

# Clark County Child Death Review

## Clark County, Nevada

2007 Annual Report  
June 30, 2008

Report Prepared by:  
Nevada Institute for Children's Research and Policy  
Tara Phebus, M.A. – Research Analyst  
Jennifer Zipoy, M.A. – Director of Research  
Denise Tanata Ashby, J.D. – Executive Director  
Karen Z. Silcott – Research Assistant

Nevada Institute For Childrens Research & Policy

# NICRP



SCHOOL OF PUBLIC HEALTH

School of Public Health

Commissioned by the Clark County Manager's Office



## TABLE OF CONTENTS

<b>Background on Clark County Child Death Review .....</b>	<b>3</b>
<b>Methodology .....</b>	<b>7</b>
<b>Limitations.....</b>	<b>9</b>
<b>Confidentiality.....</b>	<b>10</b>
<b>Findings.....</b>	<b>11</b>
<b>Summary Statistics .....</b>	<b>11</b>
<b>Non-Reviewed Cases.....</b>	<b>18</b>
<b>Natural Deaths .....</b>	<b>22</b>
<b>Acute Illness.....</b>	<b>25</b>
<b>Prematurity .....</b>	<b>27</b>
<b>SIDS.....</b>	<b>29</b>
<b>Recommendations for Prevention .....</b>	<b>32</b>
<b>Accidental Deaths.....</b>	<b>33</b>
<b>Motor Vehicle Accidents .....</b>	<b>35</b>
<b>Drowning .....</b>	<b>39</b>
<b>Suffocation or Strangulation.....</b>	<b>45</b>
<b>Recommendations for Prevention .....</b>	<b>48</b>
<b>Suicide .....</b>	<b>50</b>
<b>Situational Factors of Suicide .....</b>	<b>53</b>
<b>Method of Suicide .....</b>	<b>55</b>
<b>Circumstances of Suicide .....</b>	<b>56</b>
<b>Recommendations for Prevention .....</b>	<b>59</b>
<b>Homicide .....</b>	<b>60</b>
<b>Firearm Homicide.....</b>	<b>63</b>
<b>Non-Firearm Homicide .....</b>	<b>68</b>
<b>Recommendations for Prevention .....</b>	<b>73</b>
<b>Undetermined.....</b>	<b>74</b>
<b>Under One Year of Age .....</b>	<b>77</b>
<b>Over One Year of Age .....</b>	<b>78</b>
<b>Local Prevention Efforts .....</b>	<b>79</b>
<b>Summary of Accomplishments and Recommendations from 2007.....</b>	<b>80</b>
<b>Appendix A: Clark County Team Membership .....</b>	<b>84</b>
<b>Appendix B: NRS 432B.403-409 .....</b>	<b>85</b>

## BACKGROUND ON CLARK COUNTY CHILD DEATH REVIEW

In an effort to identify risk factors and prevent future child deaths, in 1992 the State of Nevada joined many other states in mandating Child Death Review Teams. Since that time, both the law and the regional teams throughout Nevada have evolved to facilitate the growing need for collaborative efforts to identify interventions necessary to reduce the rate of child deaths in Nevada. While the primary legislative focus of Nevada Child Death Review Teams has been on addressing fatalities related to child maltreatment and/or involvement with the child welfare system, the teams have expanded that focus to address risk factors and preventability in a wide variety of cases. As the largest county in the State, containing approximately 72% of the state's population under 18 years of age (UNLV Center for Business and Economic Research, 2007), the Clark County Child Death Review team has been, and will continue to be, a crucial part of identifying risk factors as well as recommending and implementing policies and procedures to minimize preventable child deaths in the State.

### Goals & Purpose for Teams

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

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

National Center for Child Death Review

### The Purpose

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

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

### The Operating Principles of Child Death Review

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

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

### The Objectives

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

Each regional child death review team should:

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

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

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

review teams in NRS 432B.406, which provides that local team membership should include, but may not be limited to:

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

The Clark County Child Death Review Team includes members representing all of the mandatory categories, as well as additional members from other public and private organizations including the Department of Juvenile Justice, Safe Kids Coalition, the Office of Suicide Prevention and many others. A complete list of Clark County Child Death Review Team members for 2007 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. Due to extremely high caseloads, the Clark County team is unable to review all deaths within their jurisdiction. Therefore, the Clark County team reviews all cases that are mandated by law and a selection of non-mandatory cases determined by the team chairs. The Clark County Child Death Review Team meets once a month at the Coroner's Office for a period of three hours to conduct reviews. The team reviews an average of 12.3 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.

Cases are categorized according to status: cases brought back for more information, new cases and pending cases (cases that have not been officially signed out or assigned a particular manner of death by the medical examiner at the coroner's office). Cases which are still pending at the time of the review are placed on the following months' agenda along with any cases that the team was not able to review in the allotted time period. For each case, a summary of the demographics of the child and family, as well as the circumstances of the child's death are first shared with the team by one of the team chairs or by another member of the team that has more familiarity with the particular case. Once the summary is complete, other members of the team that may have additional information on the case are then asked to share that information with the entire group. Team members are able to ask questions regarding the case and provide insight regarding particular circumstances. After the case assessment, team members have the opportunity to make and discuss improvements to laws, policies and practices which will support the safety of children and prevent future child deaths. Each quarter, the Clark County Child Death Review Team submits a report to the Nevada Division of Child and Family Services, on behalf of the Administrative Team, which identifies statistical information regarding the cases that were reviewed and recommendations made based on those reviews.

## Changes for 2008

In the summer of 2007 the Clark County Office for Organizational Effectiveness conducted an assessment of the Clark County Child Death Review Team and its processes. As a result of this study several recommendations for improvement were made and many were adopted by the local team. These changes included the creation of a set of local team protocols to improve team function. These structural changes included the creation of a “core team” which includes representatives from all agencies mandated to participate pursuant to NRS 432B.406, as well as a pediatrician and mental health professional. Core member agencies include:

- Boulder City Police Department
- Clark County Coroner’s Office
- Clark County Department of Family Services
- Clark County District Attorney’s Office
- Clark County Department of Juvenile Justice Services
- Clark County School District
- Henderson Police Department
- Las Vegas Metropolitan Police Department
- Mesquite Police Department
- Nevada Highway Patrol
- North Las Vegas Police Department
- Southern Nevada Health District

The case review process was also changed and in 2008 all child deaths in Clark County will be reviewed regardless of cause and manner. In order to re-focus the case discussion on prevention issues, cases will be categorized based on the cause and manner and reviewed as a group. Member agencies will be asked to provide case information to the team coordinators prior to the meetings and individual case summaries will be prepared. Team members will then have the opportunity to review these facts prior to the regular meeting. This will allow the time spent during the review to be focused on questions and discussion of prevention initiatives. In addition, the team will review the summary statistics monthly to identify trends more readily. These changes have been implemented for all 2008 cases that have been reviewed to date.

## METHODOLOGY

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

Data presented in this report is drawn from information gathered at each of the monthly child death review meetings. In 2007 the Clark County team reviewed 57% of the child deaths in the county, this included selected natural deaths, as well as all accidents, homicides, suicides and undetermined cases. The remaining child and fetal deaths in the county are natural deaths that are not legally mandated and for which the cause of death is unremarkable to the reviewing physician. These cases include intrauterine deaths of fetuses that were not yet viable. While these cases were not reviewed by the team, basic demographic information including cause and manner of death, age, race, and zip code of residence were collected where available on these cases. This information will be presented separately in a section entitled, "Cases not Reviewed." This will allow the county to track even those natural deaths that were deemed unremarkable, to potentially uncover any trends over time.

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 Coroner's office 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 and if there is history 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 and 2007 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.

This report is organized in terms of manner of death. The different causes of death under these manners are reported as well as some general demographic information on the cases are presented in each section. Determinations of the official cause and manner of death are made by the coroner or 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."

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



## LIMITATIONS

As with any research there are limitations of this dataset. As the second year of data collection there have been changes made to the data collection tool as well as some of the methods for collection to improve the data presented in this report. However certain limitations could not be avoided. Again this year not all information could be gathered regarding every case reviewed. This limits the level of detail provided for each case in this report. Additionally there are many sections where the total number of cases discussed is so small that statistical generalizations cannot be made. Finally, to ensure consistency in data reporting the Clark County Child Death Review database was compared with records from the Clark County Coroner's Office. The cases matched with a few exceptions. There were two cases of fetal deaths that the team reviewed, but the coroner's office did not count as a child death. According to the coroner's office, fetuses that die in-utero and never take a breath are issued a fetal death certificate which does not assign a manner of death, while a fetus who is delivered and takes a breath is considered a child and will be issued a death certificate.

In regard to accidental deaths that did not match with the Clark County Coroner's Office database, these included one case where the child died in Clark County, but resided in another County in Nevada so the case was referred to that county's regional team and not reviewed by the Clark County Team. This case is reflected in the Coroner's Office data, but not the Child Death Review Team data. Additionally, another discrepancy included a child whose county of residence was Clark County Nevada, but the child died in another state and the case was forwarded to the Clark County team for review. This case is included in our analysis, but would not come up in the Coroner's statistics because another state's medical examiner took the case.

In 2007, data collection processes have become more firm and routine. This year the child death review team was able to gain access to more pieces of information including hospital records, school records, and police investigation reports. This information was used to complete the review and later the data collection tool. Agencies have become more familiar with the team and its purpose and, upon request, are sharing the information for these purposes. However the team was still unable to obtain all information for all cases. Therefore, this information was listed as unknown. The team anticipates that this information will be more readily available in the future as relationships for data sharing are developed between the team and the relevant agencies.

## CONFIDENTIALITY

All cases reviewed by the Child Death Review Team are kept completely confidential. Information shared in the meetings is protected under NRS 432B.407 and cannot be shared with anyone outside the meeting. All records kept by NICRP are also kept confidential and are securely stored in a locked cabinet in a locked office. Because this information is confidential, every effort was made in this report to discuss cases in general terms and not make reference to any specific details of one case. Therefore, in instances where only one case fit specific criteria details are not provided in this report.

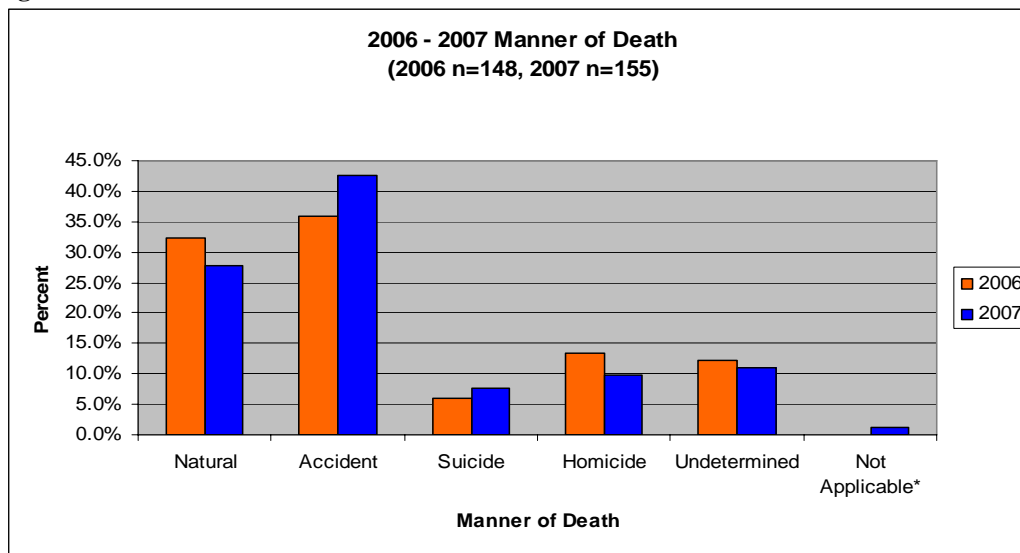
This report is intended to provide summary statistics about all child fatalities, offer a comparison between 2006 and 2007 fatalities where appropriate, as well as provide descriptive statistics regarding specific circumstances surrounding causes and manners of death to assist in generating data driven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

## FINDINGS

### Section I: Summary Statistics

In 2007 the Clark County Child Death Review Team reviewed 155 cases, slightly more than the 148 cases reviewed in 2006. These 155 cases represent 57.4% of all child deaths in Clark County (Comparison to Clark County Coroner’s Office Data, June 2008). Deaths are categorized based on the official manner of death and can be placed in one of five categories: natural, accidental, suicide, homicide, or undetermined. These classifications are determined by the coroner’s office during an investigation or by a physician signing the death certificate in the hospital, if it is not a coroner’s case. “Coroner’s case” refers to the cases that the coroner’s office investigates in order to assign manners. If hospital physicians sign the death certificate, it is because they do not feel the death needs to be investigated. In 2007, the majority of child deaths were ruled either accidental (42.6%) or natural (27.7%) by the attending physician or coroner’s office. The smallest category was suicides at 7.7% of all deaths reviewed which is just slightly more than in 2006.

**Figure 1.1**

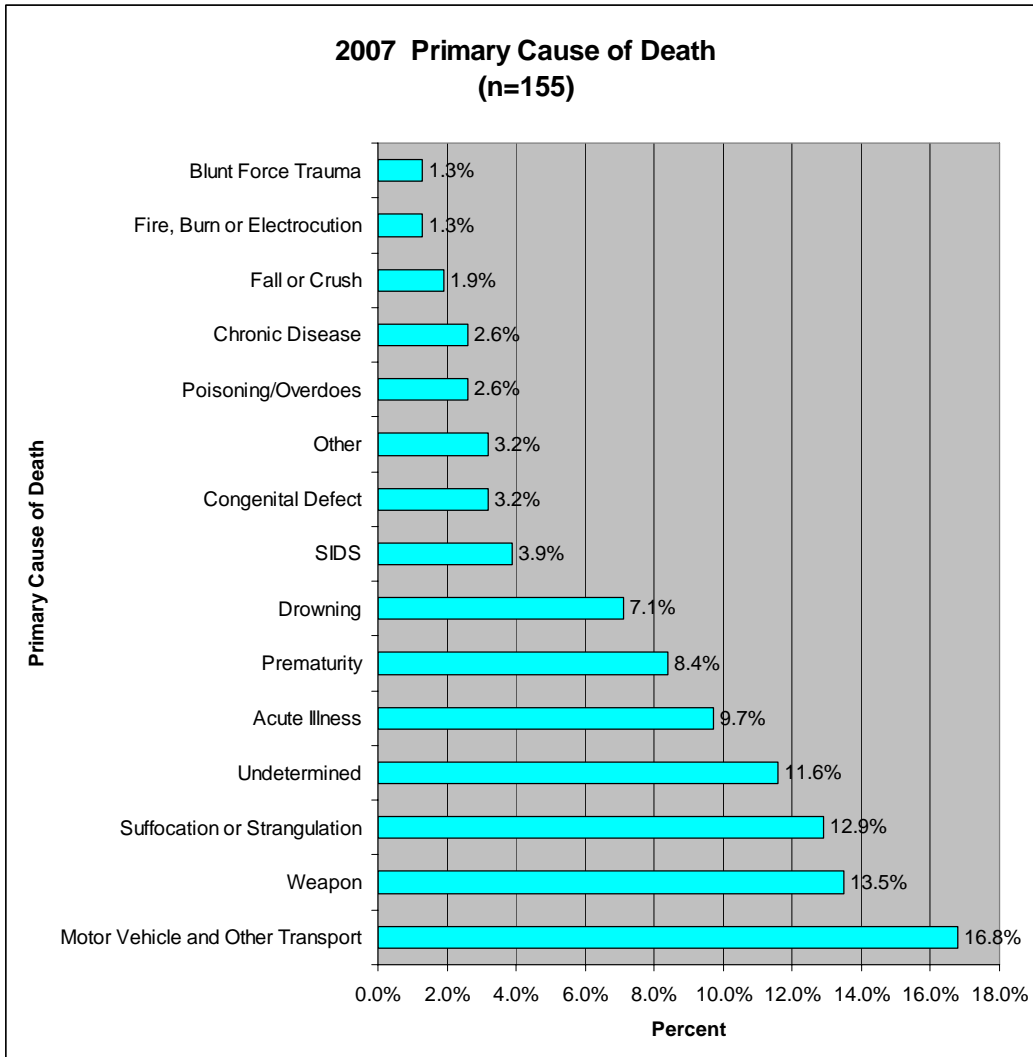


Manner	2006 (n=148)		2007 (n=155)	
	Count	Percent	Count	Percent
Natural	48	32.4%	43	27.7%
Accident	53	35.8%	66	42.6%
Suicide	9	6.1%	12	7.7%
Homicide	20	13.5%	15	9.7%
Undetermined	18	12.2%	17	11.0%
Not Applicable*	--	--	2	1.3%

*\*Manner is not applicable in fetal deaths. These cases were fetal deaths that were reviewed due to the circumstances, but were not issued a manner of death due to the age of the child. See section on Undetermined deaths, beginning on page 75, for further explanation.*

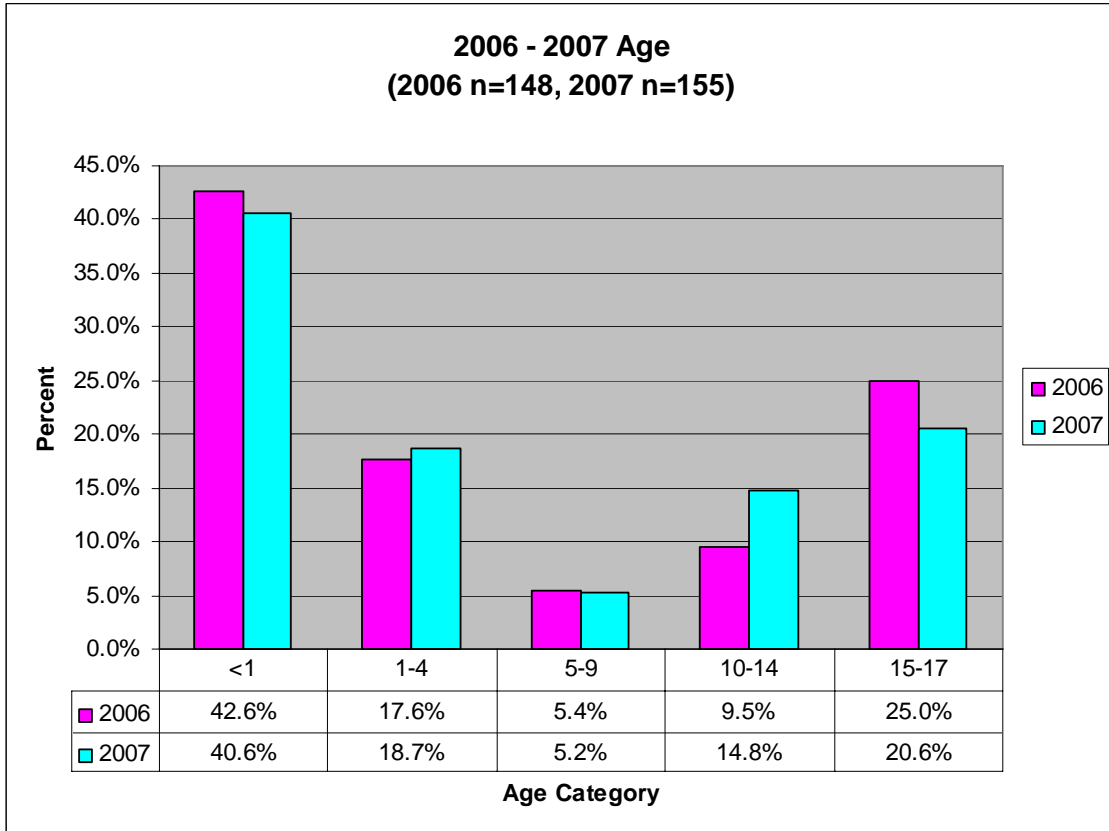
Figure 1.2 below represents the primary cause of death for all child deaths reviewed in 2007. The leading primary cause of death in 2007 were those deaths related to motor vehicles and other transport (16.8%), followed by weapons (13.5%) and suffocation/strangulation (12.9%).

**Figure 1.2**



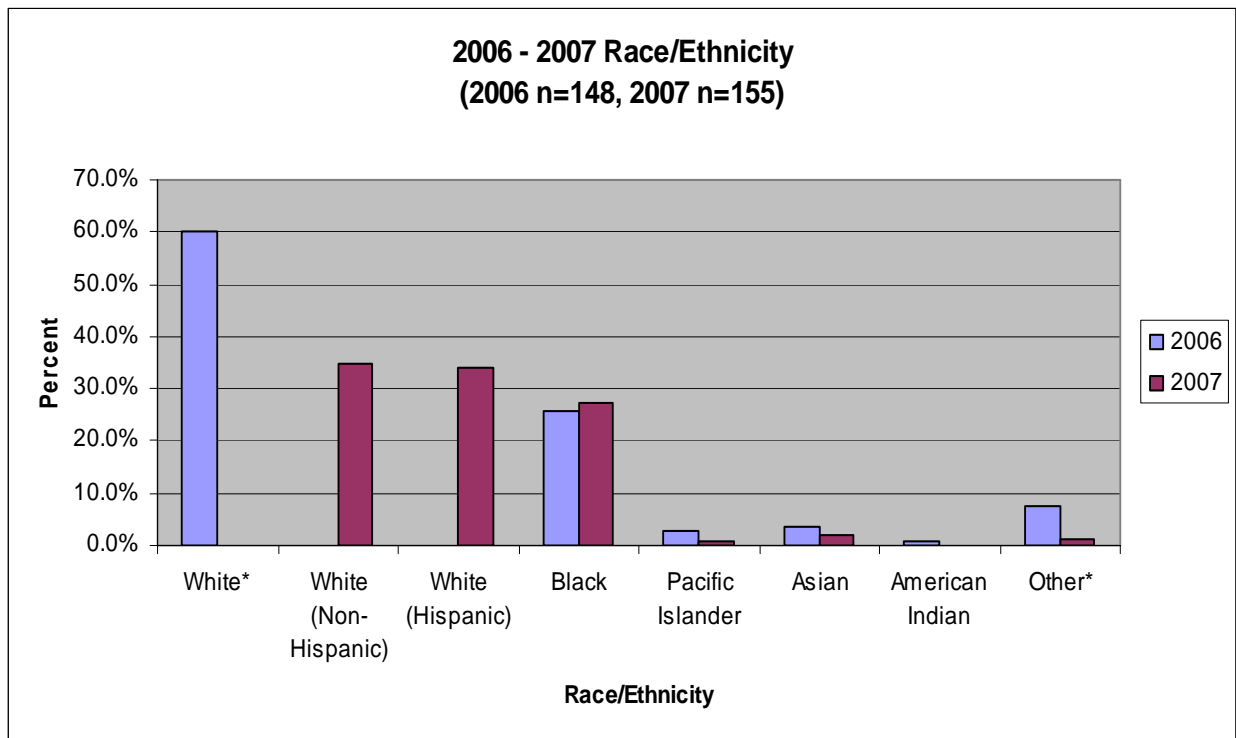
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2007, just under half of the cases reviewed were children under one year of age, while just over 20% of cases were children ages 15 to 17 years. These are consistent with 2006 data, however in 2007 there were slightly more deaths of children ages 1 to 4 years and almost twice as many deaths of children 10 to 14 years.

**Figure 1.3**



In 2007 the child's race and ethnicity were recorded separately on the data tool in an effort to be consistent with methods used on the death certificate. First the child's race was recorded (White, Black, Asian, Native American/Pacific Islander, Other), and then a separate question asks whether or not the child was of Hispanic or Latino ethnicity. However, for 2007 data were recorded to reflect the distinction between White Hispanic children and White Non-Hispanic children. This resulted in much fewer cases that were coded as "other" in the race/ethnicity field. Many of these cases in 2007 were multi-racial children. Frequencies for race and ethnicity are very similar for 2007 as they were for 2006. However in 2007 we can see the breakdown of which cases were White Hispanic and which were White Non-Hispanic. Also, the table shows that there were slightly more African American child fatalities in 2007 (27.1%) than in 2006 (25.7%). These statistics are presented in Figure 1.4 below.

**Figure 1.4**

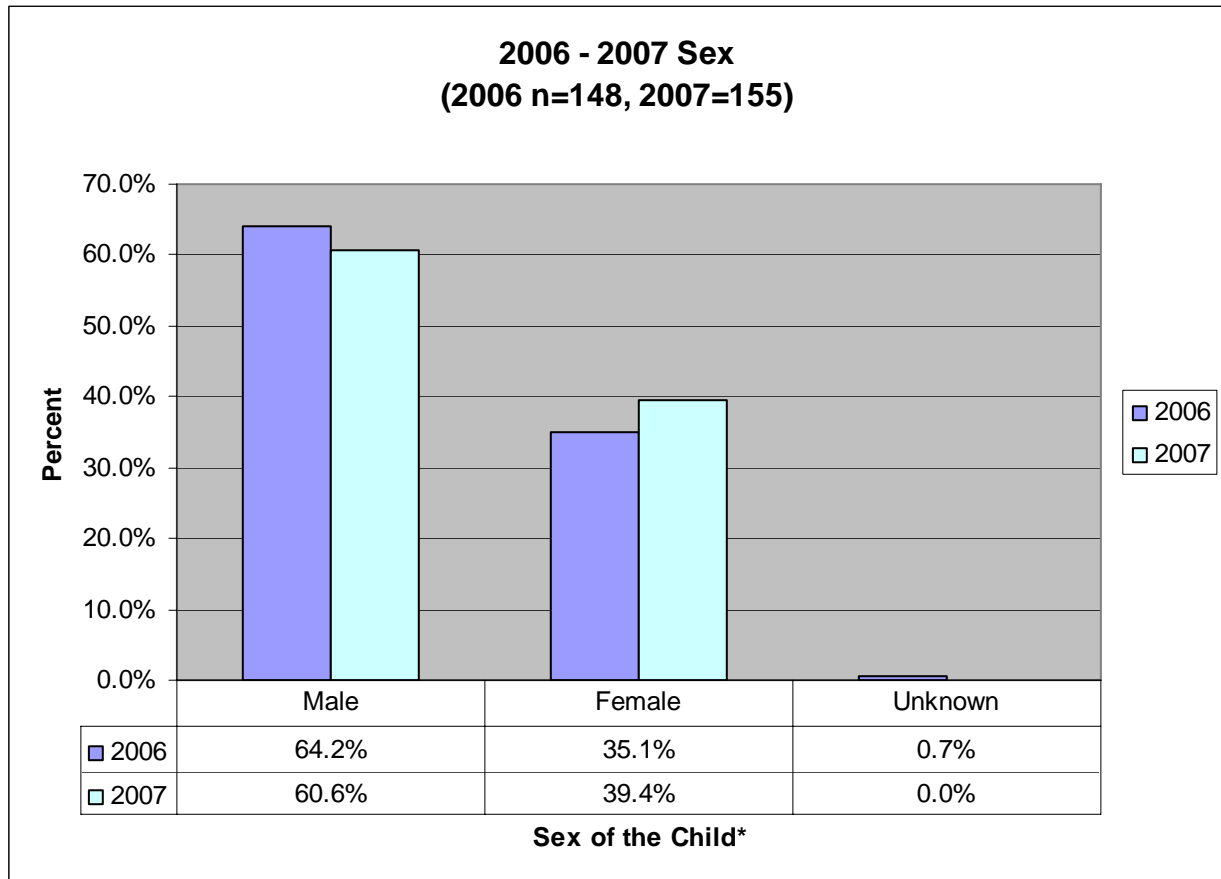


	White	White (Non Hispanic)	White (Hispanic)	Black	Pacific Islander	Asian	American Indian	Other
<b>2006</b>	60.1%	--	--	25.7%	2.7%	3.4%	0.7%	7.4%
<b>2007</b>	--	34.8%	34.2%	27.1%	0.6%	1.9%	0%	1.3%

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

Distribution of males and females is very similar for 2006 and 2007, there were more males than females in both years. However, there has been a slight increase in the percentage of females reviewed in 2007. Additionally, in 2006 there was one case that at the time of death sex was unable to be determined, that case is listed as unknown in Figure 1.5 below.

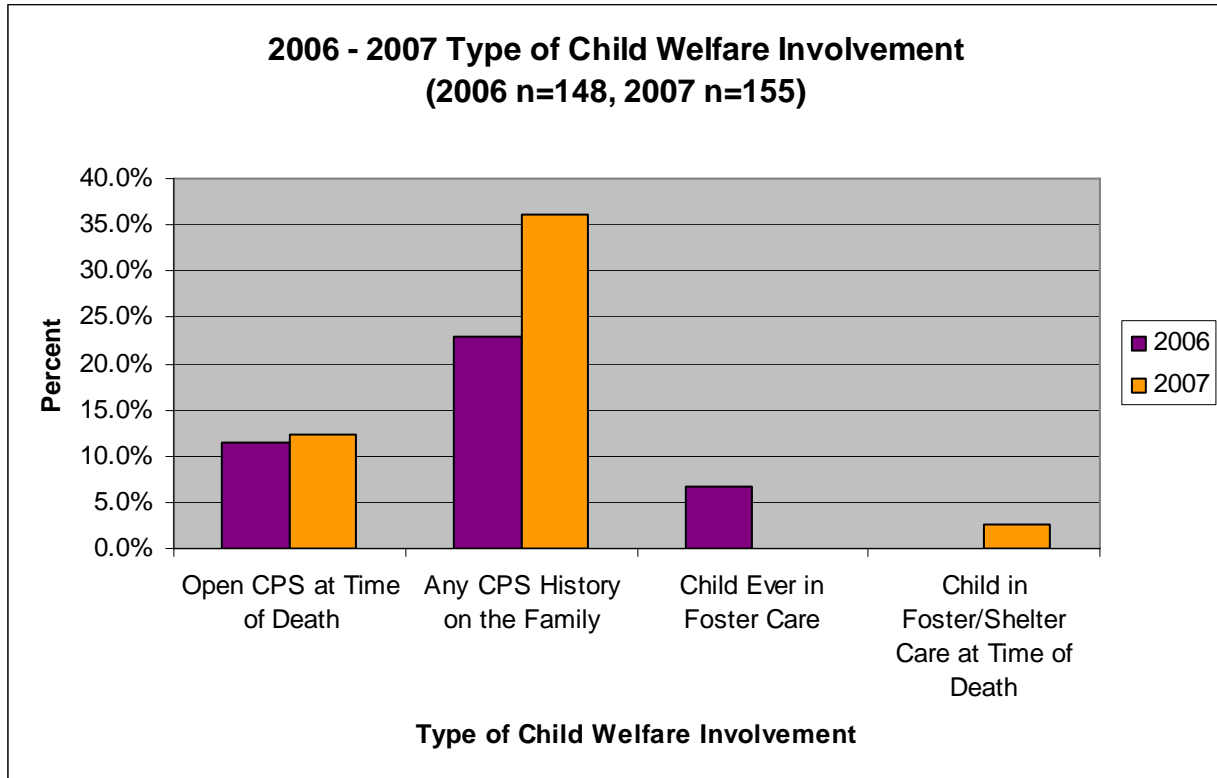
**Figure 1.5**



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

Information was also collected regarding the child or family’s history with child welfare. The table below illustrates the comparison of child welfare involvement from 2006 to 2007. Note that in 2007 there was one case with unknown child welfare history. This information could not be collected because verification data regarding the birth date of the mother could not be obtained. As Figure 1.6 shows, in 2007 there were over 10 % more cases that had any family history of involvement with child welfare. This may be due, in part, to improved data collection in this area in 2007 as the collection form was changed from 2006 to 2007.

