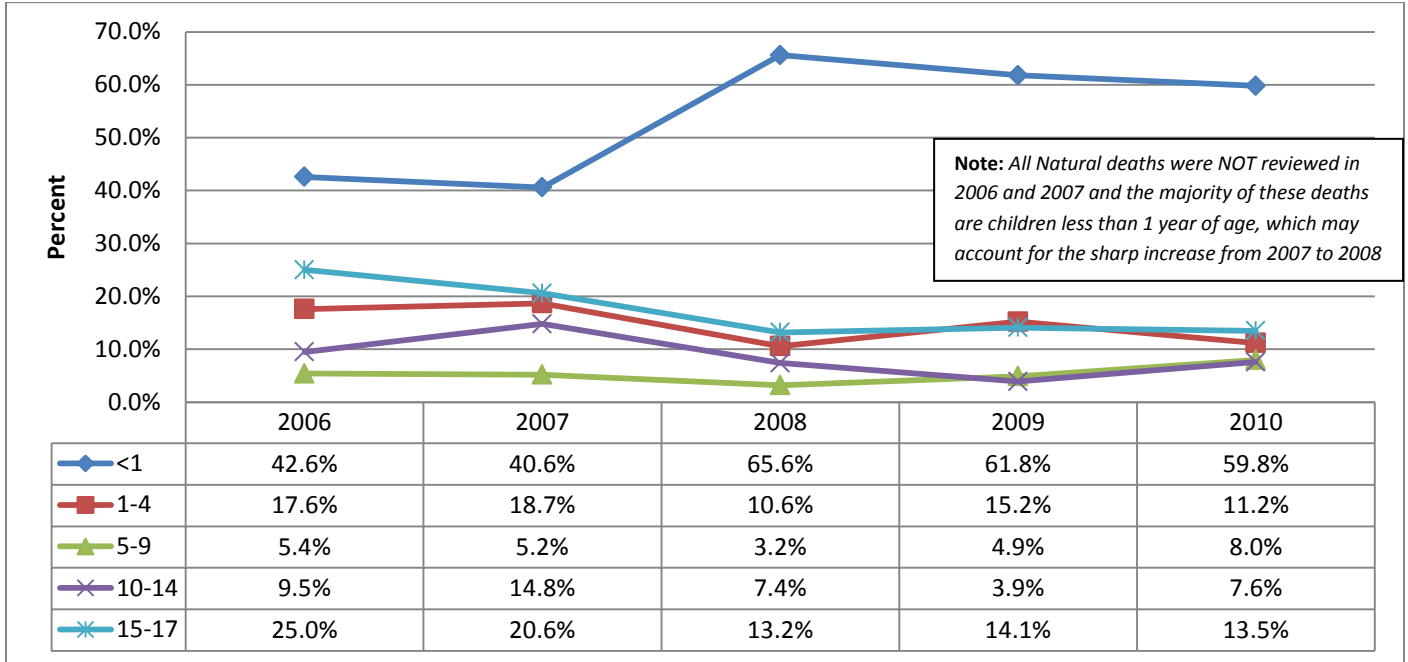
	2008	2009	2010	Change 2008 to 2010	Nevada Rate*	National Rate*
All Deaths under 18	60.22	55.31	48.91	-0.19	63.9	62.4
All Unintentional Injuries (Accidents)	12.59	11.14	8.96	-0.29	11.8	10.9
Suicide	0.77	0.78	1.36	0.77	2.5	1.3
Homicide	4.07	3.32	3.90	-0.04	3.1	2.7

*National and Nevada rates come from CDC estimates of crude child death rates from 2005-2007 (http://205.207.175.93/hdi/ReportFolders/ReportFolders.aspx?IF_ActivePath=P,21)

OVERALL DEMOGRAPHICS

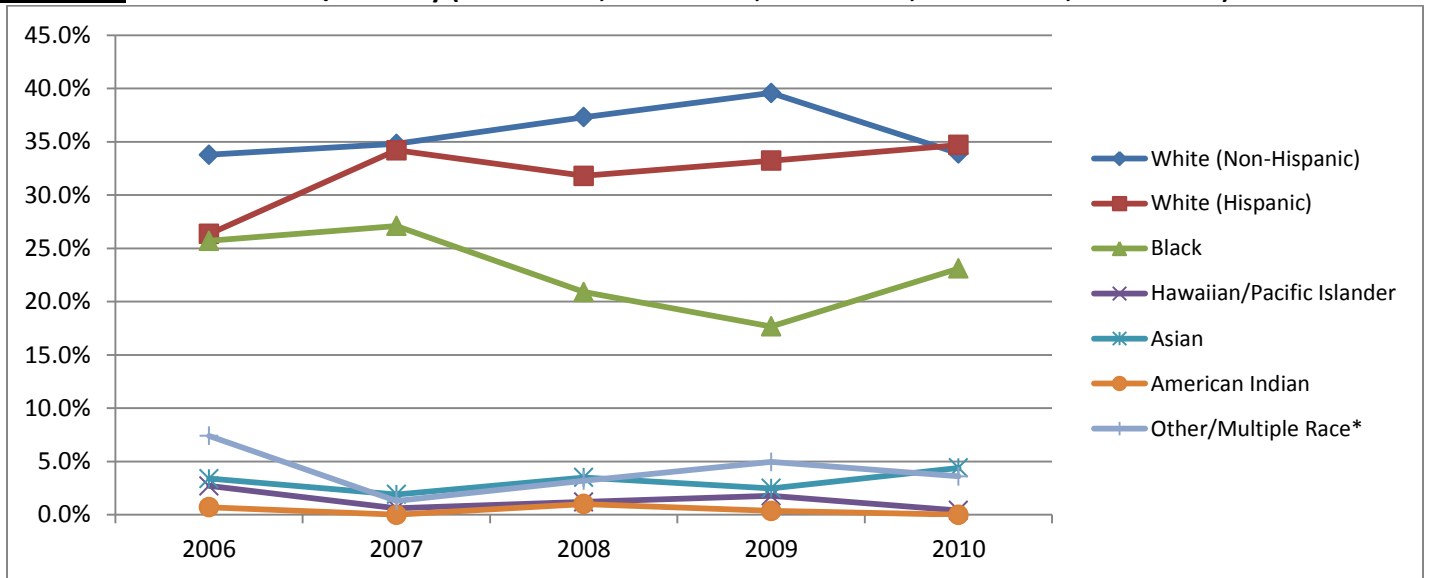
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2010 again the majority of deaths occurred in children less than one year of age (59.8%). The proportion of children in the other age categories has remained fairly consistent, however in 2010 there are twice as many cases in the 5 to 9 year old age group as compared to 2009 and this is the highest proportion since data collection started in 2006.

Figure 1.3: 2006-2010 Age (2006 n=148, 2007 n=155, 2008 n=311, 2009 n=283, 2010=251)



Data regarding race and ethnicity are collected from the child's death certificate, and presented in Figure 1.4 below. The data indicate that White Non-Hispanic children have historically had the highest number of deaths, however in 2010 this group (White Non-Hispanic, n=85) is slightly exceeded by White Hispanic children (n=87). Although starting in 2008 there was a decrease in the percentage of deaths of Black children overall, however this trend started to reverse in 2010 with an increase from 17.7% in 2009 to 23.1% in 2010. These statistics are presented in Figure 1.4 below.

Figure 1.4: 2006-2010 Race/Ethnicity (2006 n=148, 2007 n=155, 2008 n=311, 2009 n=283, 2010 n=251)



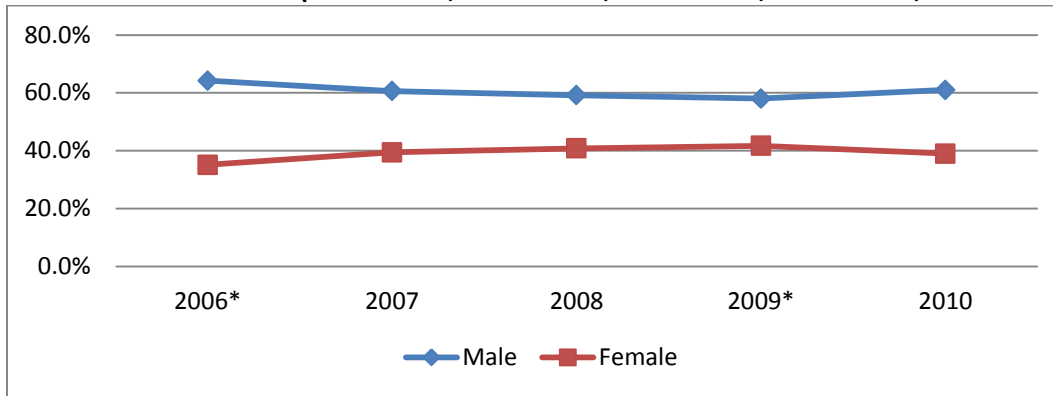
	White (Non Hispanic)	White (Hispanic)	Black	Native Hawaiian/Pacific Islander	Asian	American Indian	Other/Multiple Race	Unknown
2006	33.8% (50)	26.4% (39)	25.7% (38)	2.7% (4)	3.4% (5)	.7% (1)	7.4% (11)	--
2007	34.8% (54)	34.2% (53)	27.1% (42)	.6% (1)	1.9% (3)	0	1.3% (2)	--
2008	37.3% (116)	31.8% (99)	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)	--

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

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

The distribution of males and females is very similar for all five years. While we seem to be seeing a decrease in male child deaths from 2006 to 2009, there also seems to be an increase in female deaths, however in 2010 we saw a slight increase in male deaths and a decrease in female deaths. Additionally, in 2006 and in 2009 there was one case in each year that at the time of death sex was unable to be determined (both fetal deaths); those cases are listed as unknown in Figure 1.5 below.

Figure 1.5: 2006-2010 Sex of Decedent (2006 n=148, 2007 n=155, 2008 n=311, 2009 n=283, 2010 n=251)



* In 2006 and in 2009 there was one case where the child's sex could not be identified at the time of the investigation.

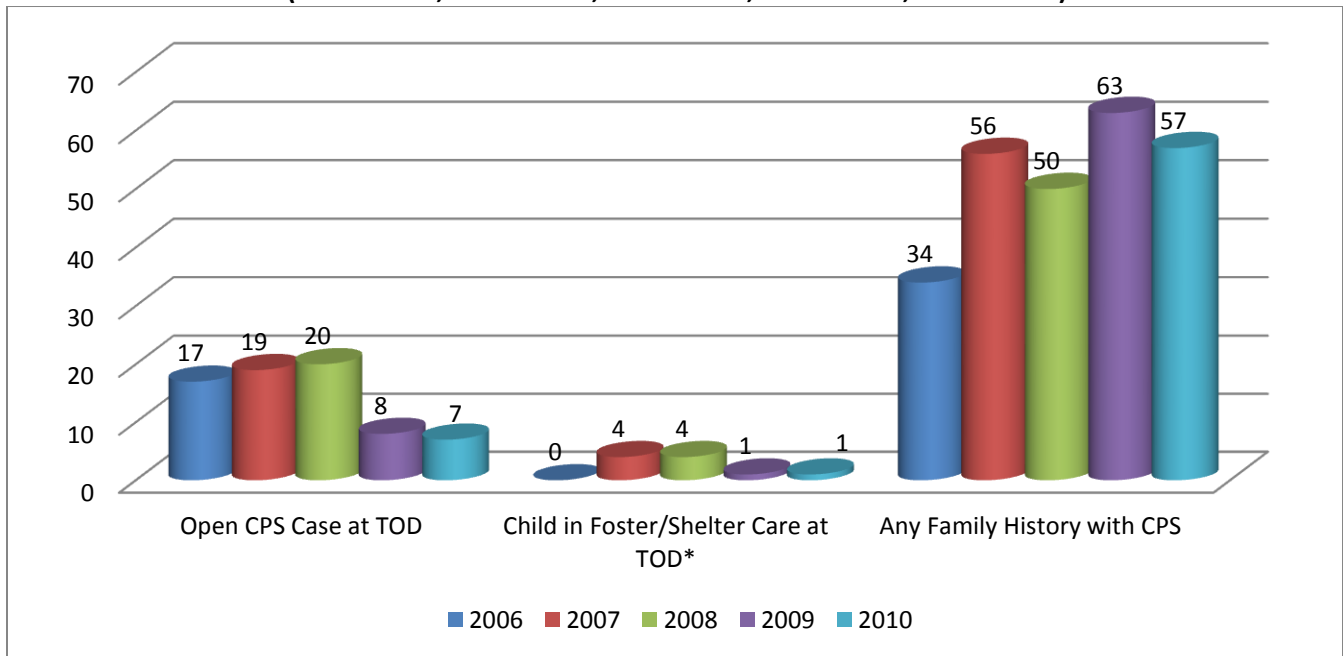
	2006*	2007	2008	2009*	2010
Male	64.2% (95)	60.6% (94)	59.2% (184)	58% (164)	61% (153)
Female	35.1% (52)	39.4% (61)	40.8% (127)	41.7% (118)	39% (98)
Unknown	0.7% (1)	0	0	0.4% (1)	0

CHILD WELFARE INVOLVEMENT

Information was collected by the team regarding the child or family’s history with child welfare. The table below illustrates the comparison of child welfare involvement from 2006 to 2010. All categories in the table below are NOT mutually exclusive, meaning that the same child may fall into multiple categories. Additionally, the reader should note that in 2007 and in 2009 there was one case in each year 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 either case.

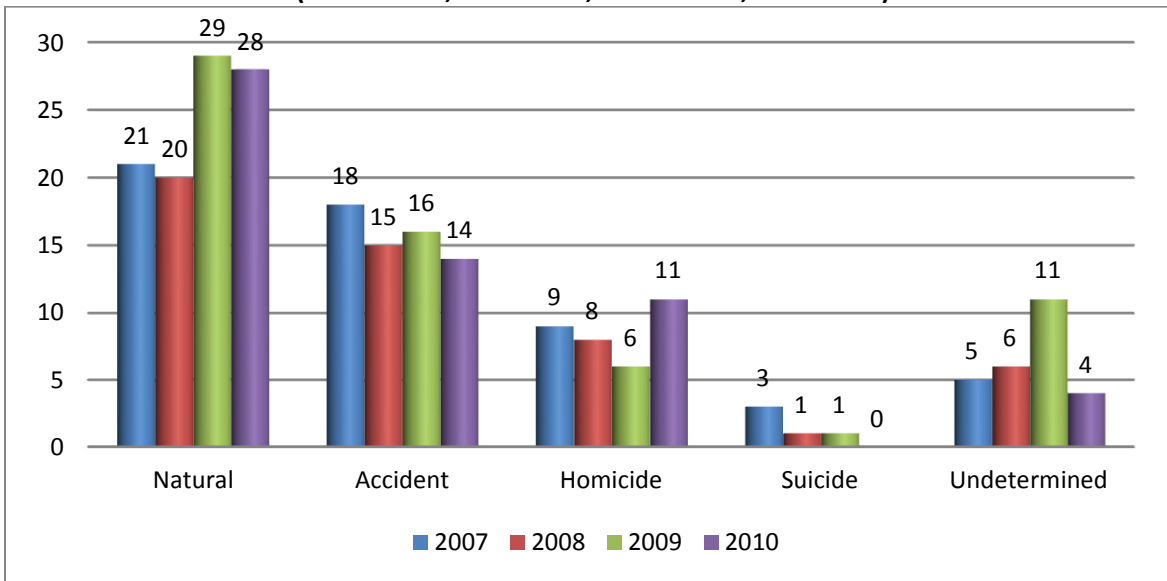
Figure 1.6 illustrates that there was a steady increase in the number of cases that had an open CPS case at the child’s time of death from 2006 through 2008. However, starting in 2009 we see these numbers start to decline to only 8 in 2009 and 7 in 2010 which is less than half of the total in 2008 (n=20). The numbers presented in Figure 1.6 below represent total counts in each of the categories.

Figure 1.6: 2006-2010 Type of Child Welfare Involvement
 (2006 n=148, 2007 n=155, 2008 n=311, 2009 n=283, 2010 n=251)



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

Figure 1.7: 2007-2010 Cases with Prior Child Welfare History by Manner of Death
 (2007 n=56*, 2008 n=50, 2009 n=63*, 2010 n=57)



**In 2007 and 2009 family history with child welfare was unknown on one case each year as the team had limited information regarding a fetal death. In 2006 data were collected differently and therefore are not comparable to other years.*

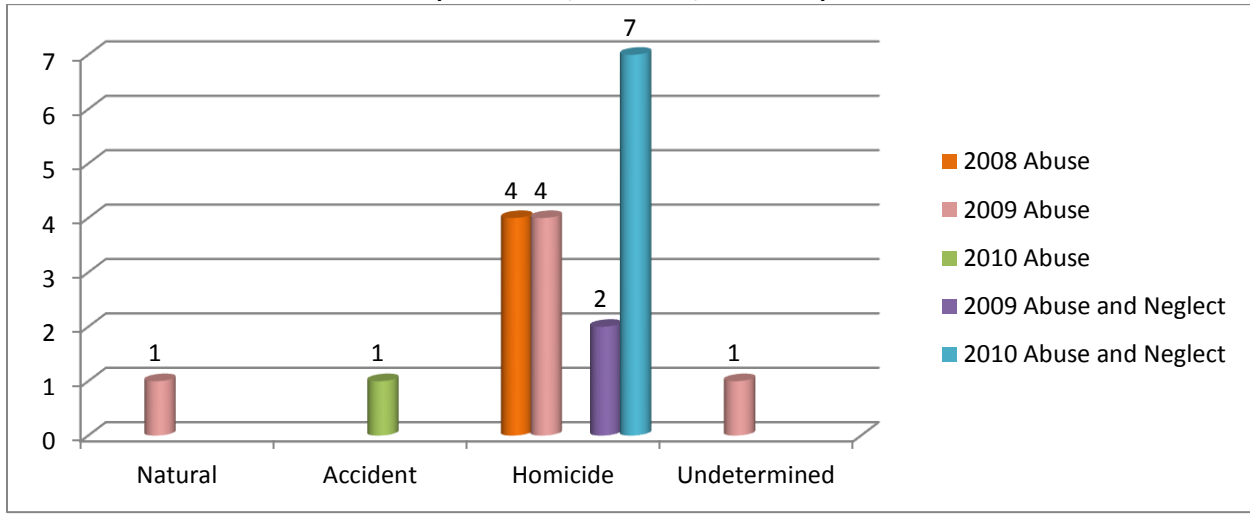
The graph above illustrates the manner of death for cases with family history of involvement in child welfare. In 2010 there were 251 child deaths and 57 of them (22.7%) had a family history of involvement with child welfare.

- For cases where the family did have a history of involvement in child welfare in 2010, the most frequently occurring manner of death was Natural (49.1%), followed by Accident at 24.6%, which follows the same pattern as in 2007-2009.
- Interestingly we see a spike in Homicides with a prior child welfare history (from 6 cases in 2009 to 11 cases in 2010). Of the eleven homicide deaths with prior child welfare history, four of these the deaths were due to child abuse.
- For those cases where the family had no prior history of involvement with child welfare, in 2009, Natural was the most frequently occurring category at 71.2%, followed by Accident at 18.7%, which is comparable to the findings in 2010 where Natural deaths represented 72.2%, followed by Accidents at 16.5%.

SUBSTANTIATED ABUSE/NEGLECT DEATHS

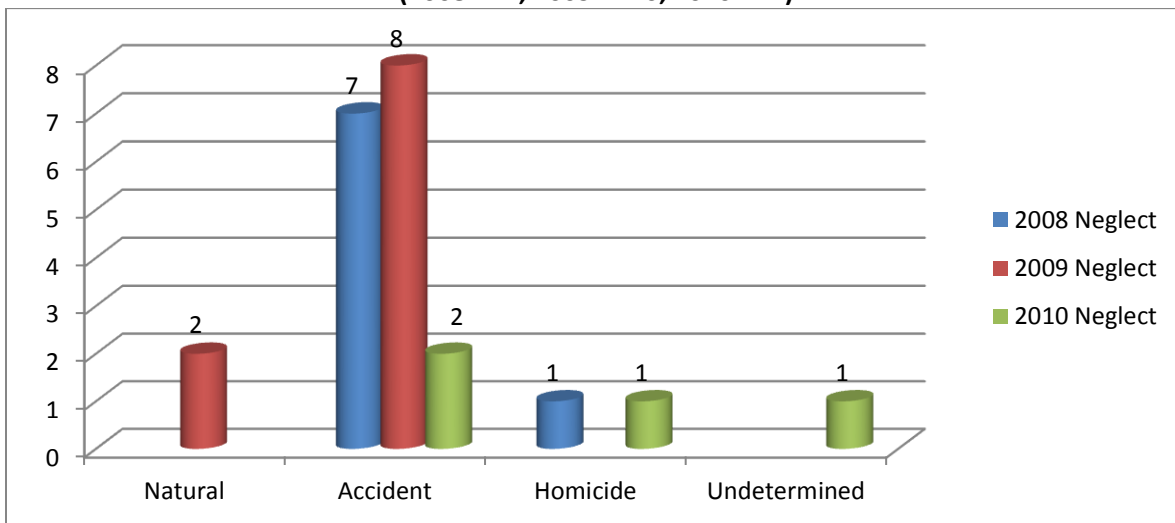
Starting with 2008 child deaths, the Clark County Department of Family Services (CCDFS) provided NICRP statistics regarding the 2010 child fatalities where their office received a death allegation of child abuse or neglect, and this allegation was substantiated. A report of abuse or neglect is “substantiated” when credible evidence of abuse/neglect has been found in accordance with criteria established in Nevada Revised Statutes and the Nevada Administrative Code 432B. In 2010, there were 12 substantiated death allegations of child abuse or neglect, this represents 4.8% of all child deaths in 2010. This is a decrease from 2009 when 6.4% of all child deaths had substantiated death allegations. Additional information regarding these cases is presented in the figures below.

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



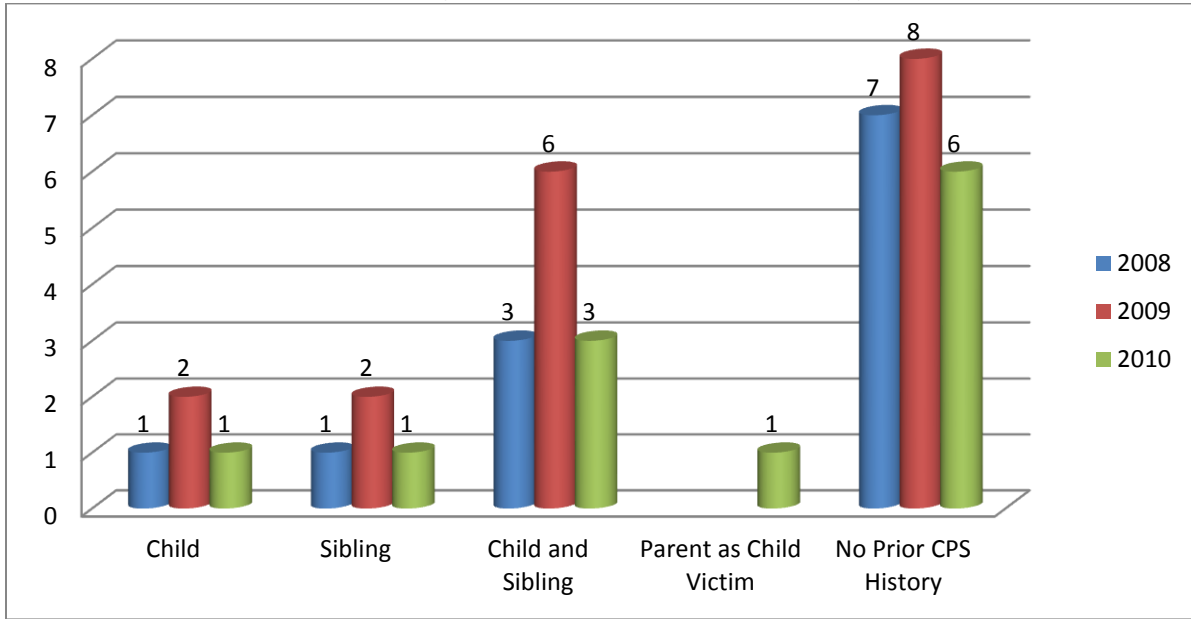
**In 2008 there were no cases of substantiated abuse and neglect*

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



In 2010 the majority of substantiated allegations were due to both abuse and neglect, and a majority of these were homicides (see Figure 1.8a). In 2010 for those cases with substantiated allegations of neglect, in two cases the deaths were accidental, one homicide, and one undetermined death (see Figure 1.8b).

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



In 2010 the distribution of cases looks very similar to that in 2008. In 2010 half of these cases (6 of 12) the decedents' and their family did not have prior history with CPS. In one case the history was regarding the decedent, and in another 3 cases the history was on the decedent and their sibling(s). In one case the only history on the family was related to the decedent's parent as a child victim. In two cases, the perpetrator was not related to the decedents and their sibling(s), however the perpetrator

SECTION II: NATURAL DEATHS

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

In 2006 and 2007 not all natural deaths were reviewed by the team. Only cases selected for review by a physician were reviewed. However, in 2007 some limited data, including basic demographic information and cause and manner, were collected for those cases that were not selected for review. ***Beginning in 2008, all natural deaths were reviewed, including fetal deaths over 20 weeks gestation.*** This information is reflected in this section and accounts for the dramatic increase in the total number of natural deaths starting in 2008. Comparisons in data for Natural deaths are most useful using only 2008 to 2010 data when all deaths were reviewed. This difference in data collection should be noted when reviewing this section.

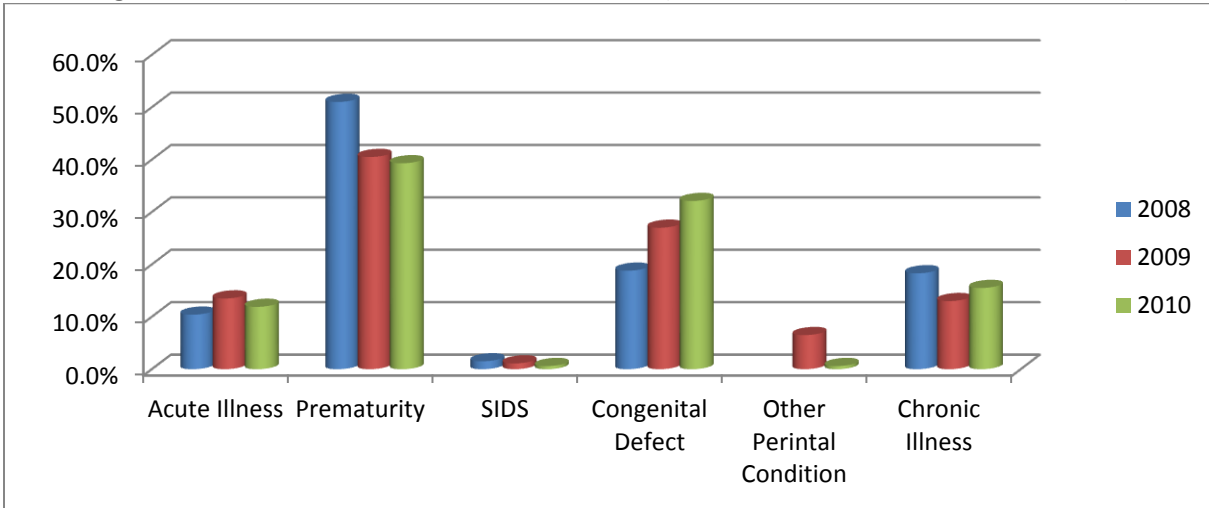
In 2010 the majority of natural deaths (70%) were among children less than one year old, which is less than in 2009 when this age group represented 77% of natural deaths. The top causes of natural deaths reviewed included:

- Prematurity (n=66)
- Congenital Anomalies (n=54)
- Acute Illness (n=20)
- Chronic Illness (n=26)

The focus of child death review is prevention, and therefore this section of the report will focus on Chronic Illness, Acute Illness and Prematurity. In the past SIDS has been one of the causes of natural death that was a focus of this report as it is one category of death for which a review is mandatory under Nevada Revised Statutes. In 2010 there was only one SIDS death, 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.

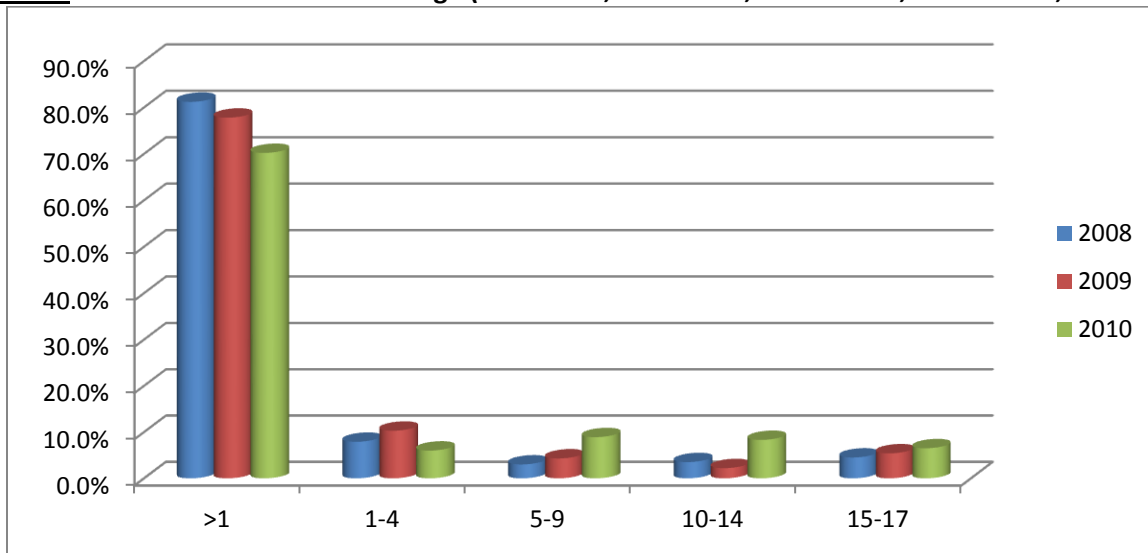
The following graph presents all the causes of natural deaths among cases reviewed from 2008 to 2010. As illustrated, the category “Prematurity” is again the leading cause of natural death in children at 39.3% which is a decrease compared to the 51% in 2008, and the 40.5% in 2009. Data for 2006 and 2007 are not presented in this section because only selected natural deaths were reviewed in those years. Starting in 2008 all child and fetal deaths over 20 weeks gestation were reviewed by the team, and therefore only data starting in 2008 is comparable to 2009 and 2010 for this manner of death.

