

Clark County Child Death Review

Clark County, Nevada

2006 Annual Report
June 30, 2007



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PUBLIC HEALTH
School of Public Health



Commissioned by the Clark County Manager's Office



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Background on Child Death Review in Clark County

In an effort to identify risk factors and prevent future child deaths, in 1992 the State of Nevada joined many other states in mandating Child Death Review Teams. Since that time, both the law and the regional teams throughout Nevada have evolved to facilitate the growing need for collaborative efforts to identify interventions necessary to reduce the rate of child deaths in Nevada. While the primary legislative focus of Nevada Child Death Review Teams has been on addressing fatalities related to child maltreatment and/or involvement with the child welfare system, the teams have expanded 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 (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

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

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.

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 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.

Methodology

In 2006 Clark County decided 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) was hired 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.

Data presented in this report is drawn from information gathered at each of the monthly child death review meetings. In 2006 the Clark County team reviewed 70% of the child deaths in the county, this included selected natural deaths, as well as all accidents, homicides, suicides and undetermined cases. The remaining 30% of child fatalities in the county are natural deaths that are not legally mandated and for which the cause of death is unremarkable to the reviewing physician.

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 crosstabulations 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.

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 of the Data

As with any research there are limitations of this dataset. This is the first year of data collection for the purpose of a Clark County report and there are several issues that were identified during this process that will be remedied for next year’s report.

First, there is an immense amount of detail included in the 2006 data collection form. While this level of detail is appropriate for the purposes of a data repository and the ability to retrieve frequencies for very specific issues, it becomes problematic if researchers intend to make statements about the general population. There are several fields where the level of detail is so small that the information is often not obtained so that reduces the number of valid cases that can be used for analysis. This issue will be addressed in 2007 by changing the collection tool to collect only the most pertinent information, allowing NICRP to spend more time ensuring that all fields are completed. In addition, some of the questions are worded such that individuals may have some confusion about the intent of the information required to answer the question. NICRP intends to clarify all subjective questions so the information obtained is usable in future analysis.

Second, NICRP receives copies of official investigation reports and official records from only one agency on the team. Because there is pertinent information on the cases in multiple agency reports, NICRP may be missing out on valuable information that could be used to complete the data tool. In 2007 NICRP will be working with the team to obtain reports from multiple agencies to ensure a much more thorough completion of the data collection tool. This information can be used to identify trends over time and target prevention efforts to areas where the data shows the greatest need.

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, 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 2006 child fatalities, because some variables presented too few cases to provide information that is not identifiable.