**Figure 1.6**

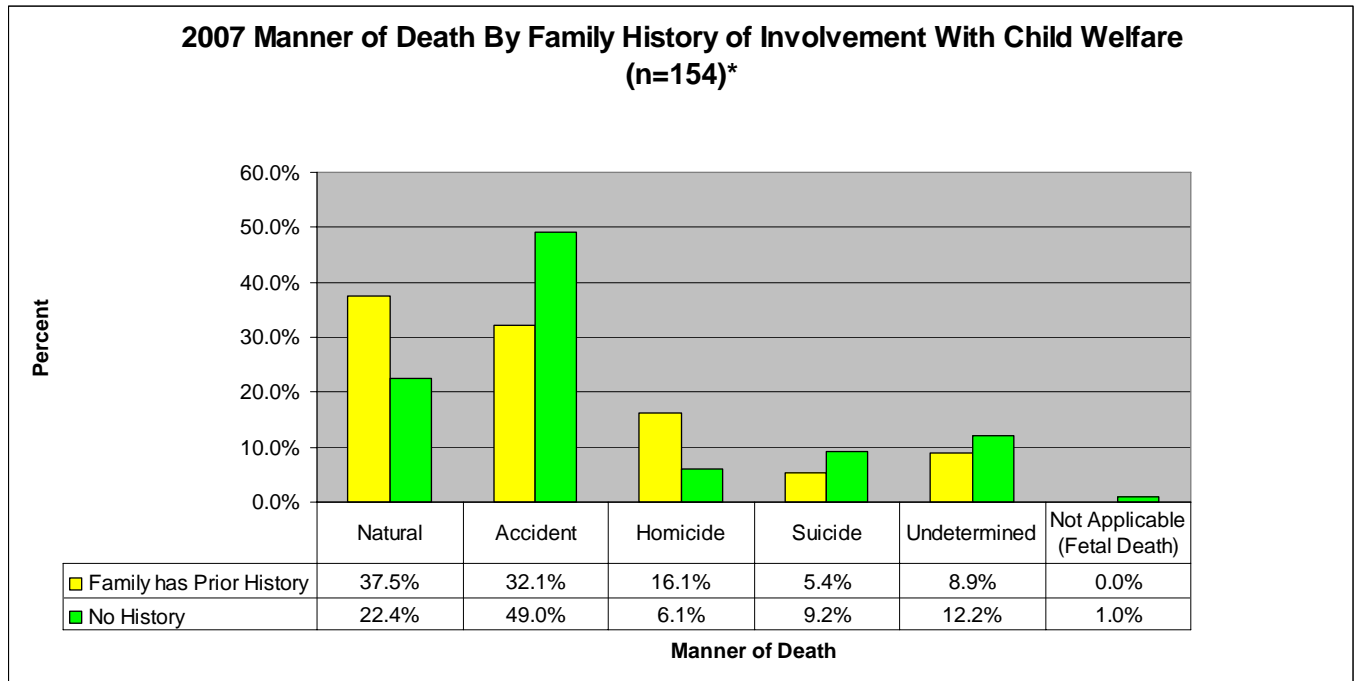


	Open CPS at Time of Death	Any CPS History on Family	Child Ever in Foster Care	Child in Foster/Shelter Care at Time of Death
<b>2006</b>	11.5%	23.0%	6.8%	--
<b>2007</b>	12.3%	36.1%	--	2.6%

\* Dashes in the table above are used to indicate where data was not collected. In 2007 data was collected on whether or not the child was in foster or shelter care at the time of death, not ever in their life as it was collected in 2006. Therefore information is not available in both years for that information.



Figure 1.7



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

The graph above illustrates the manner of death for cases compared to their history of involvement in child welfare. For cases where the family did have a history of involvement in child welfare, the most frequently occurring manner of death was Natural (37.5%), followed by Accident at 32.1%. For those cases where the family had no prior history of involvement with child welfare, Accident was the most frequent manner of death at nearly half (49.0%) of these cases, followed by Natural at 22.4%.

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

## **Section II: Non-Reviewed Cases**

The following cases were not reviewed by the Child Death Review Team. According to team protocols in 2007, cases were received from the coroner's office and screened by the team co-chairs, one of which was a forensic pediatrician. Cases not selected for review included those cases which the pediatrician deemed unremarkable, met none of the statutory requirements for review or the child was a resident of another county in the State of Nevada. Cases that fell out of the team's jurisdiction for review were forwarded to the appropriate Nevada regional team for review. Cases where the child resided out of state were still reviewed by the Clark County team and were also forwarded to a child death review contact in the child's state of residence.

Although these cases were screened out by a physician, or forwarded to another team for review, basic information was recorded regarding cause and manner, age, zip code, sex, and race. The non-reviewed cases include both child and fetal deaths. Often, the only information available was the cause and manner of death as provided on a list from the coroner's office. When a death certificate was not available, certain pieces of demographic information, including race, ethnicity and gender, could not be determined. 16.3% of the 215 deaths not selected for review by the team did not have death certificates available. Nearly all of the cases in this category (213 of 215) were Natural deaths. The two non-natural cases were both motor vehicle accidents involving children who resided outside of Clark County and, pursuant to state child death review protocols, were transferred to the Nevada child death review team within the jurisdiction of the child's county of residence.

**Figure 2.1**

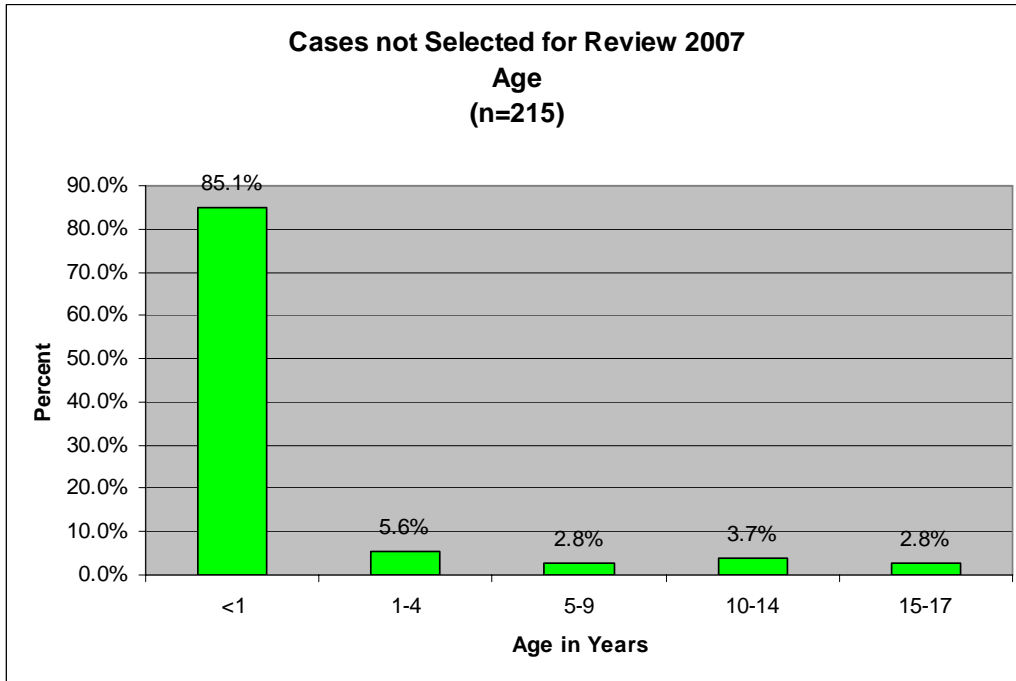


Figure 2.1 shows the age of the children in the cases not selected for review. The vast majority 85.1% (n=183) of these cases were children under one year of age. Of those, 149 cases or 81% were children less than one day old. Figure 2.2 illustrates that there were slightly more male (55.3%) than female (43.3%) cases that were not selected for review.

**Figure 2.2**

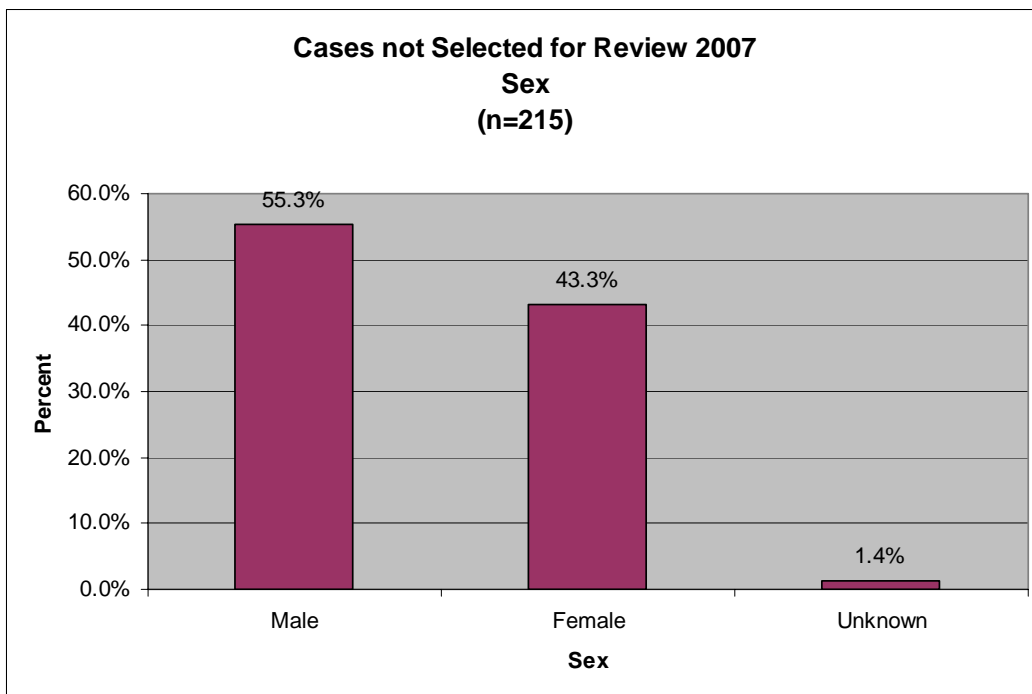
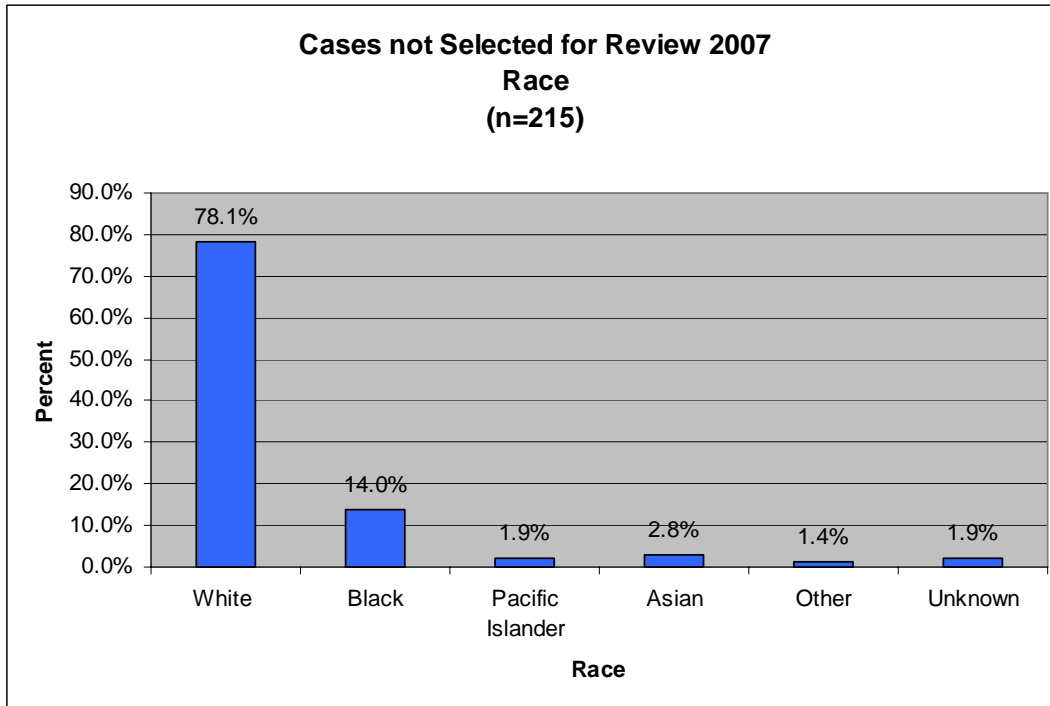
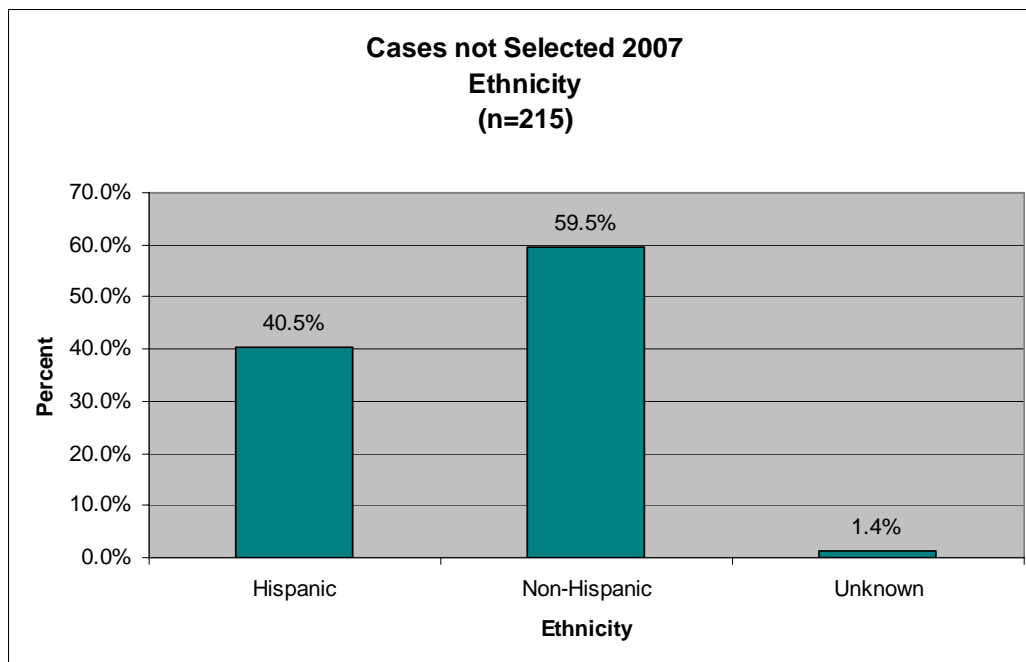


Figure 2.3 illustrates the race for the cases not selected for review. 78.1% of the deaths were White children. Ethnicity is shown in Figure 2.4 and the majority of cases (59.5%) were Non-Hispanic. Data on race and ethnicity were collected separately due to data limitations for the non-reviewed cases.

**Figure 2.3**

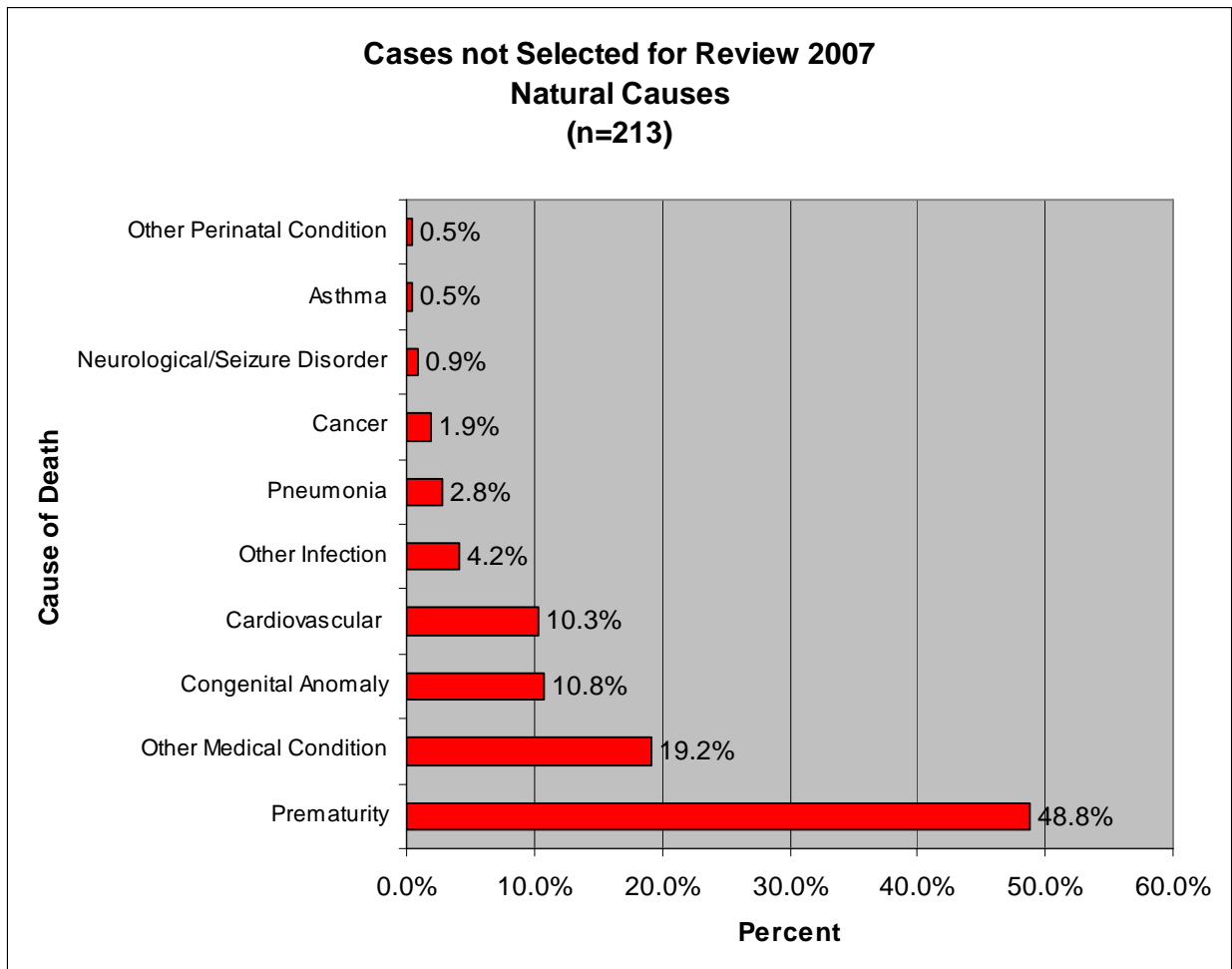


**Figure 2.4**



The vast majority of non-reviewed cases (213 out of 215) were Natural deaths. Table 2.5 indicates the various Natural causes of death for the cases not selected for review. These cases were deemed unremarkable deaths by the screening physician and did not meet any of the other criteria for a mandatory review. None of these cases had any history with the local child welfare agency.

**Table 2.5**



Almost half of the Natural deaths not reviewed were due to prematurity (48.8%) and another .5% were due to some other perinatal condition. This is consistent with the assumption that many of these deaths were fetal deaths with unremarkable circumstances and therefore not suitable for review by the child death review team.

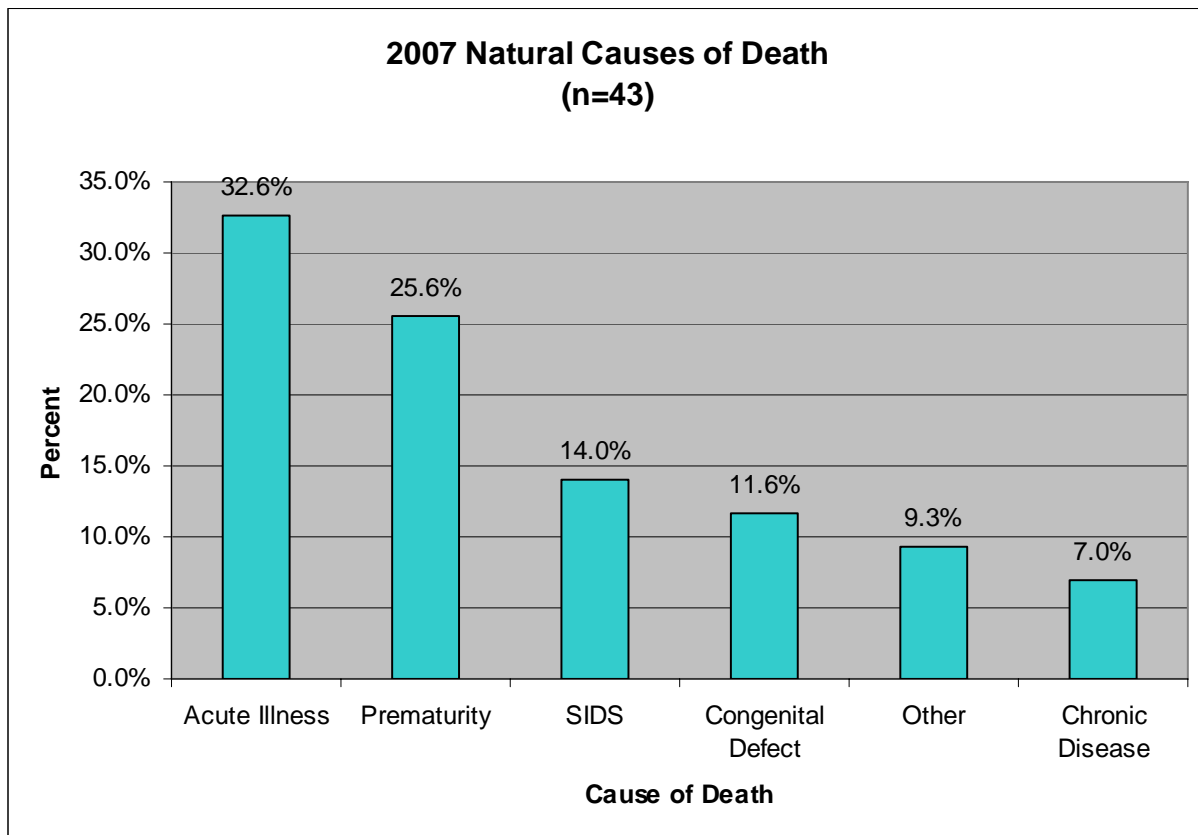
### Section III: Natural Deaths

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

In 2006 and 2007 not all natural deaths were reviewed, only those selected for review by a physician. However, in 2007 some limited data, including basic demographic information and cause and manner, were collected for those cases that were not selected for review. This information is included in the previous section, “Non-Reviewed Cases”, beginning on page 19.

In 2007 the top three causes of natural deaths reviewed included: Acute Illness, Prematurity and SIDS. Additionally, most natural deaths reviewed were children less than one year old. This is consistent with 2006 data and is to be expected because 39.6% of these deaths were due to prematurity or SIDS.

Figure 3.1



The following table presents all the causes of natural deaths among cases reviewed in 2007. As illustrated, the category “Acute Illness” is the most frequent in 2007 for Natural deaths with 32.6% of Natural deaths caused by an acute illness. This included causes such as acute and chronic asthma, pneumonia, streptococcus, staphylococcus, and sepsis.

Cause	Count	Percent
Acute Illness	14	32.6%
Prematurity	11	25.6%
SIDS	6	14.0%
Congenital Defect	5	11.6%
Other	4	9.3%
Chronic Disease	3	7.0%

Figure 3.2

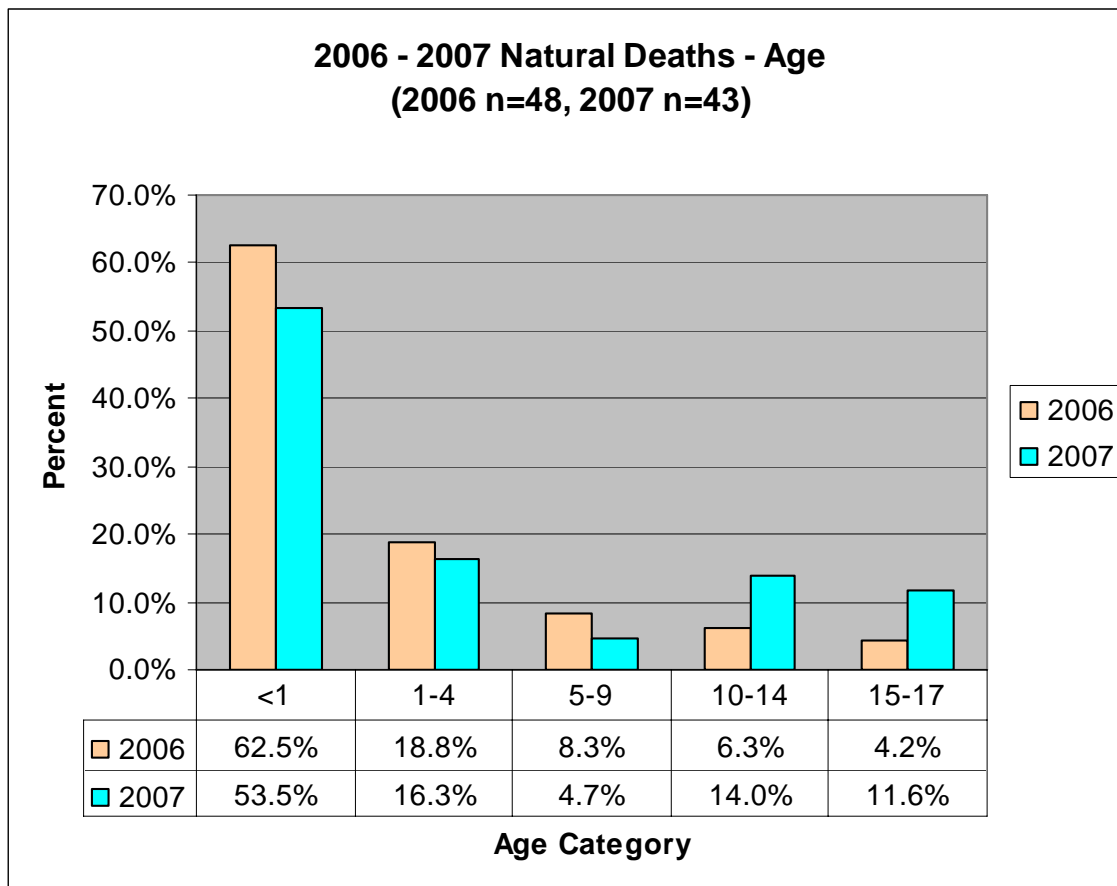


Figure 3.2 illustrates the ages of all natural deaths in 2006 and 2007. The patterns are very similar in 2006 and 2007 as the majority of natural deaths were children under one year of age. Interestingly, in 2007 there were more than twice as many natural deaths to children between the ages of 10 and 14 years and nearly three times as many natural deaths to children between the ages of 15 and 17 years. These increases were due to acute illnesses such as asthma, diabetes, and seizures. This will be an important trend to watch in the coming years, as natural causes of death in older children are not as expected as in infants and younger children.

**Figure 3.3**

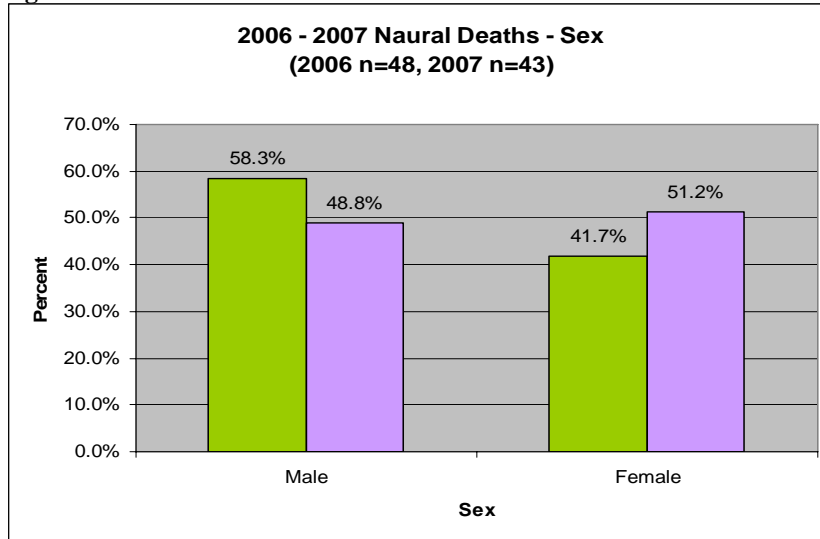
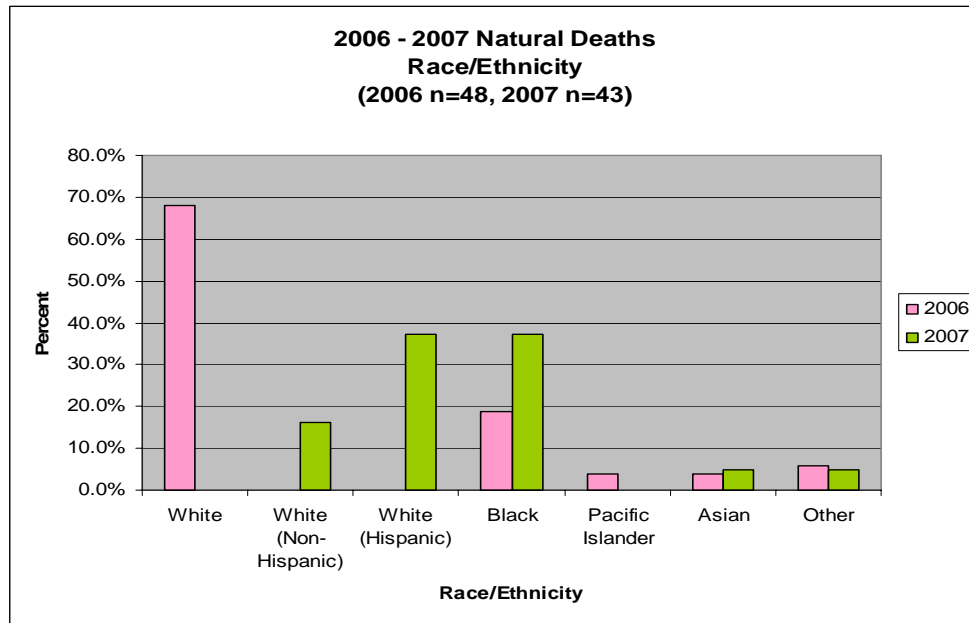


Figure 3.3 shows that in 2007 there were more females than males dying from natural causes. However the distribution is still fairly equal.

**Figure 3.4**



	White	White (Non-Hispanic)	White (Hispanic)	Black	Pacific Islander	Asian	Other
<b>2006</b>	67.9%	--	--	18.9%	3.8%	3.8%	5.7%
<b>2007</b>	--	16.3%	37.2%	37.2%	0%	4.7%	4.7%

\*Dashed lines (--) indicate data collection variations between 2006 and 2007.

Figure 3.4 shows the racial and ethnic breakdown of the Natural deaths for 2006 and 2007. In 2007 race and ethnicity data were collected slightly differently to capture the distinction between those who identified as White Hispanics and those who identified as White Non-Hispanics. In 2007 only 16.3% of all natural deaths were White Non-Hispanic children as opposed to 37.2% of White Hispanic children. Additionally, there were also a larger number of Black children (37.2%) who suffered natural deaths in 2007. This is much higher than the 18.9% of Black natural child deaths in 2006, due in part to an increase in acute illnesses, including asthma, pneumonia, and sepsis at 31.3%.



## Acute Illness

About one third (32.6%) of natural deaths reviewed were attributed to some kind of acute illness. The category of acute illness includes many different illnesses, such as:

- Asthma
- Sepsis
- Bronchopneumonia
- Staphylococcus
- Myocarditis
- Seizure Disorder
- Cardiac Arrhythmia
- Streptococcus
- Diseases of the brain

Slightly more males (53.3%) than females (46.7%) died from an acute illness in 2007. The most frequent age category for acute illness was between the ages of 10 and 14 years.