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



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

Figure 2.2: 2006-2010 Natural Deaths Age (2006 n=48, 2007 n=43, 2008 n=202, 2009 n=185, 2010 n=168)



	2006*	2007*	2008	2009	2010
<1 year	62.5%	53.5%	81.2%(164)	77.8% (144)	70.2% (118)
1-4 years	18.8%	16.3%	7.9%(16)	10.3% (19)	6.0% (10)
5-9 years	8.3%	4.7%	3.0%(6)	4.3% (8)	8.9% (15)
10-14 years	6.3%	14.0%	3.5%(7)	2.2% (4)	8.3% (14)
15-17 years	4.2%	11.6%	4.5%(9)	5.4% (10)	6.5% (11)

*For comparison purposes only 2008 -2010 data are represented in the graph because in 2006 and 2007 all natural deaths were NOT reviewed.

The graph in Figure 2.2 illustrates the ages of all natural deaths from 2008 to 2010, and the table included below the graph has information from 2006 to 2010. Data from 2006 and 2007 are not represented in the graph because only selected natural child deaths were reviewed in 2006 and 2007. We can see that the majority of natural deaths are among children less than one year of age from 2006 through 2010. However, we do see a decrease in the number of children under one year from 2008 to 2010 (81.2% in 2008 compared to 70.2% in 2010). However, there are large increases in the number of natural deaths among children in older age groups. There are twice as many cases of children ages 5-9 years and three times as many children ages 10 to 14 years from 2009 to 2010.

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

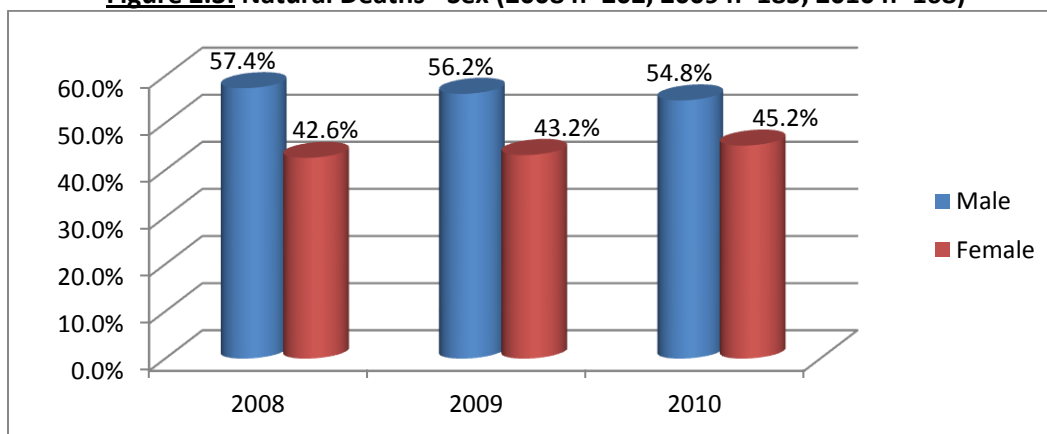
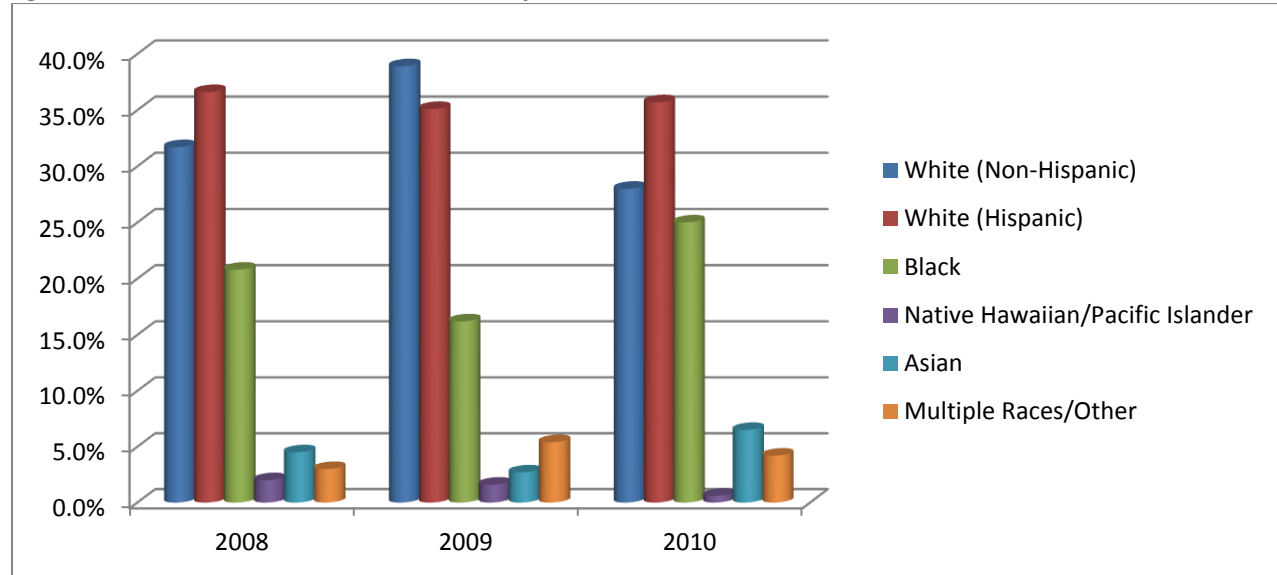


Figure 2.3 shows that in all three years more males than females died from natural causes with the distribution being very similar from year to year.

The graph in Figure 2.4 below shows the racial and ethnic breakdown of the natural deaths for 2006-2010. This table contains information for 2006 through 2010. Data from 2008-2010 are represented in the graph because all natural deaths were reviewed during these years and therefore can be compared. In 2010, 28% of natural deaths were White non-Hispanic children, followed by 35.7% White Hispanic children and 25% Black children. This is a decrease in the number of White Non-Hispanic children, but an increase in the percentage of Black children who died from natural causes in 2010. We also saw an increase in the number of Asian children who died of natural causes in 2010 (2.7% in 2009 and 6.5% in 2010).

Figure 2.4: Natural Deaths – Race/Ethnicity (2006 n=48, 2007 n=43, 2008 n=202, 2009 n=185, 2010 n=168)



	2006	2007	2008*	2009	2010
White (Non-Hispanic)	31.3%(15)	16.3%(7)	31.7% (64)	38.9% (72)	28.0% (47)
White (Hispanic)	20.8%(10)	37.2%(16)	36.6% (74)	35.1% (65)	35.7% (60)
Black	35.4%(17)	37.2%(16)	20.8% (42)	16.2% (30)	25.0% (42)
Native Hawaiian/Pacific Islander	4.2%(2)	0.0%(0)	2.0% (4)	1.6% (3)	0.6% (1)
Asian	4.2%(2)	4.7%(2)	4.5%(9)	2.7% (5)	6.5% (11)
Multiple Races/Other	5.7%(2)	4.7%(2)	3.0% (6)	5.4% (10)	4.2% (7)

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

CHRONIC ILLNESS

Less than one sixth (15.5%) 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:

• Anemia	• Cardiac Arrhythmia	• Leukemia
• Asthma	• Cerebral Palsy	• Epilepsy
• Brain Tumor	• Lupus	• Diabetes

In 2010 twice as many males (69.2%) compared to females (30.8%) died from complications associated with chronic illness. The most frequent age category for chronic illness was 10 to 14 years (34.6%) followed by 5 to 9 years (30.8%). See Figure 2.5 below.

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

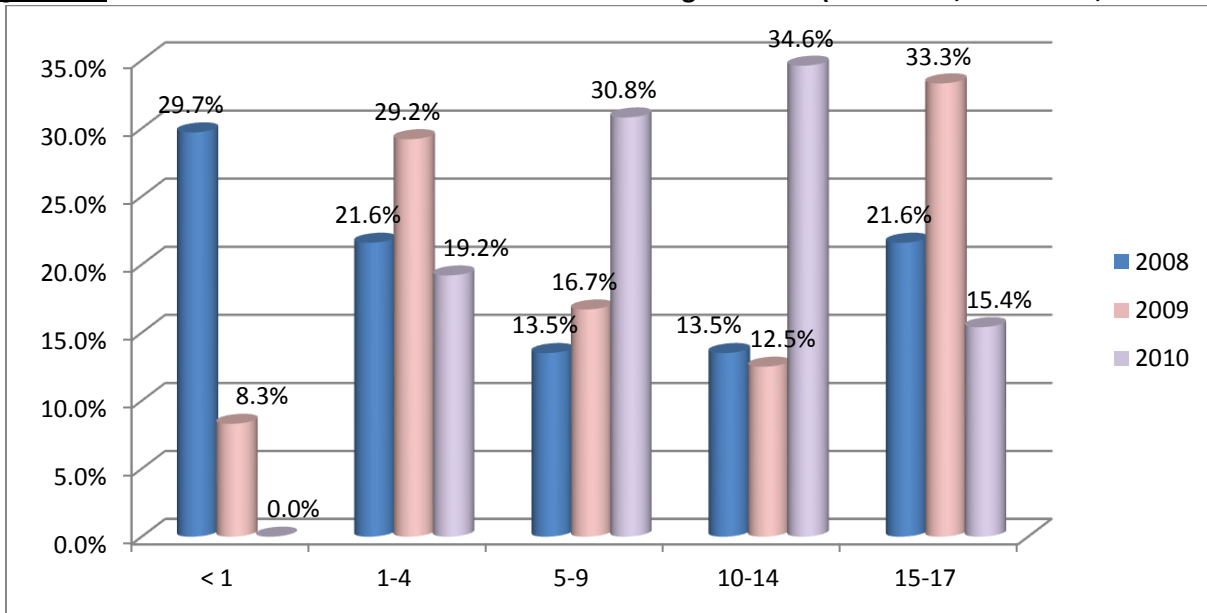
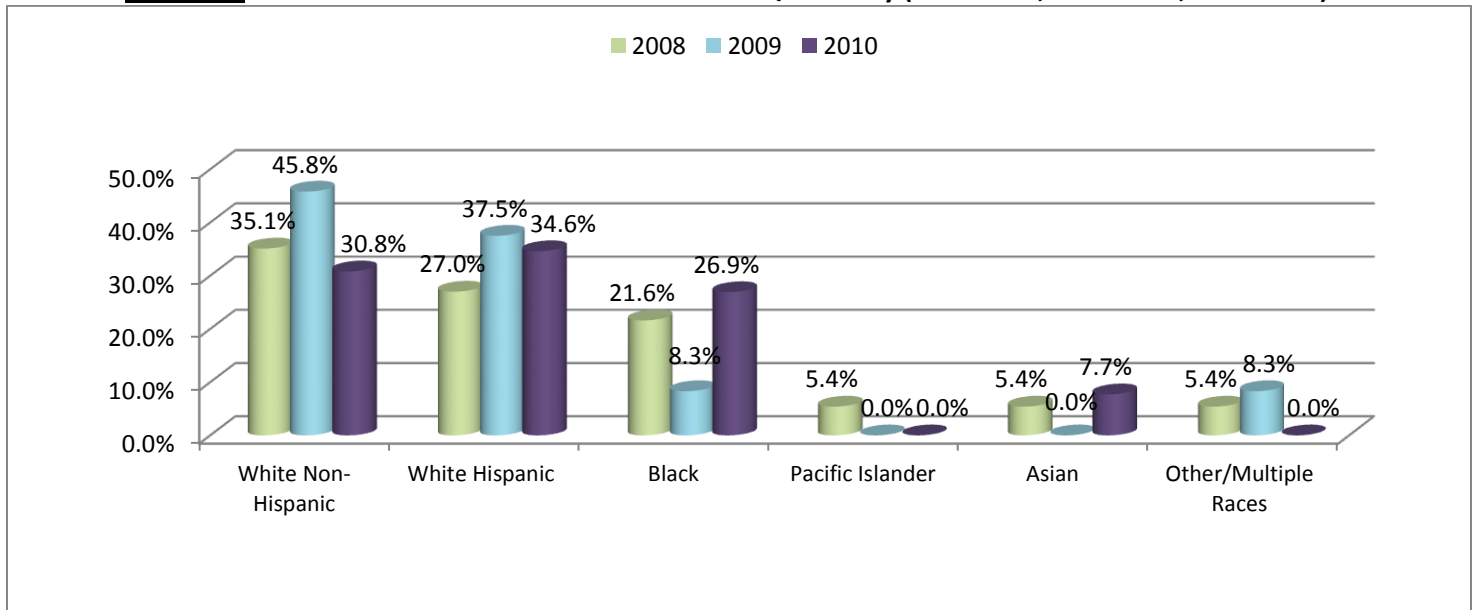


Figure 2.6 displays the racial and ethnic breakdown for deaths associated with chronic illnesses in 2008-2010. Nearly one third of these cases were White Non-Hispanic children (30.8%). This is fairly representative as overall 28% of all natural deaths reviewed were White Non-Hispanic children. In 2010 we see a large increase in the proportion of Black children who died as a result of chronic illnesses going from only 8.3% in 2009 to 26.9% in 2010.

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



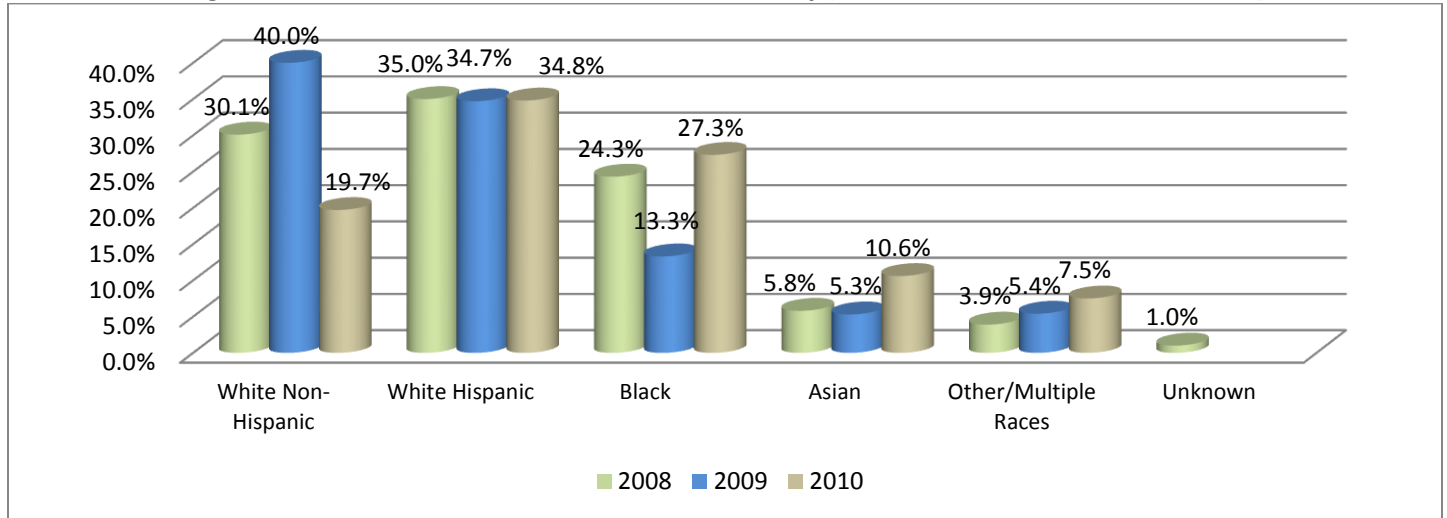
In nearly one fifth of the cases (19.2%) the child had the condition since birth, while another 23.1% had the illness for a number of years. In the other cases the illness was undiagnosed before death or had only recently been diagnosed. In 69.2% (18) of the cases death was expected as a result of the condition. 92.3% were receiving medical care for the chronic condition and almost all families were following the doctors' prescribed care plan (88.5%).

PREMATURITY

More than one third (39.3%) of all natural deaths reviewed in 2010 were caused by complications of prematurity, a decrease from 40.5% in 2009. As expected, all children in this category were less than one year of age at the time of their death. In 2010, for the first time there were slightly more females (53%) than males (47%) which is different from to the distributions in 2008 and 2009.

The most frequently occurring racial/ethnic category was White Hispanic infants (34.8%), followed by Black infants (27.3%). This year there was a decrease in the percentage of White Non-Hispanic decedents, from 40% in 2009 to 19.7% in 2010. This is consistent with national statistics that indicate that both Black and Hispanic infants are more likely than White infants to be born premature (March of Dimes, 2008).

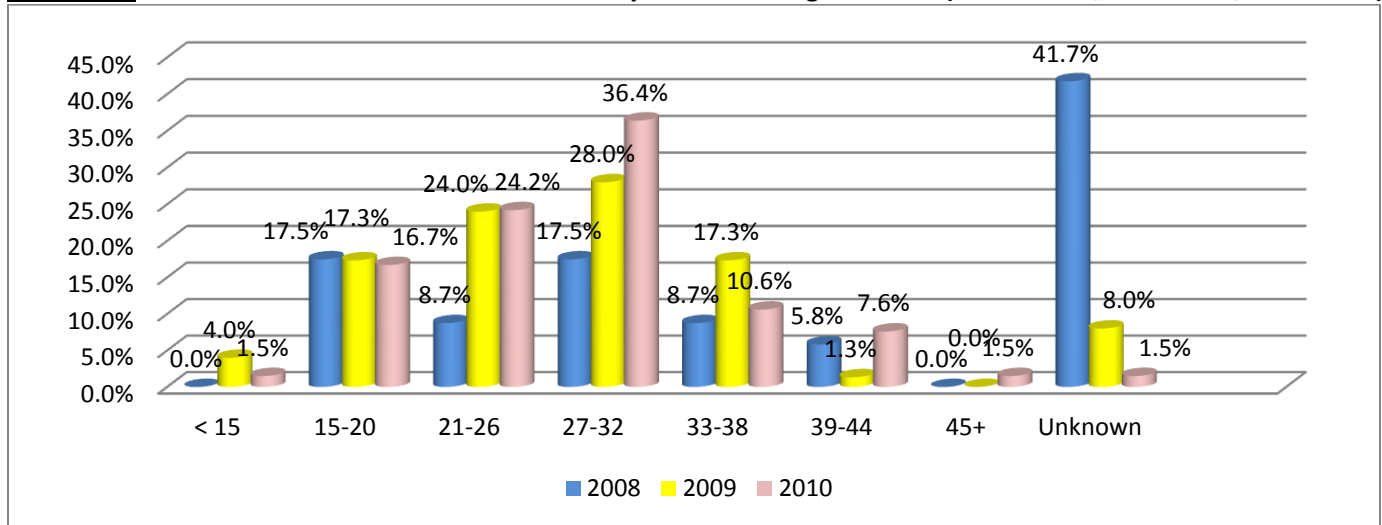
Figure 2.7: 2008-2010 Natural Deaths – Prematurity (2008 n=103, 2009 n=75, 2010 n=66)



Gestational age was known in 75.8% of cases (n=50) where the cause was listed as prematurity, ranging from 20 to 34 weeks. Only 43.9% (n=29) of the cases indicated that the mother received prenatal care, but this is an increase from the 34.7% of cases in 2009. In 9/1% (n=6) of the cases the mother had known medical complications or infections. In only 1.5% (n=1) the mother admitted to smoking tobacco during the pregnancy, and in 1.5% (n=1) of cases there was a known history of illicit drug use by the mother.

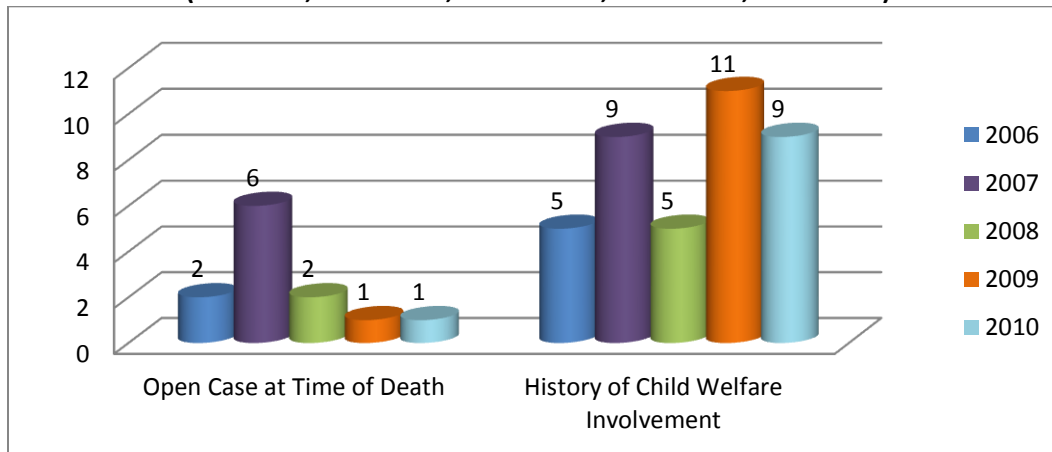
In 2010 the age of the mother was known in 98.5% of cases (n=65), and ranged from 14 to 45 years. Since maternal age is a factor that influences the likelihood of complications and premature birth this is an important variable to track. The graph below illustrates the age categories of mothers of infants who died from complications associated with prematurity in 2008-2010. Note that in 2008 mother’s age was only known in 58% of these cases, while in 2009 it was known in 92% of cases and in 2010 it was known in all but one case.

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



In previous years only certain natural deaths were selected to be reviewed, this included all cases with a history of child welfare involvement. In 2008 all child deaths were reviewed so when looking at child welfare involvement across the past five years it is important to look at the counts and not just the percentages. Percentages are calculated out of total reviewed deaths due to prematurity, since in 2006 and 2007 only selected cases were reviewed (and all cases with child welfare history were reviewed) those cases would represent a greater proportion of the total. From 2008 to 2010 all natural deaths were reviewed and therefore we can see that of all natural deaths due to prematurity 13.6% (compared to 4.9% in 2008) had any family history of involvement with child welfare and an even smaller percentage (1.3% in 2009 and 2010, 1.9% in 2008) had an open case at the time of their death.

Figure 2.9: 2006-2010 Prematurity – Child Welfare Involvement (2006 n=7, 2007 n=13, 2008 n=103, 2009 n=75, 2010 n=66)



	2006		2007		2008		2009		2010	
	Count	%	Count	%	Count	%	Count	%	Count	%
Open Case at Time of Death	2	28.6%	6	46.2%	2	1.9%	1	1.3%	1	1.5%
History of Child Welfare Involvement	5	71.4%	9	69.2%	5	4.9%	11	14.7%	9	13.6%

SUDDEN INFANT DEATH SYNDROME (SIDS)

According to the National Center for Child Death Review:

“Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age which remains unexplained after completion of a full autopsy, examination of the death scene and review of the baby’s health history. If any of these three steps are not conducted, a SIDS diagnosis should not be made. A diagnosis of SIDS reflects the clear admission by medical examiners that an infant’s death remains completely unexplained.”
(<http://www.childdeathreview.org/causesSI.htm>, 2008).

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

Because there was only one case in 2010 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 2009 the majority (70%) of natural deaths occurred among children less than one year of age. This represents a continued decline from the 81.2% in 2008 to 77.8% in 2009 and now 70% in 2010. Again this year there were a high proportion of deaths attributed to complications of prematurity (39.3%) which again provides support for improvements and continued research and tracking regarding prenatal care, parental substance abuse, exposure to environmental pollutants, etc.

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

Starting in 2009 the team worked with the Southern Nevada Health District to screen birth records for all cases reviewed to collect data on the ages of decedent's parents. Age of the mother was known in 92% (n=69) of prematurity cases in 2009 and this number increased to nearly all (98.5% (n=65) cases in 2010. Before this process was developed, in 2008 the team only had information about the mother's age in 58% of cases. 18.5% of these mothers were 20 years old or younger and another 24% were between the ages of 21 and 26 years. Because nearly half of all of these mothers were 26 years or younger, this may point to a need to focus health education regarding prenatal care on younger mothers. Statistically, teenage mothers have a much higher proportion of low birth weight babies and this again points to the importance of prenatal care, as it is a key factor in preventing preterm births and low birth weight babies. Prenatal care is also important in identifying preexisting medical conditions and lifestyle choices that can increase the risk of preterm labor and birth. Currently the Southern Nevada Health District is working to address these issues with the start of a Teen Pregnancy Prevention Program designed to provide family planning and sexual education information to at risk youth, as well as their Nurse Family Partnership Program that provides prenatal care and health education to low income pregnant and parenting mothers in Southern Nevada.

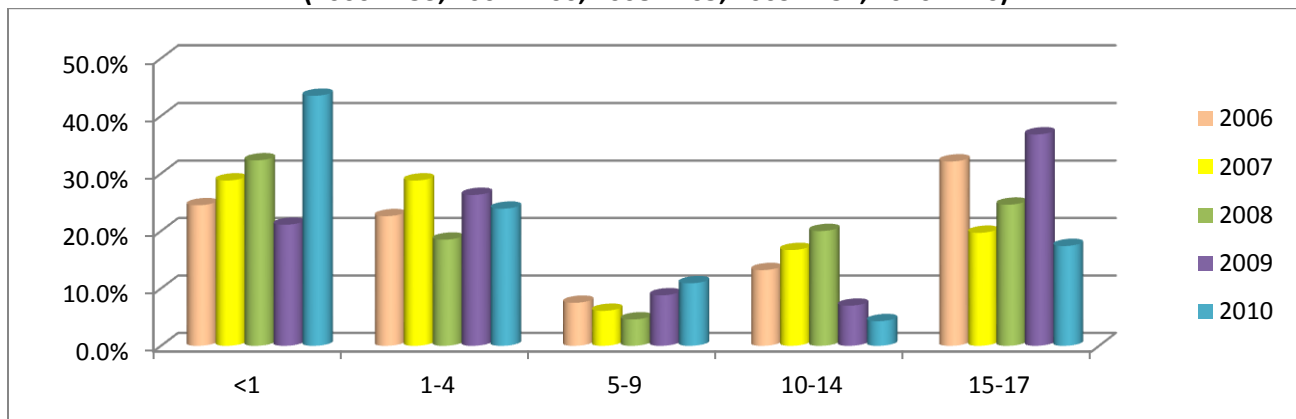
3. IMPROVE PARENT EDUCATION ABOUT PROPER MANAGEMENT OF COMMON CHRONIC ILLNESSES IN CHILDREN.

This year one of the leading causes of natural deaths was chronic illness (15.5%). 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 and maintaining regimented medication administration 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. The Clark County Child Death Review Team drafted a letter in 2010 that was sent to medical boards and associations with information on the number of child deaths seen related to complications associated with asthma as well as information regarding the proper care and management of the disease and the importance of educating parents about proper management of this chronic 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 2010, there were 46 deaths of children in Clark County that were ruled as accidental, showing a continued decrease from 65 in 2008 and 57 in 2009. All but one of the 46 cases were investigated by the coroner/medical examiner’s office (the one case not investigated by the Clark County Office of the Coroner/Medical Examiner was a fetal death). Of those 46 cases, 82.6% were male and 17.4% were female. More than half of the cases were children ages zero to 4 years of age. This pattern is different from previous years and in 2010 the most frequent age group are those less than one year (43.5%) which is the highest proportion of accidents we’ve seen in this report.

Figure 3.1: 2006-2010 Percent of Children by Age category for All Accidental Deaths
(2006 n=53, 2007 n=66, 2008 n=65, 2009 n=57, 2010 n=46)



	<1	1-4	5-9	10-14	15-17
2006	24.5%	22.6%	7.5%	13.2%	32.1%
2007	28.8%	28.8%	6.1%	16.7%	19.7%
2008	32.3%	18.5%	4.6%	20.0%	24.6%
2009	21.1%	26.3%	8.8%	7.0%	36.8%
2010	43.5%	23.9%	10.9%	4.3%	17.4%

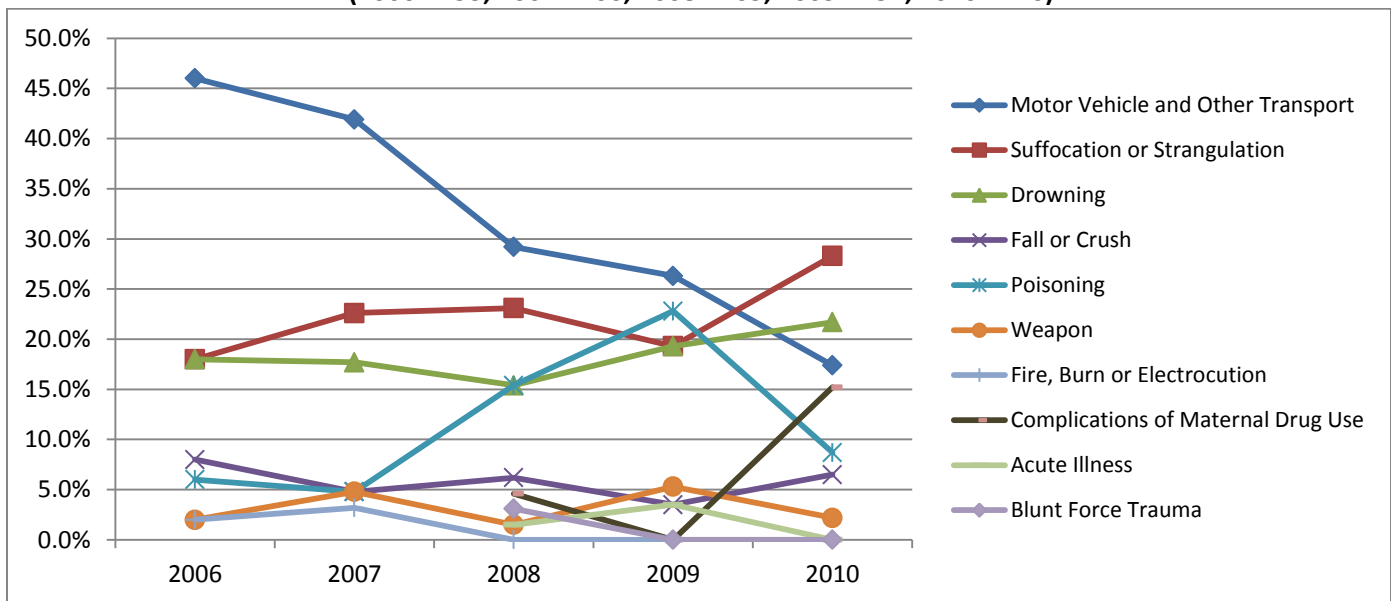
More than half of all accident victims were White Non-Hispanic (54.3%), nearly one third were White Hispanic (28.3%), 15.2% that were Black, and the remaining cases were children who were multiracial. This distribution is very similar to those seen in previous years.