**Figure 3.5**

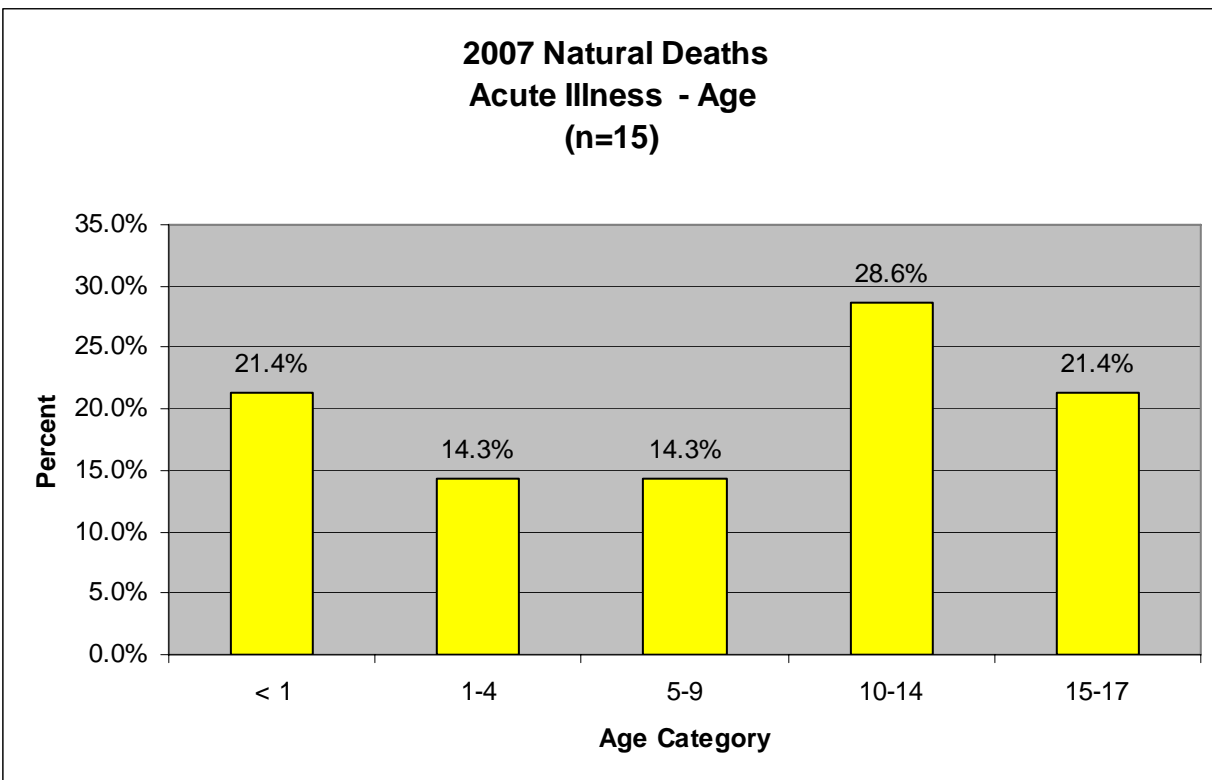
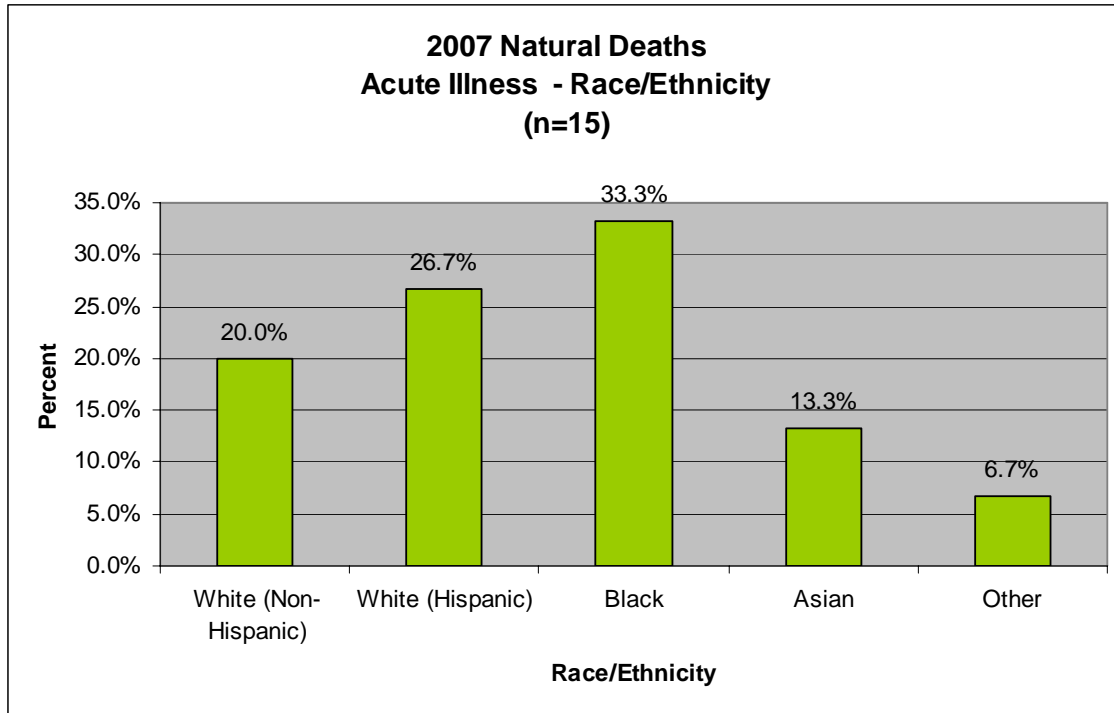


Figure 3.6 displays the racial and ethnic breakdown for acute illnesses. One third of these cases were Black children (33.3%). This represents a slight disparity since only 26.8% of all deaths reviewed were Black children.

**Figure 3.6**



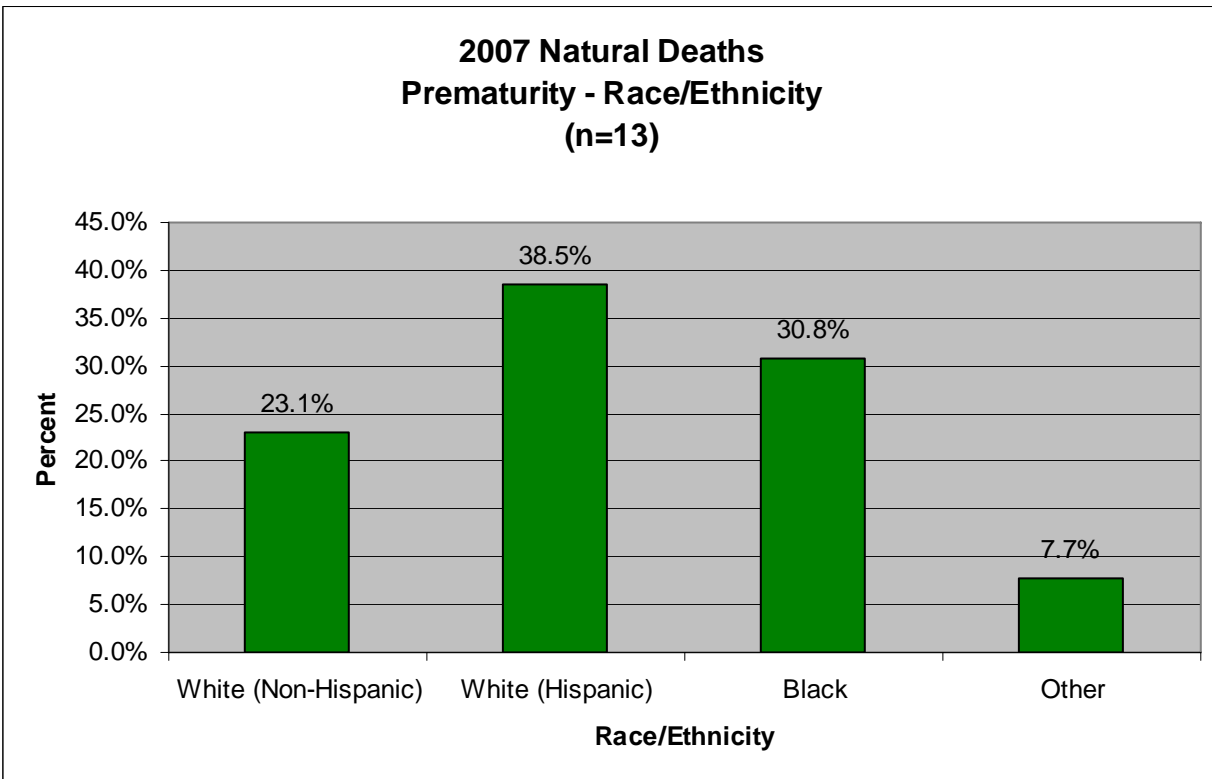
In 33.3% of cases the child had only had the condition for a matter of days<sup>1</sup> and in 80% of cases death was not expected as a result of the illness. In 66.7% of cases the child was receiving medical attention and in 86.7 % of these cases the parents were compliant with the prescribed care plan. Nearly 27% of the acute illness cases were due to asthma related complications, a disease which, if properly maintained, does not traditionally result in a fatality. In one case the child died from complications related to diabetes, another illness that requires proper maintenance to avoid health problems.

<sup>1</sup> Information on exact number of days was not collected.

## Prematurity

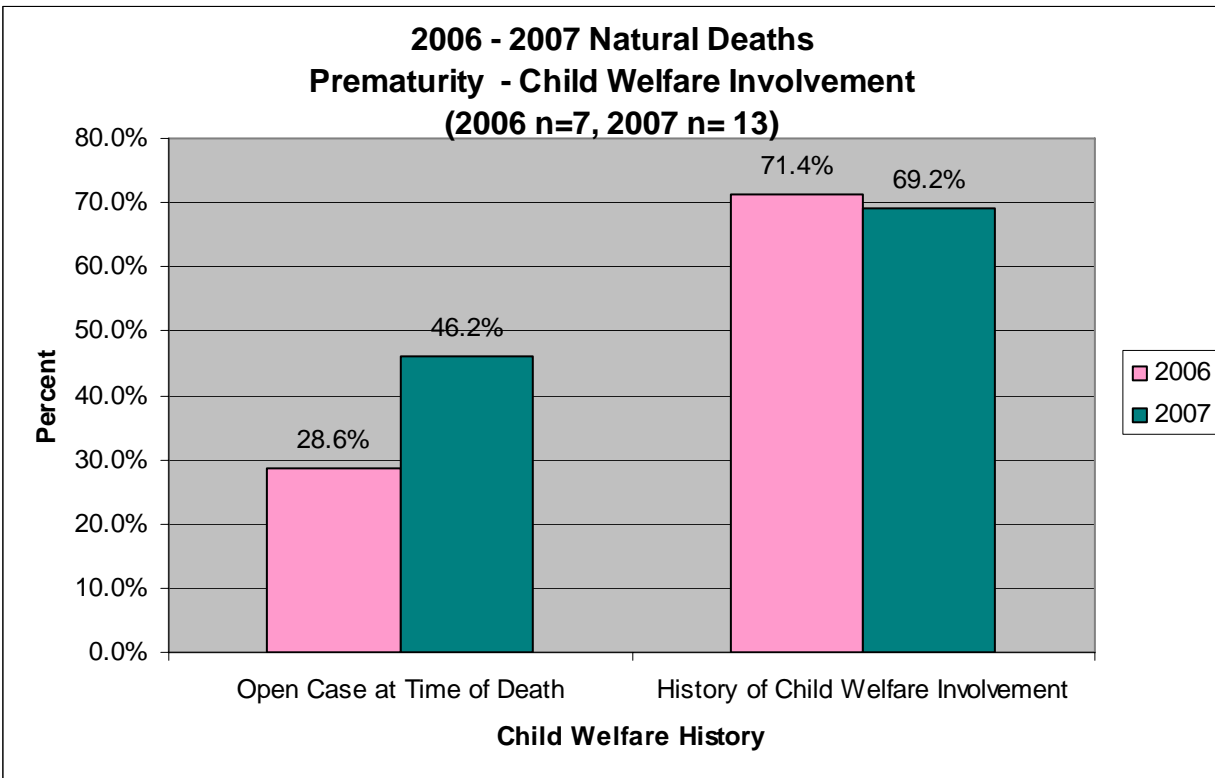
Nearly 26% of all natural deaths reviewed were due to complications of prematurity. All children in this category were one year of age or less. There were slightly more males (61.5%) than females (38.5%). The most frequently occurring racial/ethnic category was White Hispanic at 38.5% followed by Black at 30.8%. Both of these percentages are higher than the total cases reviewed. This indicates some racial or ethnic disparities in premature deaths. This is a reflection of national statistics that indicate that both Black and Hispanic infants are more likely than White infants to be born premature (March of Dimes, 2008).

**Figure 3.7**



Gestational age was known in 12 of the 13 cases where the cause was listed as prematurity, ranging from 19 to 39 weeks. Only 23.1% of the cases indicated that the mother received prenatal care. In 53.8% of these deaths the mother's history reflected the use illicit drugs during the pregnancy. In 30.8% of all the premature death cases, the infant was born drug exposed and the medical examiner determined that maternal drug use was a factor in the child's death. The age of the mother was known in over half of the cases and ranged from 22 years to 30 years with an average age of 26.3 years.

Figure 3.8



In 69.2% of the prematurity death cases the family had some history with child protective services. However, in only 7.7% of cases was the history regarding the decedent - 53.8% involved a history regarding the decedent's sibling(s). 46.2% of the cases indicated that there was an open child welfare case with the family at the time of death, and in 15.4% of the prematurity death cases there was a child welfare case that had closed within 12 months of the death.

## Sudden Infant Death Syndrome (SIDS)

In 2007, SIDS was the third leading cause of natural deaths among children at 14% of all natural deaths. 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>, 2007).

In 2007 there were almost twice as many males as females that died due to SIDS. This is down slightly from 2006 when 71.4% of SIDS deaths were male.

**Figure 3.9**

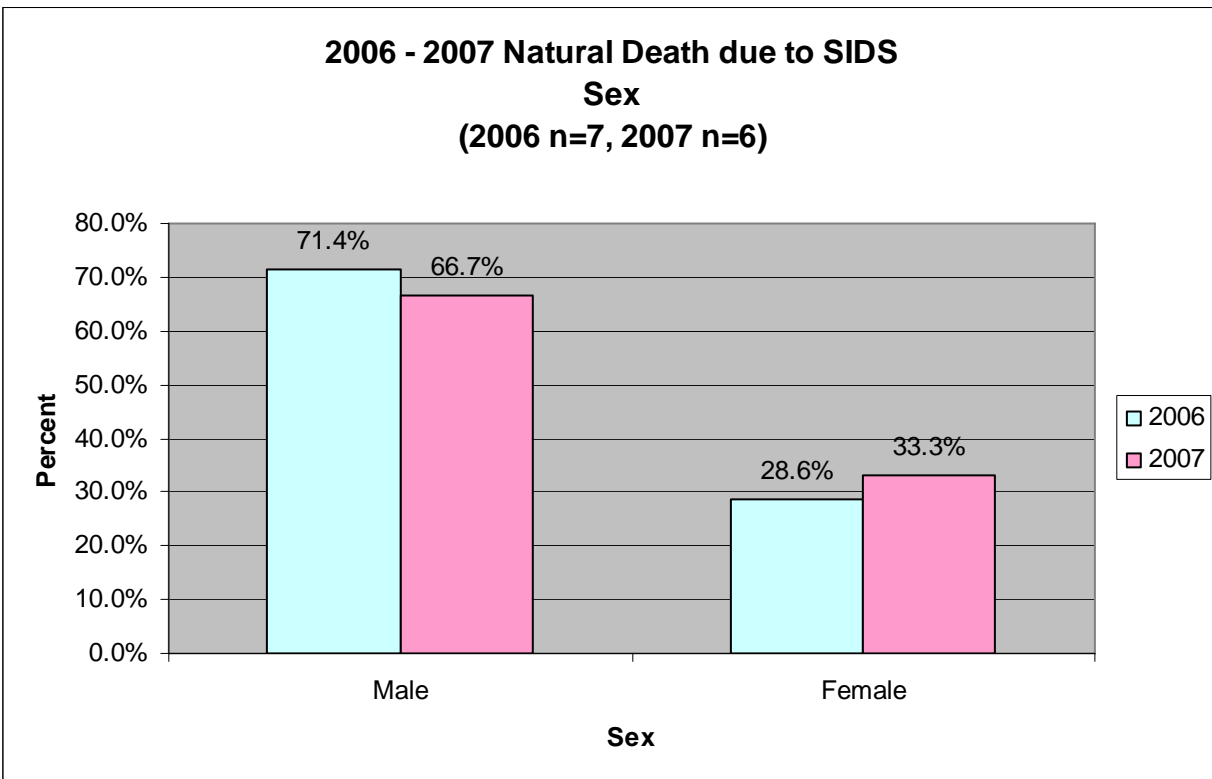


Figure 3.10 illustrates the race and ethnicity of child deaths due to SIDS. Half of all deaths due to SIDS in 2007 were Black children. This is a slight decrease from 2006 when 57.1% of SIDS deaths were Black children. Additionally, one third of SIDS fatalities were White Hispanic children. According to the American Lung Association, in 2001 African American infants were 2.5 times more likely than White infants to die of SIDS. These statistics point to the need for increased prevention efforts to eliminate this disparity.

**Figure 3.10**

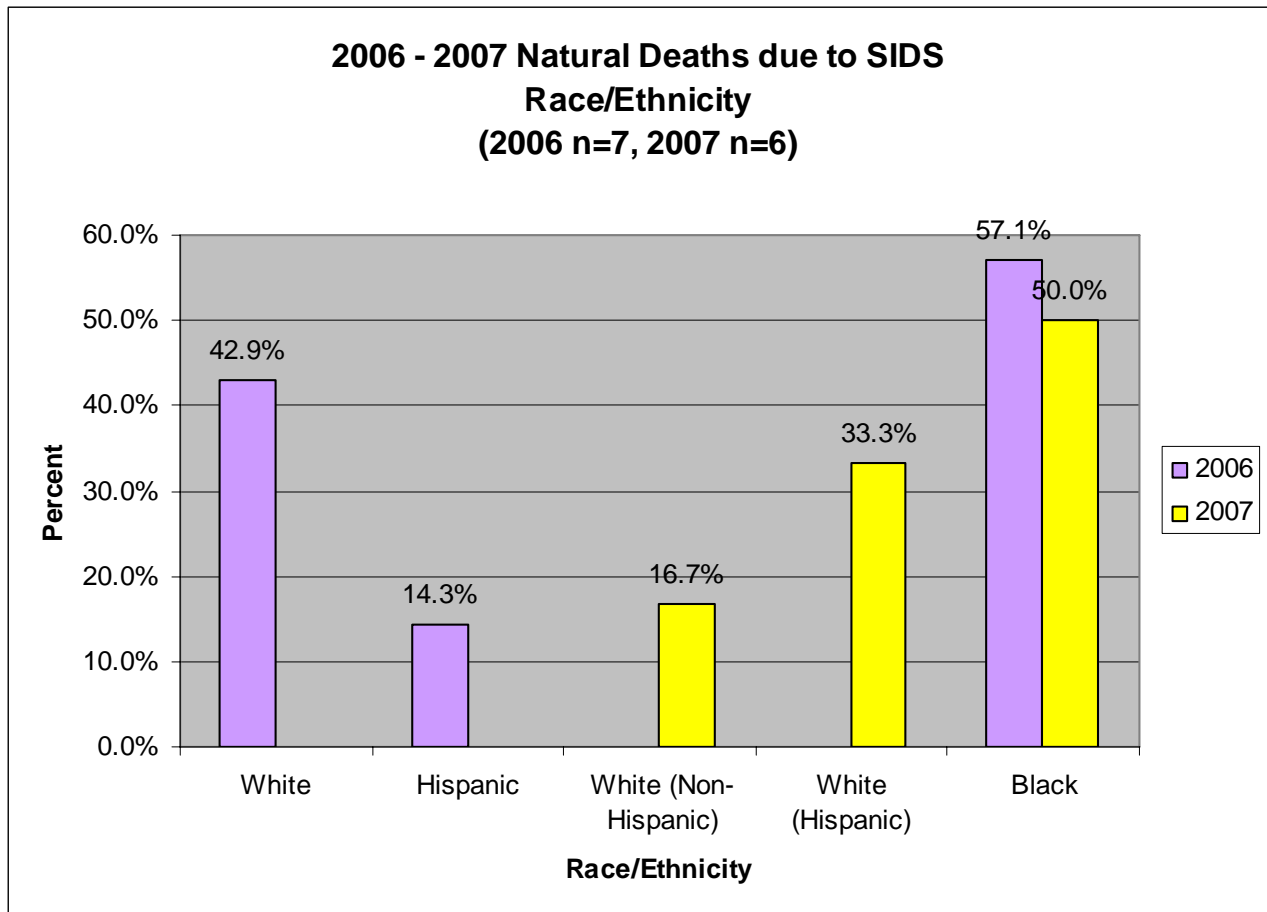
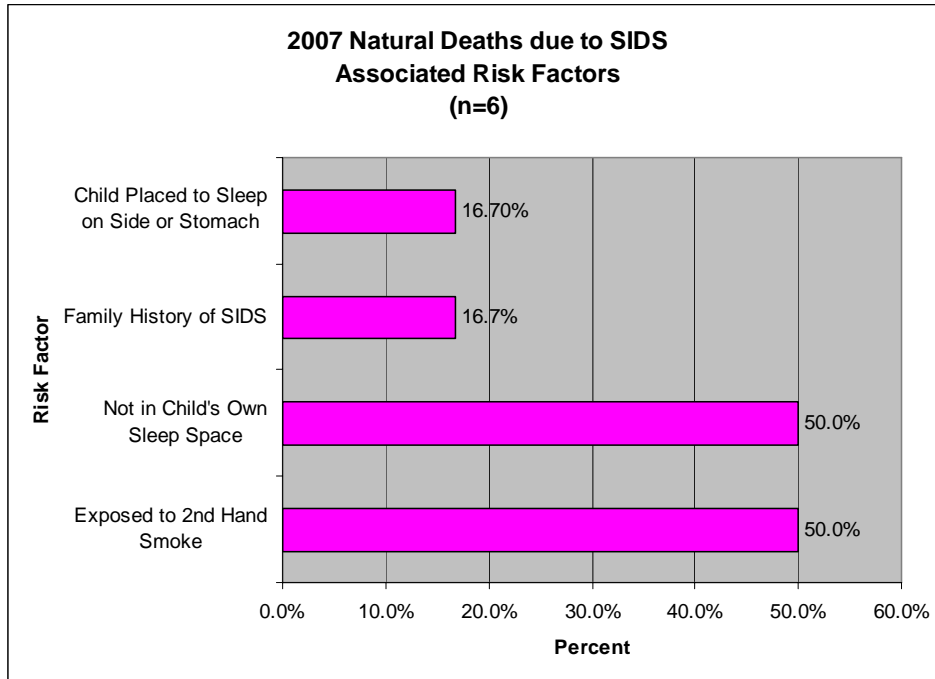
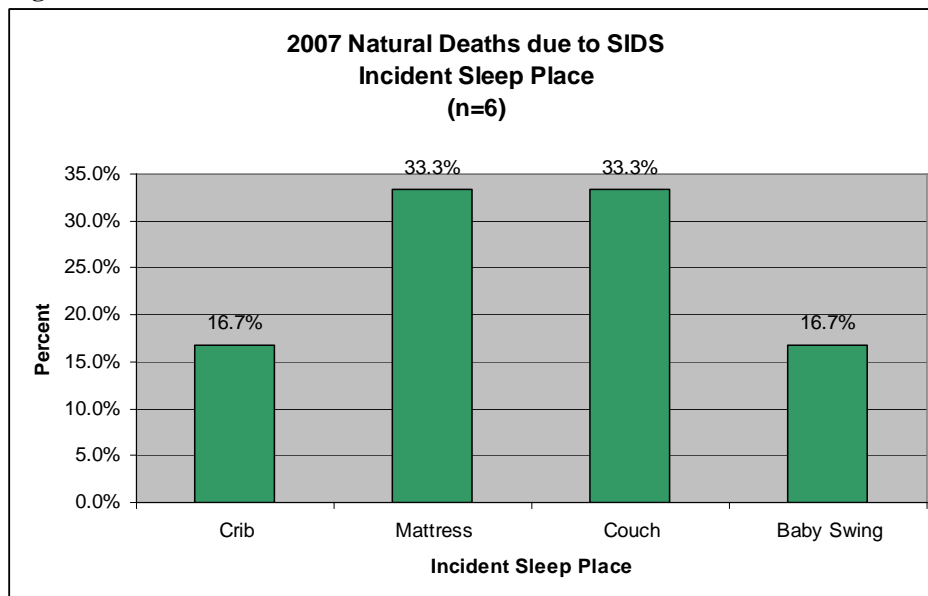


Figure 3.11 illustrates associated risk factors for SIDS. In 50% of all SIDS fatalities the child was exposed to second hand smoke. In all cases the child was in a sleeping environment. However, in 50% of cases the child was not in his/her own sleep space. Figure 3.12 shows where the child was sleeping at the time of death. Additionally, in 16.7% of cases the child had a family history of SIDS and another 16.7% of these children were placed to sleep on their side or stomach.

**Figure 3.11**



**Figure 3.12**



## Natural Deaths - Recommendations for Prevention

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

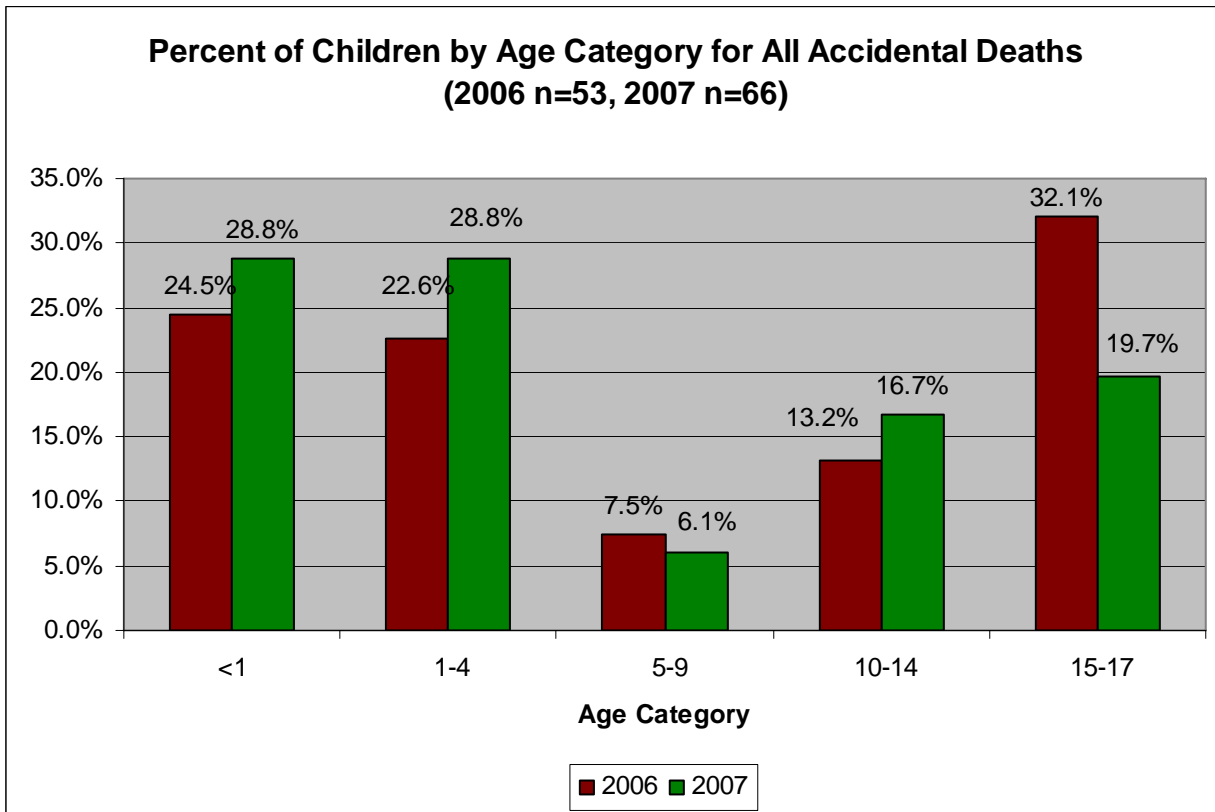
1. Again in 2007 the majority (53.5%) of Natural deaths occurred among children less than one year of age. Although this number is less than 2006, when it was 62.5% of all deaths additional research still needs to be conducted to understand the effects of prenatal care, parental substance abuse, exposure to environmental pollutants, etc. This trend will continue to be monitored in the coming years.
2. The leading cause of natural death in 2007 was “Acute Illness” (32.6%). This included several cases of asthma and diabetes related deaths. These are two extremely treatable illnesses. Simple monitoring and maintaining regimented medication administration can allow children with both asthma and diabetes to live long and normal lives. Increased educational campaigns should be created and directed toward parents to remind them of the severity of these illnesses if not carefully monitored.
3. For two years in a row now we have seen a high percentage of children dying from prematurity have a family history of involvement with child welfare. In 2006, 71.4% of these families had history with child welfare, and in 2007 there were 69.2% of these cases. This again points to the importance of prenatal care, as it is a key factor in preventing preterm births and low birth weight babies. Prenatal care is also important in identifying problems and lifestyle s that can increase risk of preterm labor and birth. Therefore it is recommended that child welfare case workers provide education and resources on the importance of prenatal care to families that they come in contact with whom either are planning on becoming pregnant or who may become pregnant even if the referral is unrelated.
4. Although the percentage has decreased since last year (57.1% in 2006 to 50% in 2007) there is still a disproportionate number of Black children that died from SIDS. According to the National Center for Child Death Review, “Blacks and American Indians still have rates two to three times higher than the national average. Many believe one major reason for this is that the Back to Sleep message is not effectively reaching these populations of parents and caregivers” ([www.childdeathreview.org](http://www.childdeathreview.org), 2008). Therefore these populations may benefit from more focused prevention messages, and social marketing campaigns.



## Section IV: Accidental Deaths

Accidental deaths are defined by the National Center for Child Death Review as “a manner of death indicating non-intentional trauma.” In 2007, there were 66 deaths of children in Clark County that were ruled as accidental, showing a 26% increase from the 53 cases in 2006. All 66 cases were investigated by the coroner. Of those 66 cases, 65% were male and 35% were female. The majority of decedents (nearly two thirds) were between the ages of zero and four, however 16.7% were between the ages of 10-14. This pattern is different than the 2006 pattern, which showed nearly one third of decedents to be between the ages of 15-17, while this age group accounts for only 19.7% of accidental deaths in 2007.

**Figure 4.1**



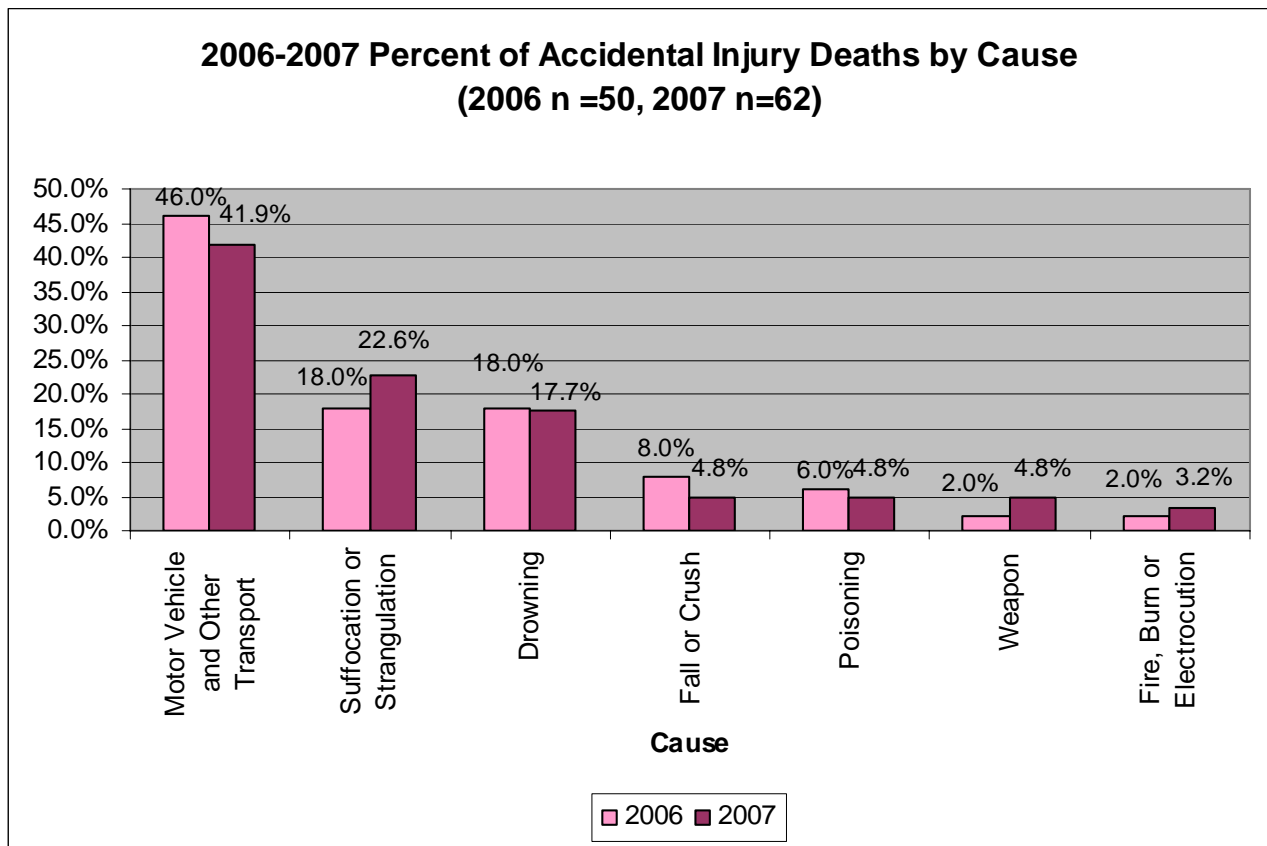
Nearly half (43.9%) of accident victims were White (non-Hispanic), and 18.2% were Black. There were no Asian/Pacific Islanders or American Indian/Alaska Natives who died from accidental causes in Clark County in 2007. Nearly 40% of decedents were of Hispanic ethnicity. These numbers do not differ significantly from 2006 cases.

Approximately 27% of cases had some type of prior involvement with the child welfare system, making these cases mandatory reviews. In the 79% of cases where supervision was needed, the primary person responsible for the supervision was the biological parent (71%), or another relative or family member (15%). The majority (46%) of cases occurred in the child’s home, or on a roadway (31%).

There were nine cases (13.6%) where children from out of state died in Clark County. Home zip codes included California, Utah, Arizona, and a child visiting from another country. Of these nine cases, 67% were due to motor vehicle accidents, while 22% of these decedents drowned and 11% died due to other medical causes.

Of the 66 accidental death cases, four (6%) were from a medical cause, and the other 94% were from an external injury. Medical causes included prematurity due to maternal drug use, placental abruption due to maternal drug use, and asthma attack due to a drug overdose. As it was in 2006, the primary cause of death for external injuries was motor vehicle accidents (41.9%), followed by suffocation or strangulation (22.6%) and drowning (17.7%). A comparison with 2006 numbers shows a reduction in the number of deaths due to a motor vehicle accident, and a slight increase in the number of accidental deaths due to suffocation or strangulation. There was also a slight reduction in the number of drowning cases as compared to 2006. Causes of accidental deaths from an external injury are illustrated in Figure 4.2 below.