In nearly one third (30.4%) of accidental cases, the child’s family had some history with the child welfare system, making these cases mandatory reviews. In 13% of accidents, the child welfare history was regarding the decedent. In 2.2% of all accidents, there was a child welfare case open at the time of the child’s death. In 80% (n=37) of cases supervision was needed, but in 19.6% of those cases the child was not supervised at the time of the incident that led to their death. For the majority of cases (54.3%), the child’s biological parent was the person responsible for supervision at the time of the child’s death. Other responsible supervisors included grandparents, friends, or adoptive parents. In 19.6% of all accidents reviewed, the supervisor was 23 years of age or younger. The majority of accidental deaths in 2010 occurred either in the child’s home (45.7%), or in a roadway, driveway or sidewalk (13%). Additionally, there were six accidental deaths where children from out of state died while in Clark County. These children were from California, Utah, Arizona, and Florida.

For the first time in five years, the leading cause of accidental death is suffocation (28.3%), and not motor vehicle incidents as it has been for the previous four years. This significant decline in MVA s 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 continued 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.

Second are drowning deaths at 21.7%, and third motor vehicle incidents which account for 17.4% of all accidental deaths. This is another change from the past two years where poisoning/overdose has been a leading cause of accidental death. In 2010 there were only four of these incidents. There were however, seven cases (15.2% of all accidental deaths) of infants who died from medical causes related to maternal substance use during pregnancy. Each of these leading causes will be examined in this section. A graph illustrating the comparison of all causes of accidental deaths from 2006 to 2010 is displayed in Figure 3.2 below.

Figure 3.2: 2006-2010 Percent of Accidental Injury Deaths by Cause
(2006 n=53, 2007 n=66, 2008 n=65, 2009 n=57, 2010 n=46)



	2006	2007	2008	2009	2010
Motor Vehicle and Other Transport	46.0%	41.9%	29.2% (19)	26.3% (15)	17.4% (8)
Suffocation or Strangulation	18.0%	22.6%	23.1% (15)	19.3% (11)	28.3% (13)
Drowning	18.0%	17.7%	15.4% (10)	19.3% (11)	21.7% (10)
Fall or Crush	8.0%	4.8%	6.2% (4)	3.5% (2)	6.5% (3)
Poisoning	6.0%	4.8%	15.4% (10)	22.8% (13)	8.7% (4)
Weapon	2.0%	4.8%	1.5% (1)	5.3% (3)	2.2% (1)
Fire, Burn or Electrocutation	2.0%	3.2%	0%	0%	0%
Complications of Maternal Drug Use	0%	0%	4.6% (3)	0%	15.2% (7)
Acute Illness*	0%	0%	1.5% (1)	3.5% (2)	0%
Blunt Force Trauma**	0%	0%	3.1% (2)	0%	0%

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

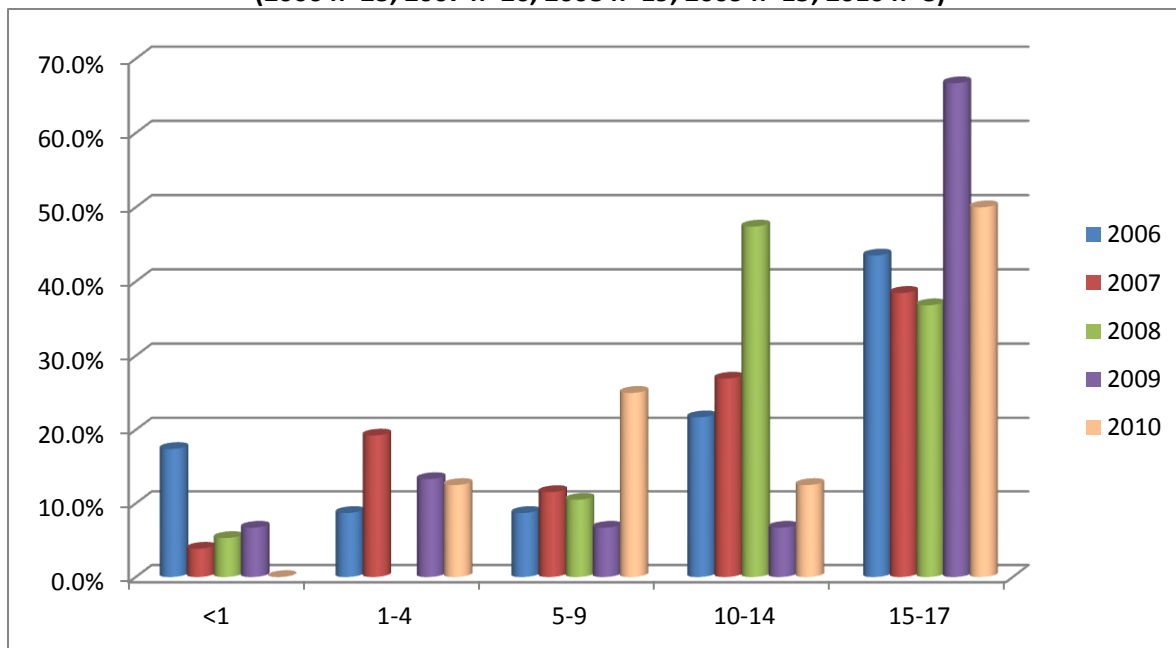
** There were 2 cases in 2008 coded as “blunt force trauma” due to fatal attacks by dogs.

Prosecution was pending at the time of review in 19.6% of cases (n=9). In just over one quarter of the cases (23.9% or 11 cases), CPS took action as a result of the death. Of those 11 cases, CPS substantiated abuse or neglect in four of them and in one case the surviving children were removed from the home as a result of the death.

MOTOR VEHICLE ACCIDENTS

There were 8 accidental deaths due to motor vehicle accidents (MVAs) in Clark County in 2010, a nearly 47% decrease from 2009 and a 69% decrease from the high of 26 cases in 2007. In 2010 all cases involved male victims. In previous years there has typically been more males than females, but this is the first time that there are no female victims. The majority (62.5% or n=5) of decedents were White Non-Hispanic and the remaining 37.5% (n=3) were White Hispanic. This year only one victim’s family had a prior history with the child welfare system and none of the decedents had a juvenile justice history. Half of the decedents (50%) were between the ages of 15-17, and 62.5% were over the age of 10 years. In 2010 there was one case of a child between one and four years and two cases of a child between the ages of 5 and 9 years. The most dramatic increase in 2009 was among those victims between 5 and 9 years old, which represented 25% of all cases this year, the highest in five years.

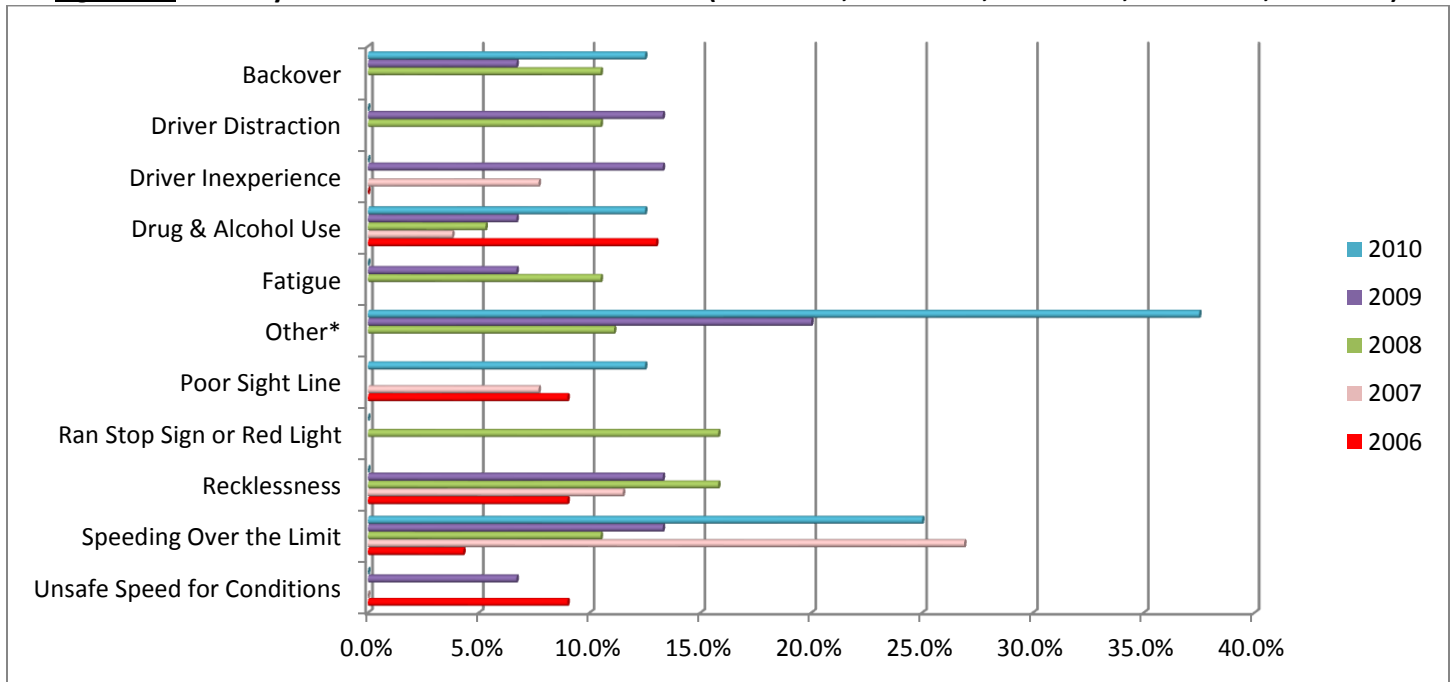
Figure 3.3: 2006-2010 Percent of Motor Vehicle Accident Victims by Age Category
(2006 n=23, 2007 n=26, 2008 n=19, 2009 n=15, 2010 n=8)



	<1 year	1-4 years	5-9 years	10-14 years	15-17 years
2006	17.4% (4)	8.7% (2)	8.7% (2)	21.7% (5)	43.5% (10)
2007	3.8% (1)	19.2% (5)	11.5% (3)	26.9% (7)	38.5% (10)
2008	5.3% (1)	0.0% (0)	10.5% (2)	47.4% (9)	36.8% (7)
2009	6.7% (1)	13.3% (2)	25.0% (1)	6.7% (1)	66.7% (10)
2010	0.0% (0)	12.5% (1)	25.0% (2)	12.5% (1)	50.0% (4)

In all accidents, there were either one or two vehicles (vehicles include golf carts, bicycles, and watercrafts) involved and cases were evenly distributed between the two. The majority of accidents occurred on a residential or city street (62.5%) which is similar to 2008, but differs from 2007 and 2009 when the majority occurred on highways. Primary causes of accidents included speeding (25%), drugs or alcohol use (12.5%), road hazards (12.5%), and 12.5% of incidents where a vehicle backs over a child (noted as “backover” in the graph). At the time of the accident, 25% (n=2) 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 (2006 n=23, 2007 n=26, 2008 n=19, 2009 n=15, 2010 n=8)



	2006	2007	2008	2009	2010
Back Over	--	--	10.5% (2)	6.7% (1)	12.5% (1)
Driver Distraction	--	--	10.5% (2)	13.3% (2)	0% (0)
Driver Inexperience	--	7.7%	0% (0)	13.3% (2)	0% (0)
Drug & Alcohol Use	13.0%	3.8%	5.3% (1)	6.7% (1)	12.5% (1)
Fatigue	--	--	10.5% (2)	6.7% (1)	0% (0)
Other*	--	--	11.1% (4)	20% (3)	37.5% (3)
Poor Sight Line	9.0%	7.7%	0% (0)	0% (0)	12.5% (1)
Ran Stop Sign or Red Light	--	--	15.8% (3)	0% (0)	0% (0)
Recklessness	9.0%	11.5%	15.8% (3)	13.3% (2)	0% (0)
Speeding Over the Limit	4.3%	26.9%	10.5% (2)	13.3% (2)	25% (2)
Unsafe Speed for Conditions	9.0%	0% (0)	0% (0)	6.7% (1)	0% (0)

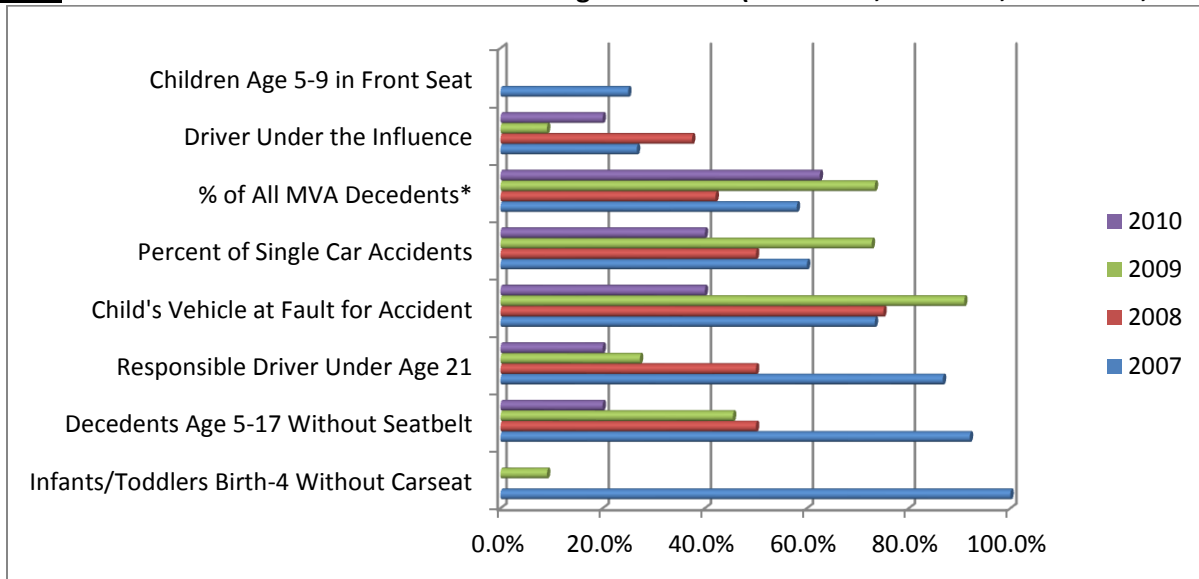
*Other causes included poor tires, other driver error, road hazards, and pedestrian running into the street

In nearly all (75%) of cases, the child’s vehicle was a car, van, SUV, or truck. One case involved a motorcycle, and in one case the child was on a bicycle, in the other the child was a pedestrian. In 50% of cases, the vehicle the decedent was in at the time was at fault for the incident.

In one case, the decedent was the driver of the vehicle involved in the accident, and in that case the decedent did have a valid driver’s license but was also under the influence of drugs or alcohol. For all other MVAs where the decedent was a passenger, all of the drivers had valid licenses, and only one of those drivers were under the influence at the time of the accident.

More than half of decedents (62.5%, n=5) were passengers in vehicles. Of those passengers killed, 40% were younger than age 10, and the majority (60%) were between the ages of 15-17. In the passenger fatalities, 40% of these accidents were single car accidents, and the other 60% were two-car accidents. In 40% of these cases, the child's vehicle was at fault for the accident. Primary causes of accidents were attributed to speeding (20%) and drug or alcohol use (20%), and road hazards (20%). Other causes included other driver error. In 40% of cases, the driver responsible was age 21 or younger, and in one of the cases the age of the responsible driver was unknown to the team at the time of the review. In two of the cases the decedent was not wearing a seatbelt. The driver was under the influence in only one case. Again in 2010 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 where 25% of those fatalities involved children ages 5-9 in the front seat.

Figure 3.5: 2007-2010 Circumstances of MVA Passenger Fatalities (2007 n=15, 2008 n=8, 2009 n=11, 2010 n=5)

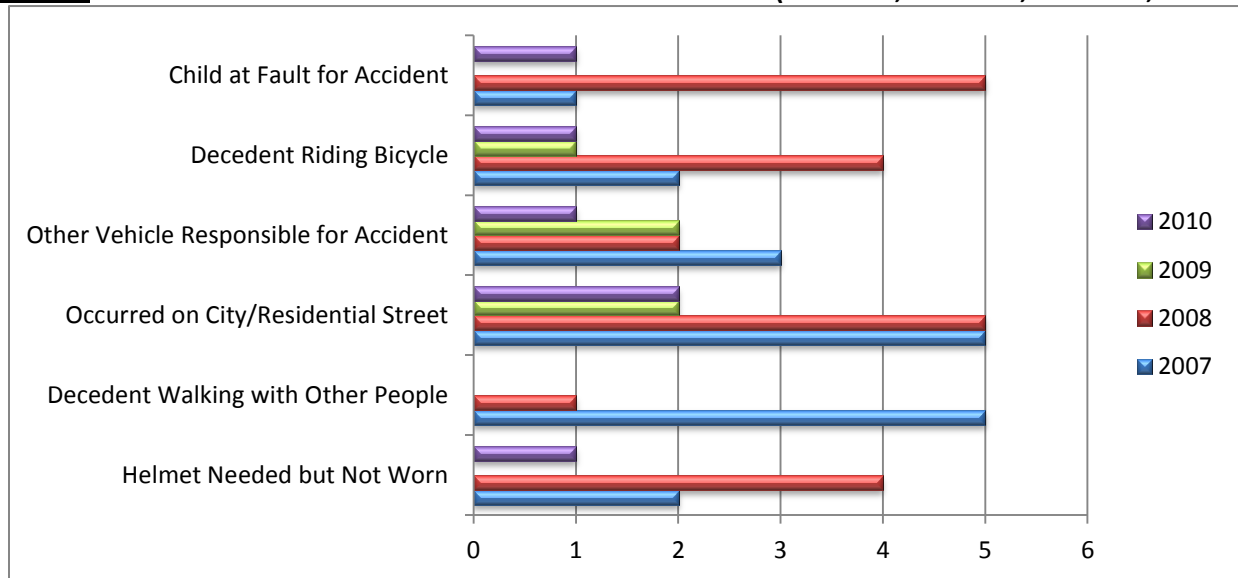


	2007	2008	2009	2010
Infants/Toddlers Birth-4 Without Car seat	100.0%	0%	9.1% (1)	0%
Decedents Age 5-17 Without Seatbelt	92.0%	50.0% (4)	45.5% (5)	20% (1)
Responsible Driver Under Age 21	86.7%	50.0% (4)	27.3% (3)	20% (1)
Child's Vehicle at Fault for Accident	73.3%	75.0% (6)	90.9% (10)	40% (2)
Percent of Single Car Accidents	60.0%	50.0% (4)	72.7% (8)	40% (2)
Driver Under the Influence	26.7%	37.5% (3)	9.1% (1)	20% (1)
Children Age 5-9 in Front Seat	25.0%	0%	0%	0%

* This percentage represents the total number of all MVA fatalities (n=5 of 8) where the child was the passenger.

In two cases, the decedent was a pedestrian. In one case the child was on a bicycle and was between 10 and 14 years old. The incident occurred on a residential street and the decedent was at fault for the accident. In the other case the child was between 1 and 4 years old and ran into the street and was backed over by a friend's vehicle.

Figure 3.6: 2007-2010 Circumstances of MVA Pedestrian Fatalities (2007 n=8, 2008 n=7, 2009 n=2, 2010 n=2)

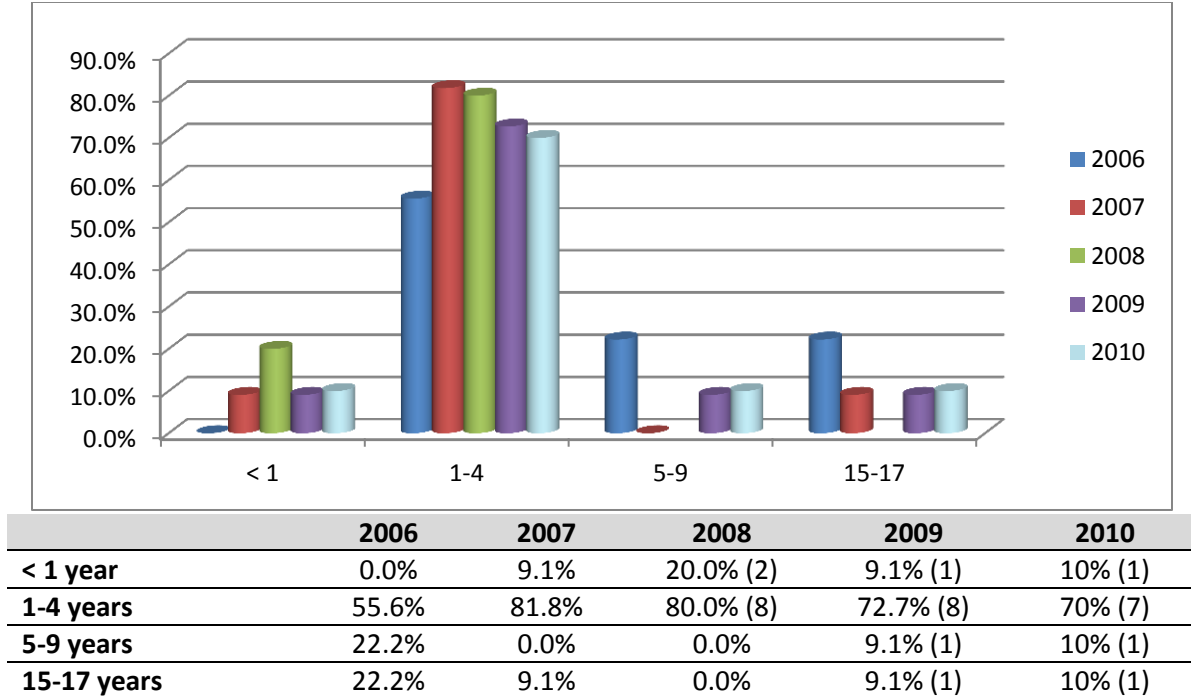


	2007	2008	2009	2010
Helmet Needed but Not Worn	2	4	0	1
Decedent Walking with Other People	5	1	0	0
Occurred on City/Residential Street	5	5	1	2
Other Vehicle Responsible for Accident	3	2	2	1
Decedent Riding Bicycle	2	4	1	1
Child at fault for Accident	1	5	0	1

DROWNING

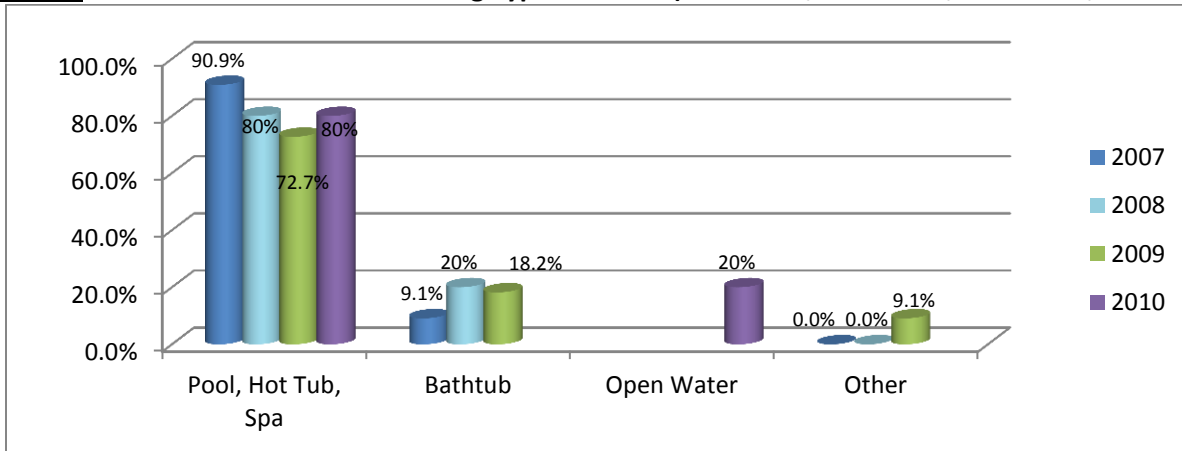
In 2010, drowning was the second leading cause of accidental deaths among children in Clark County, with 10 deaths in this category. In 2010, while the total number for the year is fairly consistent with the previous four years, this is the first time there were more fatal drowning incidents (n=10) than motor vehicle accidents (n=8). Again this year, the vast majority of fatal drowning victims (70%) were ages 1 to 4 years, indicating that prevention efforts should focus on those children under 5 years of age.

Figure 3.7: 2006-2010 Accidental Drowning – Age (2006 n=9, 2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)



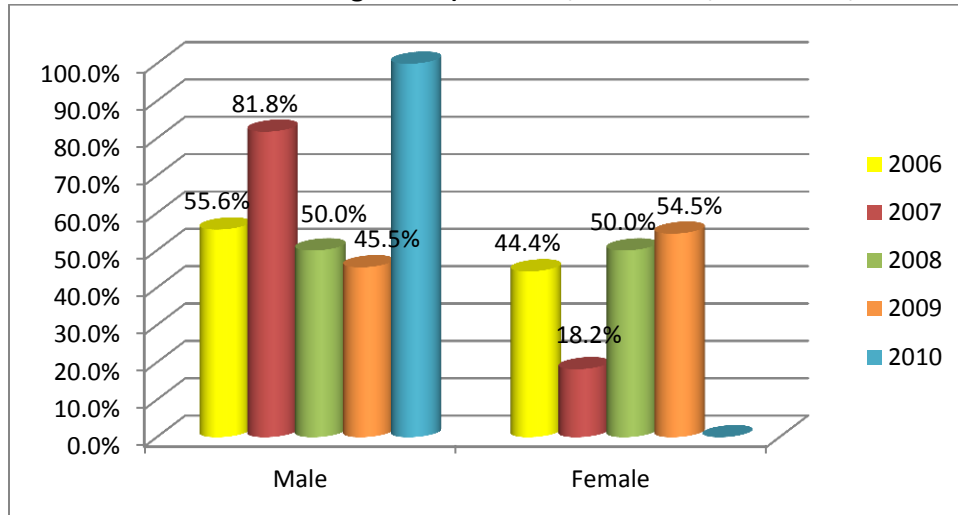
Similar to previous years, in 2010 nearly all drowning cases occurred in a pool, hot tub or spa (80%), while the remaining 20% of cases were in open water. One case involved a small pond and the other a river.

Figure 3.8: 2006-2010 Accidental Drowning Type of Water (2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)



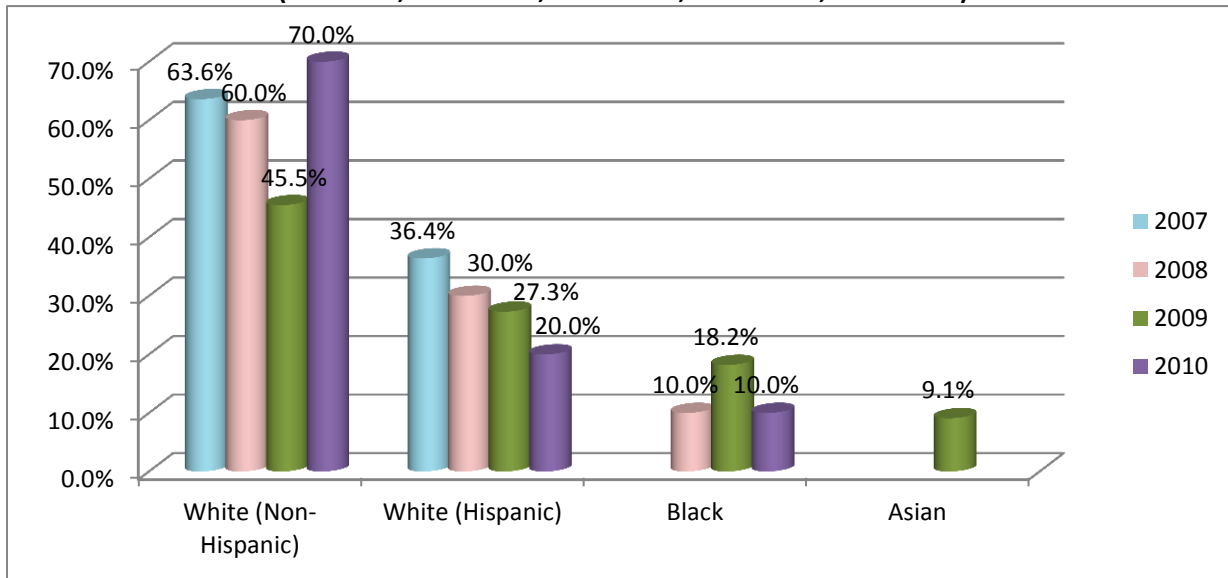
In 2010 all fatal drowning incident victims were male. This is the first time there were no female victims.

Figure 3.9: 2006-2010 Accidental Drowning – Sex (2006 n=9, 2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)



The race/ethnicity data for drowning victims in 2010 looks very similar to the distribution of that in 2007 and 2008, and we continue to see declines in the proportion of White Hispanic children. However, there were no Black children who drown in 2007, but 18.2% of the drowning cases in 2009, and 10% in 2010 were Black children. This distribution is displayed in Figure 3.10.