Figure 4.2

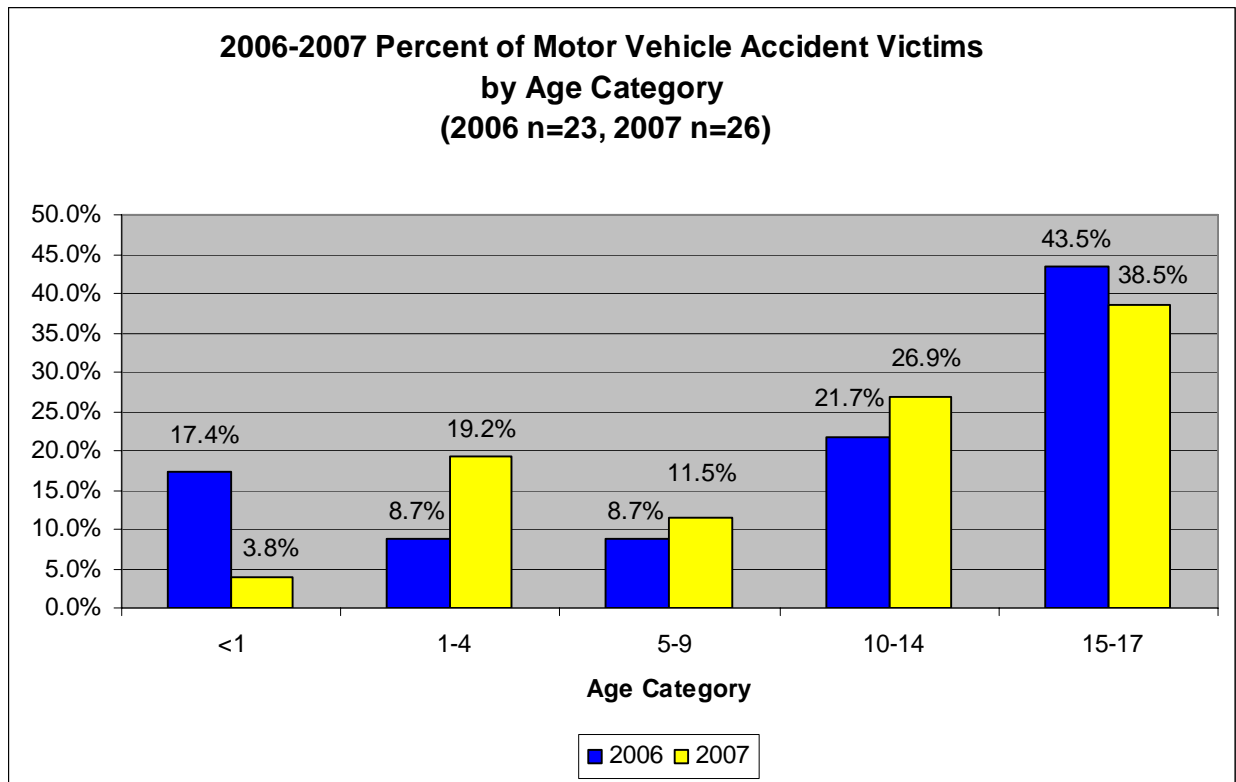


Prosecution was pending at the time of review in just over 20% of cases (22.7%). In just over one quarter of the cases (27.3%), CPS took action as a result of the death.

## Motor Vehicle Accidents

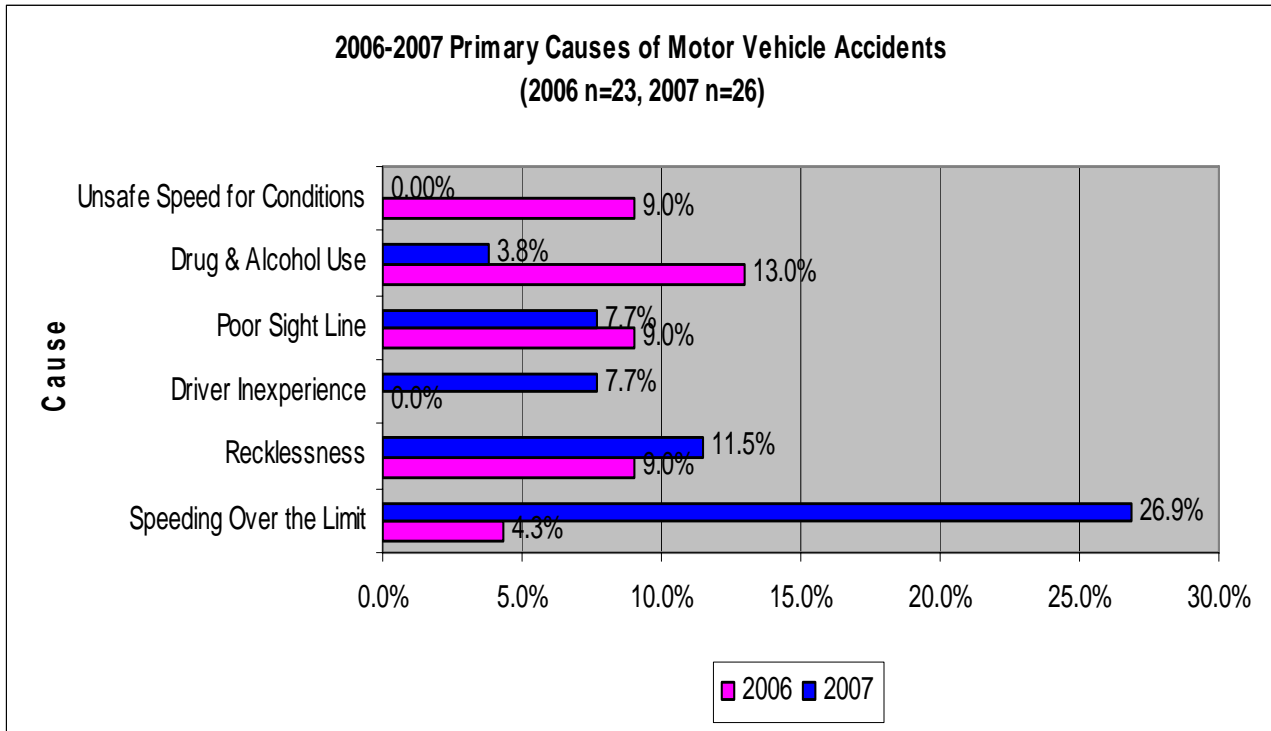
There were 26 deaths due to motor vehicle accidents (MVAs) in Clark County in 2007, a slight increase from 23 in 2006. An equal number of males (50%) and females (50%) died in MVAs, mirroring the trend from 2006. Nearly all (92%) decedents were White, and less than one tenth (8%) were Black. Exactly half (50%) of victims were of Hispanic ethnicity. Approximately one quarter (23%) of victims had a prior history with the child welfare system and approximately 4% of decedents had a juvenile justice history. More than one third (38%) were between the ages of 15-17, and nearly two thirds (65%) were over the age of 10. Approximately 20% were between the ages of 1-4, which is more than double the percentage found in this age group in 2006. The sharpest drop from 2006 was for those victims under 1 year old, from 17% in 2006 to 4% in 2007.

Figure 4.3



In all accidents, there were either one or two cars involved. Approximately 70% of cases were single-car accidents. The majority of accidents (39%) occurred on highways, followed by residential streets (27%), and city streets (23%). In 2006, the majority of accidents (44%) occurred on city streets followed by highways. Primary causes of accidents included: speeding over the limit (27%), recklessness (12%), driver inexperience (8%), and poor sight line (8%). In approximately 4% of cases, the accident was attributed to drug or alcohol use. At the time of the accident, 19.2% of drivers were alcohol or drug impaired.

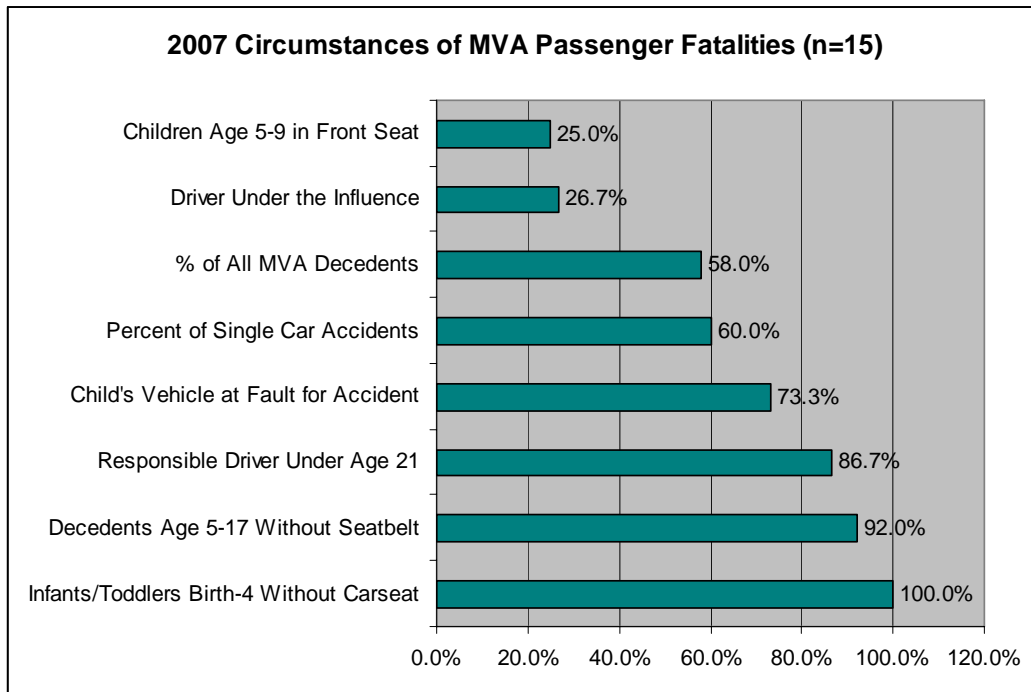
**Figure 4.4**



In approximately two thirds (61.2%) of cases, the child’s vehicle was a car, van, SUV or truck. Approximately 11% of cases involved a bicycle or a motorcycle/scooter. In 70% of cases, the child’s vehicle was at fault for the incident.

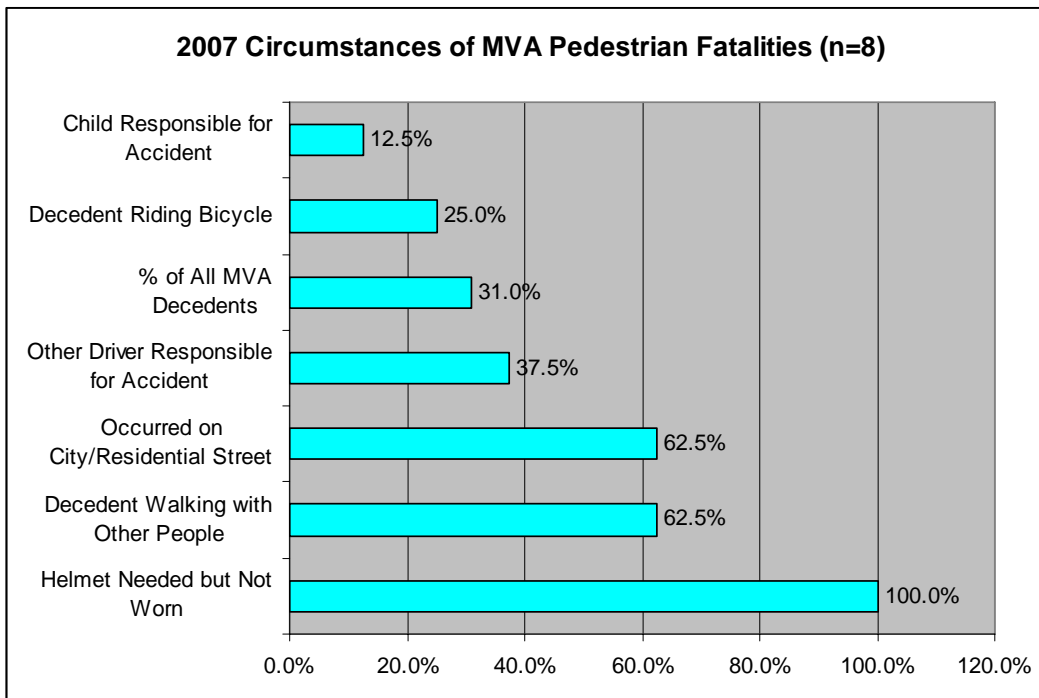
The majority of decedents (58%) were passengers. Of those passengers killed, 20% were younger than age 10, one third (33%) were between the ages of 10-14, and nearly half (46.7%) were between the ages of 15-17. In the passenger fatalities, 60% of the accidents were single car accidents, and 40% were two-car accidents. In 73.3% of these cases, the child's vehicle was at fault for the accident. Primary causes of accidents were attributed to speed (40%) and recklessness (20%). Other causes included poor tires, drugs and alcohol, fatigue/sleeping, and lane changes. In 86.7% of cases, the driver responsible was under age 21, and other drivers responsible were over the age of 60. One third of cases had 3-5 passengers in the car, and two thirds listed 6 or more passengers. More than three quarters (92%) of decedents between the ages of 5 and 17 were not wearing their seatbelt. None of the decedents under age 4 were in age-appropriate child seats. The driver was under the influence in just over one quarter of cases (26.7%). For the passenger fatalities, of those decedents in the front seat, three quarters were between the ages of 15-17, and one quarter were between the ages of 5-9, which is not recommended for children that age.

**Figure 4.5**



In approximately one third (31%) of motor vehicle accident cases, the decedent was a pedestrian. Pedestrian fatalities include bicycle/motorcycle fatalities. Slightly less than two thirds (62.5%) of pedestrian fatalities were children between the ages of 1-9, although one quarter of the decedents were aged 10-14. One quarter (25%) of the pedestrian fatalities were riding bicycles, and more than half (62.5%) were walking with other people. The majority (60%) of the toddlers between the ages of 1-4 were walking with people. In 37.5% of cases, the other vehicle was at fault. Almost two thirds of the pedestrian fatalities occurred on a city street or residential street. In all cases where the child was on a bicycle/motorcycle, a helmet was needed but not worn by the decedent. Primary causes of these accidents included the child running into the street (25%), a poor sight line (25%), and incidents where the child was backed over by a vehicle (12.5%).

**Figure 4.6**



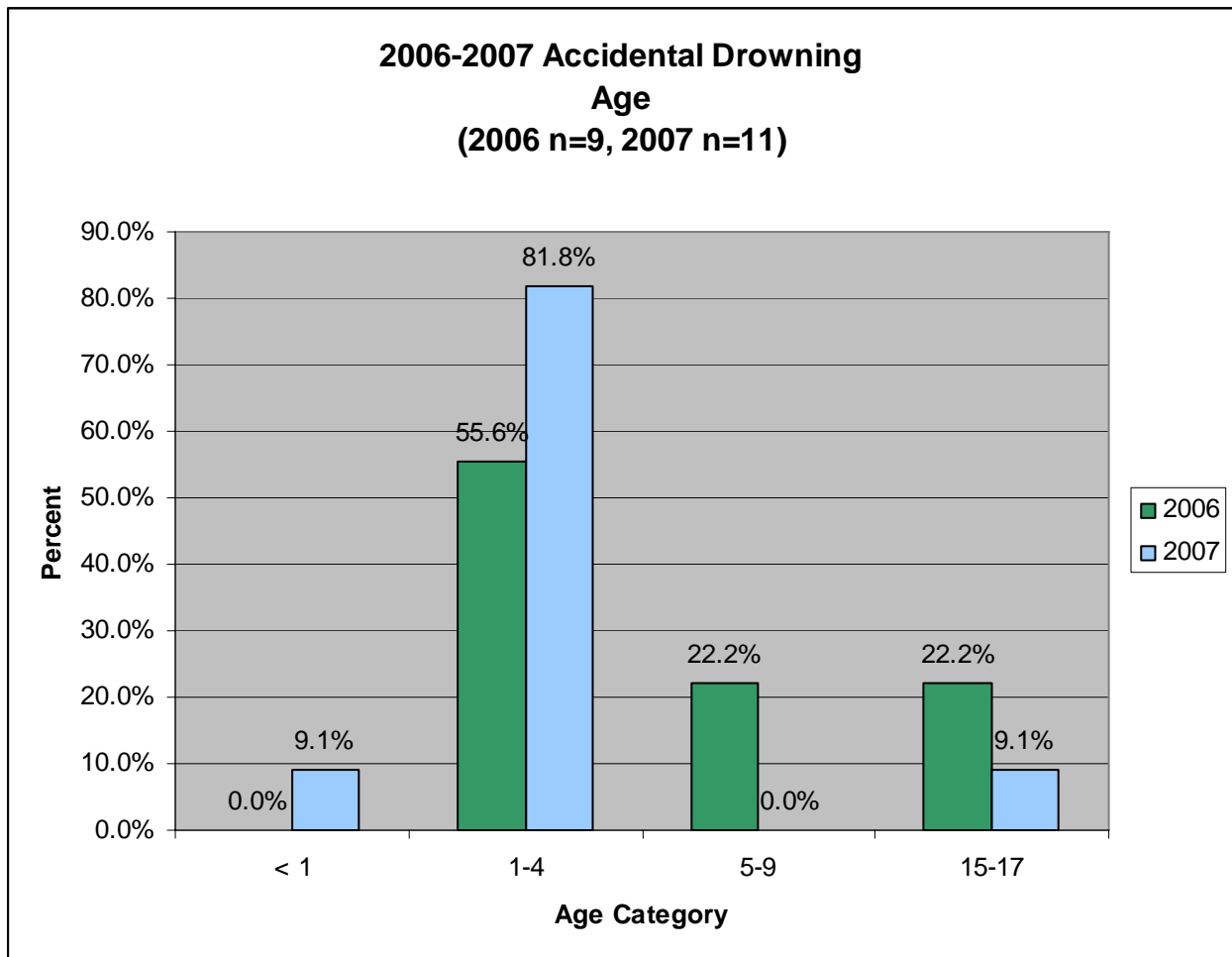
In only 8% of cases, was the decedent the driver. For those decedents who were driving at the time of the accident, 50% of them had a valid driver's license, 50% were under the influence of drugs or alcohol, and 50% had another teen in the car with them. One half of the accidents where the youth was driving (50%) occurred on a city street, and one half (50%) occurred on a highway. The primary cause of one half of the accidents where the youth was driving (50%) was listed as drug or alcohol use, and one half (50%) was attributed to other driver error. In addition, 50% of drivers were not wearing a seatbelt when they should have been.

## Drowning

In 2007, drowning was the third leading cause of accidental deaths among children in Clark County, with 11 deaths in this category. This is slightly higher than in 2006 with 9 drowning deaths. The vast majority (81.8%) of these children were ages 1 to 4 years, while the remaining cases were children less than one year (9.1%) and 15 to 17 years (9.1%). These numbers are very different from 2006 when only 55.6% of children were ages 1 to 4, and there were no cases of children less than one year drowning.

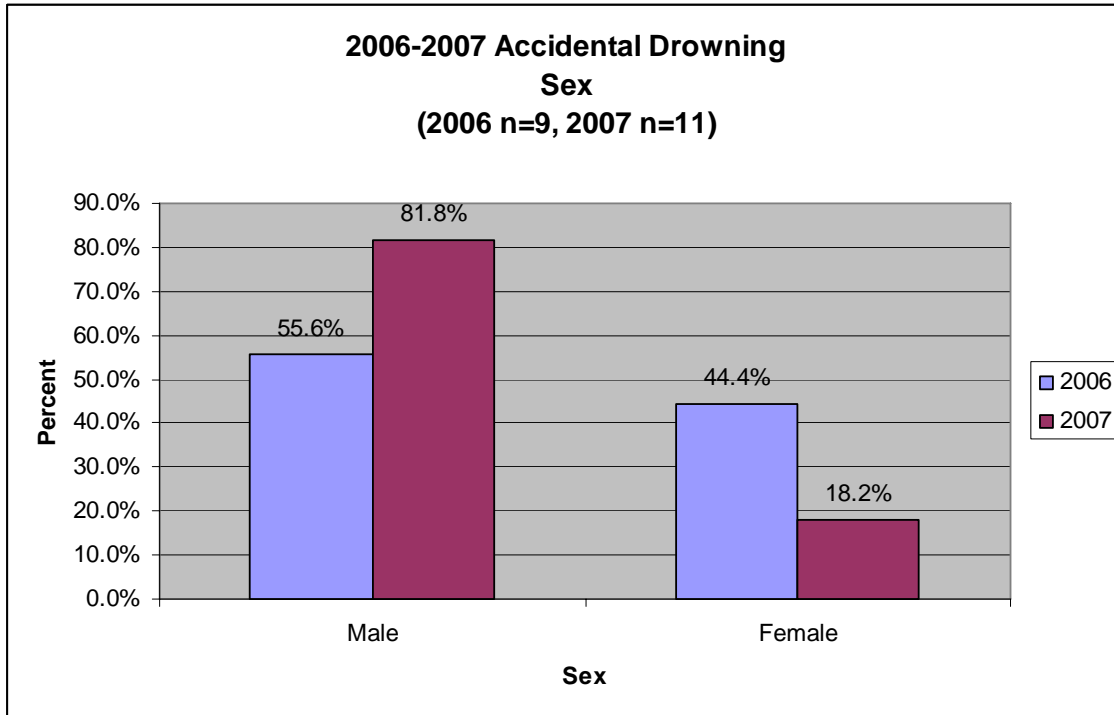
There were no drowning cases in 2007 of a child aged 5 to 9 years. Nearly all drowning cases in 2007 were in a pool, hot tub or spa (90.9%), while the remaining 9.1% of cases were in a bathtub.

**Figure 4.7**



In 2007 the distribution of male and female drowning victims is very skewed. In 2007, 81.8% of drowning victims were male, while only 18.2% were female. This is very different compared to 2006 where the distribution was much nearly equal (55.6% male, 44.4% female).

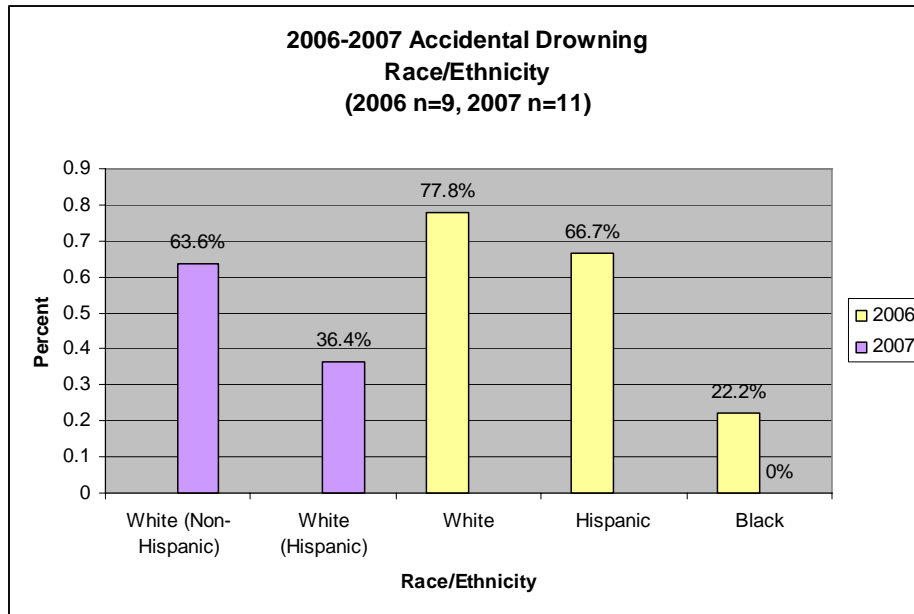
**Figure 4.8**





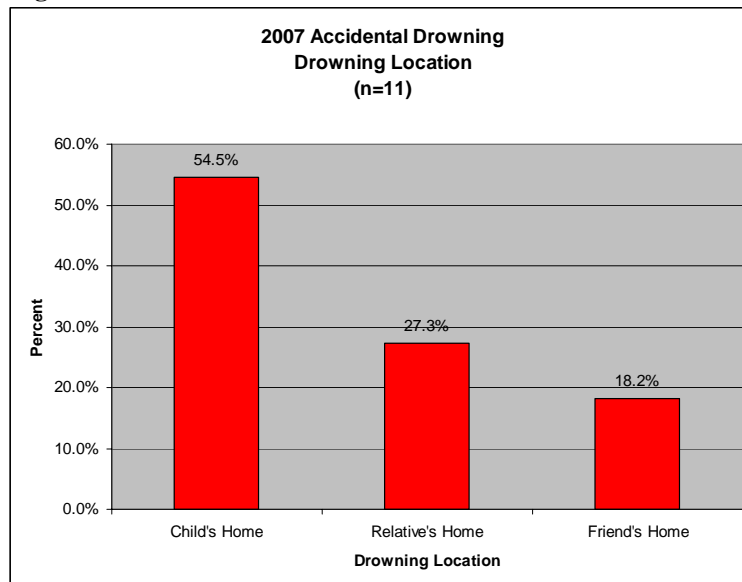
The race/ethnicity data for drowning victims in 2007 as compared to 2006 is also indicating some variation. As indicated in Figure 4.9, in 2007 all drowning deaths were among White Non-Hispanic (63.6%) and White Hispanic (36.4%) decedents. This is in contrast to 2006 where 22.2% of those cases involved Black children.

**Figure 4.9**



In regard to specific risk factors in drowning deaths, in 2007 over half (54.5%) of drowning cases occurred at the child's home. The remaining drowning fatalities occurred either at a relative's home (27.3%), or a friend's home (18.2%). No cases in 2007 occurred at a public or apartment pool.

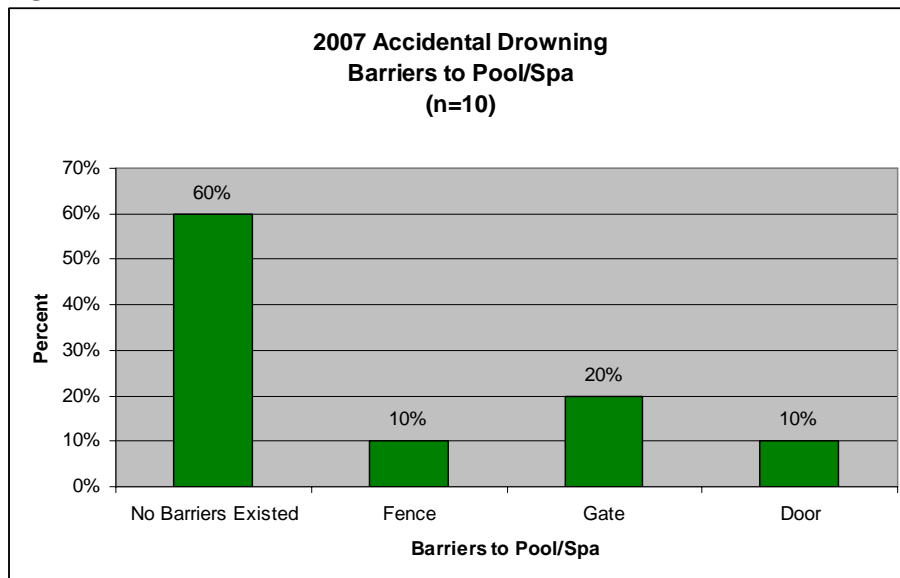
**Figure 4.10**



In 50% of pool drowning deaths the child had been supervised in the pool in the last 24 hours. Most frequently (45.5%) the biological parent was the supervisor at the time of the incident, followed by “other relatives” at 18.2%. In 90% of cases the child was last seen in the house and was subsequently left unsupervised between five minutes and one hour. The average period of elapsed time was around 19 minutes since the child was last seen. In all cases the child was not wearing a floatation device and in only one case there was a gathering or event going on at the same time as the incident.

Figure 4.11 below shows that in 60% of cases no barrier existed to prevent access to the pool or spa. In the remaining cases, 20% had a gate and another 20% had either a fence or a door blocking entrance to the pool.

**Figure 4.11**



None of these pools had alarms or covers as barriers to entrance. Children were able to breach existing barriers to the pools in 40% of these cases. In 20% of cases the gate was left open and in 10% the gate was unlocked. In one case the door was broken and in another case the child gained access through a doggy door. In only 9.1% of cases did the family have a history of involvement in the child welfare system.

Figure 4.12

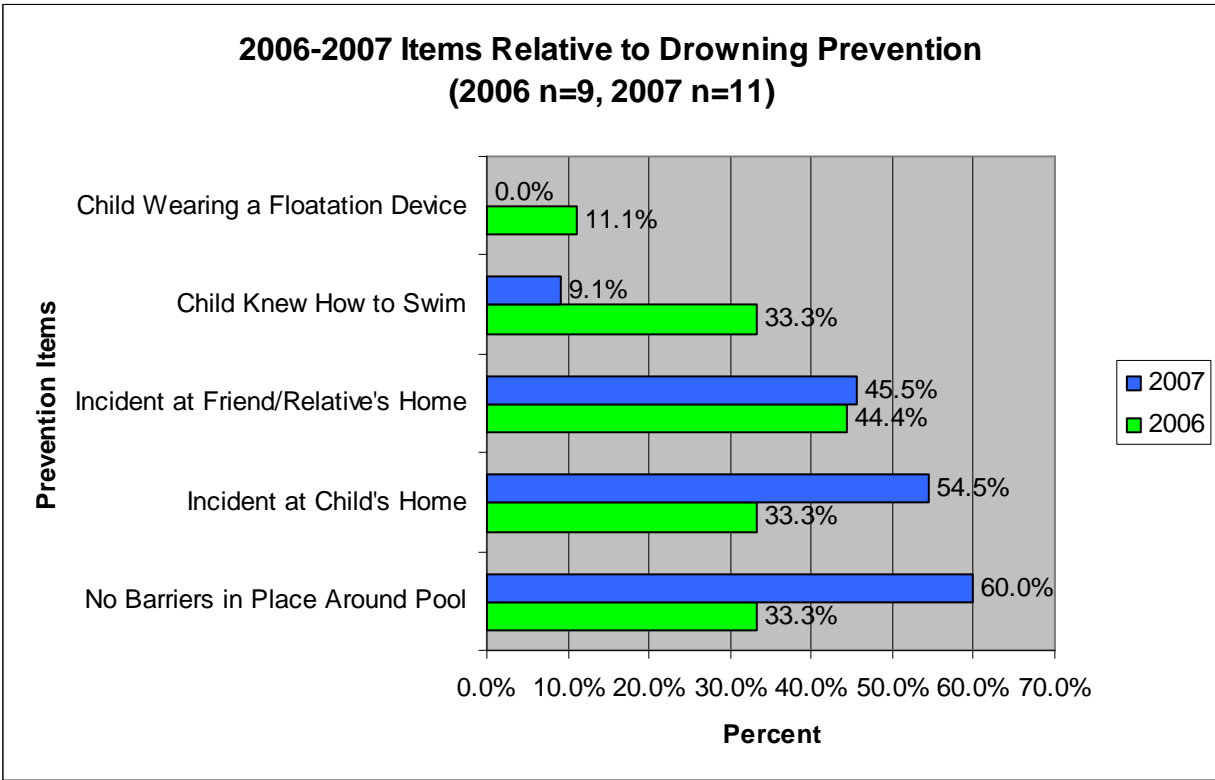
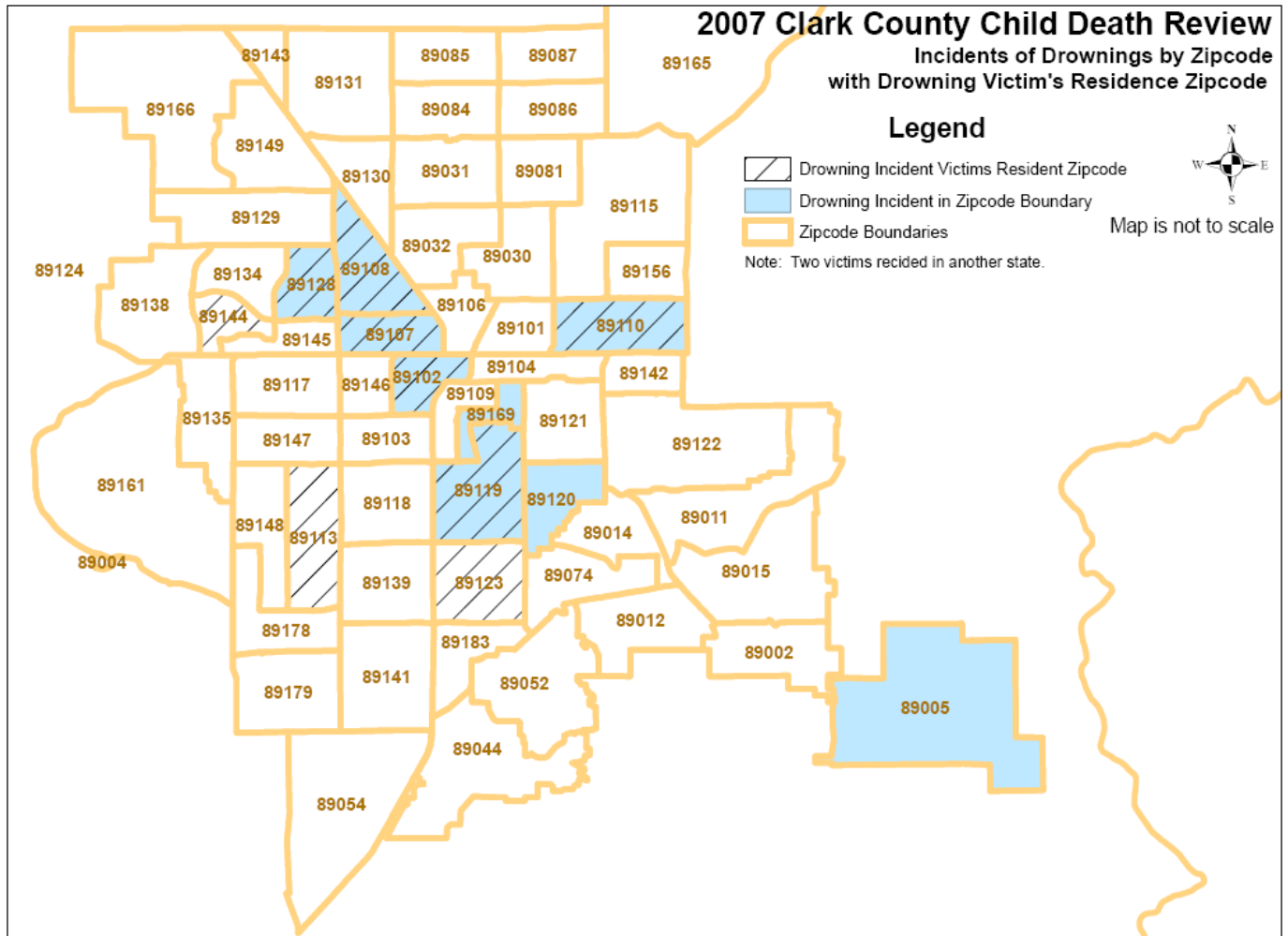


Figure 4.12 above illustrates the comparison between 2006 and 2007 in terms of some of the items relative to drowning prevention. In 2007 there were nearly twice as many drowning fatalities where no barriers to the pool existed. Additionally, many more of this year's drowning cases occurred at the child's own home.