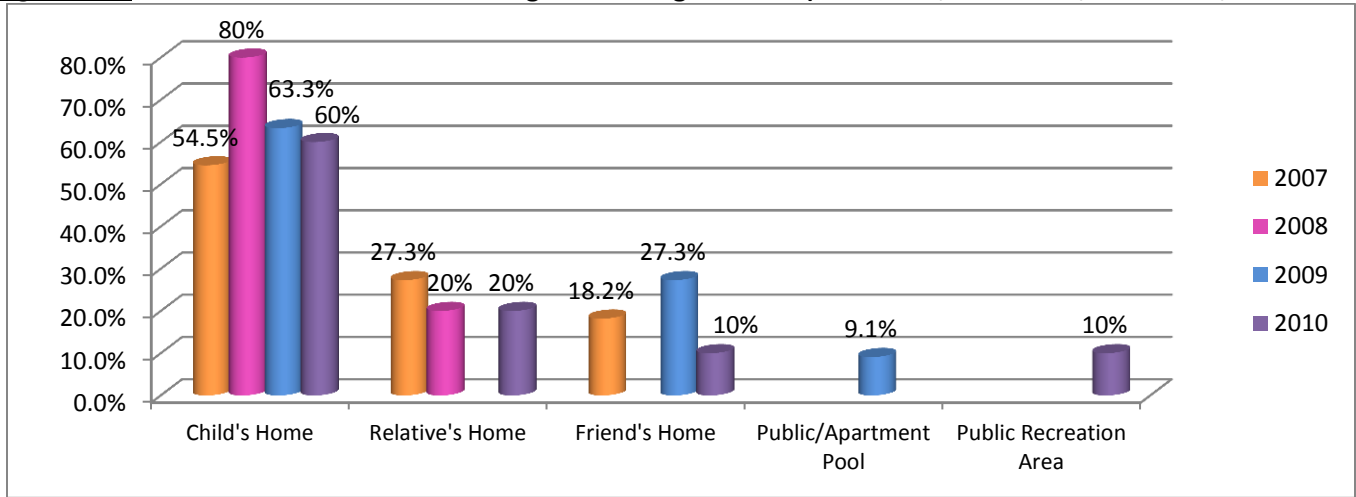
Figure 3.10: 2006-2010 Accidental Drowning – Race/Ethnicity (2006 n=9, 2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)



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

In 2010 the majority (60%, n=7) of drowning cases occurred at the child’s home. The remaining drowning fatalities occurred at a relative’s (20%) or friend’s home (10%). One case in 2010 occurred at recreation area near a river (10% n=1).

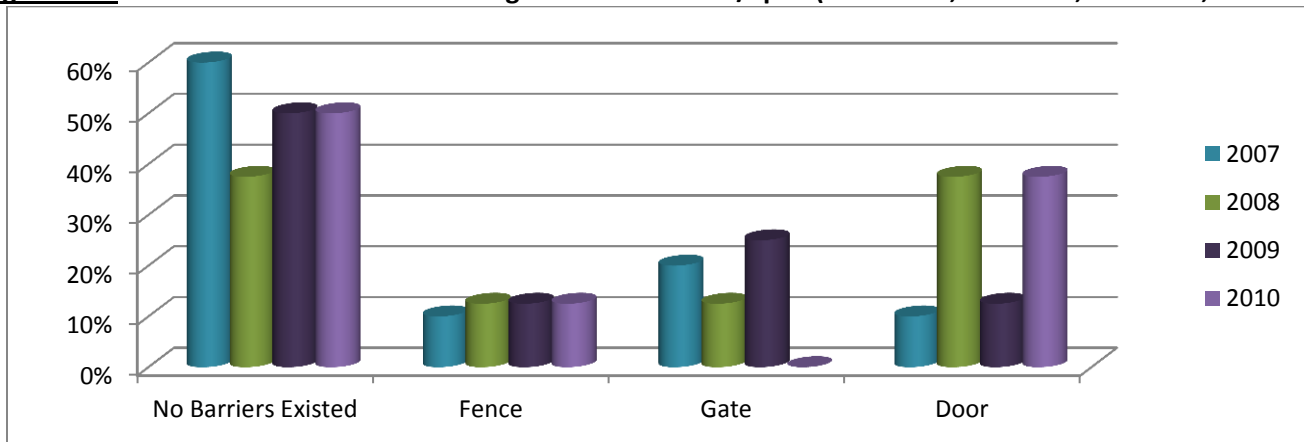
Figure 3.11: 2007-2010 Accidental Drowning – Drowning Location (2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)



In three of the pool drowning deaths the child had been supervised swimming in the pool within the previous 24 hours. Most frequently (87.5%) the biological parent was the supervisor at the time of the incident, followed by “friend” at 12.5%. In 37.5% of cases the child was last seen in the house and was subsequently left unsupervised between two and forty five minutes. The average period of elapsed time was around 12 minutes since the child was last seen. In all cases the child was not wearing a floatation device and in four cases (50% of all pool drowning incidents) there was a gathering or event going on at the same time as the incident.

Figure 3.12 below shows that in 50% of cases occurring in a pool (4 of the 8 cases), no barrier existed to prevent access to the pool or spa. In the remaining 4 cases, 1 case had a pool fence and the other three had a door blocking entrance to the pool.

Figure 3.12: 2007-2010 Accidental Drowning – Barriers to Pool/Spa* (2007 n=10, 2008 n=8, 2009 n=8, 2010 n=8)



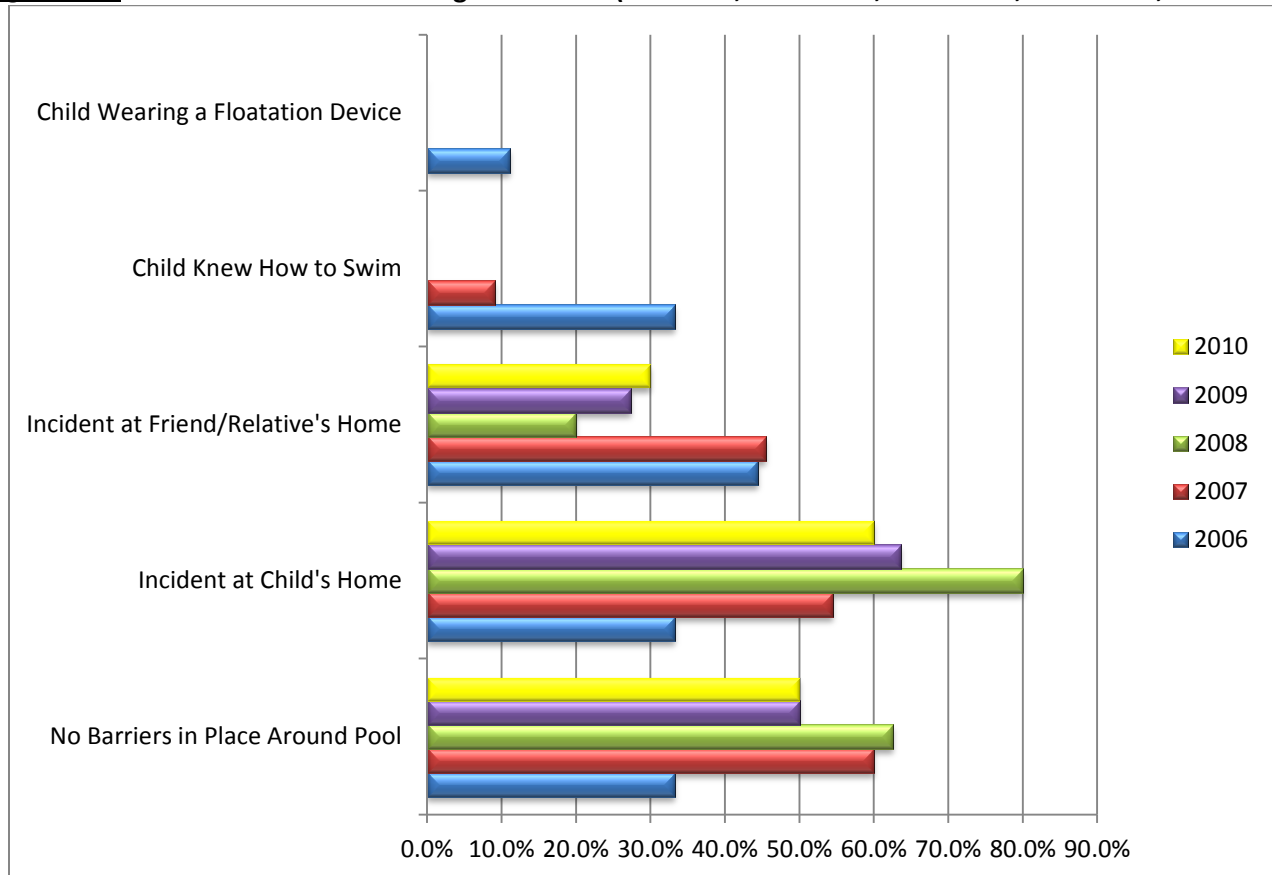
*This table represents only those cases where the drowning occurred in a pool/spa

	2007	2008	2009	2010
No Barriers Existed	60% (6)	37.5% (3)	50% (4)	50% (4)
Fence	10% (1)	12.5% (1)	12.5% (1)	12.5% (1)
Gate	20% (2)	12.5% (1)	25% (2)	0% (0)
Door	10% (1)	37.5% (3)	12.5% (1)	37.5% (3)

None of these pools had alarms or covers as a barrier to entrance. Children were able to breach existing barriers to the pools in all of the cases where barriers existed. In all of these cases barriers were working properly, however they were

either left propped open or unlocked. Two of the families of the drowning victims had a history of involvement in the child welfare system.

Figure 3.13: Items Relative to Drowning Prevention (2006 n=9, 2007 n=11, 2008 n=10, 2009 n=11, 2010 n=10)

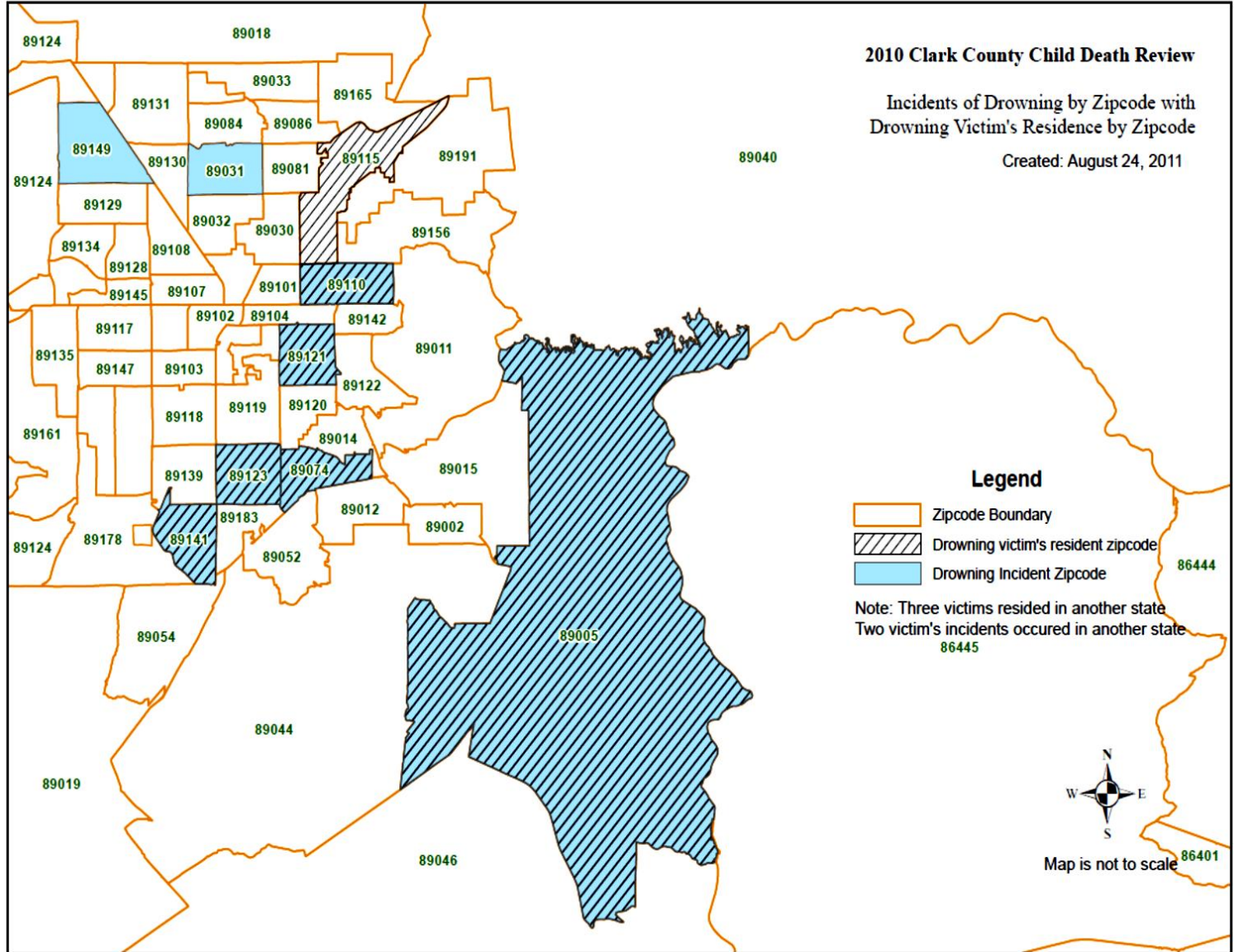


	2006	2007	2008	2009	2010
No Barriers in Place Around Pool*	33.3%	60.0%	62.5% (5)	50% (4)	50% (4)
Incident at Child's Home	33.3%	54.5%	80.0% (8)	63.6% (7)	60% (6)
Incident at Friend/Relative's Home	44.4%	45.5%	20.0% (2)	27.3% (3)	30% (3)
Child Knew How to Swim	33.3%	9.1%	0.0%	0.0%	0.0%
Child Wearing a Floatation Device	11.1%	0.0%	0.0%	0.0%	0.0%

**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 comparison from 2006 to 2010 in terms of some of the items relative to drowning prevention. Note in interpreting this figure that categories are NOT mutually exclusive, meaning that one child can fall into more than one category. In 2007, compared to 2006, there were nearly twice as many drowning fatalities where no barriers to the pool existed, and there were slightly more in 2008 (62.5%). There is a slight decrease in 2009 and 2010 at 50%. Additionally, the number of incidents occurring at the child’s home has increased from 2006 to 2009, but we see a decrease (n=1) from 2008 to 2010. This supports the prevention recommendation to promote pool safety for families with pools or spas at their homes.

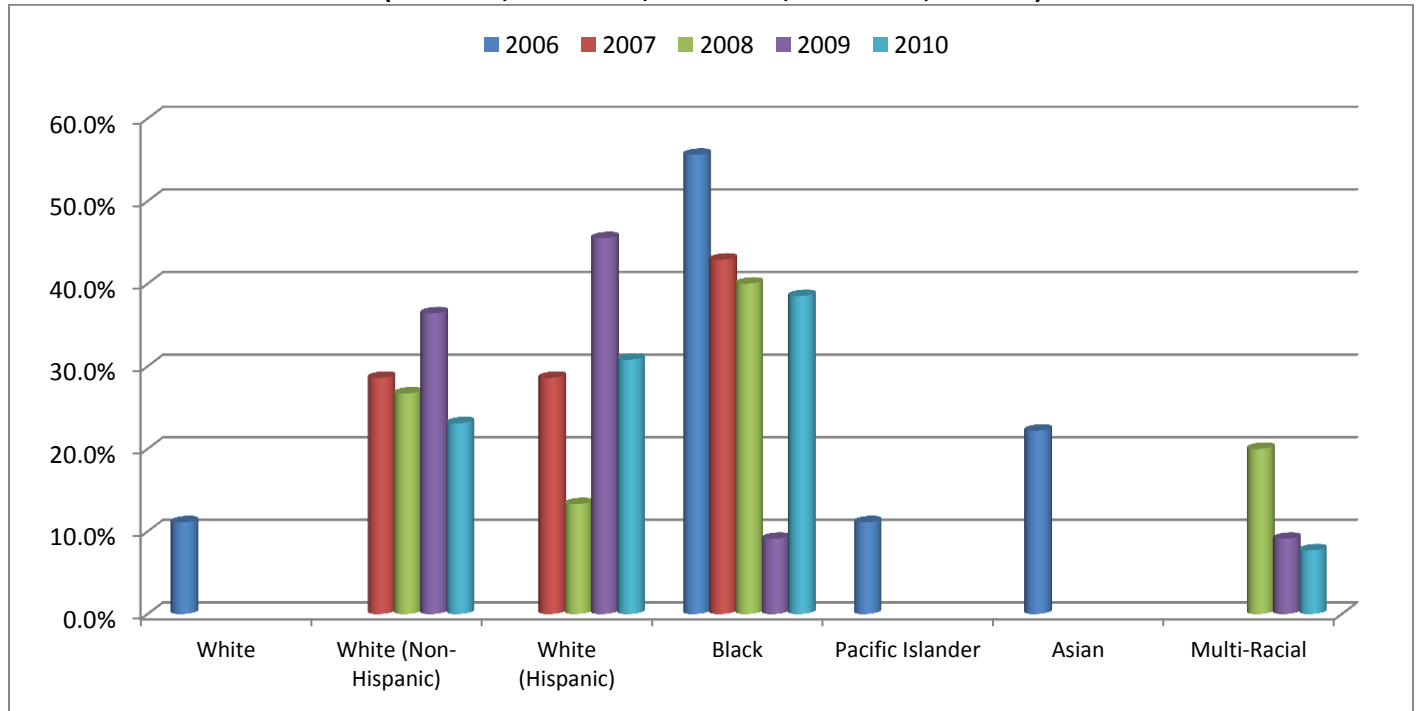
The following map illustrates that most fatal drowning incidents in 2010 occurred in the east zip codes in Clark County (shown in blue on the map). This is a slight change from previous years where there were more cases in the north central parts of the county. As was the case in 2006 through 2009, most drowning cases occurred in the older areas of Las Vegas, Henderson and Boulder City, showing support for the movement to improve safety barriers for existing pools that were not required to install fences, alarms, or other safety barriers when the Southern Nevada Pool Code was enacted in 2003 which requires some secondary barrier for pools installed after 2003.



SUFFOCATION

In 2010, there were 13 accidental suffocations in Clark County, an increase from 2009 when there were 11 incidents of accidental suffocation. All but one of the cases involved infants less than one year old. Nearly one third of the decedents (30%) were female, and 69.2% were male, which is different from previous years where these incidents have involved more females than males. Slightly less than one quarter (23.1%) were White Hispanic, with 30.8% listed as White Non-Hispanic. In Figure 3.13 below, we see the number of accidental suffocation deaths for Black children increase from less than 10% in 2009 to 38.5% in 2010.

Figure 3.13: Percentage of Accidental Suffocations by Race/Ethnicity
(2006 n=9, 2007 n=14, 2008 n=15, 2009 n=11, 2010 13)



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

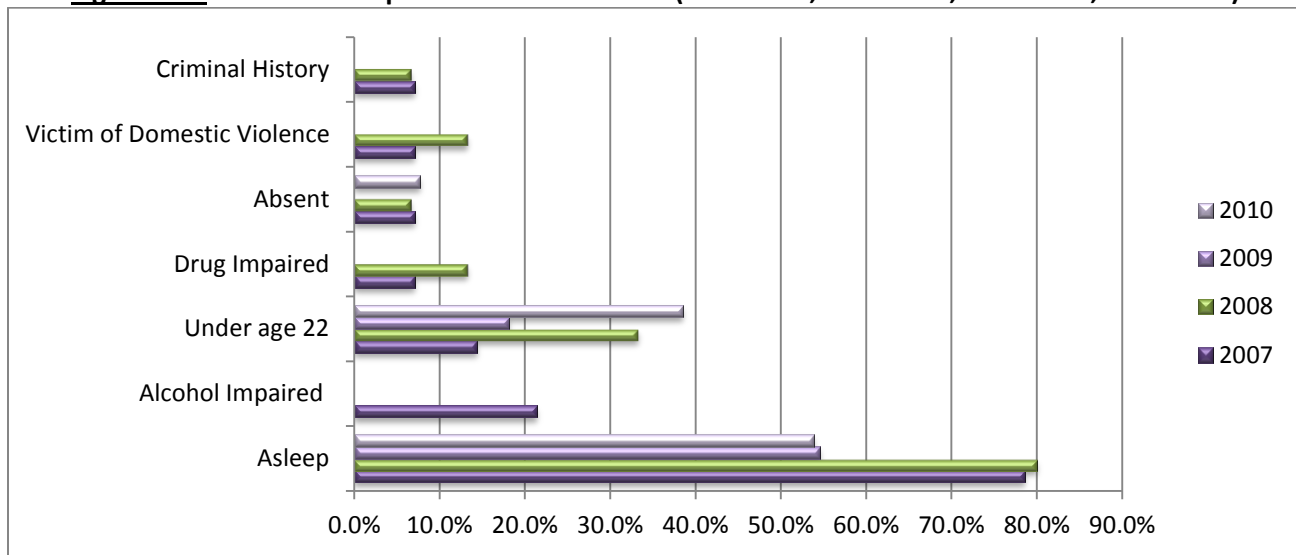
	2006	2007	2008	2009	2010
White	11.1%	--	--	--	--
White (Non-Hispanic)	--	28.6%	26.7% (4)	36.4% (4)	23.1% (3)
White (Hispanic)	--	28.6%	13.3% (2)	45.5% (5)	30.8% (4)
Black	55.6%	42.9%	40.0% (6)	9.1% (1)	38.5% (5)
Pacific Islander	11.1%	0%	0%	0%	0%
Asian	22.2%	0%	0%	0%	0%
Multi-Racial	--	0%	20% (3)	9.1% (1)	7.7% (1)

None of these decedents suffered from a disability, none had a chronic illness, and none were acutely ill in the two weeks preceding their death. In 84.6% of cases, the primary caregiver at the time of the incident was a parent. In all cases the mother had no prior child deaths. Mother's ages ranged between 18 and 35 years, with the average age being 23 years. Fathers ranged in age from 19 to 41 years and the average age was 28 years. In 2 of these cases one of the child's parents had a known history of substance abuse; in one case it was the child's mother and in the other the child's father.

In 53.8% of cases the infant had been carried to full-term (37-40 weeks) and the mother was known to have received prenatal care in 61.5% of cases. In one case the decedent’s mother had a history of misusing illicit drugs during her pregnancy, another used tobacco during her pregnancy, and in another case the mother reported medical complications during her pregnancy.

The majority (72.7%) of children had supervision at the time of their deaths, and 84.6% of those children were being supervised by their biological parent. In less than one quarter of cases (23.1%) the child was in the sight of the supervisor, and in 53.8% of cases it had been hours since the supervisor had seen the child. The minimum number of hours listed was one, and the maximum was 8, with 4 hours as the average number of hours since the supervisor had seen the child. In more than half of cases (53.8%), the supervisor was asleep at the time.

Figure 3.14: 2007-2010 Supervisor Circumstances (2007 n=14, 2008 n=15, 2009 n=11, 2010 n=13)



**Due to changes in the data collection tool, data for these elements is unavailable for 2006*

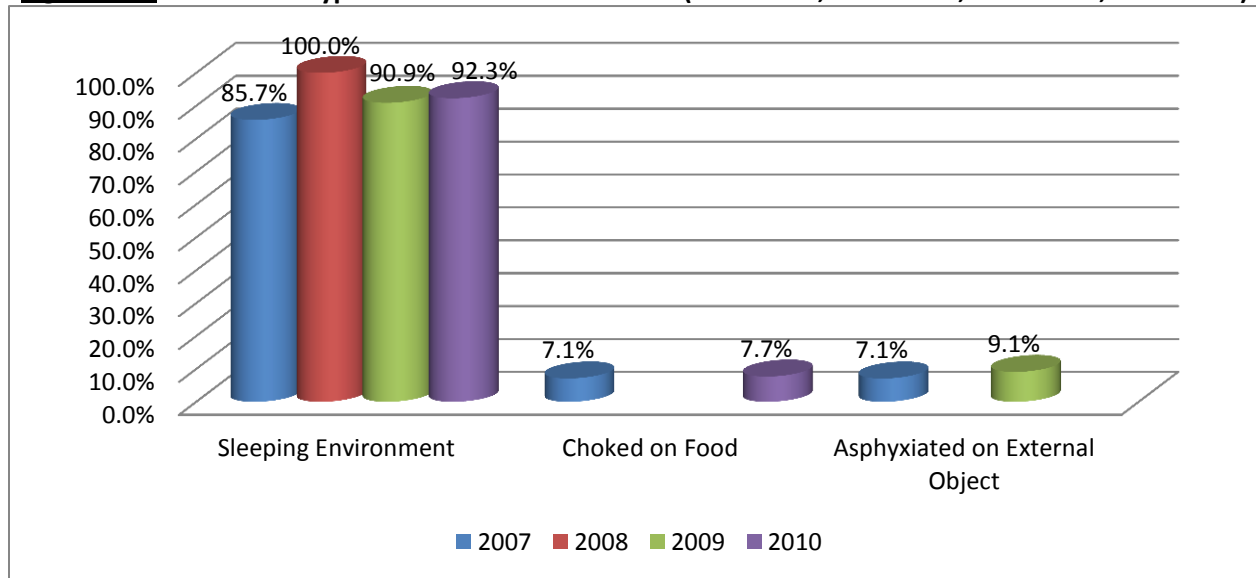
Supervisor Circumstances	2007	2008	2009	2010
Asleep	78.6%	80.0% (12)	54.5 (6)	53.8% (7)
Alcohol Impaired	21.4%	0% (0)	0% (0)	0% (0)
Under age 22	14.3%	33.3% (5)	18.2% (2)	38.5% (5)
Drug Impaired	7.1%	13.3% (2)	--	0% (0)
Absent	7.1%	6.7% (1)	0% (0)	7.7% (1)
Victim of Domestic Violence	7.1%	13.3% (2)	0% (0)	0% (0)
Criminal History	7.1%	6.7% (1)	0% (0)	0% (0)

Nearly all incidents (76.9%) occurred in the child’s home, and the remaining three cases were in the child’s relative’s home. 911 was called in all cases. CPS action was taken as a result of the death in 38.5% of cases, and there was prosecution pending at time of review in two of these cases.

Slightly more than one half (53.8%, n=7) of families had a prior child welfare history, which includes any history on the parent as a child victim. In one of the seven cases, there was CPS history on the decedent, and in five cases, there was some CPS history regarding a sibling. In the remaining case the history was on the decedent’s parent as a child victim. One of the cases had an open child welfare case at the time of death. For the seven cases with prior history, allegations were split between neglect (n=4) and abuse (n=3). Perpetrators listed in these allegations included both the mother and the child’s father.

The majority of accidental suffocation deaths involved children less than one year of age (n=12). All of the decedents under one year were in a sleeping environment at the time of their death. The remaining case was a child between 1 and 4 years of age who choked on food.

Figure 3.15: 2007-2010 Type of Accidental Suffocation (2007 n=14, 2008 n=15, 2009 n=11, 2010 n=13)



Of those decedents who died in a sleeping environment, in seven of the cases the infant was sleeping on an adult mattress, couch, or the floor, while the remaining five were in an age appropriate sleeping environment such as a crib or playpen. In five of these cases, this was a new sleep location for the child. In eight of these cases, the infant was sleeping with a parent, other adult or another child. 50% of all decedents were placed to sleep on either their stomach (33.3%) or sides (16.7%). Three of the infants were found on their backs (25%) and 58% (n=7) were found on their stomachs and position was unknown in the remaining two cases. In 9 cases the child was suffocated by bedding (blankets, pillows, etc), in two cases the child was suffocated due to overlay of another person and in the remaining case the child was found face down in her crib but there was no bedding over her head or face.

ACCIDENTAL DEATHS: RECOMMENDATIONS FOR PREVENTION

Accidental deaths are defined by the National Center for Child Death Review as “a manner of death indicating non-intentional trauma.” More than half (67.4%) of all accidental deaths of children in Clark County in 2010 were due to motor vehicle accidents, suffocation/strangulation, and drowning. By their nature, all accidental deaths are preventable and thus provide ample data to make recommendations aimed at preventing future child deaths.

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

Nearly all (70%) of drowning victims in 2010 were between the ages of one and four. Also 80% of drowning fatalities occurred in a pool or spa. In 50% of these cases, there was no barrier in place to prevent access to the pool/spa. In 2010 the majority of pool drowning incidents took place in older areas of Las Vegas, Henderson, North Las Vegas, and Boulder City which may account for the lack of appropriate barrier devices which are mandated by the County for newer pools. In addition in 2010 we did have 20% of fatal incidents occur in open water (lakes, rivers, ponds, etc) which lends support to ensure that in prevention messages parents are reminded to use the same caution around open water they should when around a pool or spa.

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

In 2010 nearly all cases of accidental suffocation were children less than one year of age (n=12 of 13) (one case was an older child involved in a choking incident) and all cases involving children less than one year occurred while the child was in a sleeping environment. A 2009 study in *Pediatrics* found that infant mortality rates attributable to accidental suffocation in bed have quadrupled since 1984 (Shapiro-Medoza, et.al, 2009). These national findings along with our local data support the need for targeted health education focused on creating safe sleep environments for infants. In addition in 2010 more than three quarters of these cases involved a racial/ethnic minority (30.8% Hispanic, 38.5% Black, and 7.7% multi-racial), pointing to the need for more culturally specific outreach and education.

3. CONTINUE TO SUPPORT EFFORTS RELATED TO THE ELIMINATION OF RECREATIONAL DRUG USE AND EXPAND EFFORTS TO PREVENT DRUG USE AMONG YOUTH AND ESPECIALLY WOMEN OF CHILD BEARING AGE.

In 2010 we saw a large spike in the number of accidental deaths related to maternal substance abuse, increasing from only three cases in 2008 to seven cases in 2010, which is nearly the same number of motor vehicle accidents (n=8). The majority of these mothers were White Non-Hispanic (85.7%), between the ages of 25 and 39 years. The team had information about whether the mother received prenatal care in 5 of the 7 cases and for those when it was known 60% or (3 out of 5) did not receive any prenatal care.