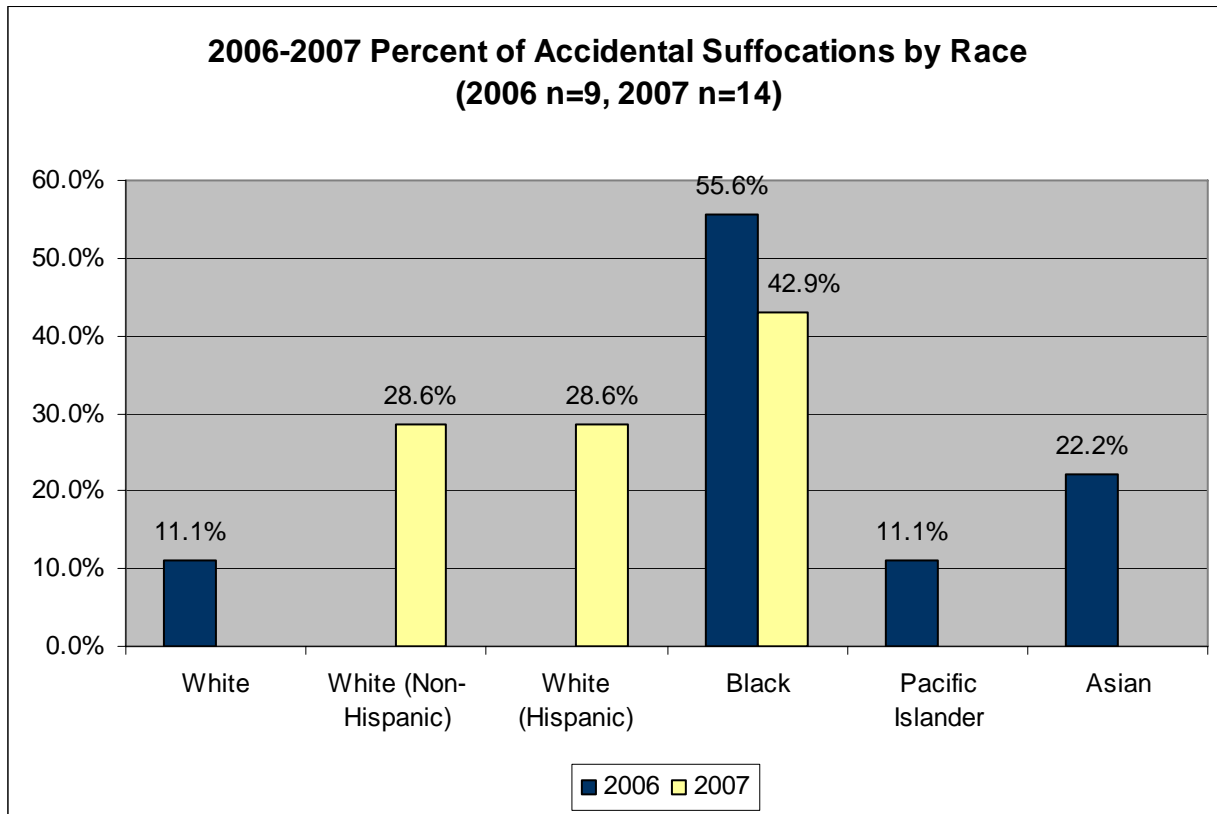
The following map illustrates that most drowning incident occurred in the central zip codes in Clark County (shown in blue on the map). As was the case in 2006, most drownings occurred in these older areas of Las Vegas, showing support for the movement to improve safety barriers for existing pools that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



## Suffocation or Strangulation

In 2007, there were 14 accidental suffocations in Clark County, an increase from the nine that occurred in 2006. More than three quarters (85.7%) were infants less than one year old, 7.1% were between the ages of one and four, and 7.1% of decedents were between the ages of 10 and 14. This pattern mirrors that of 2006, although there are a greater number of infants who suffocated in 2007. More than three quarters of the decedents (78.6%) were male, and 21.4% were female. Less than half (42.9%) were Black, with 28.6% listed as White (Non-Hispanic). One third (28.6%) listed Hispanic ethnicity, while in 2006, none of the decedents were listed with Hispanic ethnicity.

**Figure 4.13**



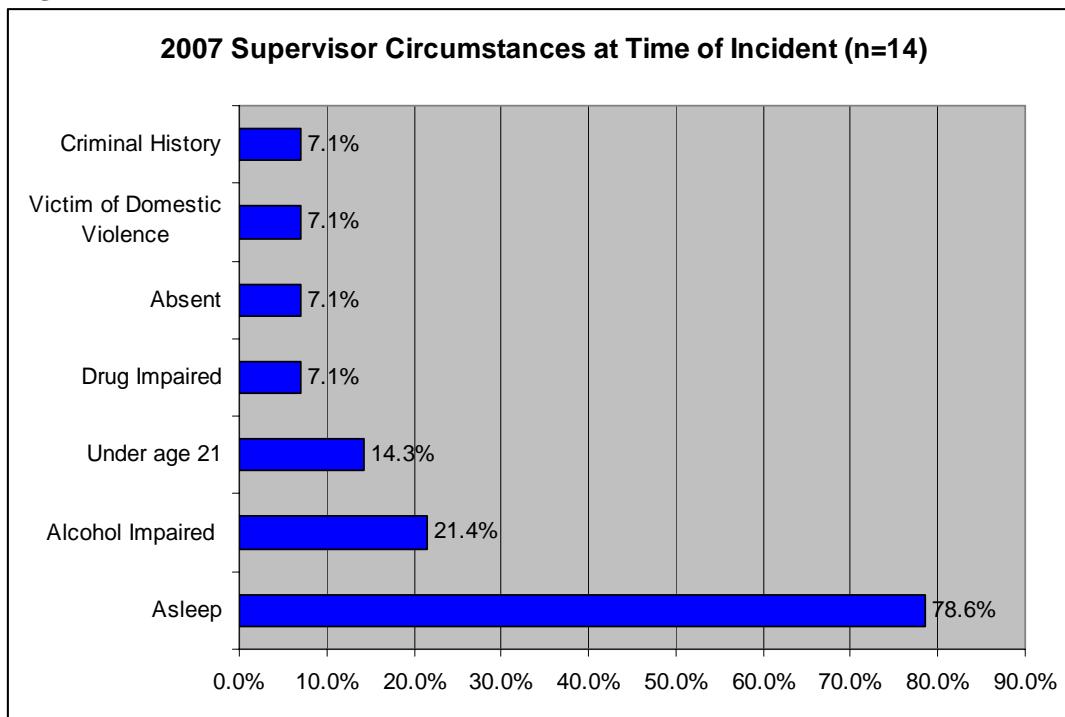
\*\* Race/Ethnicity data were collected differently in 2006 and 2007. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

Approximately 14.3% of deaths from suffocation and/or strangulation suffered from a disability, no decedents had a chronic illness, and none of the decedents were acutely ill in the two weeks preceding their death. In all cases, the primary caregiver at the time of the incident was a parent. Nearly two thirds (64.3%) had other adults living in the home. In all cases, the mother had no prior child deaths. In one fifth of cases (21.4%), one of the parents had a prior history of substance abuse. In these cases, the mother was twice as likely as the father to have a substance abuse history.

In two thirds of cases (66.7%) where the child is under one year of age, the infant had been carried to full-term (37-40 weeks), and 25% of cases were premature at 34 weeks. The mother had received prenatal care in only 50% of cases. In 25% of cases, the mother had smoked during pregnancy, and in 25% of cases, the mother had used illegal drugs or misused prescription/over the counter drugs. In less than 10% of cases, the mother had been the victim of domestic violence while pregnant.

All children had supervision at the time of their deaths, and all children were being supervised by their biological parent. In more than three-quarters of cases (78.6%) the child was in the sight of the supervisor, and in 21.4% 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 3.6 hours as the average number of hours since the supervisor had seen the child. In more than three quarters of cases, the supervisor was asleep at the time, and in more than 20% of cases the supervisor was under the influence of alcohol.

**Figure 4.14**

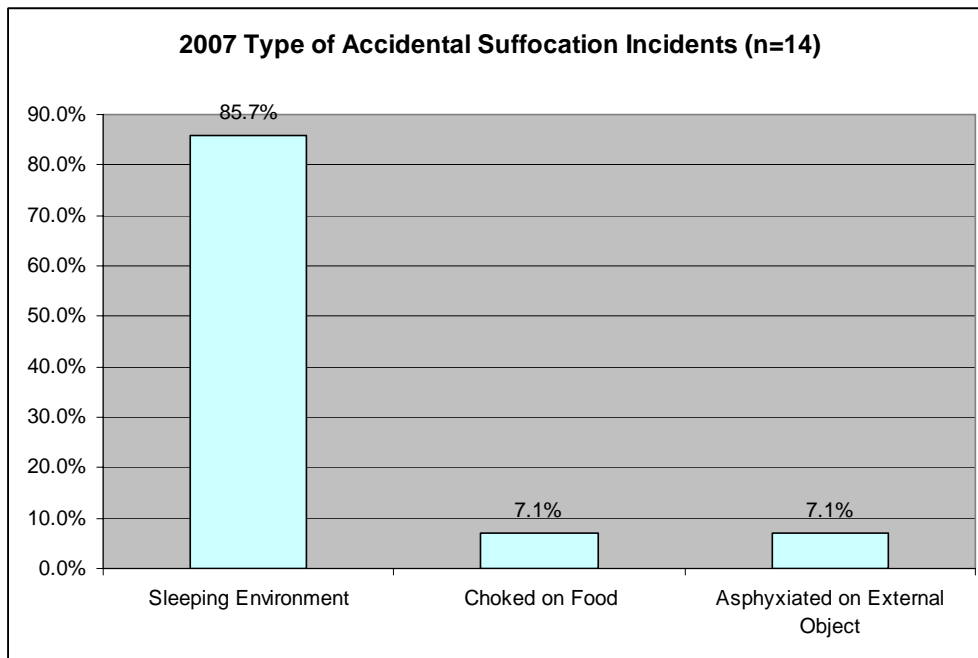


Nearly all incidents (92.9%) occurred in the child’s home, and only 7.1% occurred at a friend’s home. 911 was called in all cases. CPS action was taken as a result of the death in 42.9% of cases, and prosecution of the parents was pending at time of review in 7.1% of cases.

More than one third (35.7%) of families had a prior child welfare history. In 21.4% of cases, the CPS history was on the decedent, and in close to one third (28.6%) of cases, the CPS history was on a sibling. In 14.3% of cases, there was an open child welfare case at the time of death, and in 14.3% of cases, a CPS case had been closed within the past 12 months. All allegations were for neglect, and perpetrators listed included the mother and the grandmother.

All suffocations occurring in a sleeping environment occurred with the infants under one year of age. Nearly two thirds of the decedents suffocated in bedding due to overlay, and 21.4% were due to overlay by a person. Approximately 15% were wedged in a sleep environment. None of the decedents were strangled or confined in a tight space. In 7.1% of cases, the child choked on food, and in that case, the Heimlich maneuver was attempted. In 7.1% of cases, the child’s airway was blocked by an external object, in this case it was a tracheotomy tube.

**Figure 4.15**



Of those decedents who died in a sleeping environment, more than one half (58.3%) were sleeping on an adult mattress, one third (33.3%) were in an age appropriate sleeping environment such as a crib or bassinette, and 8.3% were sleeping on a couch. In two thirds (66.7%) of these cases, this was the usual sleeping space for the child. According to reports, 58.3% of infants usually slept in a crib or bassinette, however the percentages do not clearly lead to that conclusion. In two thirds (66.7%) of these cases, the infant was sleeping with his or her parent. Half of the decedents were put to sleep on their backs, one third (33.3%) were put down on their stomachs, and less than 20% were put down on their sides. Only 8.3% of infants were found on their backs – more than half (58.3%) were found on their stomachs. In nearly half of the cases (41.5%) the child was found face down in bedding or with bedding wrapped around them. In 8.3% of cases, the child was found face down in a memory-foam pillow. In one quarter (24.9%) of cases, the child was found under an adult.

## Accidental Deaths: Recommendations for Prevention

Accidental deaths are defined by the National Center for Child Death Review as “a manner of death indicating non-intentional trauma.” The majority of accidental deaths of children in Clark County in 2007 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. More than one third (38.8%) of all accidental deaths that occurred among children in Clark County in 2007 were the result of some type of motor vehicle accident.
  - The majority of MVA decedents (58%) were passengers. In 46.7% of the passenger fatalities, the driver was under the age of 21, and one third of the cases had 3-5 people in the car. Primary causes of these accidents included speed and recklessness. Age appropriate information should be provided to teenagers in school about riding with friends who don't drive safely.
  - In 100% of cases where an infant or toddler age birth to age four was killed in a passenger fatality, an age-appropriate child seat was not used. Prevention activities should include education to parents and older siblings about the necessity of using child seats for infants and toddlers in community centers, child care centers or preschools. Information should be presented to the legislature about increasing penalties for cases where law enforcement identifies infants or children who are not properly restrained. In addition, a system should be implemented where law enforcement officers issuing a citation for an improperly restrained child or court personnel accepting payment for such citations should provide a flyer about the Safe Kids Child Seat distribution program to parents so if a child seat is needed, the parents can access it.
2. The nearly all (82%) of drowning victims in 2007 were between the ages of one and four, which is nearly a 50% increase in deaths in this age group from 2006. In 60% of cases, there was no barrier in place to prevent access to the pool. In several of the cases where barriers existed, the children were able to gain access because the gate was left open or unlocked. A child can drown in a relatively short period of time, from seconds to just a few minutes depending on the circumstances. Therefore, it is imperative that young children are supervised constantly and that appropriate barriers are in place to prevent a young child from accessing a pool or spa.
  - The majority of pool drowning incidents in 2007 took place in older areas of Las Vegas, Henderson and North Las Vegas, which may account for the lack of appropriate barrier devices which are mandated by the County for newer pools. Prevention efforts should focus on bringing older pools up to current code by providing fences, gates, and other safety features to prevent drowning. Coordination with an Adopt-A-Fence program which is currently being implemented in Clark County and with the County's pool inspectors to go out and inspect pools built prior to the 2003 Pool Code mandating barriers could reduce the number of drownings.
  - Slightly less than half of the 2007 drowning incidents occurred at a home where the decedent did not primarily reside – usually either a friend or relative's home. Therefore, it is important to include pool safety measures even if a child does not



regularly reside at the home. Children who visit, and especially those that do not have a pool at home who may be intrigued by the water, are at risk for drowning if appropriate supervision and barriers are not in place.

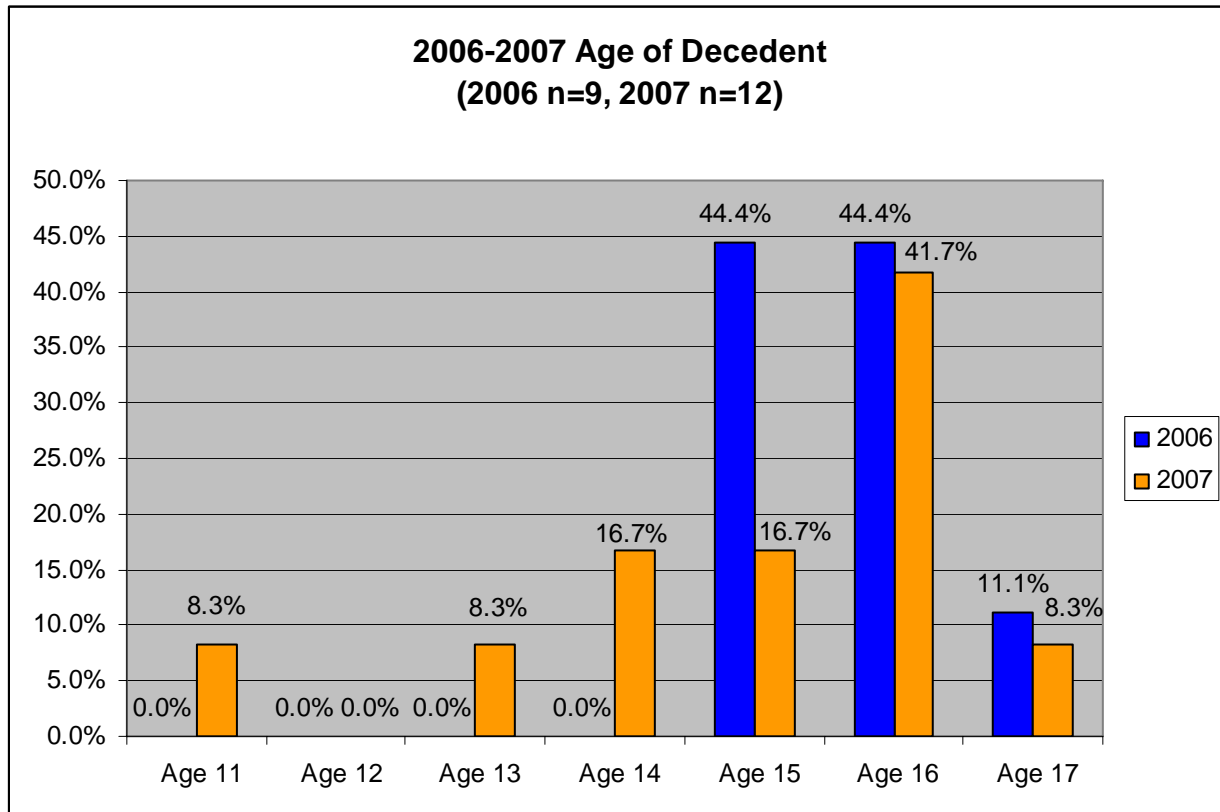
3. More than three-quarters (58.7%) of children who died from suffocation were under one year old. Additionally, all suffocation cases in this age group were sleep related, meaning that the incident occurred while the child was sleeping and/or was in a sleeping location. Suffocation of infants generally occurs when the child's face becomes pressed into a soft object, such as a blanket, pillow, or stuffed animal. Suffocation can also occur when a child's head becomes wedged between people, mattresses, chairs and other items. It is important to educate parents and caregivers on proper sleep positions and sleep environments for young children, especially those under age one. Education should focus on the need for firm, flat sleep surfaces which are clear of toys and debris, as well as the importance of providing an infant with their own sleep environment, such as a crib or bassinette.

## Section V: Suicide Deaths

Suicide is defined as the willful termination of one’s own life. According to the National Center for Child Death Review, in 2000, suicide was the third leading cause of death among young people ages 15-24, just behind unintentional injury and homicide. In 2007, there were 12 youth suicides, a 33.3% increase from nine in 2006. The percentages for sex, race and ethnicity for all 2006-2007 suicide cases are listed in the Figures below. There were equal numbers of suicide cases by hangings (41.7%) and fatal firearm injuries (41.7%). There was a 19.5% increase from 2006 in the number of firearm suicides. One quarter (25%) of cases were considered a mandatory review for the team due to prior child welfare involvement.

Ages of youth who died from suicide ranged from 11-17, with nearly half (41.7%) aged 16. One third of the victims were 14 and younger. In 2006, all suicide victims were between the ages of 15-17. The increase in the number of cases where the decedent is 14 years old and younger is a disturbing trend.

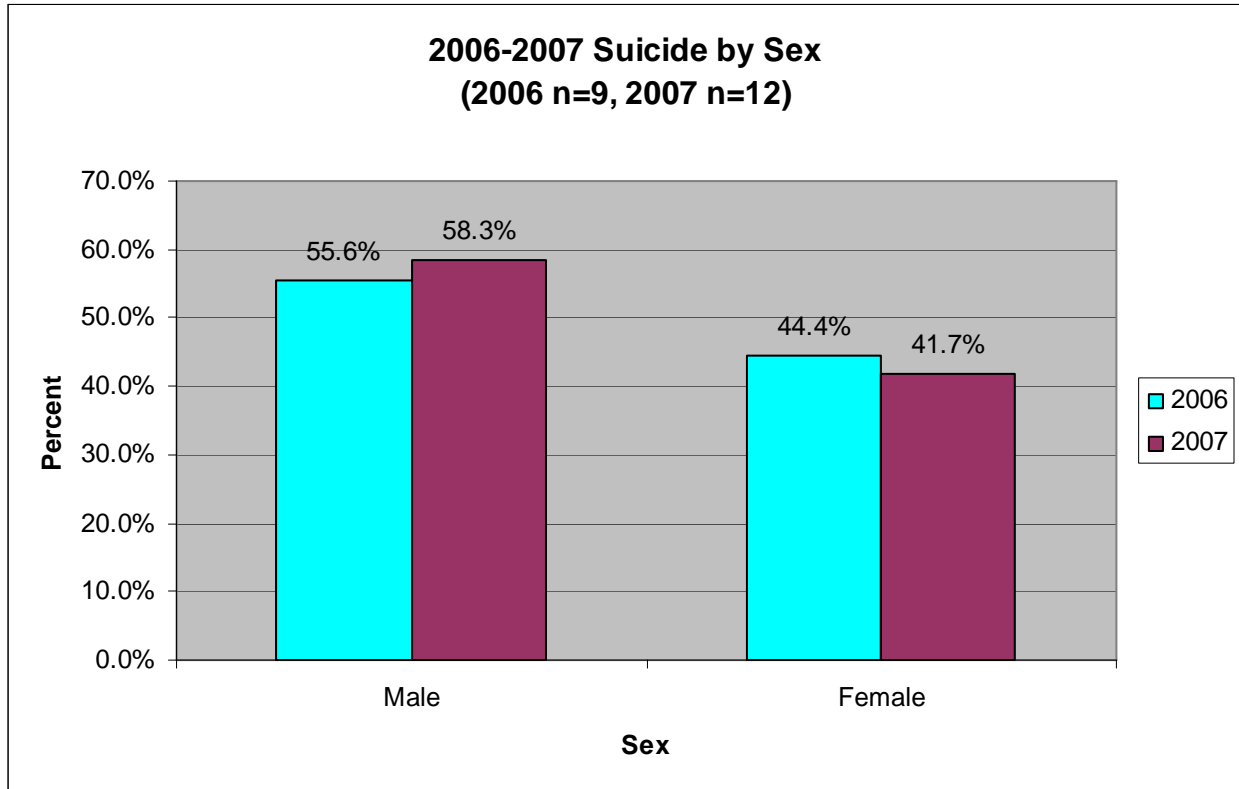
Figure 5.1



Of those youth between the ages of 10-14, 50% listed Hispanic ethnicity, while racially they included White Non-Hispanic, White Hispanic, Black, and Asian. Three quarters (75%) of these cases were female, and none had a known substance abuse history nor any involvement with juvenile justice. One quarter of the cases were mandatory reviews due to prior child welfare involvement.

Slightly over half of decedents (58.3%) were male, and just under one half (41.7%) were female. This pattern demonstrates a slight 2.7% increase in male suicides from 2006. Clark County's data does not match the national profile showing males completing suicide at nearly four times the rate of females<sup>2</sup>, which demonstrates a need for suicide prevention efforts focused on teen girls.

**Figure 5.2**

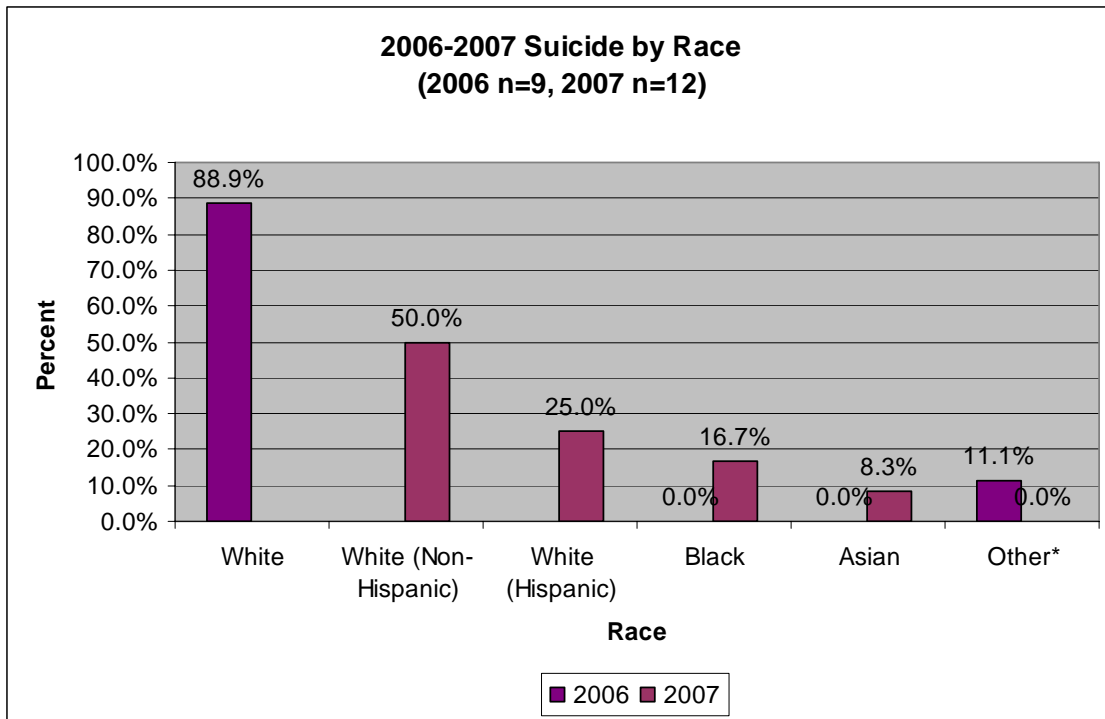


Clark County's data has consistently shown a higher percentage of female suicides than national data trends would suggest. For the girls, 40% of cases were mandatory reviews due to prior child welfare involvement, and exactly 20% had prior juvenile justice history. The majority of decedents were between the ages of 10-14, and 60% were Hispanic. Exactly 20% had a known history of substance abuse, 20% had received substance abuse treatment, and 20% had received mental health treatment.

<sup>2</sup> Centers for Disease Control and Prevention (2004). Suicide Fact Sheet.

In 2006, nearly all suicide cases were White youth; however in 2007 there is a more varied racial/ethnic profile. Half (50%) were White (Non-Hispanic), while one quarter (25%) were White (Hispanic), 16.7% were Black, and 8.3% were Asian. 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 2007, all male suicide victims were between the ages of 14 and 16. Between the ages of 15-16, twice as many White males completed suicide as all other racial/ethnic groups.

**Figure 5.3**

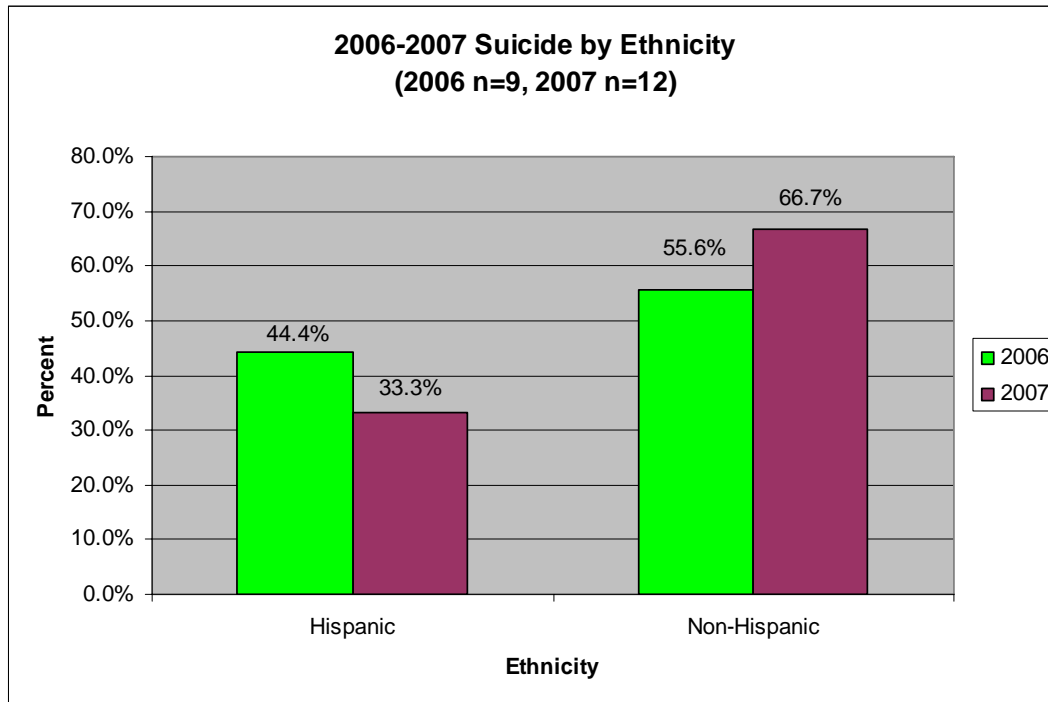


\* The "Other" race in the 2006 data was a person who did not list a race, but listed ethnicity as Hispanic

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

In 2007, 33.3% of suicide cases reviewed by the Clark County Child Death Review Team involved Hispanic decedents, a trend which is not illustrated in the national statistics. Three quarters (75%) of the Hispanic decedents were female. In addition, this percentage shows an 11.1% reduction in the number of Hispanic decedents from 2006.

**Figure 5.4**

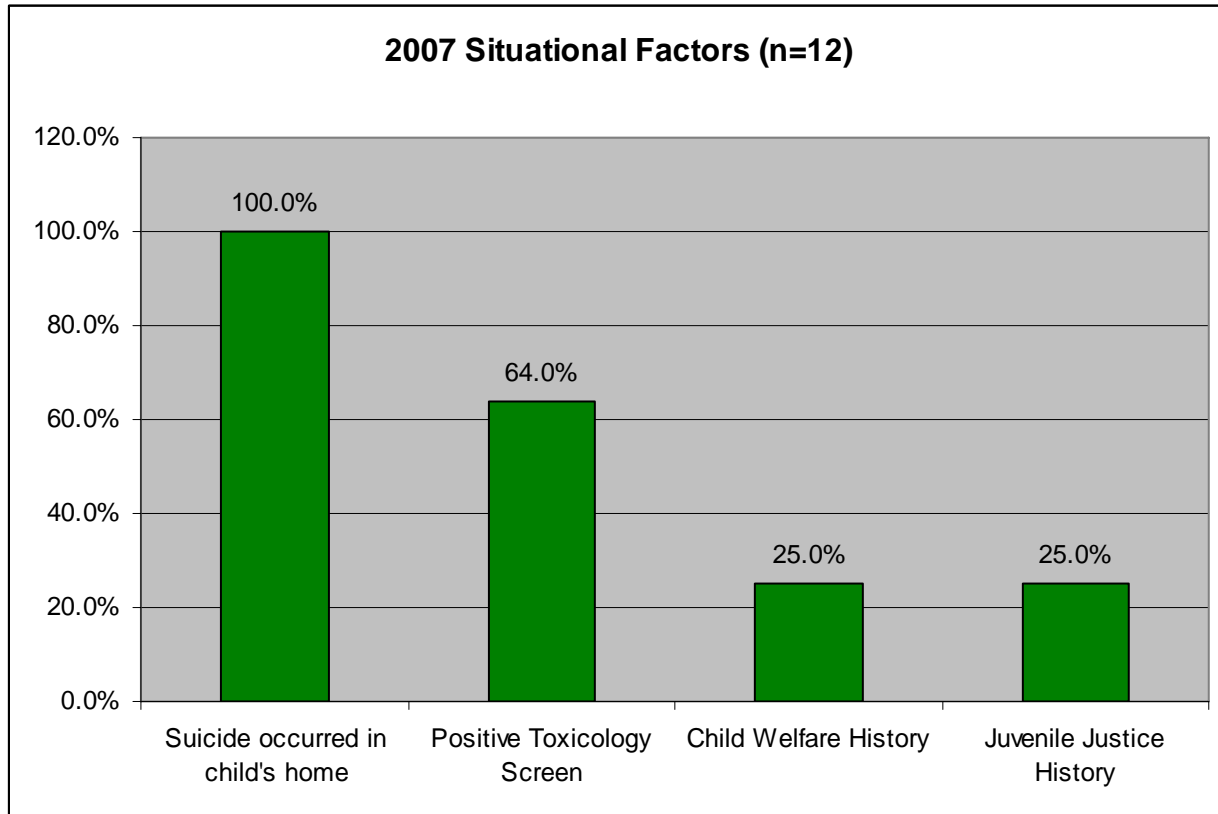


### Situational Factors of Suicide

More than one third (36%) of youth who committed suicide had a known substance abuse history. Three times as many males as females had a known substance abuse history. Of those youth with a known history, 75% were abusing alcohol, 25% had a known history of marijuana use, and 25% were using methamphetamines. In half of the cases (50%), the youth were using other prescription drugs. Finally, only half of the decedents with known substance abuse histories were receiving substance abuse treatment, although 100% were receiving mental health treatment.