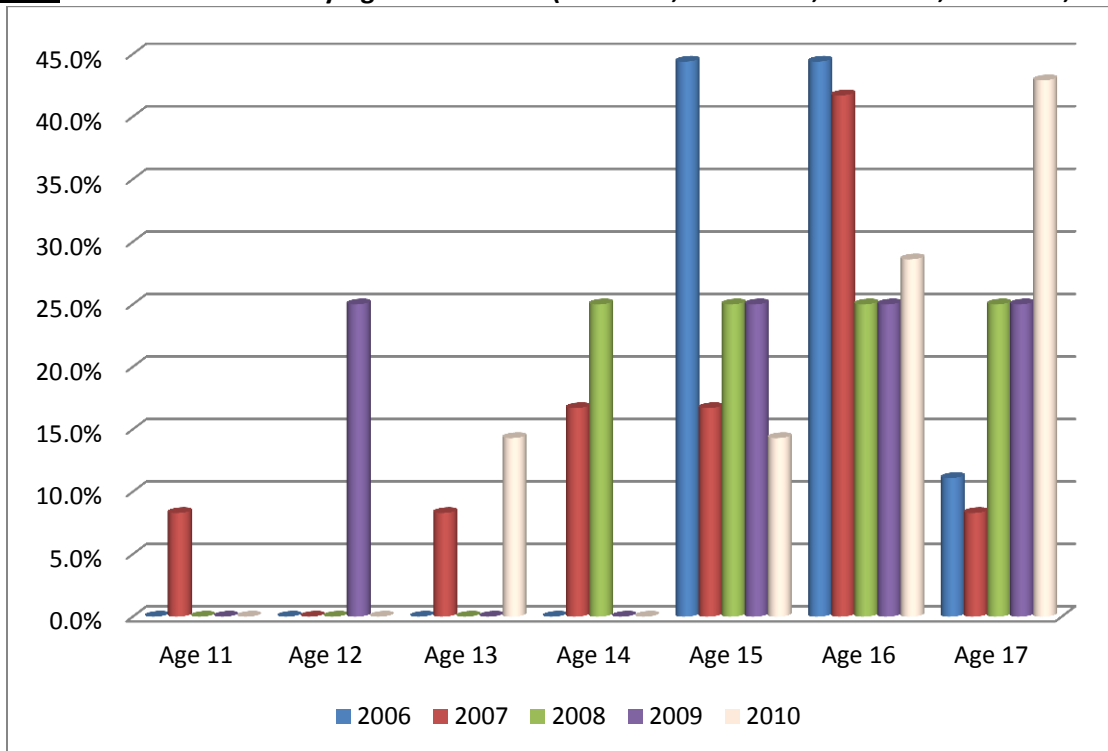
SECTION IV: SUICIDE DEATHS

Suicide is defined as the willful termination of one’s own life. According to the National Institutes of Mental Health in 2007, suicide was the third leading cause of death among young people ages 15-24, just behind unintentional injury and homicide. In 2010, there were seven youth suicides in Clark County. This is almost twice the number in 2008 and 2009, but still less than in 2006 and 2007. This year the death rate for youth suicide in Clark County was calculated at 1.36 per 100,000, compared to the national youth suicide rate of 1.3 per 100,000. The percentages for sex, race and ethnicity for all 2006-2010 suicide cases are listed in the figures below. For 2010, three of the suicide cases were due to fatal firearm injuries, three were due to hanging, and one was due to propane intoxication. None of these cases had a family history of prior child welfare involvement.

In 2010, the suicide rate for children under 18 in Clark County was 1.36 per 100,000 compared to 1.3 per 100,000 nationally.

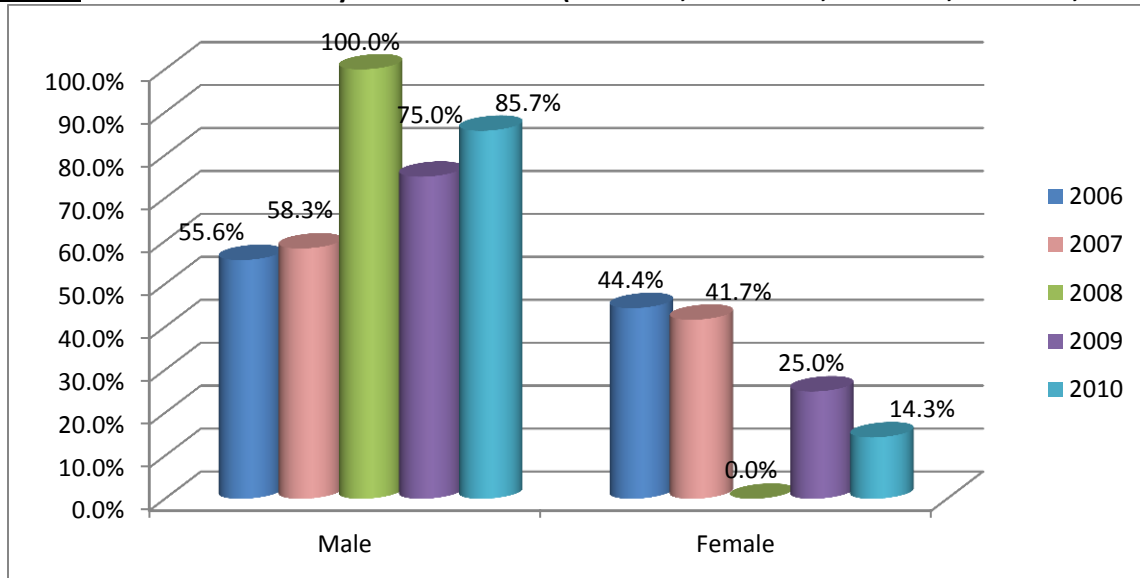
In 2010 ages of youth who died from suicide ranged from 13 to 17 years, with the majority of cases being 16 or 17 years old. The distribution of age among suicide deaths in 2010 is similar to that seen in 2007 with the exception of the increase in the number of seventeen year olds. This is illustrated in Figure 4.1 below.

Figure 4.1: 2006–2010 Suicide by Age of Decedent (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



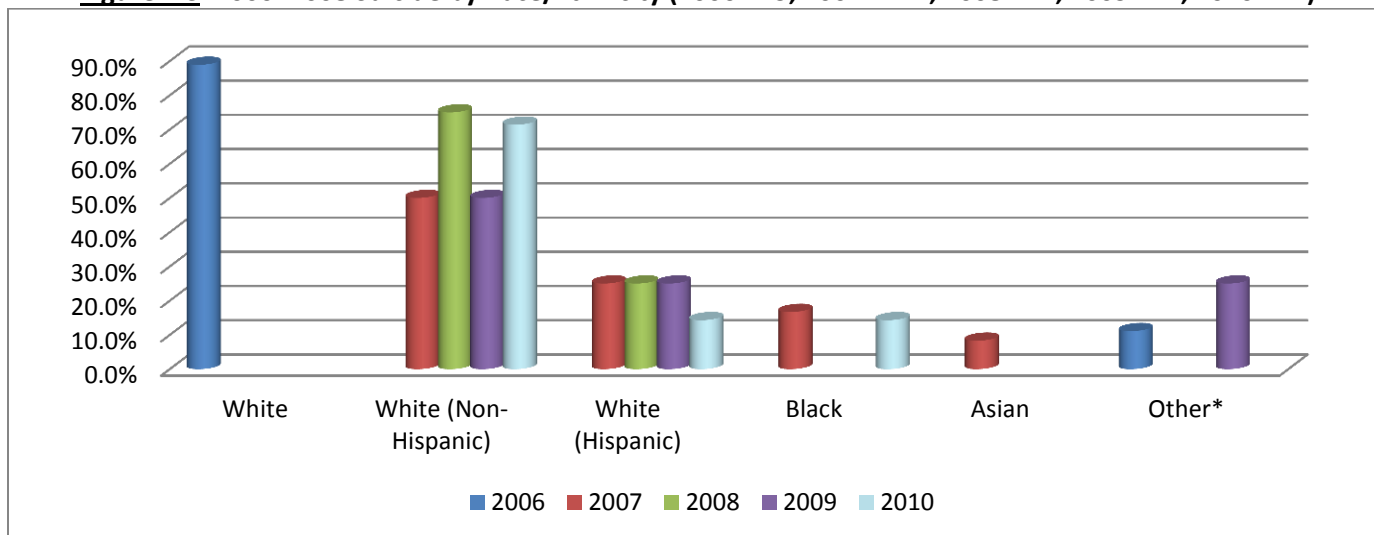
According to the National Center on Child Death Review, White males make up the greatest percentage of suicides among youth ages 15-24 years. In 2010, more than three fourths of suicide victims were males (85.7%) between the ages of 13 and 17, and 71.4% were White Non-Hispanic. Two of the youth had a history with juvenile justice services and none had a history of involvement with the child welfare system. Clark County’s data has not historically matched the national profile showing males completing suicide at nearly four times the rate of females¹. However, in 2008 all youth suicides were male, in 2009 three quarters of all youth suicides were males, and in 2010 85.7% were males. This indicates that perhaps any targeted prevention efforts for girls has had some impact on the incidence of youth suicide in Clark County.

Figure 4.2: 2006–2010 Suicide by Sex of Decedent (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



¹ Centers for Disease Control and Prevention (2004). Suicide Fact Sheet.

Figure 4.3: 2006–2008 Suicide by Race/Ethnicity (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)

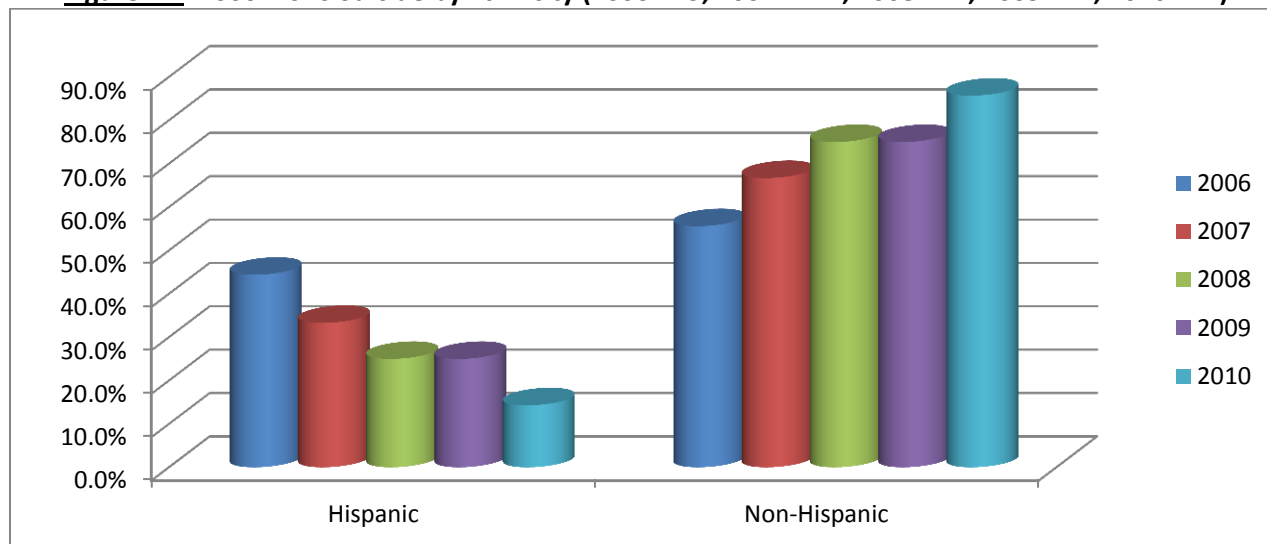


* The “Other” race in the 2006 data was a person who did not list a race, but listed ethnicity as Hispanic

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

Over the past three years we have seen a decline in the number of Hispanic youth who complete suicide, while conversely we saw an increase in Non-Hispanic youth completing suicide from 2006 to 2010 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: 2006–2010 Suicide by Ethnicity (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)

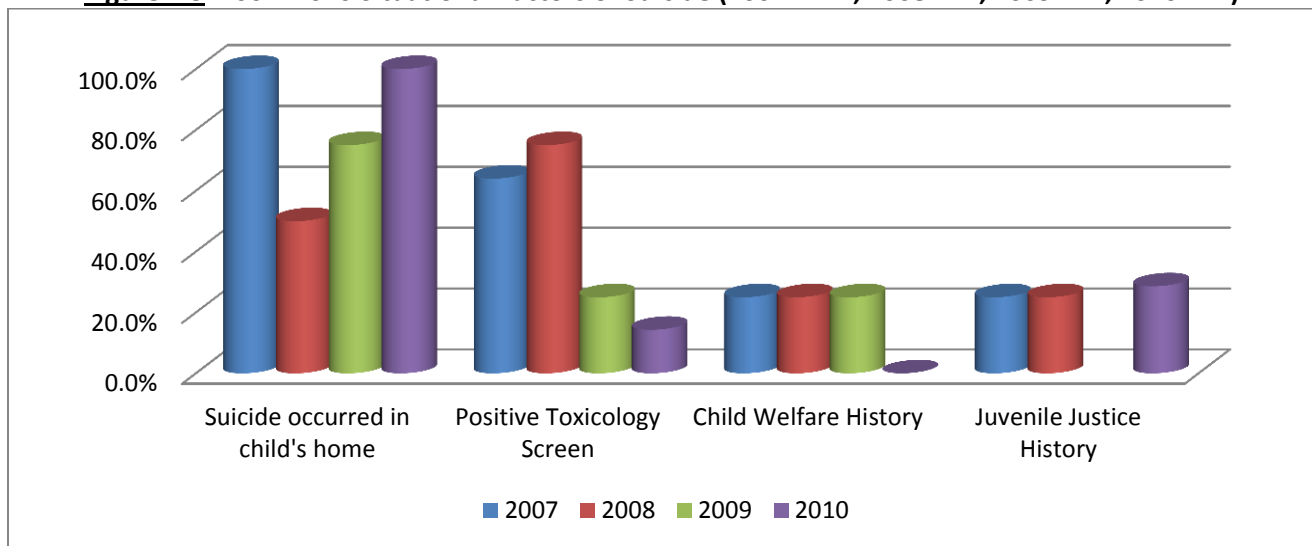


SITUATIONAL FACTORS OF SUICIDE

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

In only one of the suicide cases in 2010 the child had a history of substance abuse and two of the youth were involved in the juvenile justice system. Nearly half (42.9%) of all suicide victims had been diagnosed with a mental illness, and in two cases a prior suicide attempt had been made. In all cases, the suicide occurred in the child's home. 911 were called in all cases. In nearly all cases (85.7%), the child was attending school regularly at the time of death. However, in two cases the child was experiencing school failure and in two cases a suicide note was left by the decedent.

Figure 4.5: 2007–2010 Situational Factors of Suicide (2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



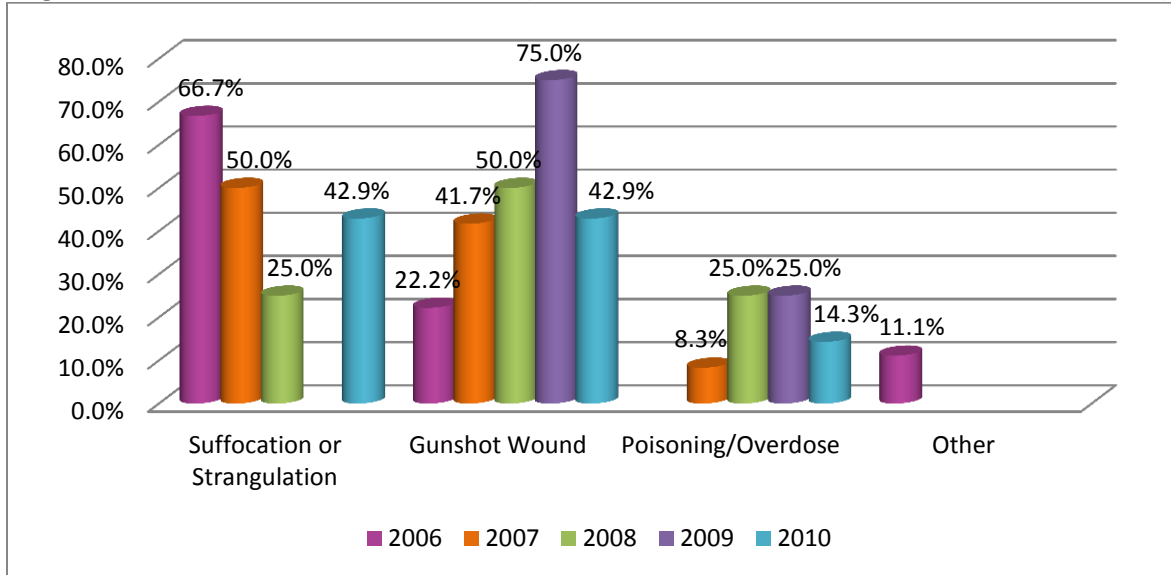
	2007	2008	2009	2010
Suicide Occurred in Child's Home	100.0%	50.0% (2)	75% (3)	100% (7)
Positive Toxicology Screen	64.0%	75.0%(3)	25% (1)	14.3% (1)
Child Welfare History	25.0%	25.0%(1)	25% (1)	0% (0)
Juvenile Justice History	25.0%	25.0%(1)	0% (0)	28.6% (2)

In 2010 a toxicology screen was conducted in only one of the suicide cases (an overdose), and an autopsy was conducted in two cases. Sexual orientation was known in two of the cases and unknown in the other five.

METHOD OF SUICIDE

A 2007 article authored by the Suicide Prevention Research Center and the Harvard Injury Control Research Center suggests that 44% of teen suicides were suffocation deaths (primarily by hanging), followed by 43% of suicides committed using a firearm². This pattern is replicated in Clark County for 2006 through 2010. For Clark County teens in 2010, the number using firearms was equal to the number using hanging for the most common method of suicide.

Figure 4.6: 2006–2009 Method of Suicide (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



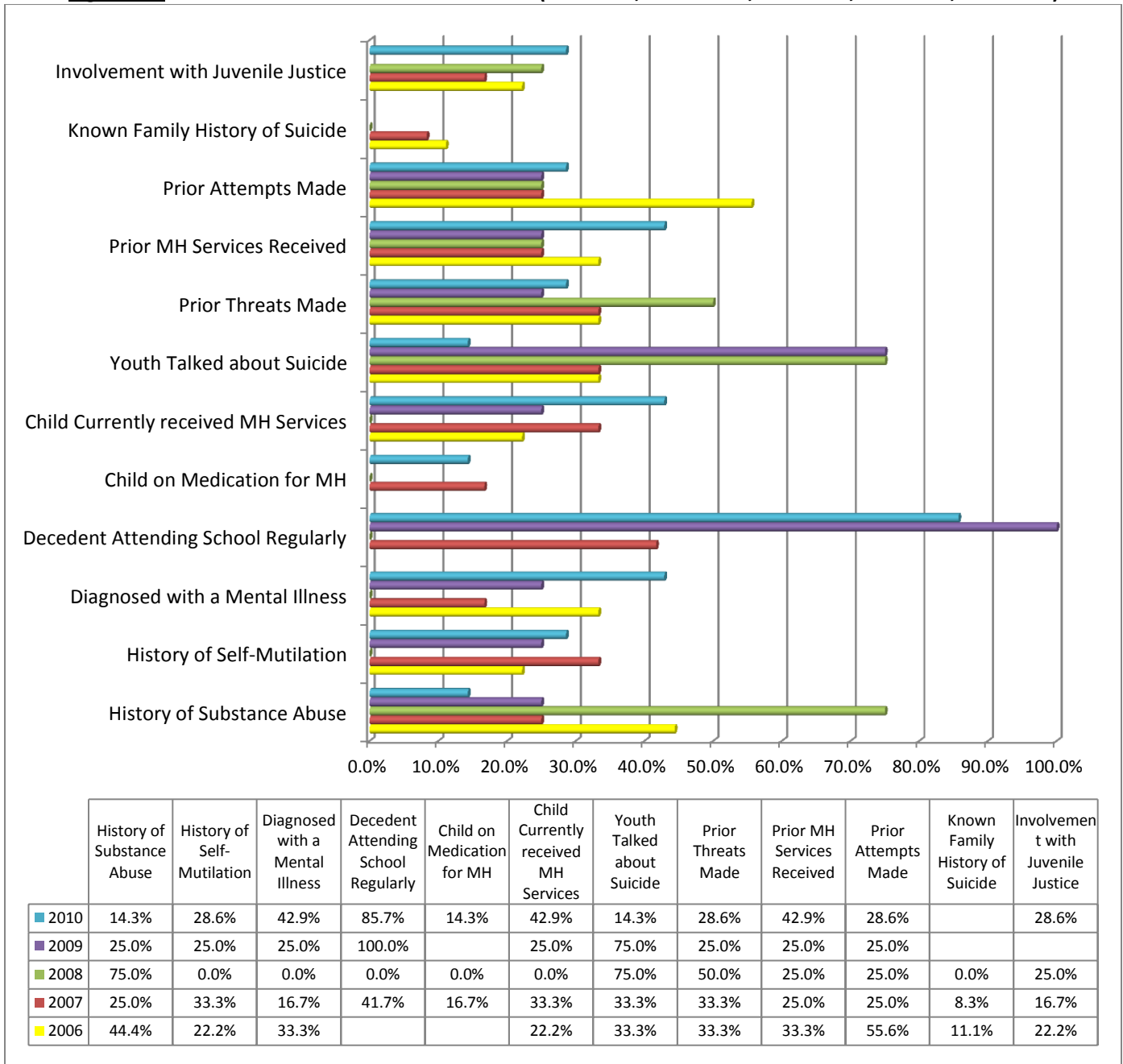
In three of the seven cases in 2010 the youth used a firearm, another three cases were hanging and the remaining case was an intentional propane intoxication. In all three of the firearm suicides a handgun was used. In one of these cases the firearm was stored in a locked cabinet, but the youth knew where the keys were stored, and in all cases the firearm was owned by a family member of the decedent. In two cases the youth had made prior attempts, and in two cases a note was left.

² <http://www.sprc.org/library/YouthSuicideFactSheet.pdf>

CIRCUMSTANCES OF SUICIDE

There are several factors that have been identified as risk factors for suicide. The circumstances that were present in the 7 cases reviewed in 2010 are listed in Figure 4.7 below.

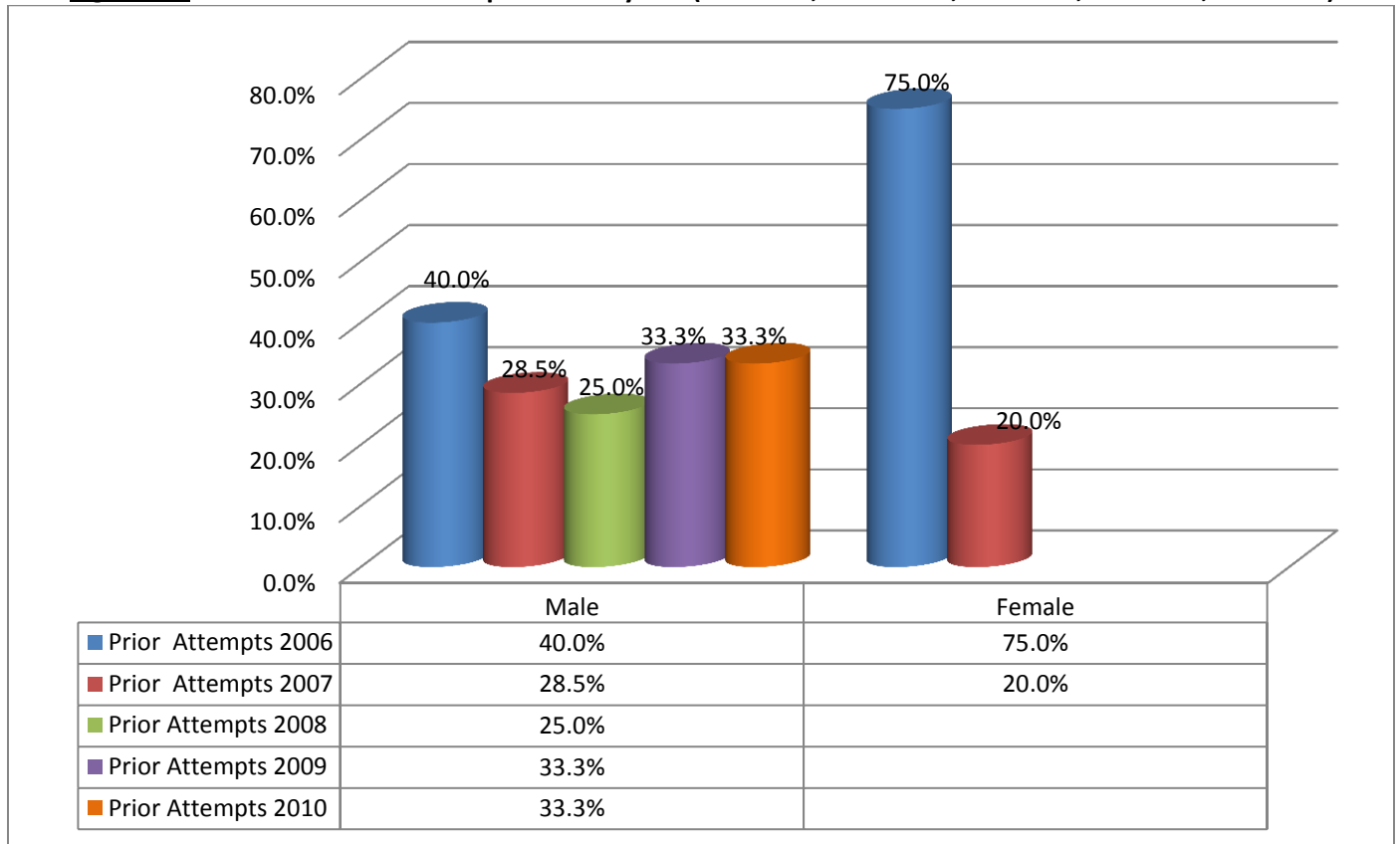
Figure 4.7: 2006-2010 Circumstances of Suicide (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



In the 2010 cases, clearly identified risk factors are more difficult to identify. All but one of the youth were regularly attending school, only two had made a known prior attempt, and only one of the decedents had talked about suicide in the past.

According to literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide³. In 2006, over half (55.6%) of suicide victims had prior attempts, while from 2007 to 2009 only one quarter (25%) of decedents had a prior attempt. National literature clearly shows that adolescent males of all races are four times more likely to complete suicide than females, but adolescent females are twice as likely as adolescent males to attempt suicide. However, among suicide fatalities in Clark County, starting in 2007 we see that the number of males and females with prior attempts is evenly split, then in 2008, 2009, and 2010 only male decedents had a history of prior attempts (Figure 4.8).

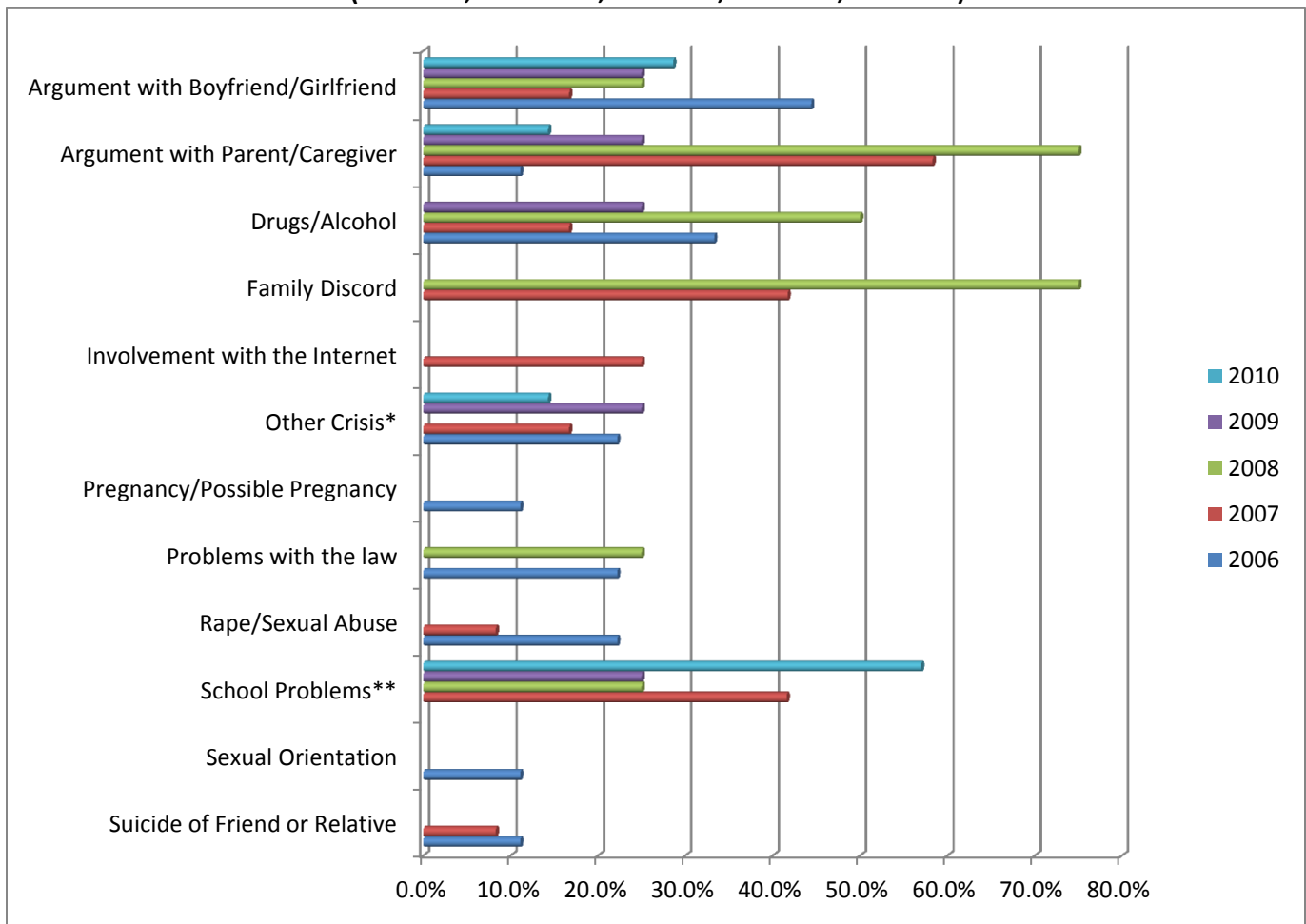
Figure 4.8: 2006–2010 Prior Attempts Made by Sex (2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



³ www.KidsHealth.org, Retrieved August 25, 2011

In taking a look at these cases and the decedent’s history of any acute or cumulative crisis, several factors were shown to be present in these cases. One of the victims had recently had a fight with their parent, and two had recently fought with their boyfriend or girlfriend. Another decedent had been the victim of bullying and rumor mongering (See Figure 4.9).