In all 12 cases, the suicide occurred in the child’s home. 911 was called in all cases. In one quarter (25%) of cases, the child was not attending school at the time of death. Three quarters of the females were attending school regularly, and slightly less than half of males (40%) were not. In addition, less than 10% of victims were experiencing school failure.

Figure 5.5



In 92% of cases, there was a toxicology screen conducted by the coroner. A study done by the Suicide Prevention Research Center and the Harvard Injury Control Research Center demonstrated that most teen suicides do not involve drugs or alcohol (only 4% do as opposed to 36% of adults), meaning that the teen's postmortem toxicology screens were negative. In Clark County, however, the majority of cases (64%) had a positive toxicology screen - the local data does not support the national trend. In approximately 10% of cases the toxicology screens were positive for alcohol, 10% were positive for cocaine, and 10% were positive for prescription drugs (drugs included Soma and Xanax).

Slightly less than one third (27%) had a prior history of child welfare involvement, and of those cases, two thirds of them the history was on the decedent, and two thirds of them had a history for the decedent's sibling(s). One third (33%) of cases were reported for neglect, and two thirds (66%) reported a sexual abuse incident. Perpetrators included the mother (33%), the mother's boyfriend (33%), and the father (33%), and all reports were unsubstantiated. In nearly 10% of cases, there was CPS involvement as a result of the death. None of the decedents were in foster care at the time of death, and there were no open child welfare cases at the time of death. One third (33.3%) of youth with a prior child welfare history also had a juvenile justice history.

In 25% of cases, the decedent had a juvenile justice history. Charges included curfew violation, petty larceny, drug/alcohol possession, graffiti, assault on a teacher, and possession of stolen property. Of the youth with juvenile justice history, 33.3% had been previously committed to the

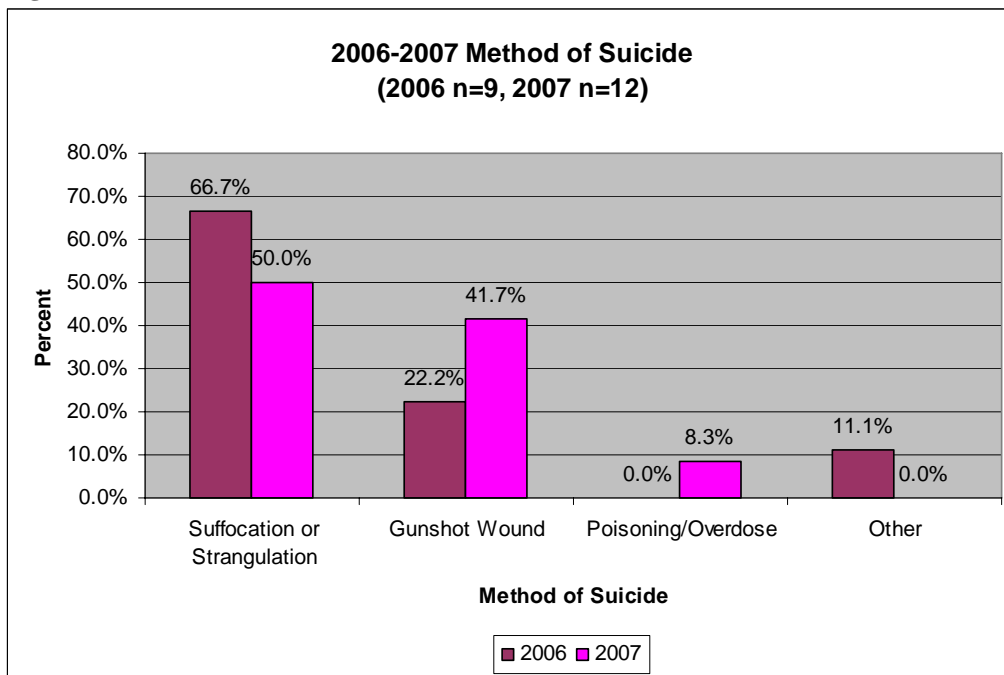
state Division of Child & Family Services. In addition, of these youth with a prior juvenile justice history, the decedent’s sibling had a juvenile justice history in 33.3% of cases.

In addition, “findings from the first national study on the issue indicate that gay or lesbian youths are more than twice as likely to attempt suicide as their heterosexual peers”. (www.childdeathreview.org.). While the team has not collected sexual orientation information for 2007 cases, local law enforcement agencies have begun utilizing a short data collection form for teen suicides which will provide additional information about the circumstances of the incident including the youth’s sexual orientation for the 2008 data.

## Method of Suicide

Firearms (60%) and hanging (26%) were the most common methods of suicide used by young people in the United States<sup>3</sup>. An additional article authored by the Suicide Prevention Research Center and the Harvard Injury Control Research Center suggests that 44% of teen suicides were suffocation deaths (primarily by hanging), followed by 43% of suicides committed using a firearm<sup>4</sup>. Regardless of the actual order, firearms and hanging appear to be the most common methods of suicide for teens, a pattern which is replicated in Clark County for both 2006 and 2007. For Clark County teens, hanging is the most common method of suicide.

**Figure 5.6**



In half the Clark County cases in 2007 (50%) the method of suicide was suffocation or strangulation. This method included both hanging deaths and carbon monoxide inhalation. In the strangulation cases, half of the cases occurred with a rope or string, one quarter utilized a belt,

<sup>3</sup> www.childdeathreview.org, 2007

<sup>4</sup> <http://www.sprc.org/library/YouthSuicideFactSheet.pdf>

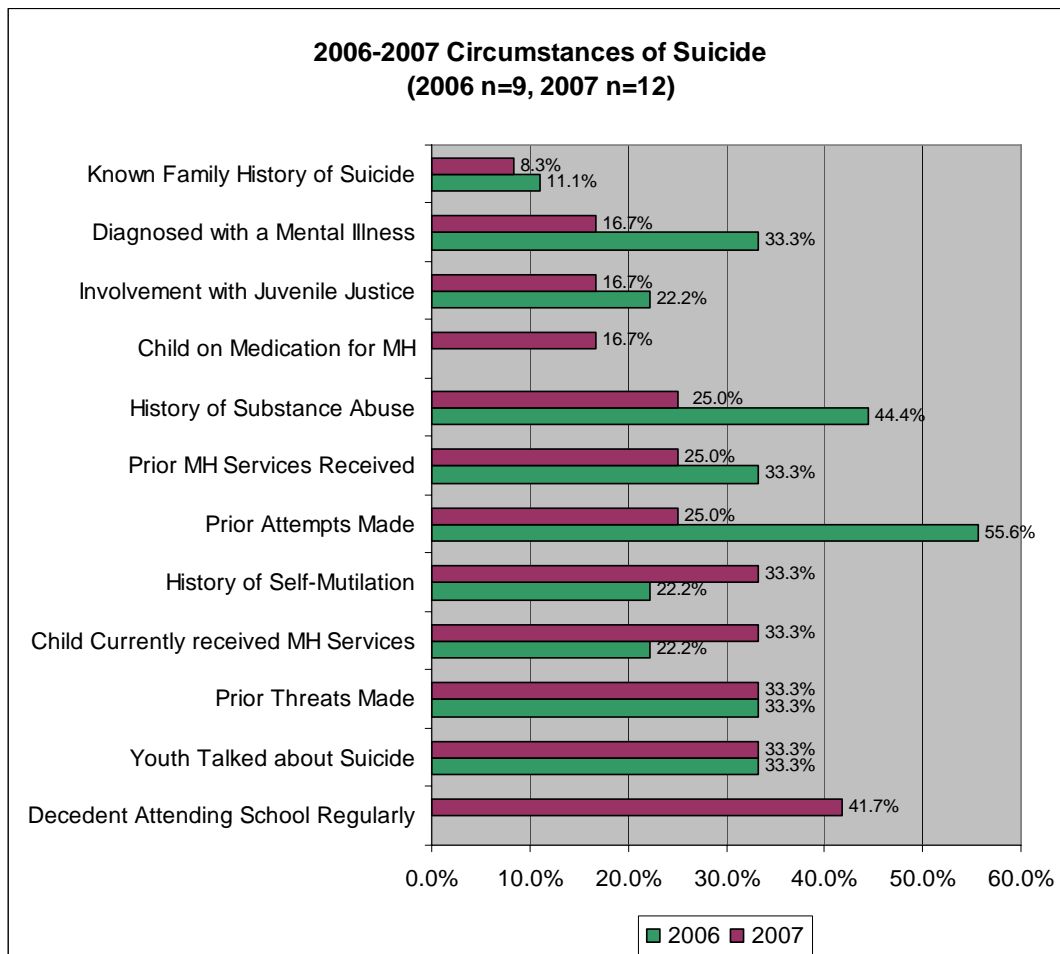
and one quarter used a leash. In none of the strangulation cases did the team suspect the Choking Game or autoerotic asphyxiation. Both of the males who died by hanging had prior suicide attempts, while the females who died by hanging did not.

In nearly half of the cases (41.7%), the decedent used a firearm. All firearm suicides involved a handgun. Nearly two thirds (60%) of firearm suicides were male, and more than one third (40%) were female. In 80% of cases, the gun was not normally stored in a locked cabinet. In 60% of the cases, the firearm was owned by a parent, stepparent or grandparent. In only 20% of the cases, a prior attempt had been made. In 40% of the cases, there was a history of substance abuse, and in 20% of the cases, the decedent had received prior mental health services. Nearly half (40%) of the decedents had not been attending school regularly.

### Circumstances of Suicide

There are several factors that have been identified as risk factors for suicide. The circumstances that were present in the 12 cases reviewed are listed in Figure 5.7 below.

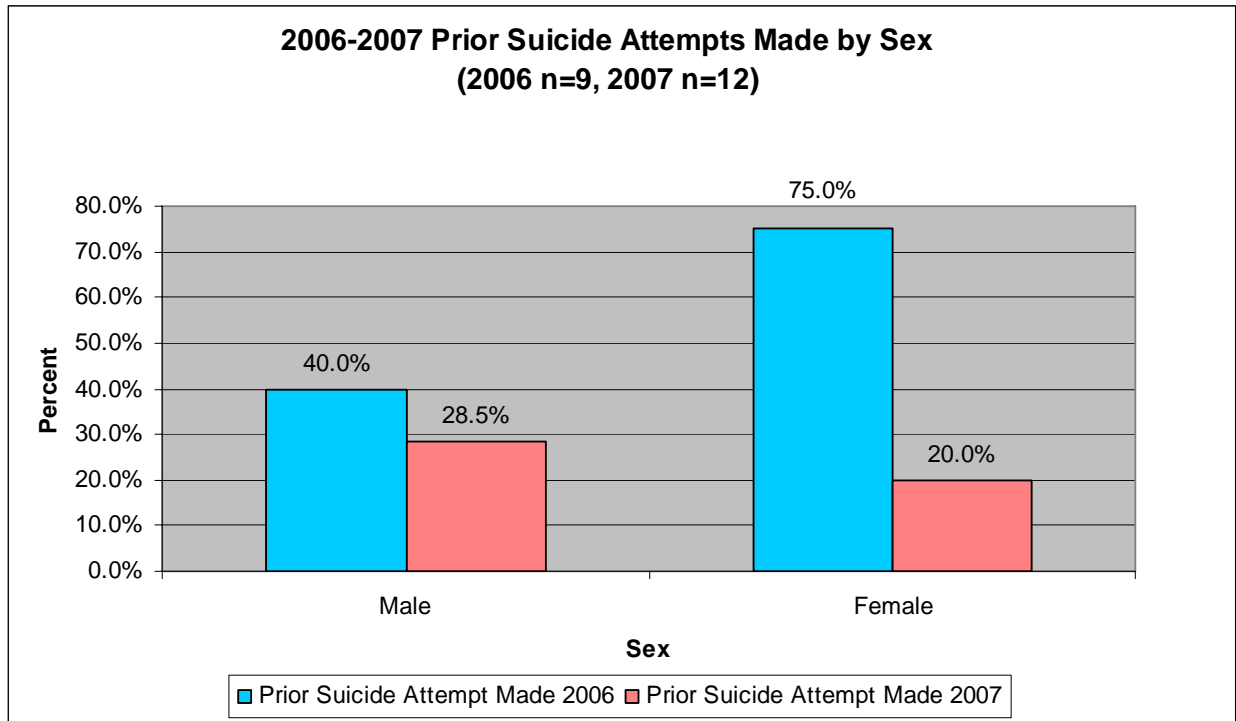
**Figure 5.7**





In the 2007 cases, there are clearly identified risk factors, such as the fact that in more than a third of the cases the youth was talking about suicide, a trend that remains steady from 2006 to 2007. One third of decedents had made prior threats. According to literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide<sup>5</sup>. In 2006, over half (55.6%) of suicide victims had prior attempts, while in 2007, slightly one quarter (25%) of decedents had a prior attempt, which is a drop of more than 50%. In addition, nearly one quarter (25%) had a history of substance abuse, and slightly less than 20% were diagnosed with a mental illness. National literature clearly shows that adolescent males of all races are four times more likely to commit suicide than females, but adolescent females are twice as likely as adolescent males to attempt suicide. The 2007 Clark County data showing attempts by sex illustrates a different trend. In 2006, girls were nearly twice as likely as males to have made a prior suicide attempt, but in 2007, the percentage of males and females who had prior suicide attempts was approximately equal.

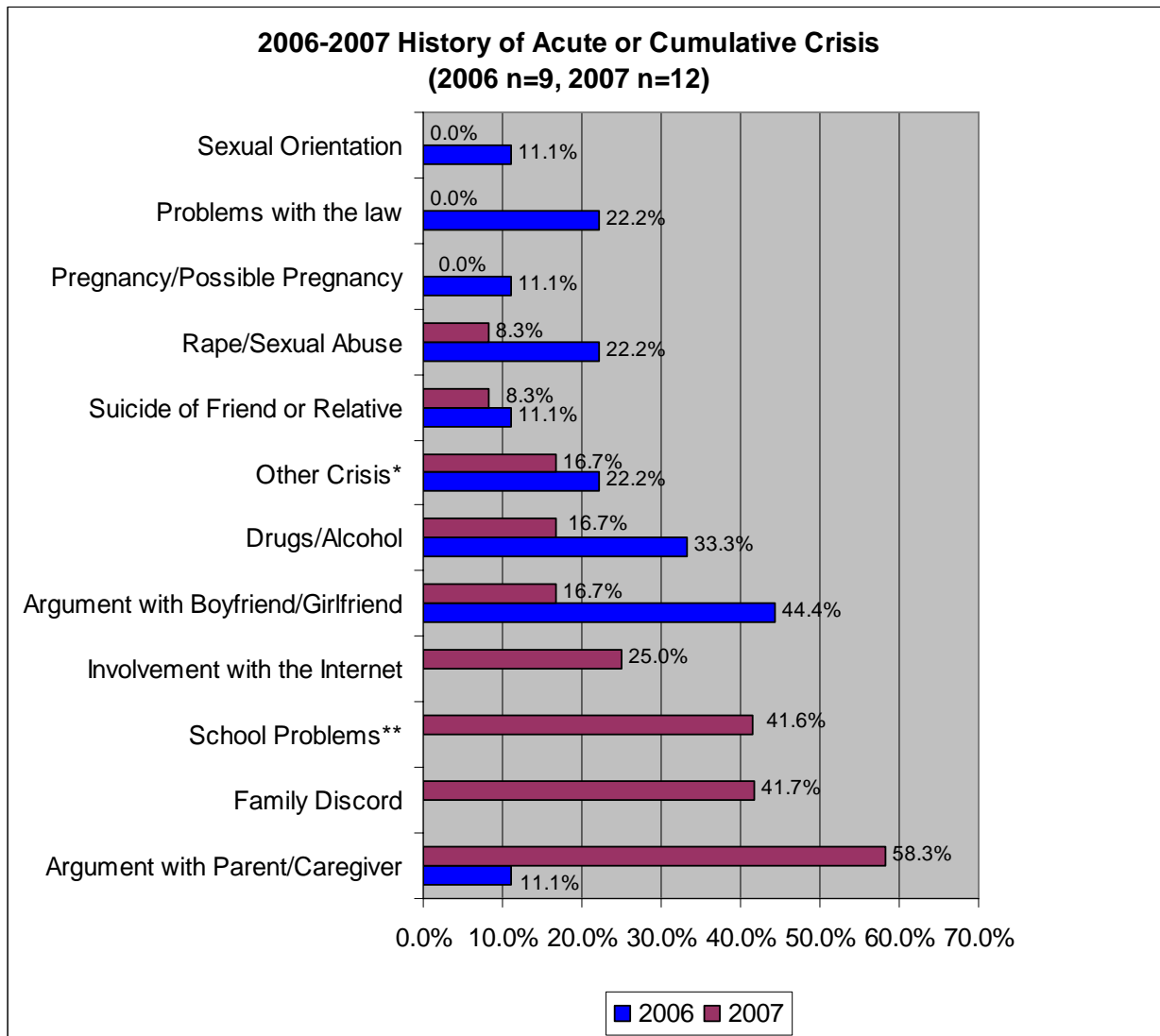
**Figure 5.8**



<sup>5</sup> www.KidsHealth.org, Retrieved June 25, 2007

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. More than half of the victims (58.3%) had recently had a fight with their parent, and nearly 1 in 5 (16.7%) had recently fought with their boyfriend or girlfriend. Approximately 20% had been involved with drugs or alcohol, and more than one third (41.6%) were experiencing problems in school. General family discord and school problems each appear in 41% of cases.

**Figure 5.9**



\* Other Crisis includes alleged sexual abuse

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

## **Suicide Deaths: Recommendations for Prevention**

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

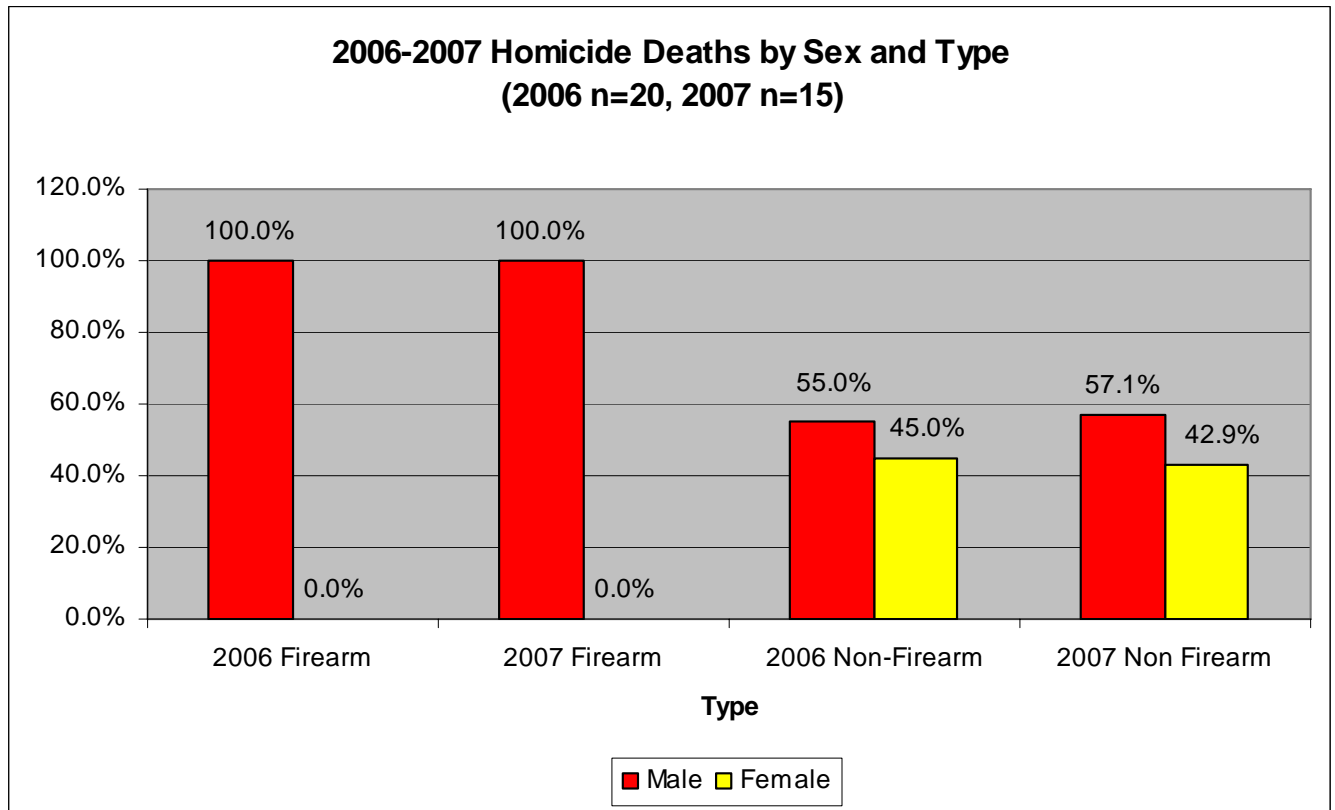
1. In 2006, all teen suicides occurred in the 15-17 age group. In 2007, ages of decedents ranged from 11-17, with one third (33.3%) between the ages of 11-14. The appearance of such young teens completing suicide is disturbing and needs immediate attention from the community. It is essential that mental health screenings occur in children that are middle school aged, and that teachers and other non-family members are educated about the signs and risk factors for suicide.
2. Clark County's data has consistently shown a higher percentage of female suicides than national data trends would suggest. It is essential that consistent data is collected by investigators that describes specific circumstances of all youth suicides, but particularly the females, as there may be risk factors that do not apply to the boys, and therefore targeted outreach efforts may focus on girls.
3. More than one third (36%) of youth had a known substance abuse history. Of those youth with a known history, 75% were abusing alcohol, 25% had a known history of marijuana use, and 25% were using methamphetamines. In half of the cases (50%), the youth were using other prescription drugs. Prevention efforts should focus on reducing youth access to substances which may impair their ability to think rationally, particularly if other risk factors exist. However, it is important to note that substance abuse and suicide seem particularly connected in males, since three times as many males as females had a known substance abuse history. In addition, all decedents with a known substance abuse history were receiving mental health treatment. Providing quality substance abuse treatment and mental health treatment to males may be able to reduce the potential suicide risk of these youth.
4. Nearly one in five (16.7%) of all youth who committed suicide in 2007 had recently been in an argument with their boy/girl friend. Prevention efforts should attempt to include other youth in recognizing the signs of suicide, as well as measures that can and should be taken to intervene.

## Section VI: Homicide Deaths

Homicide is legally defined as the killing of one human being by another human being. The CDC lists youth homicide as the second leading cause of death for the 10-24 age group<sup>6</sup>, and further states that “among 10-24 year olds, 86% of homicide victims were male, and 82% were killed with a firearm.”<sup>7</sup> Further, “among 10 to 24 year-olds, homicide is the leading cause of death for African Americans; the second leading cause of death for Hispanics and Asian/Pacific Islanders; and the third leading cause of death for American Indians and Alaska Natives.”<sup>8</sup>

In 2007, there were 15 homicides of children and youth, which is a reduction of 25% from the 20 in 2006. The 2007 homicides fell into two categories – those that were committed using a firearm (53.3%) and those that were committed without a firearm (46.7%). Overall, victims were four times more likely to be male (80%) than female (20%), and primarily between the ages of 15-17 (40%). All victims of firearm homicides were male in both 2006 and 2007.

Figure 6.1



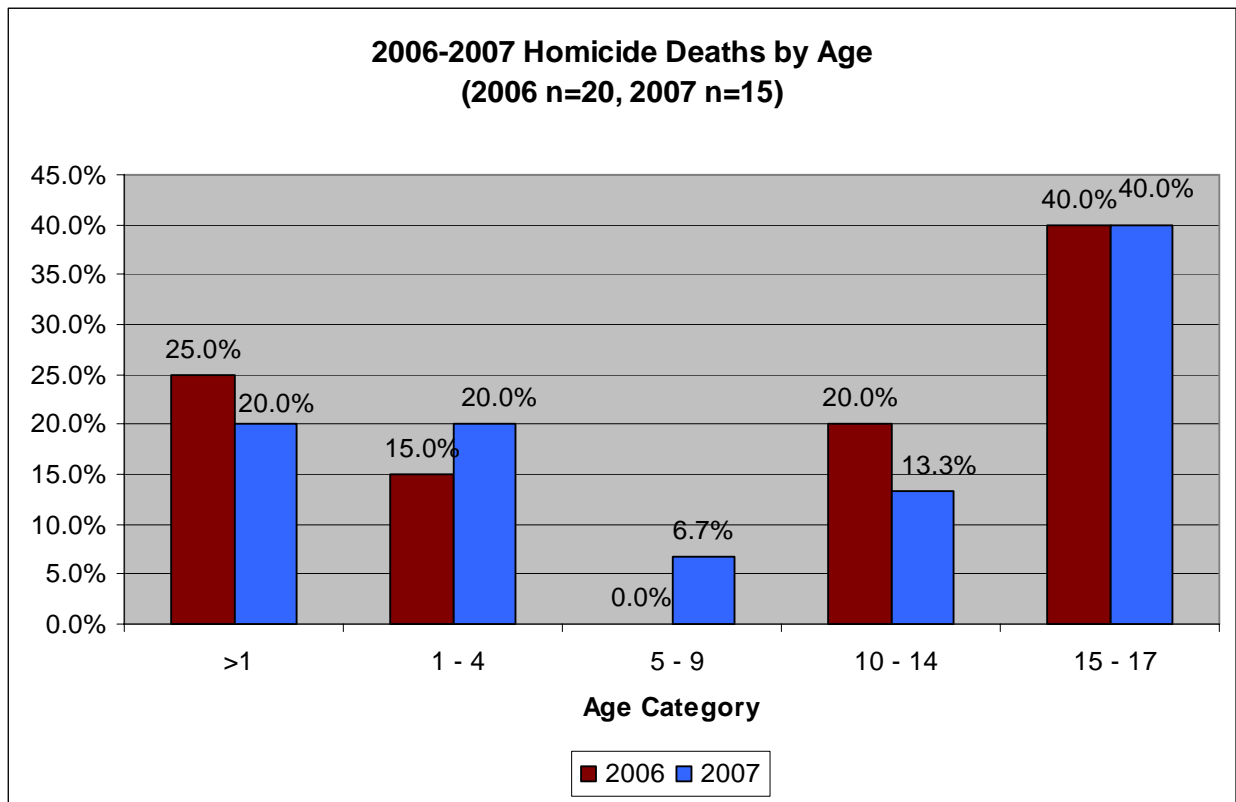
<sup>6</sup> <http://www.cdc.gov/ncipc/pub-res/YVFactSheet.pdf>

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

<sup>8</sup> [http://www.cdc.gov/ncipc/dvp/YV\\_DataSheet.pdf](http://www.cdc.gov/ncipc/dvp/YV_DataSheet.pdf)

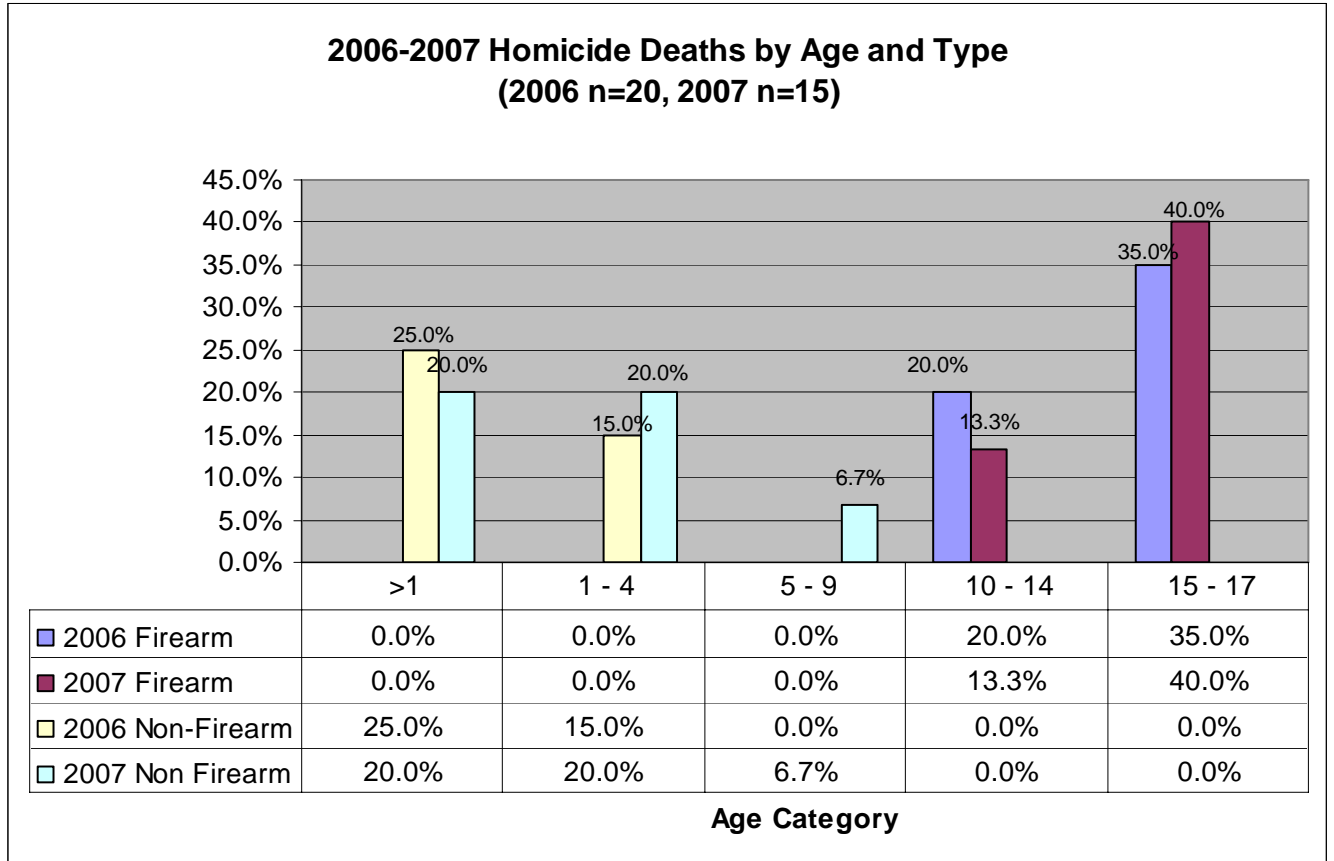
One third of the victims (33.3%) were White (Non-Hispanic), more than one third (40%) of victims were Black, and 20% were listed as having Hispanic ethnicity. This data indicates that Black and Hispanic teens are disproportionately victimized by homicide. It is also interesting to note the bimodality of the age distribution in both 2006 and 2007. No children between the ages of 5-9 were homicide victims in 2006 although there were victims in this age group in 2007, and the oldest group (ages 15-17) and the youngest group (infants <1 year) demonstrated the highest percentages of victims in both 2006 and 2007.