Figure 4.9: 2006–2010 History of Acute or Cumulative Crisis
(2006 n=9, 2007 n=12, 2008 n=4, 2009 n=4, 2010 n=7)



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

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

	2006	2007	2008	2009	2010
Argument with Parent/Caregiver	11.1%	58.3%	75.0%(3)	25% (1)	14.3% (1)
Family Discord	0.0%	41.7%	75.0% (3)	0.0%	0.0%
School Problems**	0.0%	41.6%	25.0% (1)	25% (1)	57.1% (4)
Involvement with the Internet	0.0%	25.0%	0.0%	0.0%	0.0%
Argument with Boyfriend/Girlfriend	44.4%	16.7%	25.0% (1)	0.0%	28.6% (2)
Drugs/Alcohol	33.3%	16.7%	50.0% (2)	25% (1)	0.0%
Other Crisis*	22.2%	16.7%	0.0%	25% (1)	0.0%
Suicide of Friend or Relative	11.1%	8.3%	0.0%	0.0%	0.0%
Rape/Sexual Abuse	22.2%	8.3%	0.0%	0.0%	0.0%
Pregnancy/Possible Pregnancy	11.1%	0.0%	0.0%	0.0%	0.0%
Problems with the law	22.2%	0.0%	25.0% (1)	0.0%	0.0%
Sexual Orientation	11.1%	0.0%	0.0%	0.0%	0.0%

SUICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

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

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

In 2010 there were seven youth suicide deaths. While this is a decrease from the 2006 and 2007, it is nearly twice as many as in 2008 and 2009. All deaths were among youth ages 13 to 17 years of age indicating that middle and high schools are still the most appropriate place to target prevention interventions, but since we have seen cases as young as 12 years old, we may want to increase efforts in elementary schools as well. It is essential that mental health screenings occur in children that are school aged, and that teachers and other non-family members are educated about the signs and risk factors for suicide. Like most educational efforts if the information is provided early and consistently it may have a greater impact.

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

In 2010 nearly half (42.8%) of all suicide victims used firearms. This is one of the means of suicide that should be most difficult for children and youth to get a hold of. Families that choose to have firearms in their homes must be especially careful about ensuring that they are stored in a locked secured location where children and youth do not have access, especially if that child has a history of mental health issues or substance abuse.

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

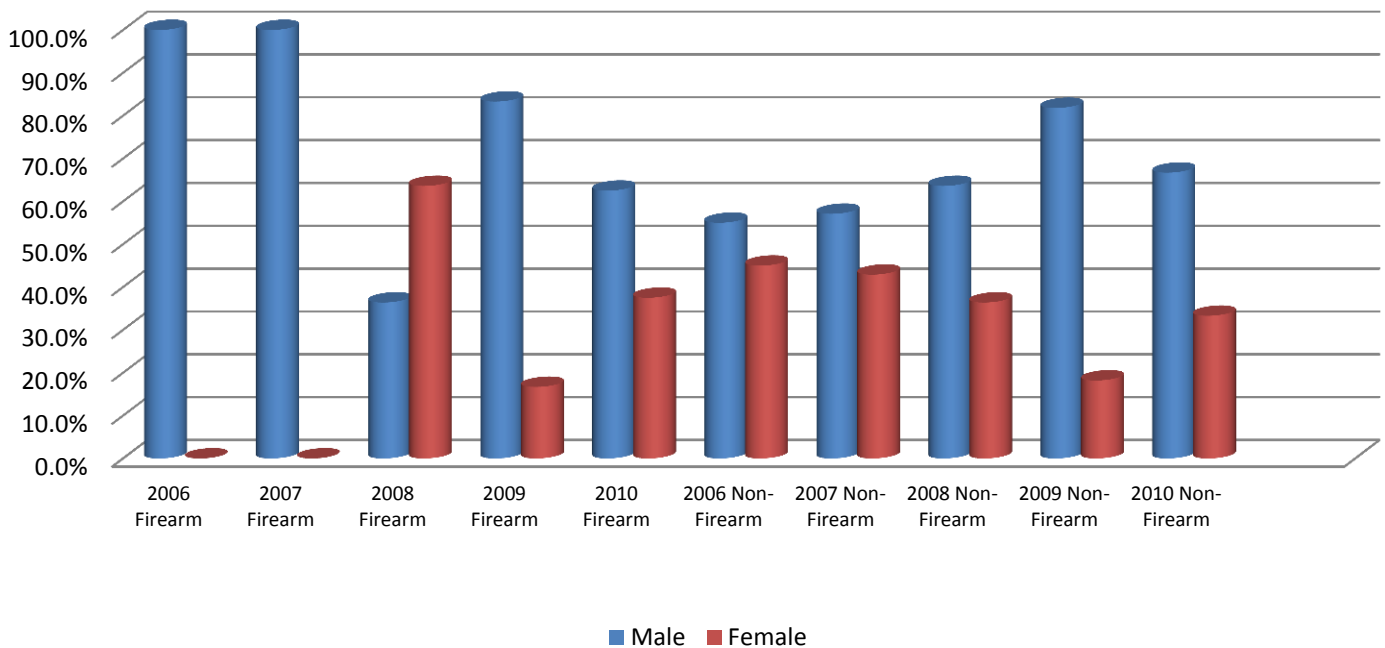
In more than 40% of youth suicides in 2010 the child was currently receiving mental health services and in nearly 30% of cases the child had made prior attempts and 30% had made suicide threats. Verbalizing suicidal ideation should always be taken seriously. However many parents, teachers, friends, etc. do not take action to get professional help until after an attempt. Prevention efforts including suicide gatekeeper training should attempt to include other youth in recognizing the signs of suicide, as well as measures that can and should be taken to intervene. The Nevada Office of Suicide Prevention currently offers gatekeeper training designed to help people recognize the signs and symptoms of suicidal ideation and provides information on what to do to help. The training also provides information about suicide risk to reduce some of the stigma attached to mental illness and suicide.

SECTION V: HOMICIDE DEATHS

Homicide is legally defined as the killing of one human being by another human being. The Centers for Disease Control and Prevention lists youth homicide as the second leading cause of death for the 10-24 age group⁴, and states that “among 10-24 year olds, 86% of homicide victims were male, and 82% were killed with a firearm.”⁵ Furthermore, “among 10 to 24 year-olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics and Asian/Pacific Islanders, and the third leading cause of death for American Indians and Alaska Natives.”⁶

In 2010, there were 20 homicides of children and youth, which is a slight decrease from the 21 in 2008, but an increase from the 17 in 2009. The 2010 homicides fell into two categories – those that were committed using a firearm (40%) and those that were committed without a firearm (60%). Overall, victims were about two times as likely to be male (65%) than female (35%, See Figure 5.1). This year we saw a large proportion of homicide victims less than four years of age (50%), which is similar to 2009, but a very different trend when compared to previous years where the majority of homicide victims are between 15 and 17 years of age.

Figure 5.1: 2006 – 2010 Homicide Deaths by Sex and Type (2006 n=20, 2007 n=15, 2008 n=21, 2009 n=17, 2010 n=20)



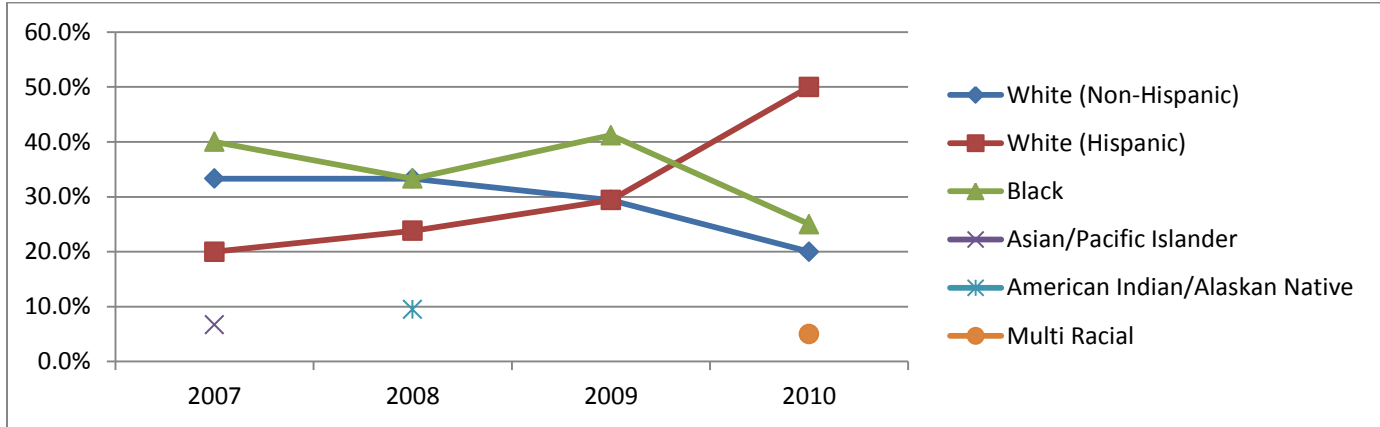
⁴ <http://www.cdc.gov/ncipc/pub-res/YVFactSheet.pdf>

⁵ http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf

⁶ http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf

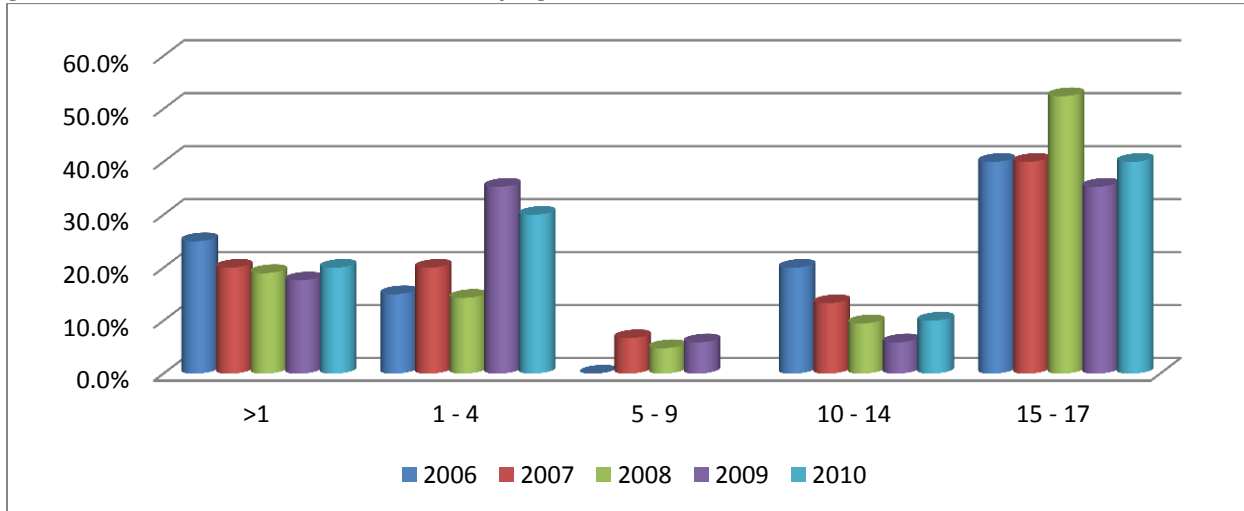
Half (50%) of all homicides in 2010 were White Hispanic children and Black children (25%) were the second most frequent racial/ethnic group in this manner of death. The remaining 20% of cases (n=4) were White Non -Hispanic children in 2010. These data indicate that Black and Hispanic teens are disproportionately victimized by homicide, and that these disparities are increasing from 2007 to 2009. In 2010 we see a sharp increase in the proportion of White Hispanic children and a continued decline in White Non-Hispanic children, as well as a decline in Black children (Figure 5.2).

Figure 5.2: 2007-2010 Homicide Deaths by Race/Ethnicity (2007 n=15, 2008 n=21, 2009 n=17, 2010 n=20)



It is also interesting to note the bimodality of the age distribution in 2006 through 2010. The oldest group (ages 15-17) and the youngest group (infants <1 year, and children ages 1 to 4 years) demonstrated the highest percentages of victims in all four years. Also in 2010 we see a slight decrease in the percentage of children ages 1 to 4 years, going from only 35.3% in 2009 to 30% in 2010.

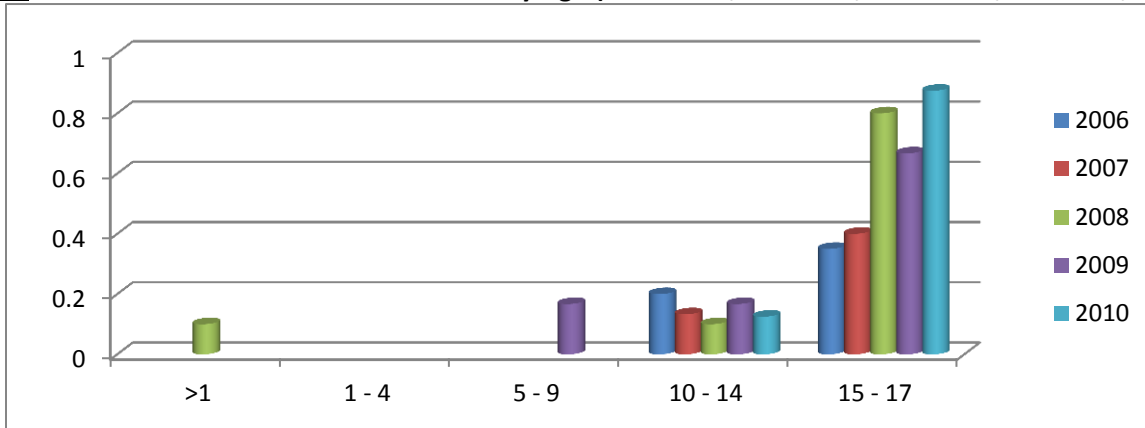
Figure 5.3: 2006–2009 Homicide Deaths by Age (2006 n=20, 2007 n=15, 2008 n=21, 2009 n=17, 2010 n=20)



	2006	2007	2008	2009	2010
Less than 1 year	25.0%	20.0%	19.0% (4)	17.6% (3)	20.0% (4)
1 – 4 years	15.0%	20.0%	14.3% (3)	35.3% (6)	30.0% (6)
5 – 9 years	0.0%	6.7%	4.8% (1)	5.9% (1)	0%
10 – 14 years	20.0%	13.3%	9.5% (2)	5.9% (1)	10.0 (2)%
15 – 17 years	40.0%	40.0%	52.4% (11)	35.3% (6)	40.0% (8)

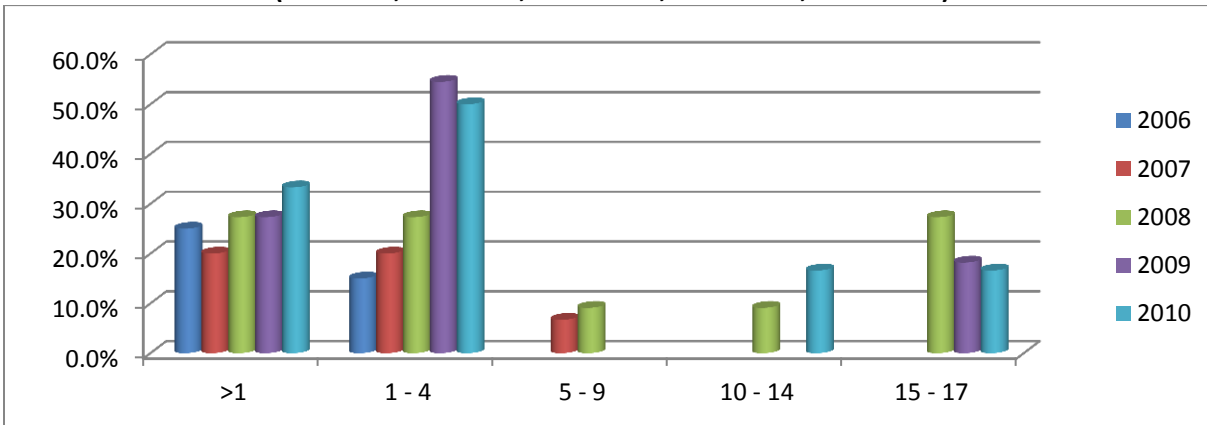
The type of homicide clearly divides the age categories in all three years, showing different trends in victimization by age. In all years, youth ages 10-17 are most frequently victimized by firearms and children 9 years and younger are most frequently victims of non-firearm homicides (Figure 5.4).

Figure 5.4: 2006–2010 Firearm Homicide Deaths by Age (2006 n=11, 2007 n=8, 2008 n=10, 2009 n=6, 2010 n=8)



	2006	2007	2008	2009	2010
>1 year	0.0%	0.0%	10.0% (1)	0.0%	0.0%
1 – 4 years	0.0%	0.0%	0.0%	0.0%	0.0%
5 – 9 years	0.0%	0.0%	0.0%	16.7% (1)	0.0%
10 – 14 years	20.0%	13.3%	10.0% (1)	16.7% (1)	12.5% (1)
15 – 17 years	35.0%	40.0%	80.0% (8)	66.7% (4)	87.5% (7)

Figure 5.4: 2006–2010 Non-Firearm Homicide Deaths by Age (2006 n=9, 2007 n=7, 2008 n=11, 2009 n=11, 2010 n=12)



	2006	2007	2008	2009	2010
>1 year	25.0%	20.0%	27.3% (3)	27.3% (3)	33.3% (4)
1 – 4 years	15.0%	20.0%	27.3% (3)	54.5% (6)	50% (6)
5 – 9 years	0.0%	6.7%	9.1% (1)	0.0%	0.0%
10 – 14 years	0.0%	0.0%	9.1% (1)	0.0%	8.3% (1)
15 – 17 years	0.0%	0.0%	27.3% (3)	18.2% (2)	8.3% (1)

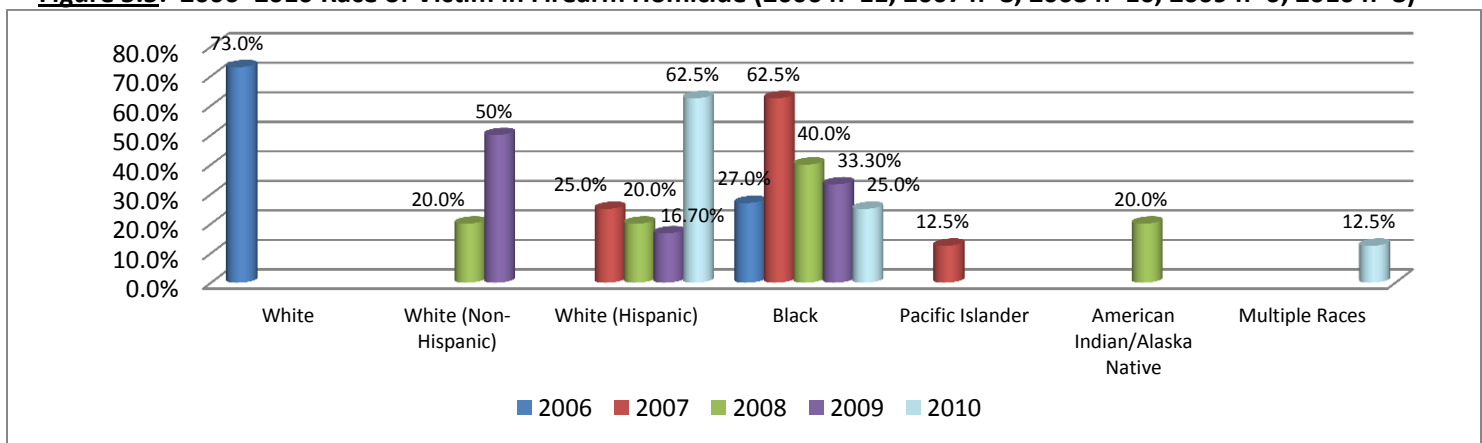
FIREARM HOMICIDE

Nationally, youth homicides represent the greatest proportion of all firearm deaths⁷. 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.”⁸ Clark County’s data in 2010 once again supports the importance of these factors. Specifically in Clark County, substance abuse history, gang involvement, and school failure are demonstrated risk factors for youth homicide. In addition, “these homicides usually occur in connection with an argument or dispute. Firearm homicides among teens are almost always committed by casual acquaintances of the same gender, race, and age, and almost always committed using inexpensive and easily acquired handguns.”⁹

In 2010 we see a shift in the type of homicide cases, firearm homicides represent 40% (n=8) while non-firearm homicides represent 60% (n=12) of all homicides. Historically this proportion has been more evenly split. This likely explains the higher proportion of younger victims of homicide in 2010 as younger children are more likely to be victims of non-firearm homicide (see Figure 5.4). 62.5% of firearm homicide victims in 2010 were male.

In 2010, more than half of victims were White Non-Hispanic (62.5%) while the other half were either Black (25%) or Multi-racial (12.5%). For the first time there were no White Non-Hispanic victims of firearm homicide. Again this year, although there was a decline in the proportion of Black firearm homicide victims, the percentage of Black victims of firearm homicide is disproportionate to the population distribution in Southern Nevada and represents a clear area for intervention and prevention.

Figure 5.5: 2006–2010 Race of Victim in Firearm Homicide (2006 n=11, 2007 n=8, 2008 n=10, 2009 n=6, 2010 n=8)



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

Nearly all victims (87.5%) were regularly attending school at the time of their death. None of the victims had a chronic illness or disability; however in five cases the victim had a known history of substance abuse (two had a history of alcohol abuse two with marijuana, and one victim had a history with both alcohol and marijuana) and only one victim

⁷ www.childdeathreview.org (2007)

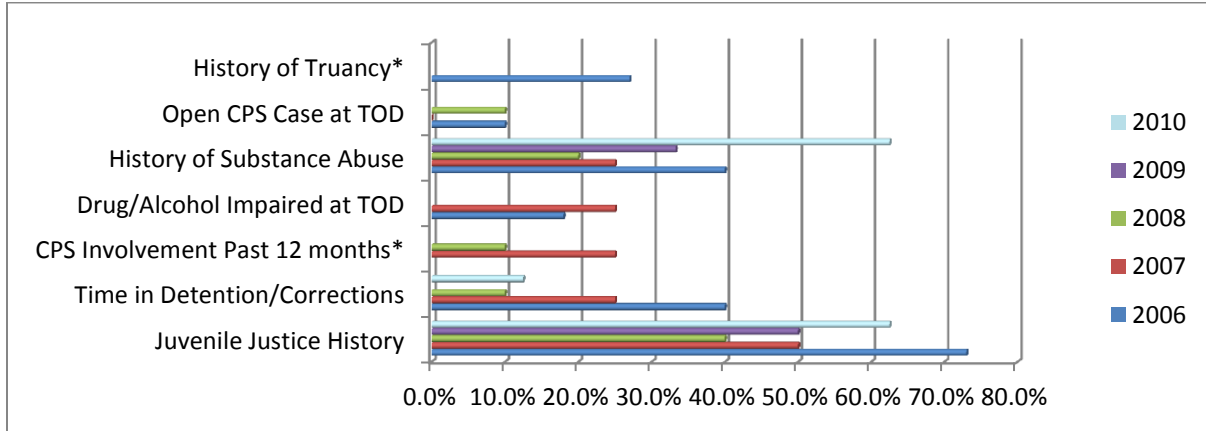
⁸ www.childdeathreview.org (2007)

⁹ www.childdeathreview.org (2007)

had received any substance abuse treatment. None of the victims tested positive for drugs at the time of their death. In two of these cases, prosecution was pending at the time of the review.

More than half of firearm homicide victims (62.5%) had a known juvenile justice history, which is a reduction from 2006, when approximately three quarters had a known juvenile justice history, but an increase from 2009 when 50% had a history. Charges included: battery, larceny, solicitation, truancy, drug possession and weapons. In 2010 none of the youth had been incarcerated in a juvenile correctional facility prior to death.

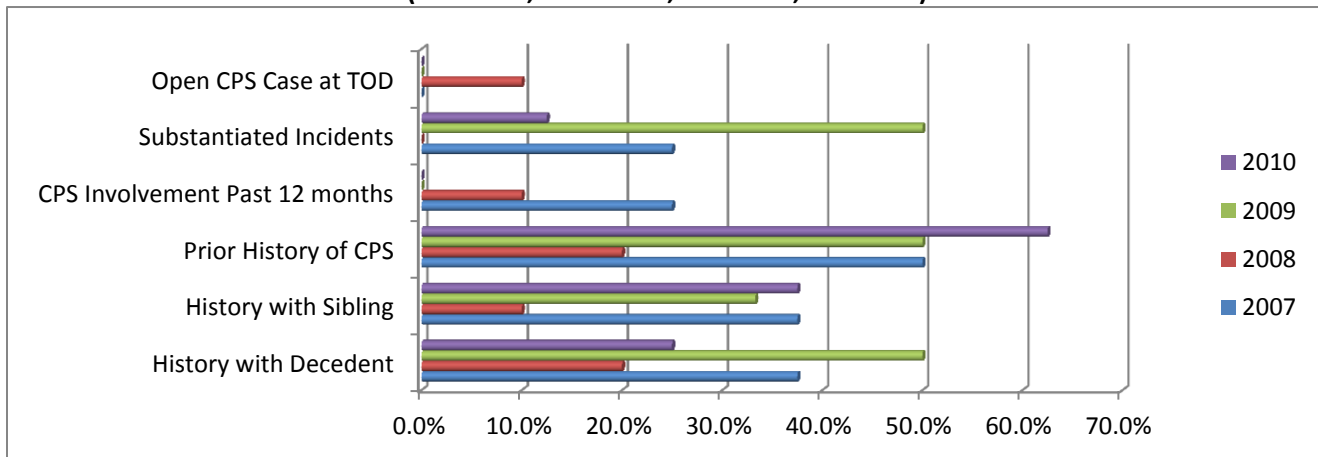
Figure 5.6: 2006–2010 Characteristics of Firearm Homicides (2006 n=11, 2007 n=8, 2008 n=10, 2009 n=6, 2010 n=8)



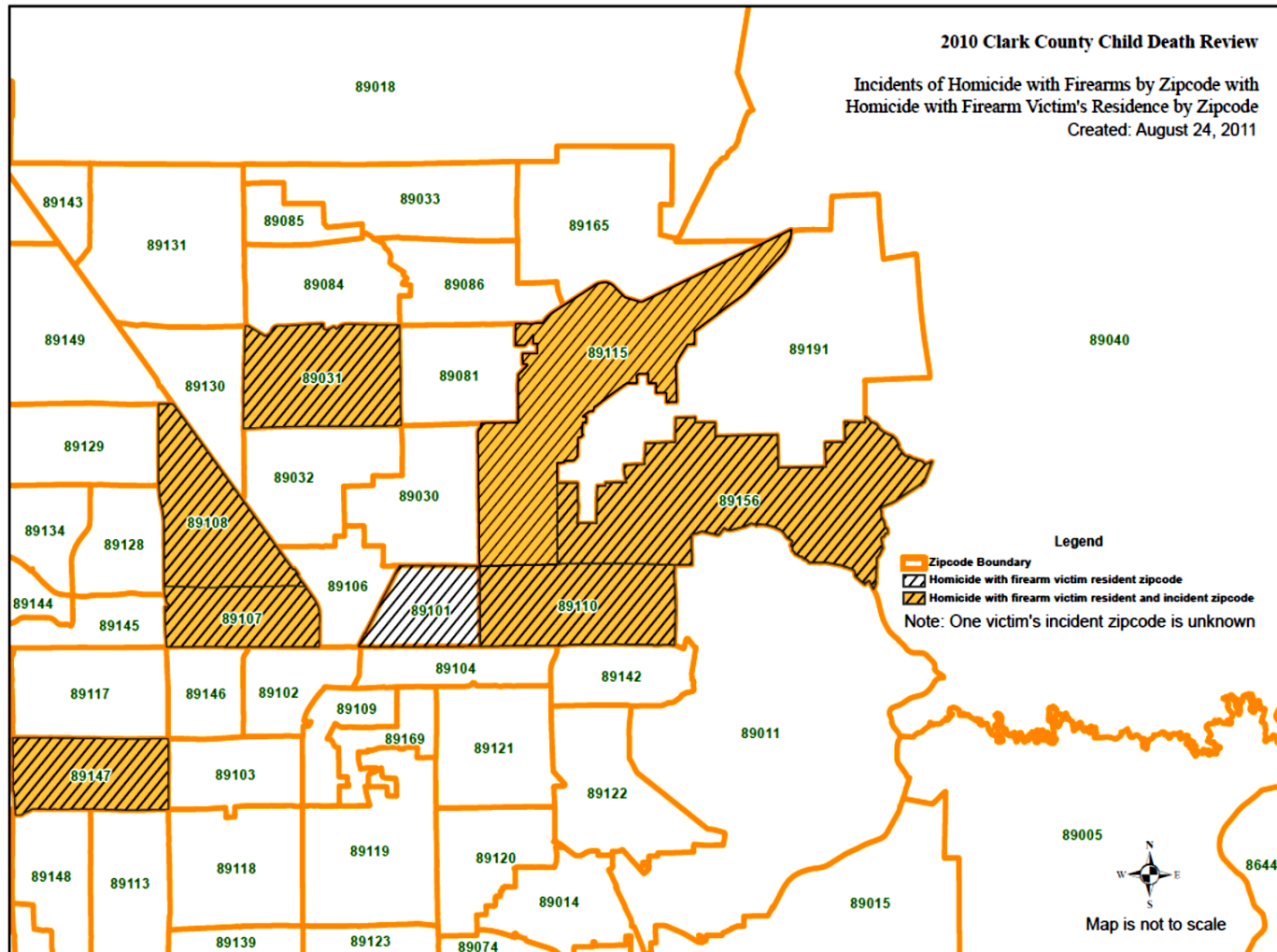
*These questions were not asked in both 2006 and 2007 and therefore data does not exist for both years for the variables; “History of Truancy” or “CPS Involvement Past 12 Months.”