**Figure 6.2**



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

Figure 6.3



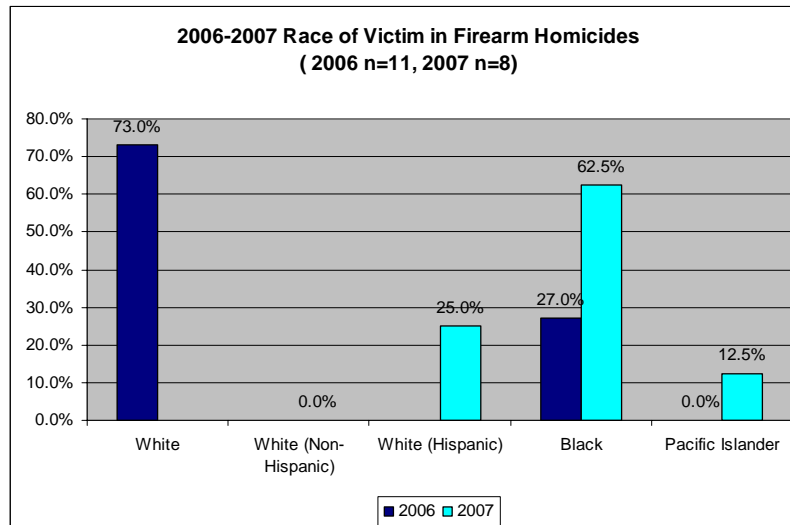
## Firearm Homicides

Youth homicides represent the greatest proportion of all firearm deaths<sup>9</sup>. Youth living in neighborhoods with high rates of poverty, social isolation and family violence are particularly at risk for victimization, as these contribute to the prevalence of specific risk factors for youth homicide. “Major contributing factors in addition to poverty include easy access to handguns, involvement in drug and gang activity, family disruption and school failure.”<sup>10</sup> Clark County’s data supports these factors, particularly the substance abuse history, gang involvement, and school failure. In addition, “these homicides usually occur in connection with an argument or dispute. Firearm homicides among teens are almost always committed by casual acquaintances of the same gender, race, and age, and almost always committed using inexpensive and easily acquired handguns.”<sup>11</sup>

The percent of firearm homicides (53.3%) in 2007 is nearly equal to the percent of non-firearm homicides (46.7%) and does not show significant change in the pattern since 2006. There are unique characteristics of the firearm homicides, however. Firearm homicides occurred exclusively in the 10-17 age group, and primarily among 15-17 year olds (75%). None of the infants or children were killed using firearms. All (100%) of firearm homicide victims in both 2006 and 2007 were male.

Racially, all victims were minorities: nearly two thirds (62.5%) were Black, one quarter (25%) of victims were White (Hispanic), and 12.5% were Pacific Islander. There were no White (Non-Hispanic) youth victimized by firearm homicide in 2007. The percentage of Black victims is disproportionate to the population distribution in Southern Nevada and represents a clear area for intervention. In addition, 45% of victims of firearm homicides in 2006 listed Hispanic ethnicity, and in 2007 25% of victims listed Hispanic ethnicity.

**Figure 6.4**



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

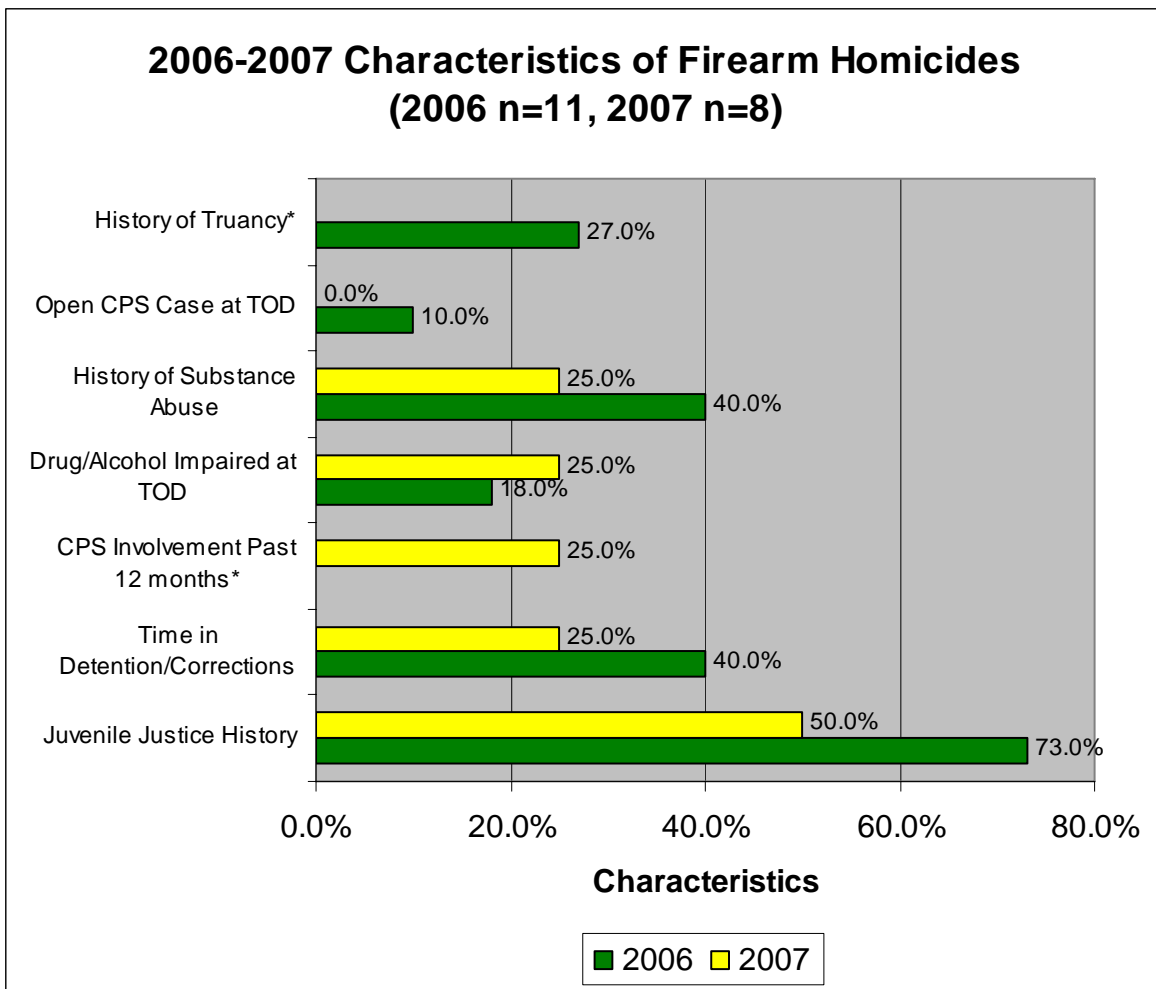
<sup>9</sup> www.childdeathreview.org (2007)

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

<sup>11</sup> www.childdeathreview.org (2007)

Three quarters of victims were attending school regularly. None of the firearm homicide victims had a disability. Approximately one quarter (25%) had a known history of substance abuse, and one quarter (25%) were positive for drugs at the time of death. A toxicology screen was conducted in 62.5% of cases, and of those who had one, 40% were positive for marijuana and 20% were positive for methamphetamines. All victims with a known history of substance abuse were using marijuana, and half of those victims were using methamphetamines. None of these victims were known to be receiving substance abuse treatment or mental health treatment. In 75% of cases, the youth’s primary caregiver was a parent, and in 12.5% of cases, there was a known history of substance abuse by the mother. In more than a third of cases, the youth had 2 or more siblings living with them.

**Figure 6.5**

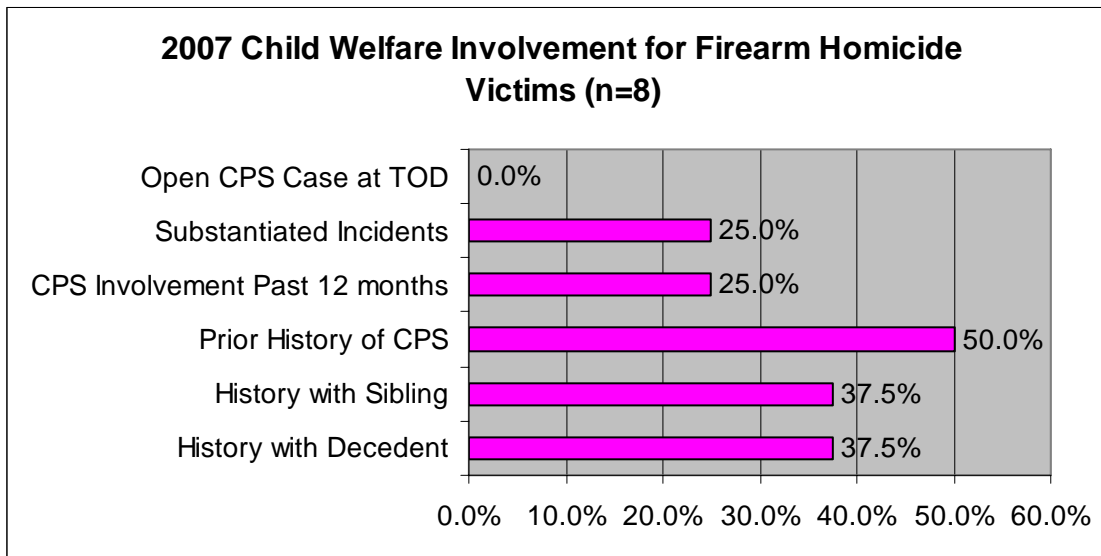


*\*NOTE: These questions were not asked in both 2006 and 2007 and therefore data does not exist for both years for the variables; “History of Truancy” or “CPS Involvement Past 12 Months.”*



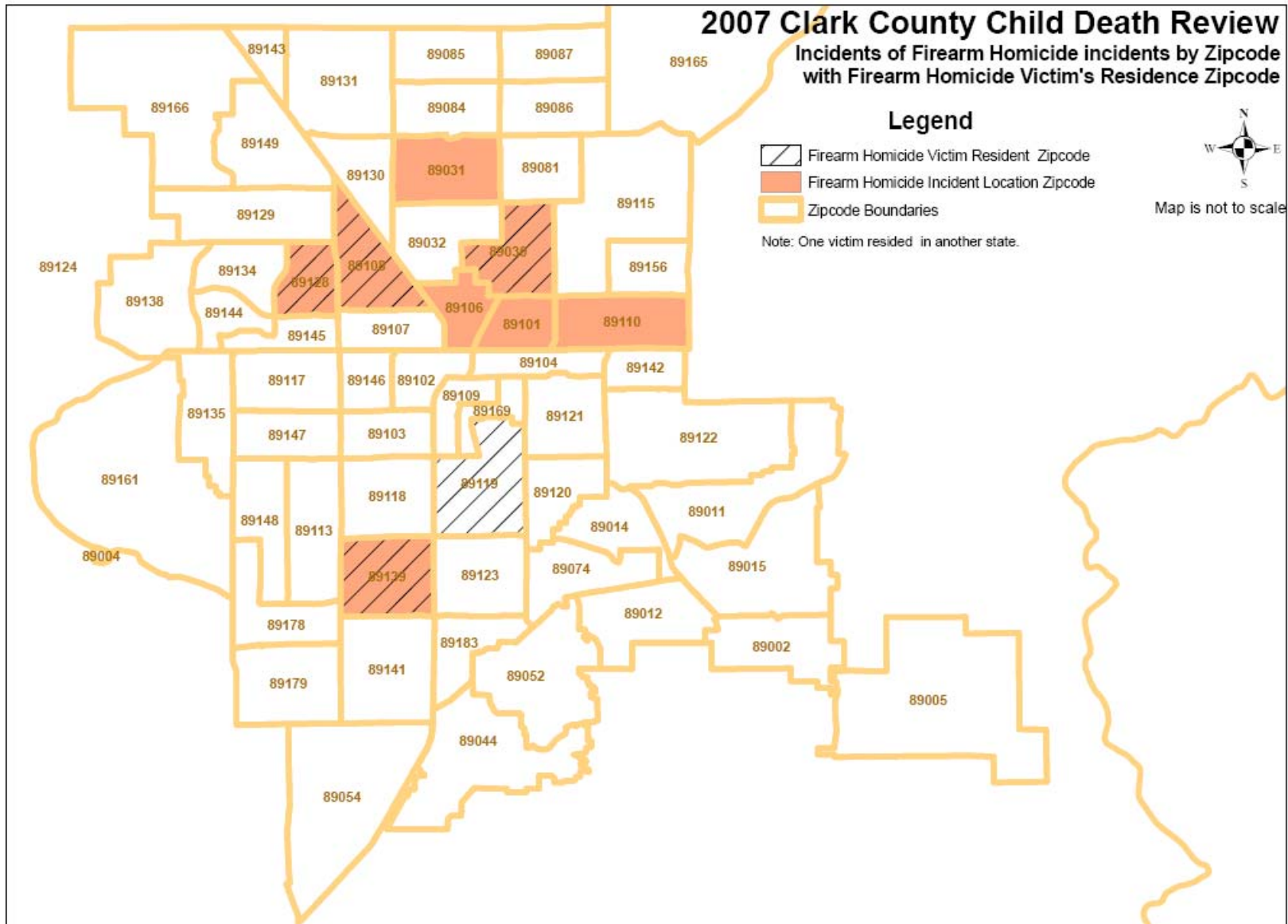
Half (50%) of these cases were mandatory case reviews due to a prior history of child welfare involvement. In both of the cases where the child had a known history of substance abuse, the case also had a prior history of child welfare involvement. CPS action was taken as a result of the death in none of the cases. Of those cases where there was prior CPS involvement, 75% of cases had a history with the decedent, and 75% had a history with the sibling. None of the cases were open at the time of death, but 25% had had a case closed within the last 12 months, demonstrating a recent level of family disruption. Incidents included neglect, physical abuse, and sexual abuse, with perpetrators listed as mother, father, and mother with mother's boyfriend. Incidents were substantiated in 25% of cases.

**Figure 6.6**



One half of firearm homicide victims had a known juvenile justice history, which is a reduction of approximately 30% from 2006, when approximately three quarters had a known juvenile justice history. Charges included: burglary, larceny, truancy citations, curfew violations, trespassing, and driving without a license. Several charges were handled informally, however 25% of cases were sent to a correctional institution or placed on parole, demonstrating a higher level of criminal sophistication. In 25% of cases, there is a known history of juvenile justice involvement with a sibling.

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

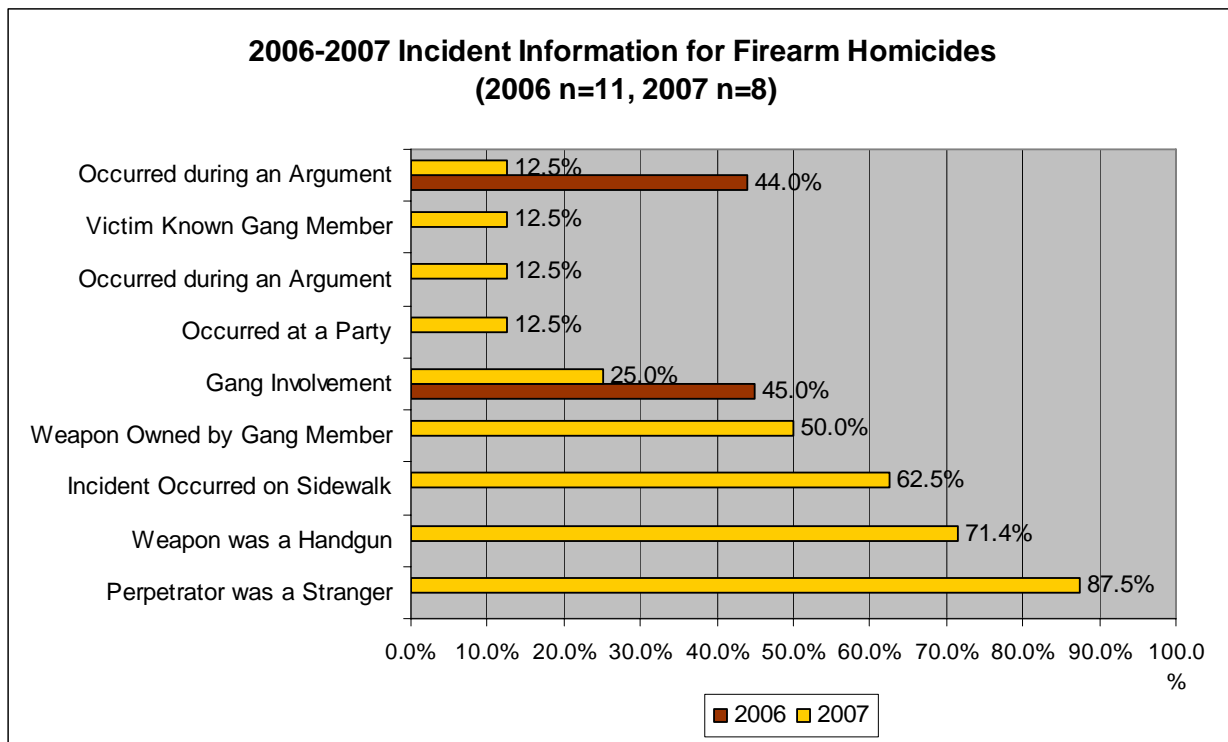


In 25% of cases, the incident occurred at a friend or relative's home, however almost two thirds (62.5%) of incidents occurred on a sidewalk. Nearly all (87.5%) were committed with a handgun, however 12.5% of cases were committed using an assault rifle. In none of the cases was the handgun known to be stored in a locked cabinet. In 25% of cases, the handgun was owned by a friend or neighbor, and in 50% of cases, the weapon was known to be owned by a gang member. Weapon ownership was unknown for 25% of victims. One quarter of victims were killed during the commission of a crime, 12.5% were killed during a drive-by shooting, and one third (37.5%) were killed in random violence.

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

There was suspected gang involvement in one quarter of the cases. In 12.5% of cases the victim was known to be in a gang and 12.5% of victims were suspected members of a gang. In 12.5% of cases, the perpetrator was known to be in a gang, and in 37.5% of cases the perpetrator was a suspected gang member. Nearly all (87.5%) victims were killed by a stranger. Slightly more than one third of cases (37.5%) occurred between 12pm and 6pm, slightly more than one third of cases (37.5%) occurred between 8pm and 12am, and one quarter (25%) occurred between 12am and 6am. Only 12.5% of incidents occurred at a party, and 12.5% of incidents occurred during an argument.

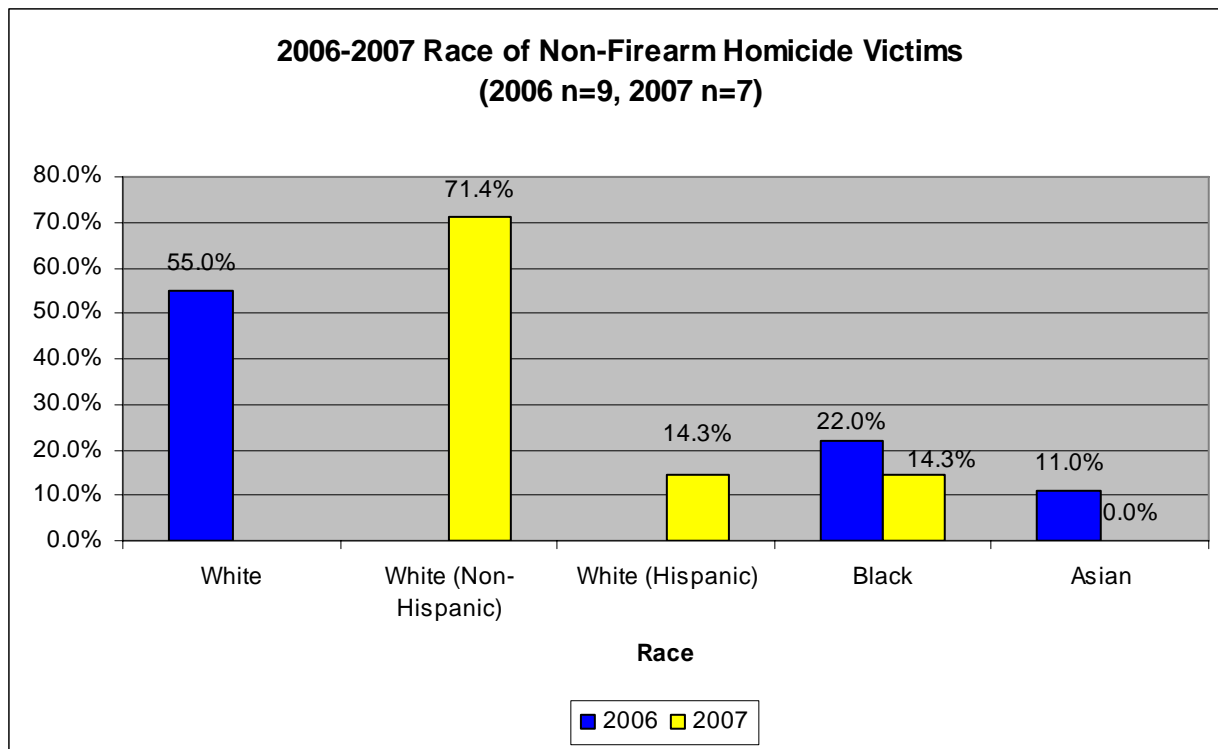
**Figure 6.7**



## Non-Firearm Homicides

Clark County's seven non-firearm homicides demonstrated an entirely different pattern of circumstances than firearm homicides. Of the seven cases in 2007, nearly all victims were age four or under, and 43% of all victims were under age one. The majority of victims (71.4%) were White (Non-Hispanic), with 14.3% of victims listed as Black, and 14.3% listed as having Hispanic ethnicity. The sex of non-firearm homicide victims was much more evenly split, with 57.1% being male and 42.9% being female. Contrary to the firearm homicide victims, where none of the victims had a known disability or chronic illness, 14.3% of non-firearm homicide victims had a known disability or chronic illness. This percentage shows a decrease from 2006 in the number of victims with a known disability or chronic illness. None of the victims were ill in the two weeks prior to death.

**Figure 6.8**

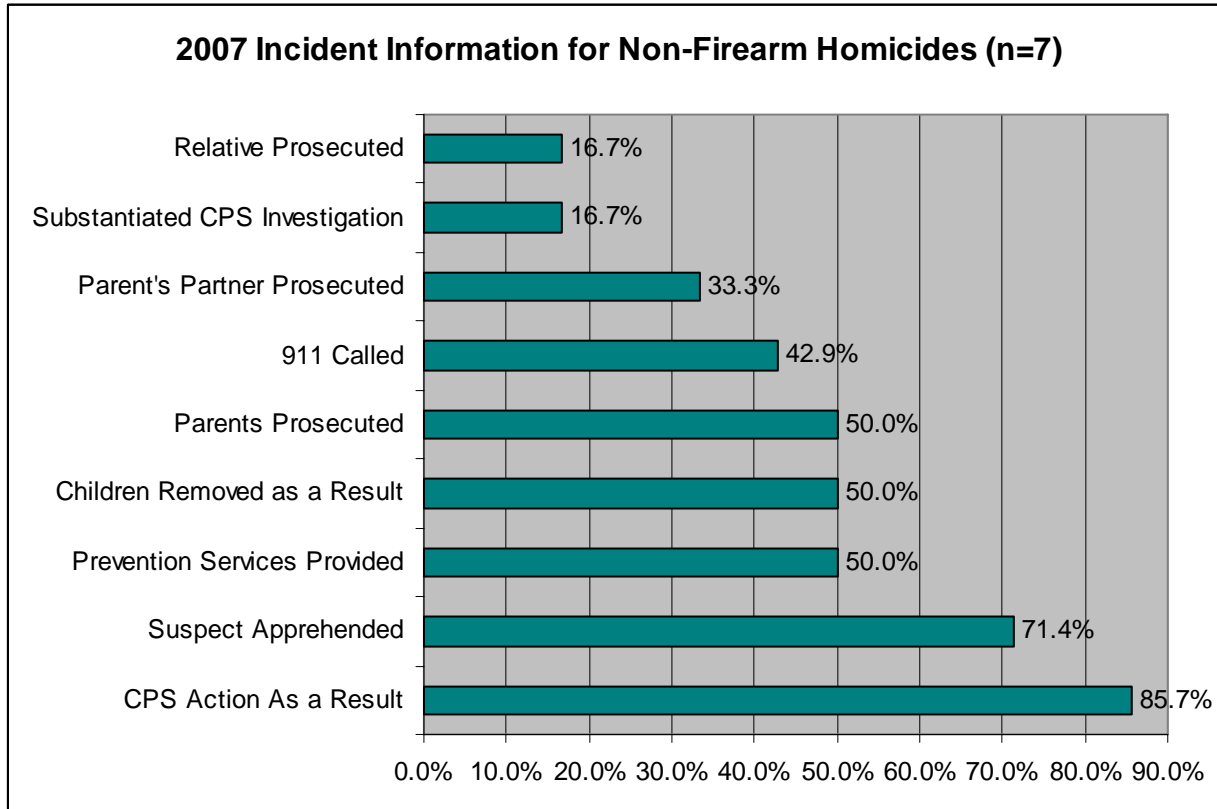


\* Race/Ethnicity data were collected differently in 2006 and 2007. In 2006, data did not differentiate between White (Non-Hispanic) and White (Hispanic).

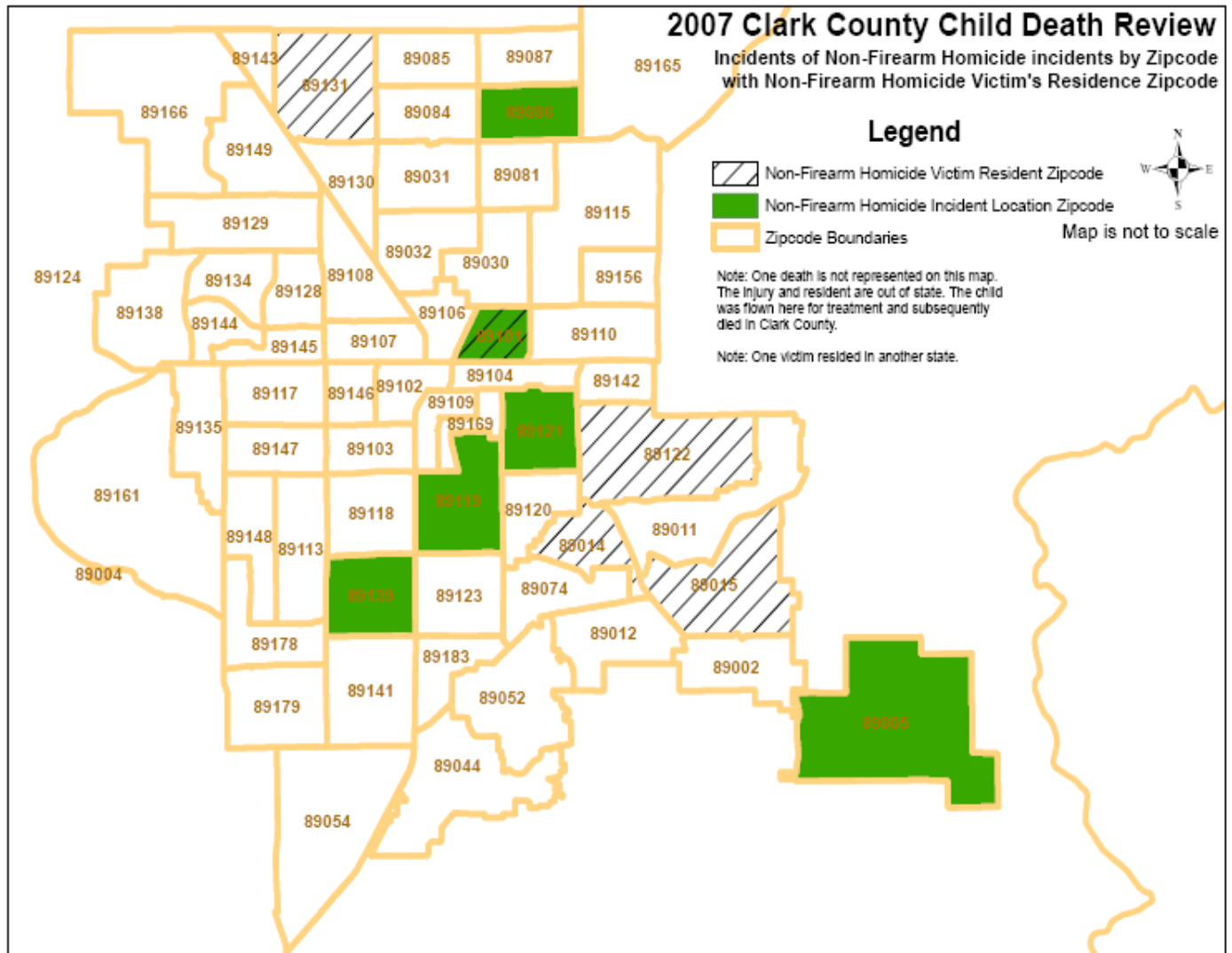
Due to the age of the majority of the victims, 85.7% were not attending school at the time of death. All victims were in the primary care of their biological parent at the time of death. More than three quarters (85.7%) had other adults living in the home, including their parent's boyfriend or girlfriend (66.7%), and grandmother (33.3%). None of the biological mothers or fathers had prior known child deaths. However, more than a quarter (28.7%) of decedents had a family member with a known substance abuse history, which includes the mother (14.3%), father (14.3%), grandmother (14.3%) and aunt (14.3%). Of those children under a year old, 33% were premature, and 33% were full term. In addition, none of the decedents were born drug exposed.

In these non firearm homicides, 85.7% were committed by a person without using a weapon. In those cases, the child was beaten, punched, and pushed. Approximately 15% were committed using a knife. In more than half (57.1%) of cases, the perpetrator was a relative and in 42.9% of cases the perpetrator was a friend (includes parent’s boyfriend or girlfriend). In the majority of cases (57.1%), the age of the perpetrator was known, and in 50% of those cases the perpetrator was aged 21 or younger. In 71.4% of cases, the time of day of the incident was known. Of those cases, 60% were committed between 11am and 4pm, and 40% were committed between 6pm and 9pm.

**Figure 6.9**



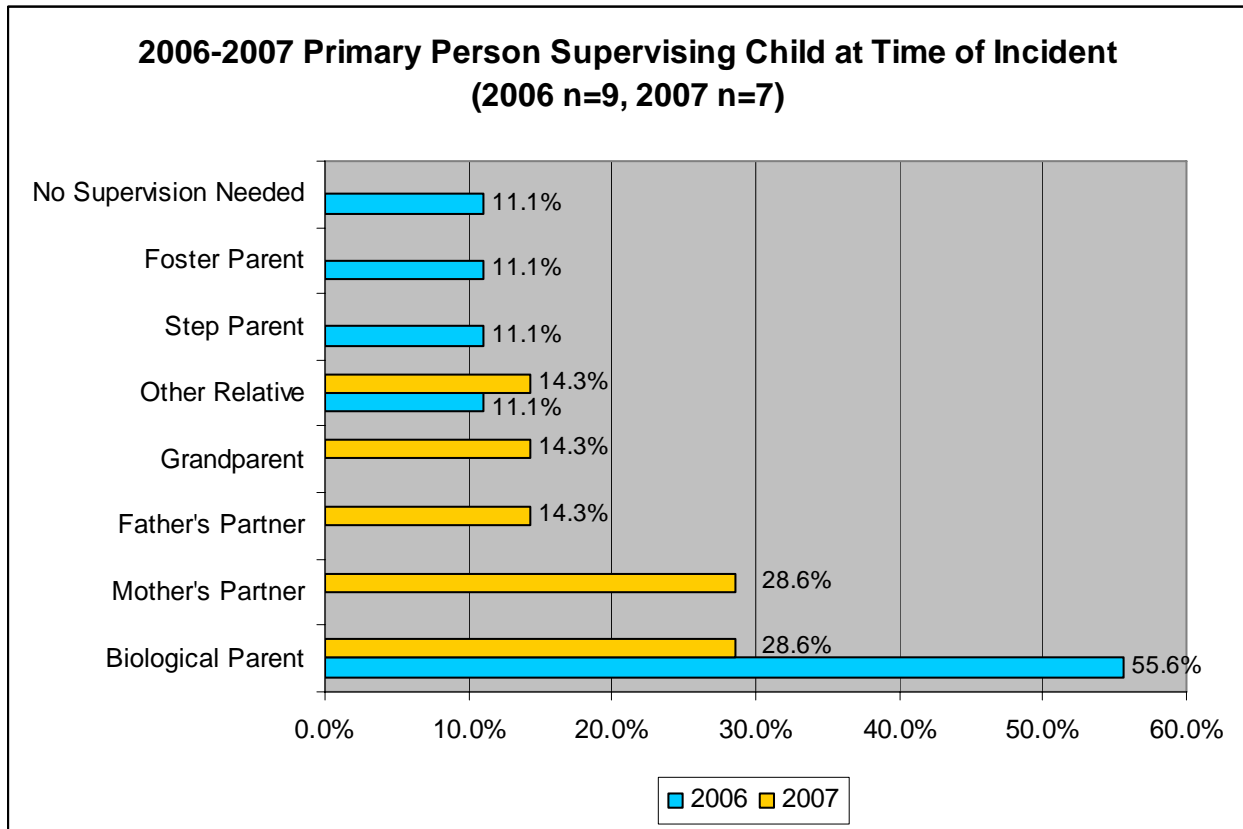
911 was called in less than half (42.9%) of cases. CPS action was taken in 85.7% of cases as a result of the death. As a result of the death, prevention services were provided to the family in 50% of cases, the investigation was substantiated in 16.7% of cases, and children were removed in 50% of cases. The suspect in the case was apprehended in 71.4% of cases. Prosecution was pending in 85.7% of cases at the time of review. Parents were being prosecuted in 50% of cases, the parent’s boyfriend or girlfriend was being prosecuted in 33.3% of cases, and another relative was being prosecuted in 16.7% of cases.