Families of firearm homicide victims had a history with child welfare in 62.5% of the cases in 2010 (Figure 5.7). CPS action was taken as a result of the death in one instance. There were also a variety of circumstances surrounding these fatalities. In one case (12.5%) there was some kind of argument that preceded the homicide, in two cases (25%) youth were playing with the firearms and in three cases gang involvement was either known or suspected.

Figure 5.7: 2007–2010 Child Welfare Involvement for Firearm Homicide Victims (2007 n=8, 2008 n=10, 2009 n=6, 2010 n=8)



The map below illustrates the incident location as well as the location of the child's residence by zip code. Zip codes colored in orange indicate the location of the incident leading to the child's death, and the diagonal stripes indicate the zip code of the child's residence. Some zip codes are both colored orange and have diagonal stripes. This indicates zip codes where the incident occurred in the same zip code where the child lived. You can see that many of the incidents occurred in neighboring zip codes in the north central part of the County.

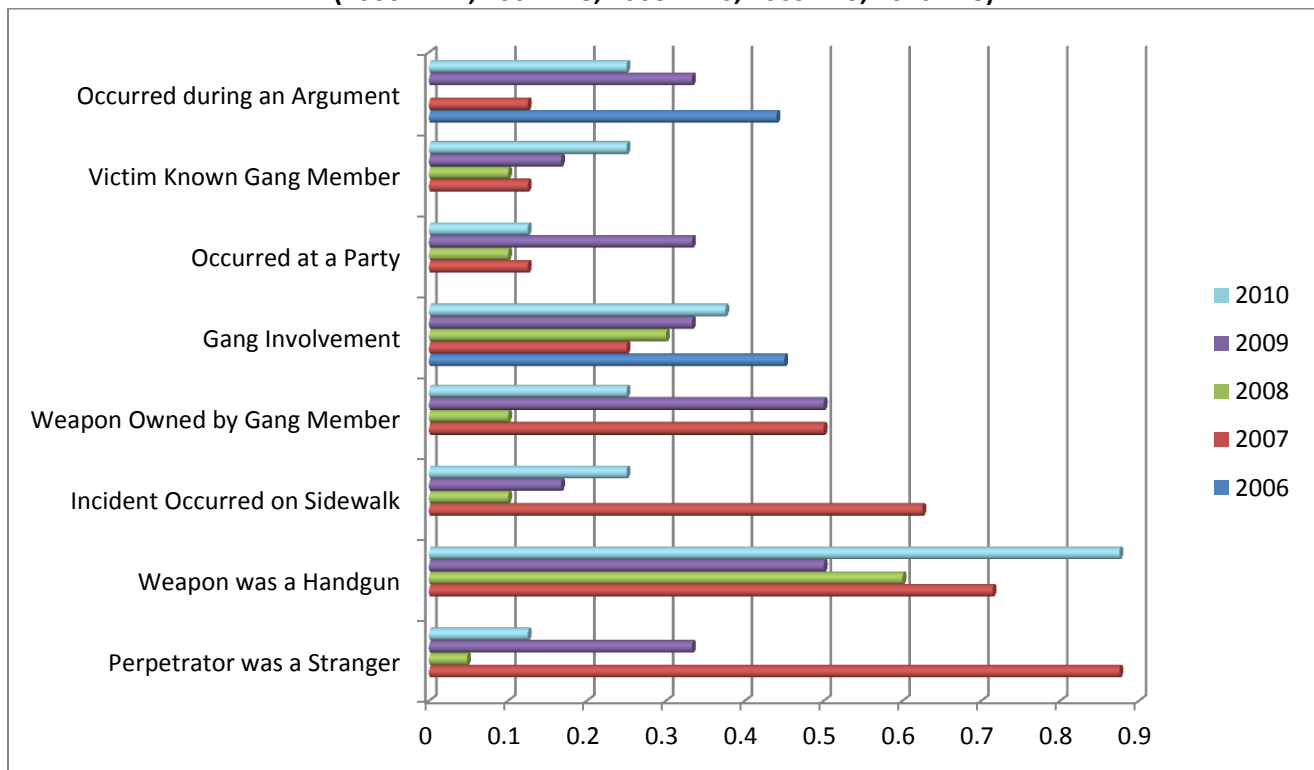


In 62.5% of cases (n=5) the incident occurred either at the child’s residence or the residence of a friend or other family member. The remaining three incidents occurred on a sidewalk or roadway. The majority (87.5%) of incidents involved a handgun, and in one case the type of firearm was unknown at the time of the review. In the majority of cases, the firearms were not owned by family or friends of the decedent. In two cases the firearm was owned by a gang member and in one case the firearm was owned by a stranger. In three cases the firearm was not recovered and therefore the owner was unknown at the time of review.

Among all homicides in 2010, one incident occurred during the commission of a crime, in one incident the child was a bystander, and in another case the incident was a random act of violence.

There was suspected gang involvement in one third of the cases (37.5%) which is the highest proportion since 2006. This may be a product of better data collection methods and not necessarily an increase in gang involved youth homicides. In two cases the victim was known or suspected to be in a gang, and in three cases, the perpetrator was known or suspected to be in a gang. One incident occurred at a party, and 12.5% of incidents occurred during an argument.

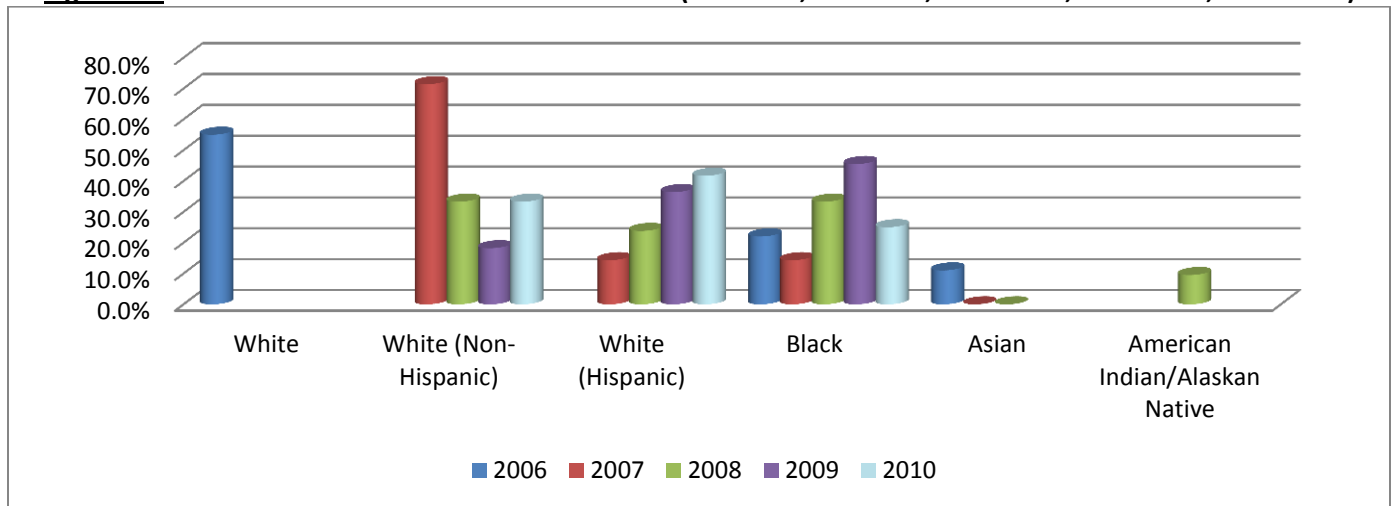
Figure 5.8: 2006–2010 Incident Information for Firearm Homicides
(2006 n=11, 2007 n=8, 2008 n=10, 2009 n=6, 2010 n=8)



NON-FIREARM HOMICIDES

In 2010 there were 12 non-firearm homicides. These cases display an entirely different set of characteristics than the firearm homicides. This year 50% (n=6) of non-firearm homicide victims were between the ages of 1 and 4 years, 33.3% (n=4) were less than one year of age, 8.3% (n=1) between 10 and 14 years of age, and another 8.3% (n=1) were between 15 and 17 years of age. This year minority children were disproportionately represented in non-firearm homicides (Figure 5.9). 41.7% (n=5) of victims were White Hispanic, 33.3% (n=4) were White Non-Hispanic, and the remaining 25% (n=3) were Black. The majority of non-firearm homicide victims were male (66.7%) and none of these children had a chronic illness or disability.

Figure 5.9: 2006–2010 Race of Non-Firearm Victims (2006 n=9, 2007 n=7, 2008 n=11, 2009 n=11, 2010 n=12)



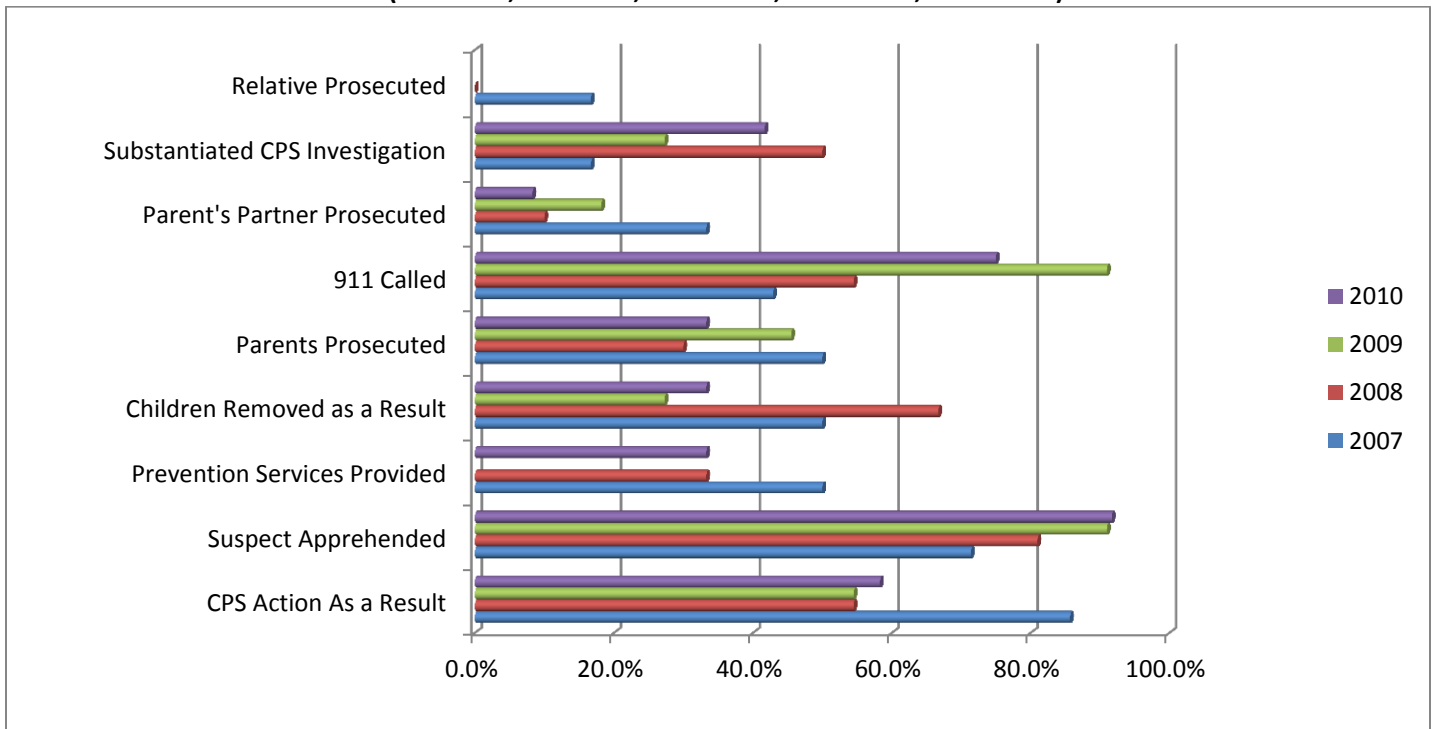
* Race/Ethnicity data were collected differently in 2006. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

There were only two non-firearm homicide victims in 2010 that were school aged and both were attending school regularly at the time of their death. In 50% of cases (n=6) 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 or a step parent. For the remaining three cases, two cases involved a child that was of an age that they did not require direct supervision, and in the other the child was in the hospital at the time of the incident. None of the parents of these children had any prior child deaths, in two cases the decedent’s biological parent had a history of substance abuse, and in two cases the parent’s partner had a history of substance abuse.

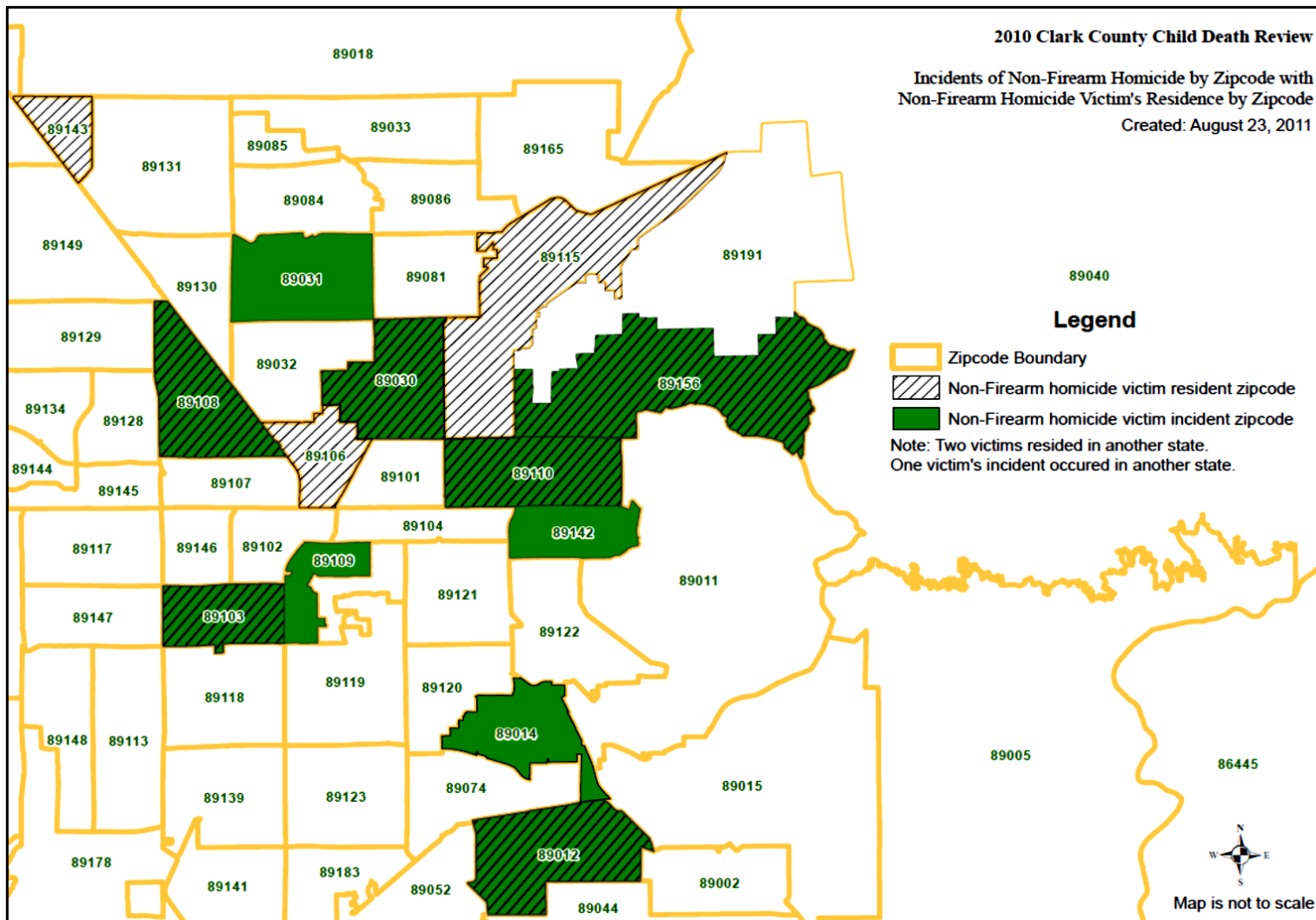
In 2010, 58.3% of non-firearm homicides (n=7) were a result of child abuse. In four of the cases the perpetrator was the decedent’s biological mother’s boyfriend, in two of the cases the perpetrator was the child’s biological father, in one case the perpetrator was the child’s stepmother. Circumstances include the child being beaten or shaken (66.6% n=8), an axe used in a random act of violence (n=1), a youth who attempted to rob a store and was hit with a baseball bat (n=1), an incident in a hospital where the decedent’s umbilical artery catheter has been severed (n=1), and an assault by a stranger (n=1).

In 66.7% of cases prosecution was pending at the time of the review.

Figure 5.10: 2006–2010 Incident Information for Non-Firearm Homicides
 (2006 n=9, 2007 n=7, 2008 n=11, 2009 n=11, 2010 n=12)



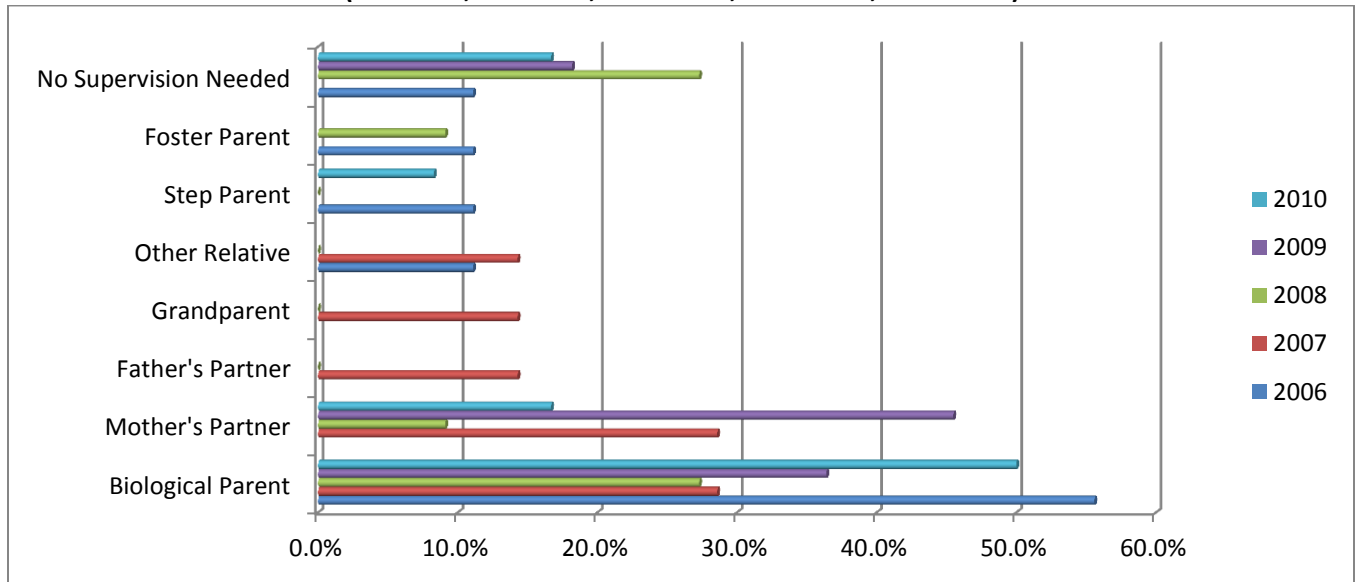
In nine of the twelve cases 911 was called. CPS action was taken as a result of the death in 58.3% (n=7) of cases. Action for these seven cases included removal of remaining children and additional services provided by CPS. In 41.7% (n=5) of cases the allegations were substantiated by CPS. In the other five cases CPS did not take action for a variety of reasons. Primarily CPS did not take action because in many cases the deceased child was the only child in the home, or the child's death was a result of an injury inflicted by someone other than a family member.



The map above illustrates the zip codes for the incident location that led to the child's death as well as the zip code for the child's residence for all 2010 non-firearm homicides. Because the local team reviews deaths of all children that die in Clark County, unless they reside in another Nevada county, there were some cases that are not represented on this map. There were two cases where the child was a resident of another state and the incident occurred in Clark County, and one incident that occurred out of state but the child subsequently died in Clark County.

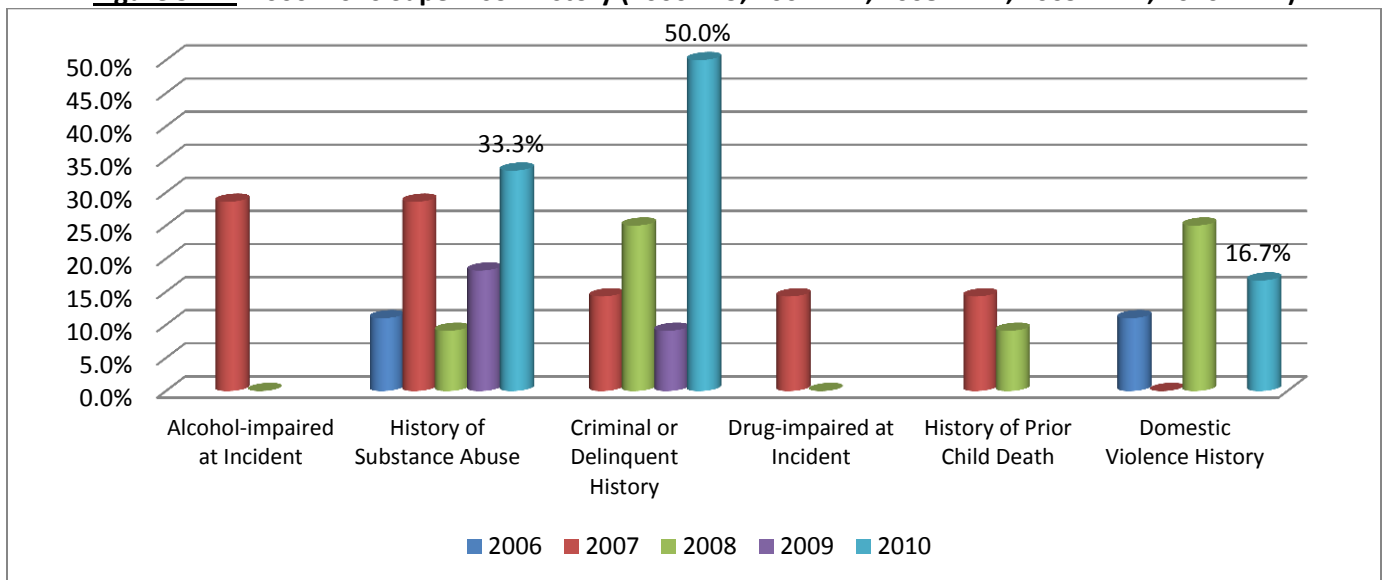
In all cases the decedent had proper supervision at the time of death 83.3% (n=10) required direct supervision due to their age and the remaining two victims were of an age that they did not need direct supervision. In 83.3% (n=10) of cases the supervisor was also responsible for inflicting fatal injuries. In the remaining two cases, the perpetrator was unknown at the time of review. Figures 5.11 and 5.12 provide additional information about the child’s supervision at the time of the incident.

Figure 5.11: 2006–2010 Primary Supervisor at Time of Incident (2006 n=9, 2007 n=7, 2008 n=11, 2009 n=11, 2010 n=12)



In 2010, 33.3% (n=4) of supervisors had a known history of substance abuse, which is almost twice as many as in 2009. None of the supervisors were drug or alcohol-impaired at the time of the incident. In addition, 50% (n=6) of supervisors had a delinquent or criminal history, but none had a history of prior child deaths (See Figure 5.12).

Figure 5.12: 2006–2010 Supervisor History (2006 n=9, 2007 n=7, 2008 n=11, 2009 n=11, 2010 n=12)



Half (n=6) of the cases had a prior family history of involvement in child welfare. Regarding those cases with a previous child welfare history, 50% of those cases (n=3) involved both the decedent and his/her siblings, and three involved just the siblings. Four cases had an open child welfare case with the family at the time of the child's death.

The majority of non-firearm homicides (58.3%, n=7) were caused by child abuse and all of these cases were due to abusive head trauma. In all seven cases, during the review the team determined that child abuse caused the child's death and in one additional non firearm homicide case the team determined that child abuse contributed to the child's death. In 33.3% (n=4) of cases the team determined that neglect contributed to the child's death. There were two cases that involved assault and not child abuse.

When abusive injuries are inflicted upon a child by someone other than a family member this is considered to be assault, and not child abuse. In the remaining two cases assault was determined to be the causal factor in the child's death. Both cases involved adolescents and the fatal injuries were inflicted by a store owner in self-defense and the perpetrator is unknown in the other case.

HOMICIDE DEATHS: RECOMMENDATIONS FOR PREVENTION

Homicide, by definition, is the intentional killing of another human being. Twenty children and youth were the victims of homicide in Clark County in 2010. The data indicates two distinct categories for child homicides: firearm related and non-firearm related, and each category has a distinct pattern of circumstances.

FIREARM HOMICIDES:

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

In 2010 all firearm homicides occurred among youth ages 10-17, primarily among 15-17 year olds (87.5%), and 65% of victims were male. The data in 2010 indicate that all victims were minorities, split between White Hispanic (62.5%), Black (25%) and Multiracial (12.5%) youth. Again the percentage of both White Hispanic and Black victims are disproportionate to the population distribution in Southern Nevada and identifies a specific target population for intervention efforts. The data also shows that 62.5% of the victims had a prior juvenile justice history, and that approximately 37.5% of the incidents were suspected to be gang related. Prevention efforts aimed at reducing firearm related youth homicides should focus on addressing the needs of these youth through community based outreach programs and gang prevention activities. All efforts should take into consideration the language and cultural needs of the populations most at risk.

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

www.childdeathreview.org, 2007

NON-FIREARM HOMICIDES:

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

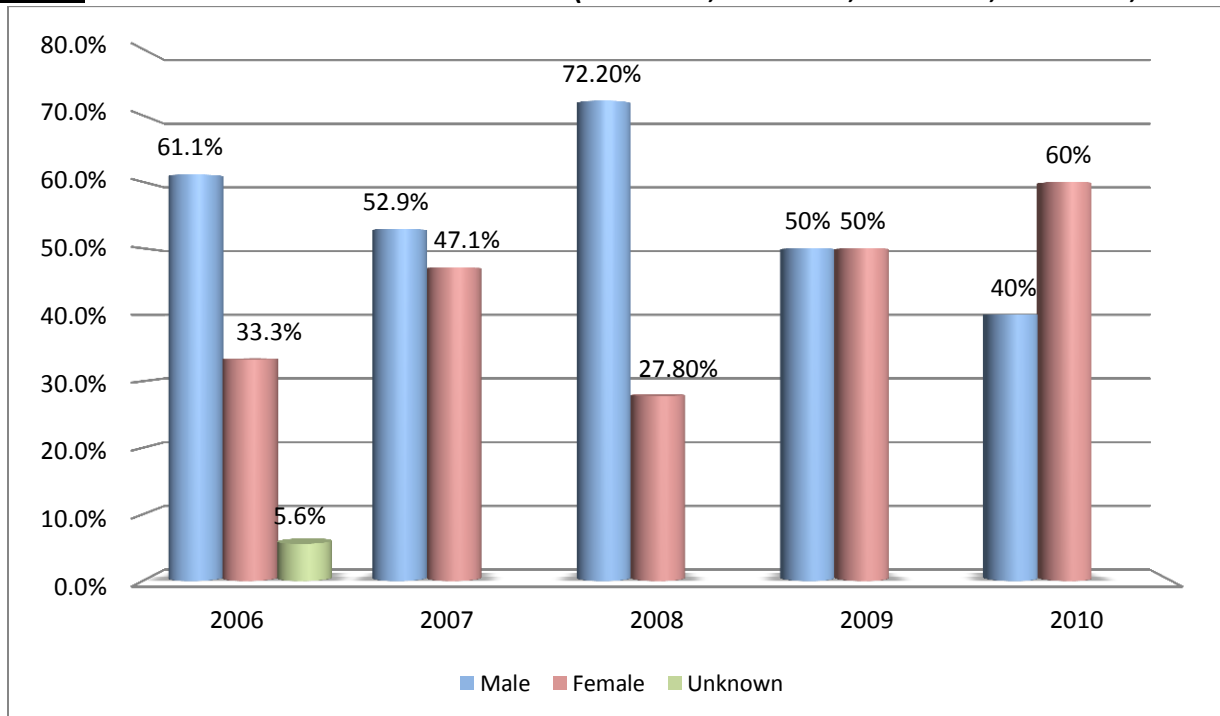
In 2010 non-firearm homicides represented over half (60%) of all youth homicides. The majority of non-firearm homicide victims were less than four years of age (n=10), the remaining victims were between 10 to 17 years (n=2). In 2010, 58.3% of non-firearm homicides were a result of child abuse (n=7). In 4 cases the perpetrator was the mother's boyfriend, in three cases it was a parent (in one case the biological father, in the other the child's stepmother). Prevention efforts should focus on developing networks of services in the community to reach out to these at-risk families. Providing services and resources to parents of young children that educate parents and new partners who are willing to participate on basic parenting skills and ways to cope with stress and anger may also reduce the potential for child abuse related homicides.

SECTION VI: UNDETERMINED DEATHS

In 2010 Clark County reviewed 10 cases where the death was ruled “undetermined.” This ruling is used by the Office of the Coroner/Medical Examiner when information regarding the circumstances of the death make it difficult for the medical examiner to make a distinct determination about the manner of the death. The coroner/medical examiner may rule a death “undetermined” when sufficient evidence or information cannot be obtained to assign another manner of death.

In eight of those cases the cause was also listed as “undetermined.” For the remaining cases the cause listed on the death certificate was “acute maternal hydrocodone intoxication” and “suffocation”. The following tables represent the descriptive statistics regarding undetermined deaths reviewed by the Clark County Team from 2006 to 2010. Figure 6.1 provides information about the sex of these decedents.

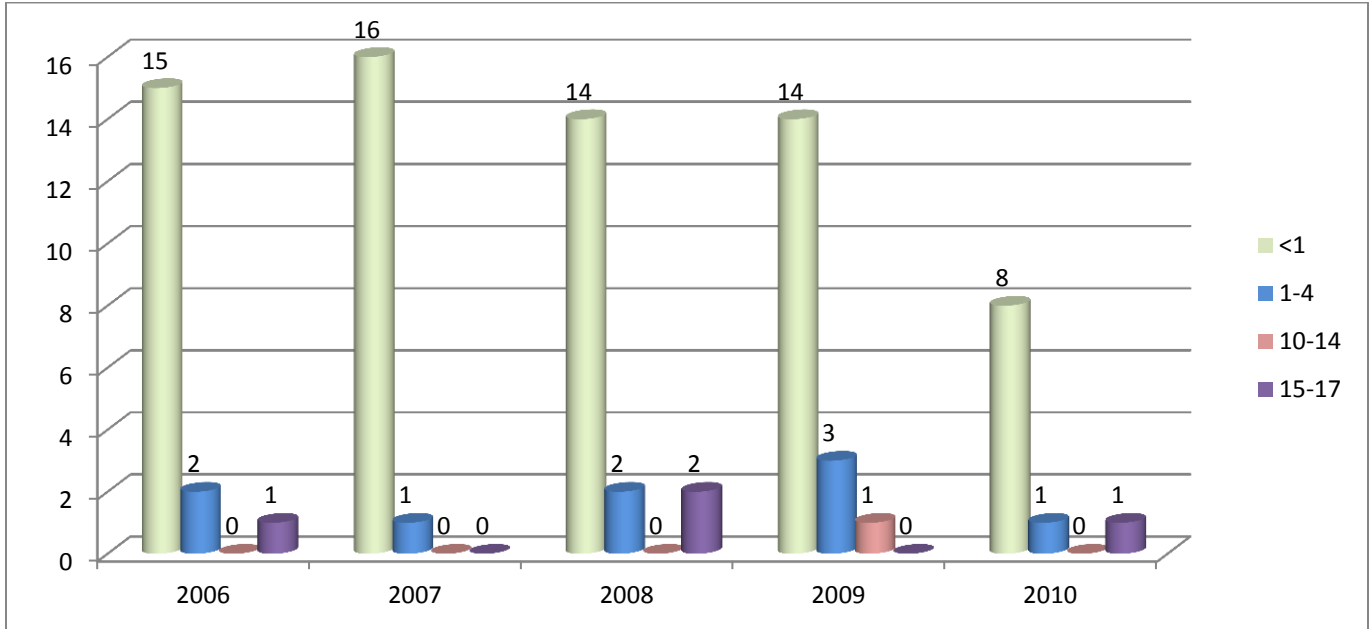
Figure 6.1: 2006-2010 Undetermined Deaths: Sex (2006 n=18, 2007 n=17, 2008 n=18, 2009 n=18, 2010 n=10)



NOTE: In 2006 there was one case where the condition of the body at autopsy made it impossible to determine Sex

Again in 2010 the majority of undetermined child deaths were those less than one year of age (80% or 8 cases, See Figure 6.2). However there are far fewer undetermined cases than in 2009, and in 2010 we saw the fewest number of undetermined deaths in the past five years at only 10 cases.

Figure 6.2: 2006-2010 Undetermined Deaths: Age (2006 n=18, 2007 n=17, 2008 n=18, 2009 n=18, 2010 n=10)

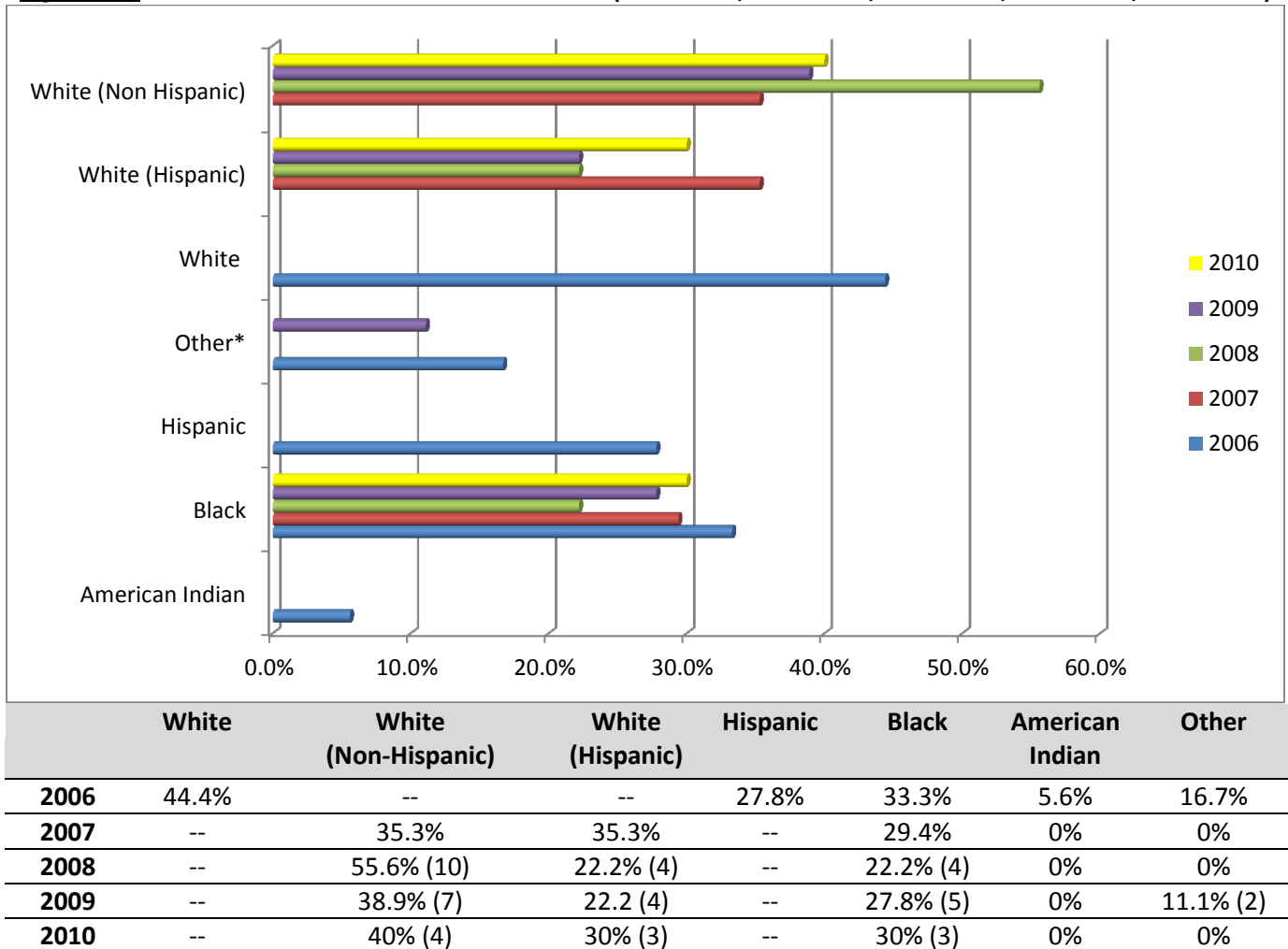


	Less than 1 year	1 to 4 years	10-14 years	15 to 17 years
2006	83.3% (15)	11.1% (2)	0%	5.6% (1)
2007	94.1% (16)	5.9% (1)	0%	0%
2008	77.8% (14)	11.1% (2)	0%	11.1% (2)
2009	77.8% (14)	16.7% (3)	5.6% (1)	0%
2010	80.0% (8)	10.0% (1)	0%	10.0% (1)

In 2010 there were slightly more undetermined deaths of White Non-Hispanic children than in 2009, but fewer than in 2008. In 2010 we see another increase in the percentage of Black children with undetermined deaths at 30% overall (Figure 6.3).

For undetermined deaths nearly half of families had prior history with child protective services, 40% (4 cases) had a history of child welfare involvement, and the history only involved siblings in all cases. Additionally, there were no cases where the child was in foster care at the time of death.

Figure 6.3: 2006-2010 Undetermined Deaths: Race (2006 n=18, 2007 n=17, 2008 n=18, 2009 n=18, 2010 n=10)



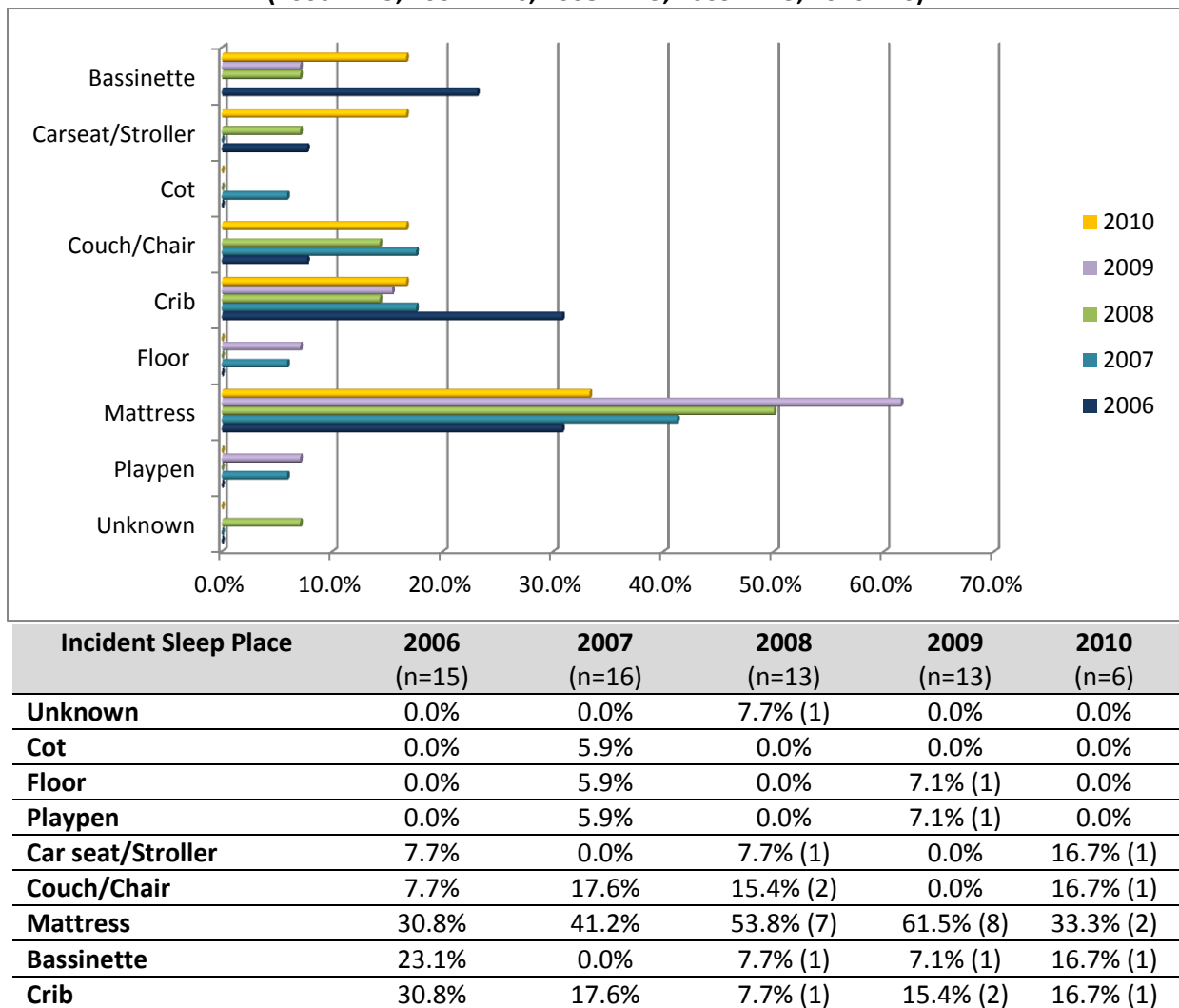
* Race/Ethnicity data were collected differently in 2006 and 2007. Dashed lines (--) indicate where this separate data was not collected in that year.

UNDETERMINED DEATH – LESS THAN ONE YEAR OF AGE

Nearly all of undetermined deaths in 2010 were again those children under one year of age (80% or 8 cases). In six of the eight cases the child’s death occurred while the child was in a sleeping environment. In 66.7% of these cases (4 of the 6 children found in sleeping environments) the child was sleeping on a mattress, couch, or car seat at the time of their death. In three of these cases the child was sleeping with another person, most frequently a parent, or a sibling, or both.

Figure 6.4 illustrates the various sleep locations for these children. Most notable we see a decrease in 2010 in children less than one year of age sleeping on adult mattresses. From 2006 to 2009 we saw an increasing trend, but in 2010 there were 33.3% of cases where the child was sleeping on an adult mattress which is back to low 2006 levels.

Figure 6.4: 2006-2010 Children <1 year old: Sleep Location
(2006 n=15, 2007 n=16, 2008 n=13, 2009 n=13, 2010 n=6)



Among the deaths of children less than one year of age that were in sleeping environments, 33.3% (2 cases) of these children were placed to sleep on either their side or stomach, while in another 33.3% (2 cases), the child was placed to sleep on his/her back (placement was unknown in two cases). When found, most children were on their stomach or side (50%, n=3), positioning was unknown in the other three cases.

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.

In 2010 most undetermined deaths of children under one year of age occurred while the child was in a sleeping environment (75%). There were two cases where the death did not occur in a sleeping environment. Both of these infants died shortly after birth. In one case the mother did not know she was pregnant, delivered at home and the fetus was deceased upon arrival at the hospital. In the other case, the decedent's mother overdosed on prescription medication inducing labor and the child's ultimate demise.

UNDETERMINED DEATHS – OVER ONE YEAR OF AGE

Of the 10 undetermined deaths in 2010 only two were children over one year of age. This included one case of a child between one and four years of age and another 15- 17 years. In both of these cases the cause of death was also undetermined. In each of these cases the circumstances surrounding the child's death were not clear, and therefore were 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 2010 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 Reviews. These are examples of how the local annual report, as well as multidisciplinary participation in the review meetings can have an impact in the community through improved policy and practice as well as prevention activities.

TEAM STRUCTURE

In 2010 the team continues to use the protocols created in 2008 to support team function. A new co-chair was elected in 2010 and accepted new at large members using application protocols. In 2010 the team added members from the North Las Vegas Fire Department, Henderson Fire Department, and Sunrise Hospital. All of these new members add a fresh perspective on case reviews and help to facilitate prevention recommendations.

TEAM EDUCATION AND INVITED PRESENTATIONS

In 2010 the team continued to support efforts related to safe sleep by serving as the local point of contact for distribution of safe sleep brochures printed by the Nevada Executive Committee for the Review of Child Deaths.

Dr. Sandra Cetl, one of the pediatricians on the team, was invited to present on issues related to prescription drug overdose among teens in our community at the November 2010 CAN Prevent Annual Conference in Reno, Nevada.

INFORMATION DISSEMINATION

In 2010 the Clark County Team drafted a letter intended for physicians and nurses to provide information about the number of asthma related deaths in our community. The letter provided information about best practices for asthma management as well as the importance of educating parents about this chronic condition. The letter was adopted by the statewide group and was distributed to state licensing boards and professional organizations for dissemination among their members. In addition this information was placed in the state medical board's newsletter.

DROWNING PREVENTION

Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. Recently the Southern Nevada Drowning Prevention Coalition has been re-energized to coordinate efforts related to water safety and drowning prevention. There are three members of the Clark County CDRT that serve on this coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County.

SAFE SLEEP – SUFFOCATION PREVENTION

In December of 2010 the Las Vegas Review Journal printed an article on the importance of safe sleep practices. The article featured comments from several members of the team and also statistics compiled for this report regarding the number of fatalities related to unsafe sleep environments. Additionally, NICRP and the Southern Nevada Health District applied for federal funding to start a safe sleep hospital education program in Clark County and are currently awaiting the final funding decision.

OVERALL CHILD SAFETY

The Nevada Institute for Children's Research and Policy developed a "Child Safety Booklet" for parents in Clark County. The booklet is organized by age group and used data and statistics from this report to provide information for parents about how to keep their children safe from injury. 1,000 of these booklets were printed and inserted into 500 diaper bags assembled by the Southern Nevada Maternal Child Health Coalition. The booklets were also distributed to several child care facilities in Clark County.

2010 RECOMMENDATIONS TO THE STATE ADMINISTRATIVE TEAM

Summary of Recommendations Reported to the State Administrative Team for 2010 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 2010. "Action" listed under each recommendation represents the response from the Administrative Team.

2010-01: *Promote and provide additional information/education for families regarding utility company policies regarding life sustaining machines in their homes.*

Action: Collaboration from Nevada Statewide CASA Association, Safe Nest, Safe Kids Clark County, the Southern Nevada Health District and the Division of Child and Family Services (DCFS) for the creation of new child safety page and content on DCFS website that currently exists.

2010-02: *Create a campaign or expand on an existing campaign to promote firearm safety using national statistics about the increased risk of injury when a firearm is in the home.*

Action: Recommendation was referred to the state Executive Committee and it was determined that the 2010 *Bullets Leaves Holes* campaign was currently running which promotes firearm safety.

2010-03: *Create a technical bulletin or other type of announcement for professionals and parents regarding the dangers of using improper or unstable stands for large televisions.*

Action: Recommendation was referred to the state Executive Committee which will be reviewed for the future creation of a technical bulletin that will provide summary prevention information.

2010-04: *Identify existing materials or create print material that can be provided to parents when a prescription is written or filled to encourage medical professionals to discuss the risks of sharing prescriptions among siblings.*

Action: Recommendation was referred to the state Executive Committee for review and possible action for their Public Awareness Subcommittee.

2010-05: *Existing drowning campaigns should explicitly focus on the importance of selecting a designated adult to watch children in and around the water especially when there are large gatherings around water.*

Action: Adult supervision information provided in PINK packet flyer (packet provided to new mothers in all Nevada birthing hospitals) and ongoing efforts through the Southern Nevada Health District's "A,B,C, and D's of Drowning Prevention" campaign.

2010-06: *Provide additional education and awareness for safe placement of political signage as to not obstruct the view of drivers and pedestrians and to promptly remove them at the end of the election season.*

Action: Recommendation for the identification of additional stakeholders for a letter. This recommendation is still under review by the Administrative Team.

2010-07: *Provide public awareness message to let people know that you only need to suspect abuse to call CPS and you will not be held responsible if the allegations are unfounded. Additionally people should know that they can report to CPS hotlines without identifying themselves.*

Action: Discussion for potential activities included developing a press release and/or PSA for local news stations and newspapers related to abuse and neglect, while also enlisting reporters who typically cover abuse/neglect stories. This recommendation is still under review by the Administrative team.

2010-08: **Emphasize the increased risk of suicide for very high achieving youth, in training and other public awareness campaigns.**

Action: This recommendation is still under review by the Administrative team.

2010-09: **Provide additional education or information about the importance of death certificate sign outs for statistical tracking.**

Action: This recommendation is still under review by the Administrative team.

2010-10: **Nevada should implement regulations regarding minimum age for passengers of motorcycles to prevent young children from these injuries.**

Action: This recommendation is still under review by the Administrative team.

APPENDIX A: 2010 CDRT MEMBERSHIP LIST

2010 Core Members

Dr. Andrew Eisen	2010 Team Chair	Vicki Monroe	Clark County District Attorney's Office
Gwen Osburn	2010 Team Vice Chair	Alane Olson	Clark County Office of the Coroner/Medical Examiner
Sally Jost	Clark County School District	Mark Reeping	Mesquite Police Department
Dave McKenna	Henderson Police Department	Joseph Smith	Nevada Highway Patrol/Department of Public Safety
Ricky Crosby	Clark County Department of Juvenile Justice Services	Robert Sullivan	North Las Vegas Police Department
Tom Morton	Clark County Department of Family Services	Lisa Teele	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail

2010 At Large Members

Alma Angeles	University Medical Center of Southern Nevada	Paula Haynes-Green	Clark County Department of Family Services
Troy Armstrong	Clark County Department of Family Services	Kathryn Hooper	Henderson Fire Department
Sue Battaglia	Las Vegas Metropolitan Police Department – Abuse/Neglect Detail	Michelle Isham	Boulder City Police Department
Marion Biron	Clark County Department of Family Services	Tracy Kingera	Clark County Department of Juvenile Justice Services
Julie Bolton	Clark County School District	Doug Koch	University Medical Center of Southern Nevada
Mary Brown	Clark County District Attorney's Office	Natasha Koch	Nevada Highway Patrol
Toni Castillo	Clark County Office of the Coroner/Medical Examiner	Jill Marano	Nevada Division of Child and Family Services
Catherine Coleman	University Medical Center of Southern Nevada	Marisa Marano	Nevada Institute for Children's Research and Policy
Ron Cordes	Clark County District Attorney's Office	Dr. Neha Mehta	Sunrise Hospital
Jeanne Cosgrove	Clark County SAFE Kids	Liza Morris	University Medical Center of Southern Nevada
Ricky Crosby	Clark County Department of Juvenile Justice Services	Tara Phebus	Nevada Institute for Children's Research and Policy
Linda Flatt	Nevada Office of Suicide Prevention	Lisa Popovsky	Southern Nevada Area Health Education Center - Prevent Child Abuse Nevada
Deborah Flowers	Nevada Department of Child and Family Services	Peggy Rowe	Clark County Department of Family Services
Dr. Tony Fredrick	Southern Nevada Health District	Gregory Schultz	Las Vegas Metropolitan Police Department
John Fudenberg	Clark County Office of the Coroner/Medical Examiner	Bruce Swanson	Henderson Police Department
Paula Hammack	Clark County Department of Family Services	Denise Tanata Ashby	Nevada Institute for Children's Research and Policy
Marion Hancock	Sunrise Hospital	Rosemary Virtuoso	Clark County School District
Janne Hanrahan	Clark County District Attorney's Office	Timothy Wolfe	North Las Vegas Fire Department

APPENDIX B: NEVADA REVISED STATUTES RELATING TO CHILD DEATH REVIEW

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

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

(Added to NRS by 2003, 863)

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Medical personnel;

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

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

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

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

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

(Added to NRS by 2003, 863)

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

1. A multidisciplinary team to review the death of a child is entitled to access to:

- (a) All investigative information of law enforcement agencies regarding the death;
- (b) Any autopsy and coroner's investigative records relating to the death;
- (c) Any medical or mental health records of the child; and
- (d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.

2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.

3. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.

4. Information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

(Added to NRS by 2003, 863)

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

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted to an administrative team for review.

2. An administrative team must consist of administrators of agencies which provide child welfare services, and agencies responsible for vital statistics, public health, mental health and public safety.

3. The administrative team shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

(Added to NRS by 2003, 864)

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

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of representatives from multidisciplinary teams formed pursuant to NRS 432B.405 and 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.

2. The Executive Committee shall:

- (a) Adopt statewide protocols for the review of the death of a child;
- (b) Designate the members of an administrative team for the purposes of NRS 432B.408;
- (c) Oversee training and development of multidisciplinary teams to review the death of children; and
- (d) Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes.

3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.409, inclusive.

(Added to NRS by 2003, 864)

Summary of Findings from the 2010 Child Death Review Annual Report

The 2010 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 2010. This represents the third year that the Child Death Review Team in Clark County reviewed 100% of the child deaths referred to the team by the Clark County Office of the Coroner/Medical Examiner; this includes all natural deaths, as well as all accidents, homicides, suicides, and undetermined cases. The team also reviewed all fetal deaths over 20 weeks gestation.

Overall 2010 Child Death Statistics

Manners of Death in 2010

- 251 cases reviewed in 2010 (11.3 % decrease from 283 cases in 2009, a 19.3% decrease since 2008)
- 168 Natural (decrease of 9.2 % from 185 in 2009)
- 46 Accidents (decrease of 19.3 % from 57 cases in 2009, still lower than 66 cases in 2007)
- 7 Suicide (an increase from 4 in 2009 and 2008, but down from 12 in 2007)
- 20 Homicide (an increase of 17.6 % from 17 in 2009)
- 10 Undetermined (44.4% decrease from 2009 (n=18), 2006 (n=18) and 2008(n=18))

Causes of Death in 2010

- Decrease in motor vehicle incidents from 16 in 2009 to 8 in 2010
- SIDS decreased from 2 cases in 2009 to 1 cases in 2010
- Increase in deaths caused by weapons from 14 in 2009 to 22 in 2010
- Increase in suffocation/strangulation deaths from 13 in 2009 to 18 in 2010.
- Drowning down by one case (11 in 2009, 10 in 2010)
- Poisoning/Overdose cases decreased from 12 in 2008 and 16 in 2009, to only 5 in 2010

2010 Child Deaths by Manner of Death – Additional Details and Recommendations for Prevention

Natural – There were 168 natural deaths reviewed in 2010. 39.3% of these deaths were due to complications of prematurity, followed by congenital defect (32.1%) and chronic illness (15.5%). 70.2% of natural deaths were children less than one year of age. We continued to see a decrease in the number of SIDS deaths in 2010 from 3 in 2008 down to 2 in 2009, then 1 in 2010.

Recommendations:

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

Accident- Accidental deaths accounted for 18.3% (46 cases) of child deaths in 2010. The leading causes of accidental death included suffocation at 28.3%, followed by drowning at 21.7% and motor vehicle accidents (MVA) at 17.4 %. For the first time in five years the leading cause of accidental deaths were suffocations. In 2010 nearly all accidental suffocations (n=13) were children less than one year of age and nearly all of those cases (n= 12) occurred in a sleeping environment. Similar to 2009, in 2010, nearly all (70 %) of the drowning victims in Clark County were between the ages of one and four years and 80 % of all victims drowned in a pool or spa. Motor vehicle accidents decreased 47% from 15 in 2009 to 8 in 2010. This significant decline reflects national trends showing a reduction in motor vehicle related fatalities for all ages.

Recommendations:

- Focus on changing regulations to bring older pools up to current standards for barriers to accessing the pool including, fences, gates, alarms, etc.
- Improve/expand culturally sensitive outreach and education efforts regarding safe sleep environments for infants.
- Continue to support efforts related to the elimination of recreational drug use and expand efforts to prevent drug use among youth and especially women of child bearing age.

Homicide- In 2010 12% (20 cases) of child deaths were categorized as homicides. This is a increase from 17 deaths in 2009 but a decrease from 21 deaths in 2008. In 2010 children ages 1-4 years and youth 15-17 years were the most frequent age groups at 30% and 40% respectively. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2010 there were more non-firearm homicides (n=12) than firearm homicides (n=8). For firearm homicides (n=8) the data show that 62.5 % of the victims had a prior juvenile justice history, and in 3 of these incidents gang affiliation was known or suspected. For non-firearm homicides (n=12), 58.3% were a result of child abuse (n=7) and in almost half of those cases (n=4) the perpetrator was the mother’s boyfriend. Half (n=6) of the decedents’ families had a history of involvement with the child welfare system.

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



Recommendations:

- Firearm Homicides: Focus on addressing the needs of minority youth through community based outreach and gang prevention activities, especially African American and Hispanic populations. These groups continue to be over represented among youth homicides in 2010.
- Non Firearm Homicides: Prevention efforts should focus on developing a network of services within our community to reach out to families at risk. Additionally, providing parenting/stress management training to adult caregivers in the home other than biological parents could also help reduce the risk of abuse.

Suicide –Suicide was the cause of 4.2 % (7 cases) of child deaths in Clark County which represents an increase from 2008 and 2009 when there were 4 suicide deaths. 86 % (6 cases) of the decedents attended school regularly, one decedent talked about suicide prior to their death, and in two cases the decedent had made a previous attempt.

Recommendations:

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

Undetermined – 4% (10 cases) of child deaths were ruled undetermined, which is a decrease from 2008 (n=18). This ruling is used by the Office of the Coroner/Medical Examiner when information regarding the circumstances of the death makes it difficult for the medical examiner to make a distinct determination about the manner of the death. 8 of these 10 cases (80%) were infants less than 1 year of age. 2010 showed a slight increase in undetermined deaths for African American children rising to 30 % of all undetermined deaths from 27.8 % in 2009. Among children less than 1 year of age (n=8), 6 died in a sleeping environment and in 3 of the 6 cases the child was sleeping with another person (parent, sibling or both).

Summary of Child Welfare History for all 2010 Child Deaths

The team records whether a child or their family has ever had any involvement with the Department of Family Services (DFS).

- 57 of the 251 cases reviewed had some family history of involvement with DFS – a decrease from 2009 (n=63).
- In 7 cases the child/family had an open case with DFS at the time of the child’s death.
- In 1 case the child was in foster/shelter care at the time of their death (the same as in 2009).
- In 2010 there were 12 substantiated death allegations of abuse or neglect.
- Of the 12 substantiated allegations (4.8 % of all child deaths in Clark County), 3 were ruled accidents, while 8 were ruled homicides. In half (n=6) of these cases the child, sibling, or parent as a child victim had prior history with CPS.

2010 CDR Team Prevention Activities

- In 2010 one of the team’s pediatricians, Dr. Sandra Cetl was invited to present at the November 2010 CAN Prevent Annual Conference in Reno, Nevada to discuss issues related to substance abuse among teens, specifically the recreational use of prescription and over the counter medications.
- This year the team drafted a letter informing physicians and nurse about best practices for asthma management as well as education for parents of children with asthma. This information was distributed statewide to licensing boards and professional organization. It was also featured in the state’s medical board newsletter.
- Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. Recently the Southern Nevada Drowning Prevention Coalition has been re-energized to coordinate efforts related to water safety and drowning prevention. There are three members of the Clark County CDRT that serve on this coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County.
- In December of 2010 the Las Vegas Review Journal published an article on the importance of safe sleep practices. The article featured comments from several members of the team and also statistics compiled for this report regarding the number of fatalities related to unsafe sleep environments. Additionally, NICRP and the Southern Nevada Health District applied for federal funding to start a safe sleep hospital education program in Clark County and are currently awaiting the final funding decision.
- The NICRP developed a “Child Safety Booklet” for parents in Clark County. This booklet is organized by age group and provides prevention information and statistics for parents to keep their children safe from accidental injuries. The booklet was distributed by the Southern Nevada Maternal Child Health Coalition and also to several child care facilities in Clark County.

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