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 2007 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. One of these cases involved a child where both the injury incident location and the child’s residence were in another state and therefore not represented on this map. The case was reviewed in Clark County because the child was treated at a local hospital and subsequently died in that hospital.

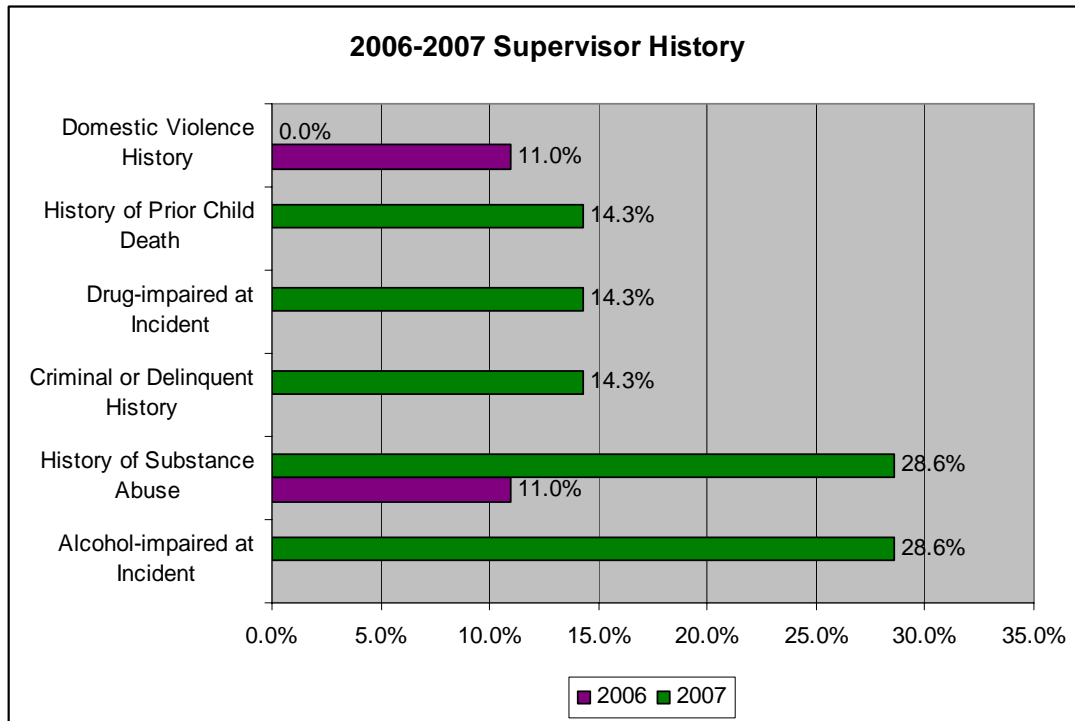
All decedents were supervised at the time of their death. More than half (57.1%) of cases, the child was in sight of the supervisor at the time of the incident. In slightly less than a third (28.6%) of the cases, supervision was provided by the child’s biological parent, and in slightly less than a third (28.6%) of the cases, supervision was provided by the mother’s partner. Less than 1 in 5 (14.3%) were supervised by the father’s partner, and less than one third (28.6%) were supervised by a grandparent or other relative.

Figure 6.10



In 2007, nearly a third (28.7%) of supervisors had a known history of substance abuse. Approximately one third (28.7%) of supervisors were alcohol-impaired at the time of the incident, and 14.3% were drug-impaired at the time of the incident. In addition, almost 15% of supervisors had a delinquent or criminal history, and 14.3% had a history of prior child deaths.

**Figure 6.11**



More than three-quarters of the cases (85.7%) were mandatory reviews due to prior child welfare history or death due to child abuse. Almost three quarters (71.4%) had a family history of CPS involvement, with the history on the decedent in 57.1% of cases and on the decedent’s sibling in 71.4% of cases. Nearly a third of cases (28.6%) had an open CPS case at the time of death, and 28.6% of families had had a case closed in the previous 12 months. Child welfare allegations included physical abuse, neglect, and unspecified abuse, and the father and mother were the alleged perpetrators in all reported incidents.

In only 14.3% of cases, assault which was not child abuse was determined to be a causal factor. Child physical abuse was determined to be a causal factor in the death in 85.7% of cases. Over half (57.1%) of cases were determined to have abusive head trauma as a component of the physical abuse, and 14.3% of cases were determined to be chronic battered child syndrome. In half of the abusive head trauma cases, there were retinal hemorrhages found by the medical examiner, and in one quarter of the abusive head trauma cases, the child had been shaken by the supervisor. Causes of the abuse were listed as crying and toilet training mishaps.



## Homicide Deaths: Recommendations for Prevention

Homicide, by definition, is the intentional killing of another human being. Fifteen children and youth were the victims of homicide in Clark County in 2007. The data indicates two distinct categories for child homicides: firearm related and non-firearm related, and each category had a distinct pattern of circumstances.

### *Firearm Homicides:*

1. All firearm homicides occurred to youth ages 10-17, primarily among 15-17 year olds (75%), and all victims were male. The data indicates that all victims were minorities, primarily Black (62.5%) and White (Hispanic) (25%) male youth. The percentage of Black victims is disproportionate to the population distribution in Southern Nevada and identifies a specific target population for intervention efforts. The data also shows that 50% of the victims had a prior juvenile justice history, 25% of victims had a sibling with a known juvenile justice history, and that approximately half 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. In addition, because nearly two thirds of the incidents occurred between 8pm and 6am, working with law enforcement agencies to develop protocols for the strict enforcement of curfew laws may remove some of these youth from potentially deadly situations.

### *Non-Firearm Homicides:*

1. All homicide victims aged less than one to four years in 2007 were the victims of non-firearm related homicides. More than three quarters (85.7%) of these homicides involved physical abuse and more than half (57.1%) of the cases abusive head trauma was noted in the autopsy. One quarter (25%) had indications of Shaken Baby Syndrome. One third of these children were in the care of their biological parent at the time of death, and nearly half (42.9%) had been supervised by their father or mother's partner. Almost three-quarters (71.4%) of the families involved had a history of involvement with the child welfare system. Prevention efforts should focus on developing networks of services in the community to reach out to these at-risk families. Providing services and resources to parents of young children that educate parents and new partners who are willing to participate on basic parenting skills and ways to cope with stress and anger may also reduce the potential for child abuse related homicides.

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

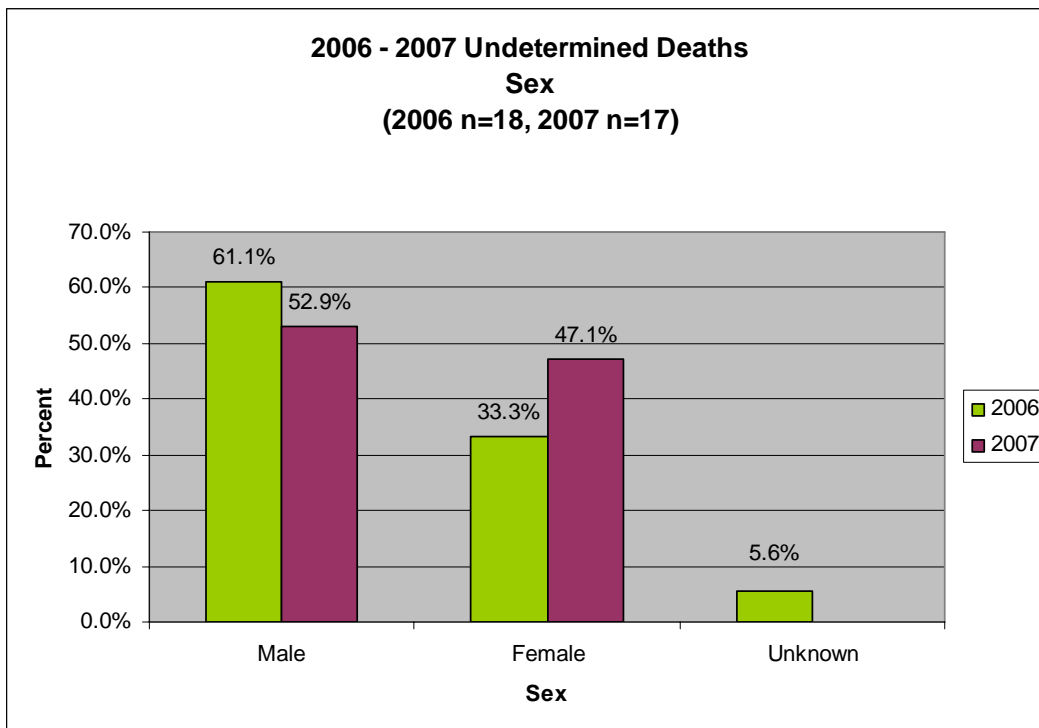
www.childdeathreview.org, 2007

## Section VII: Undetermined Deaths

In 2007 Clark County reviewed 17 cases where the death was ruled “undetermined.” This ruling is used by the Coroner’s office when information regarding the circumstances of the death make it difficult for the medical examiner to make a distinct determination about the manner of the death. The coroner may rule a death “undetermined” when sufficient evidence or information cannot be obtained, usually about intent, to assign a manner of death.

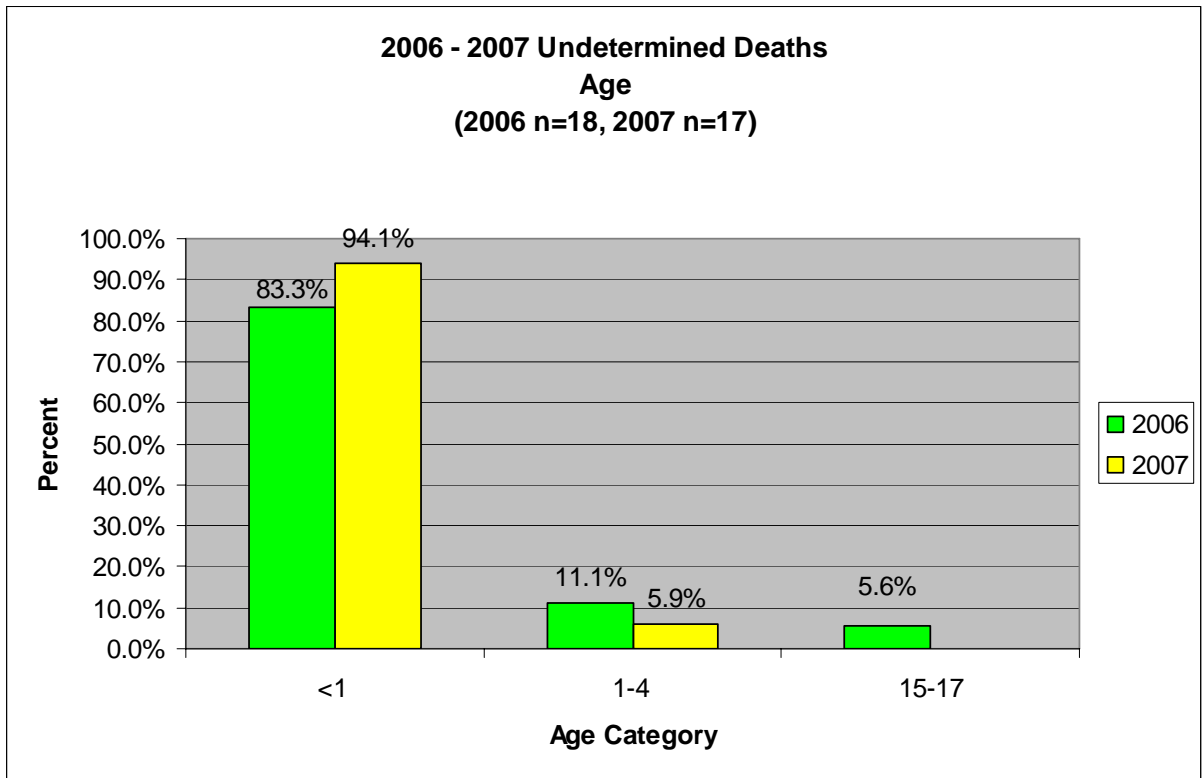
In 16 of those cases the cause was also listed as “undetermined.” The remaining case was caused by cardiac arrhythmia. The following tables represent the descriptive statistics regarding undetermined deaths reviewed by the Clark County Team in 2007.

Figure 7.1



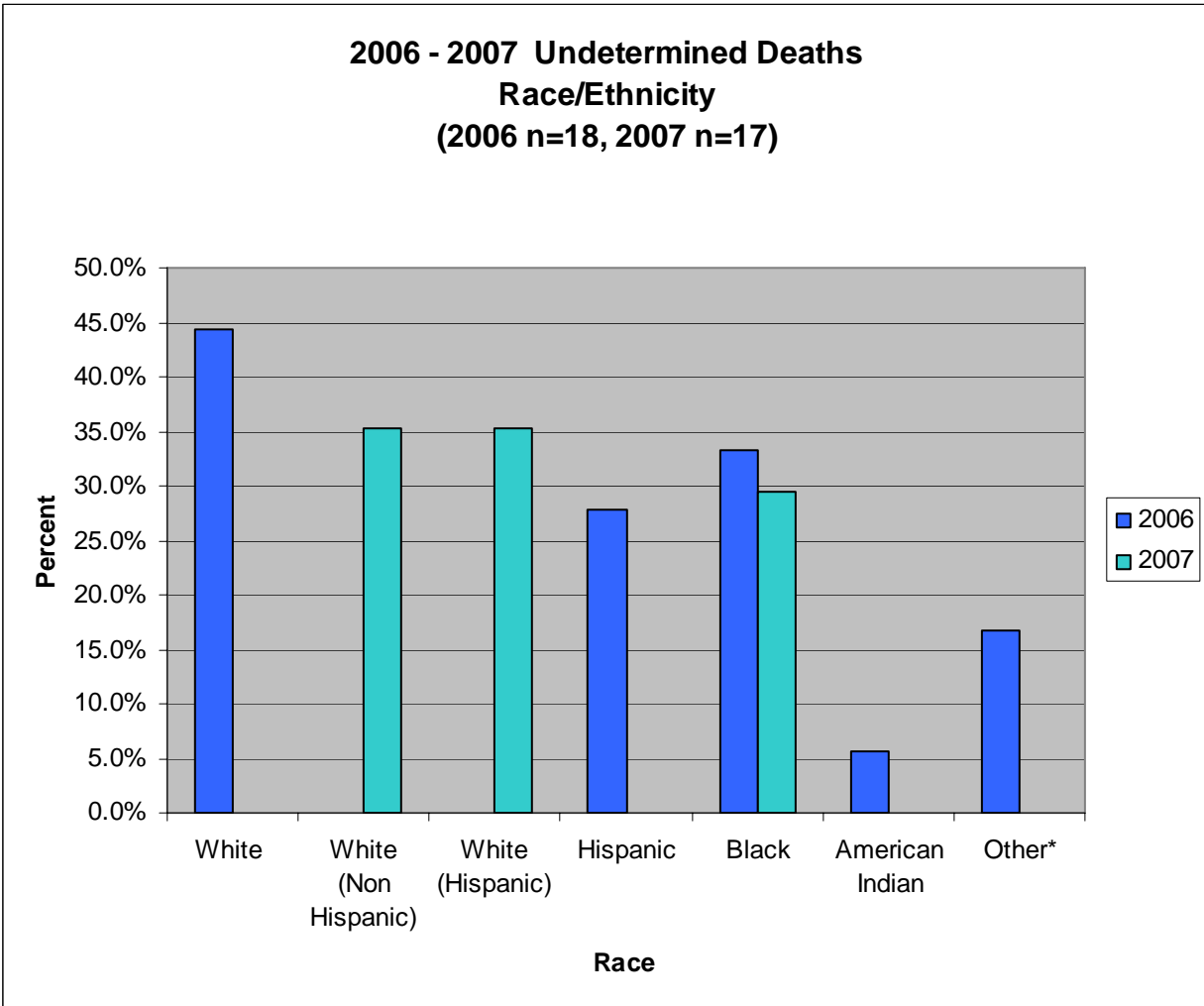
In 2007 there continues to be a higher number of males (56.3%) than females (43.8%). However in 2007, there were more females than in 2006. Additionally, in 2007 the sex of all cases reviewed was known.

Figure 7.2



In 2007 nearly all (94.1%) of the undetermined cases were children less than one year of age. In only 5.9% of cases in 2007 was the child between the ages of 1 and 4 years. This is consistent with data collected in 2006.

**Figure 7.3**



	White	White (Non-Hispanic)	White (Hispanic)	Hispanic	Black	American Indian	Other
2006	44.4%	--	--	27.8%	33.3%	5.6%	16.7%
2007	--	35.3%	35.3%	--	29.4%	0%	0%

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

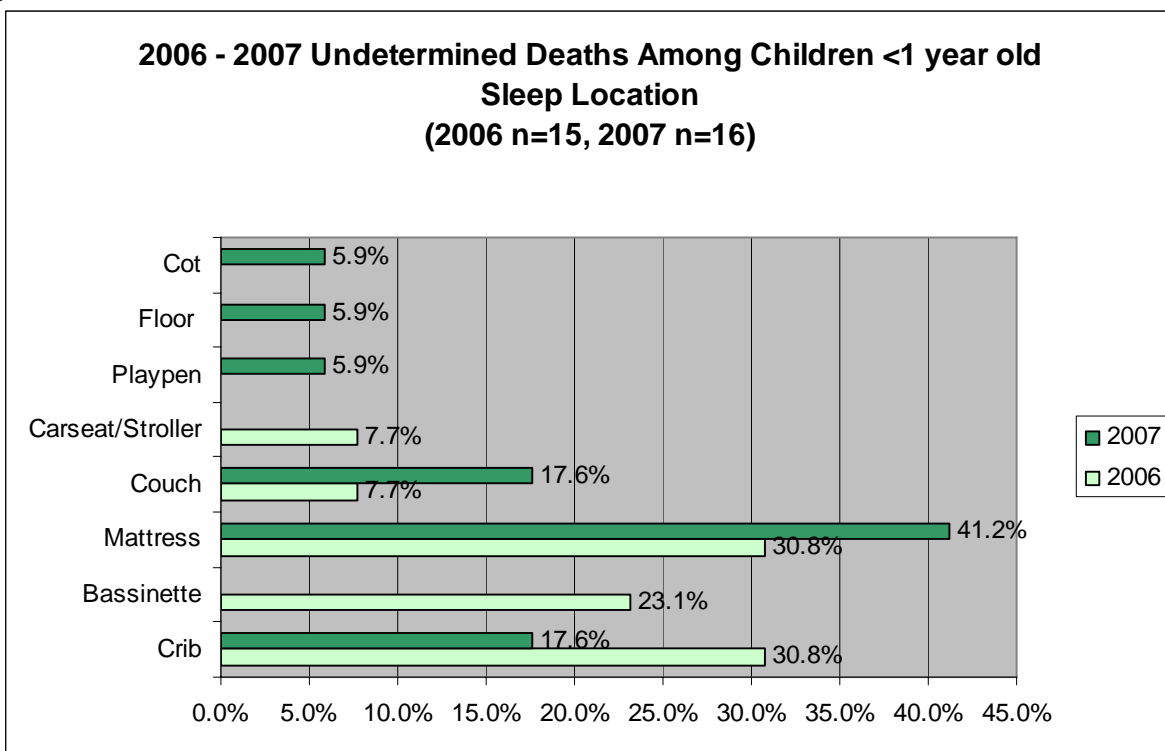
Patterns in race and ethnicity for undetermined deaths are fairly consistent from 2006 to 2007. In 2007 there were less Black children than in 2006 (25% compared to 33.3% respectively).

For undetermined deaths the majority did not have any prior history with child protective services, only 31.3% had a history of child welfare involvement, and in only 12.5% of those cases was the history on the decedent. Additionally, in 6.3% of cases the child was in foster care at the time of death.

## Undetermined Death – Less than One Year of Age

Nearly all (94.1%) of undetermined deaths in 2007 were children less than one year of age. In 100% of these cases in 2007 the death occurred in a sleeping environment. In 41.2% of these cases the child was sleeping on a mattress. In half of the cases the child was not in his or her own sleep space. In 41.2% of all cases the child was sleeping with a parent and in 5.9% of cases the child was sleeping with a sibling. Figure 6.4 illustrates the various sleep locations for these children. Most notable we see a steep increase from 2006 to 2007 of children less than one year of age sleeping on adult mattresses, increasing from 30.8% in 2006 to 41.2% in 2008. Along those same lines there was a dramatic increase in children sleeping on couches, 7.7% in 2006 to 17.6% in 2007.

**Figure 7.4**



Among the deaths that occurred in a sleeping environment, most children (35.3%) were placed to sleep on their backs followed by 29.4% placed on their stomachs and another 23.5% placed on their sides. When found children were found most frequently on their stomachs at 47.1% followed by 23.5% of children found on their backs. Positions the child was found varies from face down in blankets, under comforters, underneath mother's arm or face down on a couch. All undetermined child deaths in 2007 under one year of age died in a sleeping environment.

## **Undetermined Deaths – Over One Year of Age**

There was one undetermined death of a child over one year of age. This child died from a cardiac arrhythmia, but investigation was not definitive and therefore the case was signed out as undetermined.

### **Manner Not Applicable**

In addition to these undetermined deaths there were two deaths that manner was listed as “Not Applicable”. In both of these cases the death was a fetal death that was determined to be caused by intrauterine asphyxiation, but because the death was a fetus and not a child no manner of death was assigned. However, due to the circumstances of these cases they were still reviewed by the team and information was included in the overall statistics

## LOCAL PREVENTION EFFORTS

In 2007 the Clark County Child Death Review Team made an even more concerted effort to act locally to prevent child deaths. There were several primary activities highlighted below.

### *Youth Suicide:*

The Child Death Review Team worked to implement a youth suicide checklist developed by the team in 2005 in the local police jurisdictions. In 2007, the Las Vegas Metropolitan Police Department has committed that the Abuse & Neglect Detail should investigate every case of a youth suicide, regardless of age. In addition, in 2007, the Las Vegas Metropolitan Police Department began using the checklist consistently. This commitment has resulted in improved data collected about local youth suicide cases and will ultimately allow the data to be used by the team to advocate for improved programs and services in the community to prevent youth suicide.

The Nevada Office of Suicide Prevention has worked closely with the Committees to Review the Death of Children statewide. Many MDT recommendations were already being addressed by the Nevada Suicide Prevention Plan, and some MDT recommendations helped prioritize objectives of the state plan. The NSSP is closely based on the *National Strategy for Suicide Prevention, 2001*. The Nevada Suicide Prevention Plan has eleven goals and 35 objectives. Those goals and objectives include three major focal points: Awareness, Intervention and Methodology (AIM) of suicide prevention in the State of Nevada.

### *Safe Sleeping:*

The Child Death Review Team worked together to revise the language for the discharge instructions at Sunrise Hospital regarding safe sleeping for infants. The changes were developed by a subcommittee of team members and forwarded to Sunrise Hospital for implementation. Once the revisions were completed, a letter was then drafted to go to all local hospitals with statistics about deaths in sleeping environments and suggested language for discharge instructions regarding safe sleeping for infants.

### *Drowning:*

The Child Death Review Team has been working with community partners to research and promote the development and implementation of an Adopt-a-Fence program similar to one that has been successful in Arizona's Maricopa County. In 2007 the team worked on gathering data and soliciting interested parties. This program is still underdevelopment and the team is continuing to work with local prevention organizations as well as the local health district.

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

*Every quarter the Clark County Child Death Review Team provides a set of recommendations to the state Administrative Team to Review the Death of Children. These recommendations are reviewed and some action or response is generated. These responses are summarized in reports that are forwarded to the local representatives that serve on the Executive Committee. Listed below are all recommendations that were made by the Clark County Child Death Review team to the Administrative Team to Review the Death of Children in 2007. Where responses were provided as of February 11, 2008 they are indicated below the recommendation. Recommendations are in no particular order.*

1. Future safe sleeping campaigns should include information about the risk of wedging if an infant is put in an adult bed or other place to sleep which could result in wedging (such as chair or couch). Investigation of one case showed that a parent that knew it was unsafe to sleep with the baby thought it was okay for the baby to sleep on a chair/bed if the baby was alone.

**Response:** Referred to Executive Committee for review to expand the existing Safe Sleeping Campaign

2. Child welfare staff, foster parents and shelter parents need to be provided with medical information regarding the children that they are being asked to care for. Medical passports need to be provided to anyone providing care for the child.

**Response:** Referred to the DMG (Decision Making Group for Child Welfare Agencies) for review of protocols and potential implementation. DCFS workgroup on medical passports has addressed this recommendation.

3. Fire safety education on the importance of supervision of young children.

**Response:** Referral sent to Statewide Training Coordinator to evaluate the foster parent PRIDE curriculum and review the Title IV-B training for fire safety and parental supervision. This was reviewed by the Administrative Team and considered it sufficient for this purpose.

4. Training for social workers assigned to foster care licensing and permanency planning regarding appropriate assessment of homes and family constellations. Training should address how to identify risk factors, who to report them to once identified, as well as how to investigate and properly document. Though should be given to establishing protocols regarding communication between all child welfare entities regarding identified issues.

**Response:** This is being addressed through a new web based training that is being developed by DCFS.



5. Establish a system for independent evaluation of youth being released from mental health facilities if there is still concern by others (parents, PO) of suicidal ideation of other serious mental health condition. Establish a system to streamline transfers, particularly insurance paperwork, to and from mental health facilities to ensure that patients are not released while still in need of treatment.

**Response:** Clarification was requested and a QI review of the case was conducted and supplemental recommendations were provided to the Administrative Team.

6. Mandate that all foster parents (as well as all shelter parents and shelter workers) receive training, which is regularly reinforced, regarding proper sleep positions for infants and the proper administration of medication (including seeking medical advice for administering medication to young infants.)

**Response:** Safe Sleeping brochures were provided in electronic format to local child welfare agencies for printing and dissemination to foster and shelter parents. Discussion of the proper administration of medication was held until the next meeting.

7. Educate parents and caregivers about the dangers of using drugs while pregnant and while caring for children. Emphasize that drug use impairs thinking, decision making skills and response times, potentially putting children at risk.

**Response:** Referred to the Executive Committee regarding public awareness.

8. Provide education to parents and pool owners regarding the danger of drowning, including specifically the need for constant supervision, especially for young children, as well as the need for barriers to prevent access to the pool area.

**Response:** The Statewide Injury Prevention Taskforce does this annually, therefore no further action needs to be taken by the Administrative Team.

9. Provide education to nurses and other maternity unit staff regarding the importance of advising parents regarding safe sleeping positions for infants, especially placing children on their back to sleep.

**Response:** This issue is being currently addressed by an existing co-sleeping campaign.

10. Educate parents regarding the dangers associated with furniture and placing large/heavy objects on top of furniture that have the potential to fall down. Provide information about securing potentially dangerous furniture and other items to prevent them from falling on and crushing young children.

**Response:** This issue was specific to one case and a minimum of three cases must exist for the Administrative Team to address an issue, therefore this recommendation could not be addressed.

11. The State of Nevada should put in place legislative restrictions on the number of youth who may be in a vehicle driven by another youth and should consider the implementation of graduated driver licensing. Additionally, if not already done, the Department of Public Safety, through the Department of Motor Vehicles should provide information to young drivers (and parents) regarding the risks of common distractions such as friends in the car, cell phones, radios, etc.

**Response:** This is addressed by Senate Bill 293 passed by the 2007 Nevada Legislature. Also referred to the Executive Committee's Public Awareness Subcommittee.

12. The State of Nevada should enact legislation which would make failure to wear a seat belt a primary violation. Alternatively, the State could look at an incremental approach which would have a primary seat belt law applicable only if there are children in the vehicle.

**Response:** A bill was introduced in the last legislative session to address this but it did not pass. A letter of support of this bill was sent to its sponsor, Senator Dennis Nolan.

13. Incorporate suicide education (recognizing signs, telling someone if a friend is cutting or showing signs of suicidal ideation, etc.) into late elementary and/or middle school education, possible incorporate into the DARE program curriculum.

**Response:** Recommendation was referred to the Coalition for Suicide Prevention as well as the State Department of Education for action.

14. This recommendation has three parts. (1) Child welfare agencies should do group staffing (including a qualified physician or nurse practitioner) of child abuse neglect cases/investigations where there are questions or concerns regarding abuse. This should also include a physical examine of the child by the consulting physician. (2) Child welfare agencies need an on-call, state-funded physician or nurse practitioner to staff cases on a regular basis and conduct physical exams of children who are suspected of being physically abused. (3) Require all judges and hearing masters (or, at a minimum, all family court judges and hearing masters) in the state of Nevada to participate in Child Abuse and Neglect training.

**Response:** (1) Already required by state PIP policy and monitored through the QI process. (2) Forwarded to DCFS for review during their budget planning meetings. (3) This is being addressed through the Court Improvement Project.

15. Continued education to new parents, hospital staff and others about safe sleeping conditions for infants.

**Response:** Executive Committee Public Awareness Subcommittee is addressing this through their continued distribution of the safe sleeping brochure.

16. Community education to reinforce the proper management and seriousness of asthma – especially for children.

**Response:** Safe Sleeping brochures were provided in electronic format to local child welfare agencies for printing and dissemination to foster and shelter parents. Discussion of the proper administration of medication was held until the next meeting.

17. In addition to current public education campaigns from the State Child Death Review as well as local media from the Las Vegas Metropolitan Police Department regarding safe sleep positions, the Clark County Child Death Review Team is working with local hospitals to update maternity discharge instructions regarding safe sleep positions for infants which includes information regarding mattresses, pillows, etc. The Clark team also recommends sending a letter to the State Board of Nursing and the Nevada Chapter of the American Academy of Pediatrics regarding advising new parents of proper sleep positions and conditions for infants. Also potentially include letters to colleges and universities that offer nursing programs in an effort to educate new nurses on proper instructions. These letters should include local death statistics, as well as recommended instructions on sleep positions for parents and caregivers.

**Response:** None to date.

18. This recommendation has three parts. (1) Training should be required for “fictive kin” placement. (2) Look at the number of children allowed in one home, especially with multiples, high needs, etc. Especially for families with no specific training. (3) Also look at the education of the judiciary as well as family services regarding placing multiple children in a home (especially multiples & special needs). The law is only a presumption – the judge should look at the judgment/recommendations of case workers. \*\*Connect with judicial college.

**Response:** None to date.

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

Rebecca Baltz	Las Vegas Metropolitan Police Department		Dave McKenna	Henderson Police
Marion Biron	Clark County Department of Family Services		Dr. Neha Mehta	Sunrise Hospital
Julie Bolton	Clark County School District		Vicki Monroe	District Attorney's Office
Heidi Campbell	Las Vegas Metropolitan Police Department		Tom Morton	Clark County Department of Family Services
Catherine Coleman	University Medical Center		Alane Olson	Clark County Coroner's Office
Jeanne Cosgrove	SAFE Kids		Gwendolyn Osburn	Southern Nevada Health District
Det. Mike Daniel	Boulder City Police Department		Kim Rakou	Clark County School District
Daphne Dwitt	North Vista Hospital		Peggy Rowe	Clark County Department of Family Services
Dr. Andrew Eisen	Touro University		Debbie Ruiz	Area Health Education Center - Prevent Child Abuse Nevada
Gary Erickson	Mesquite Police		Cynthia Sauchak	Las Vegas Metropolitan Police Department
Robert Everett	Mesquite Police		Dr. Edith Schmidt	Sunrise Hospital
Thomas Finn	Boulder City Police Department		Victor Hugo Schultze, II	Attorney General's Office
Mark Fitzgerald	Clark County Department of Family Services		Sgt. Darrell Semper	North Las Vegas Police Department
Linda Flatt	Office of Suicide Prevention		Joseph Smith	Nevada Highway Patrol
Deborah Flowers	Department of Child and Family Services		James Sweetin	District Attorney's Office
Dr. Tony Fredrick	Southern Nevada Health District		Teresa Tavarez	Las Vegas Metropolitan Police Department
John Fudenberg	Clark County Coroner's Office		Lisa Teele	Las Vegas Metropolitan Police Department
Troy Hatch	Henderson Police		Rosemary Virtuoso	Clark County School District
Paula Hammack	Clark County Department of Family Services			
Paula Haynes-Green	Clark County Department of Family Services			
Marion Hancock	Sunrise Hospital			
Celia Hoggard	Mesquite Police			
Sally Jost	Clark County School District			
Tracy Kingera	Department of Juvenile Justice			
Kevin Larsen	Nevada Highway Patrol			
Antony Lettieri	North Las Vegas Police Department			
Teresa Lowry	District Attorney's Office			
Carole Mankey	Southern Nevada Health District			
Beth Marek	Department of Juvenile Justice			

## 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)