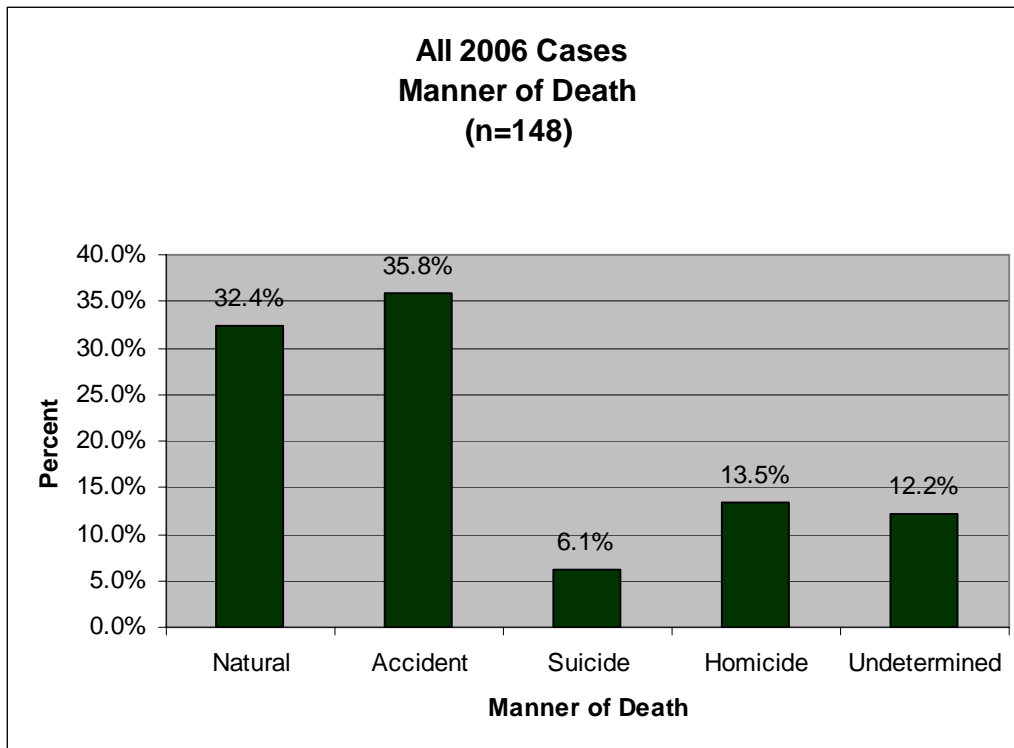
Findings

The following section will provide summary statistics for the total database. The graphs represent all 148 reviews that the team completed regarding children that died in 2006. Descriptive statistics are provided for cases regarding manner of death, age, race, ethnicity, and involvement in child welfare.

Summary Statistics

In 2006, the Clark County Child Death Review Team reviewed 148 cases of child deaths. 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 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 2006, the majority of child deaths were ruled either accidental (35.8%) or natural (32.4%) by the coroner's office. The smallest category was suicides at 6.1% of all deaths reviewed.

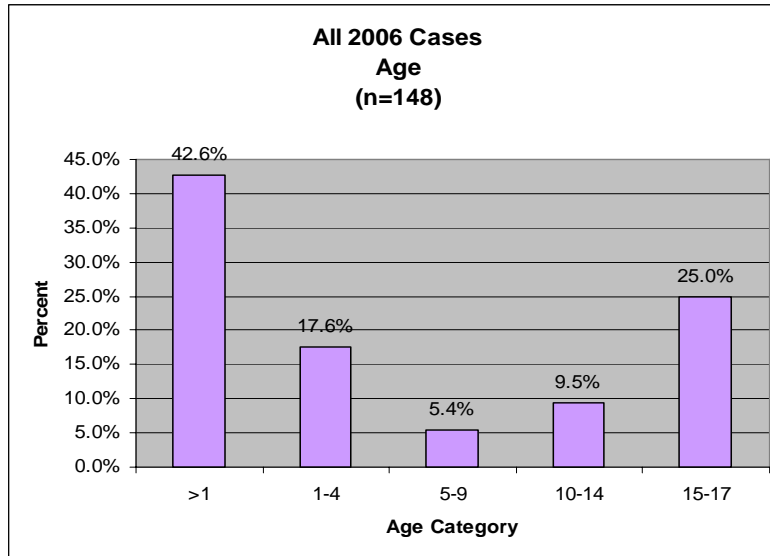
Figure 1.1



Manner	Number	Percent
Natural	48	32.4%
Accident	53	35.8%
Suicide	9	6.1%
Homicide	20	13.5%
Undetermined	18	12.2%

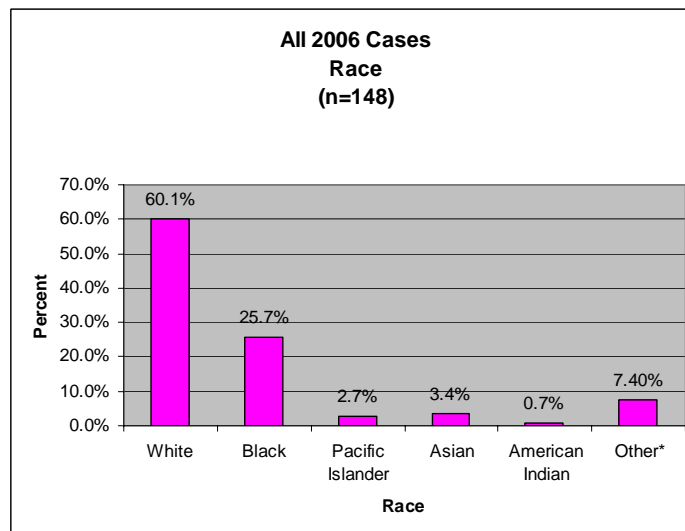
The Clark County team reviews the deaths of children from birth to 17 years of age. In 2006, almost half (42.6%) of cases reviewed were children less than one year old, and 25% of all cases reviewed were those children ages 15 to 17 years.

Figure 1.2



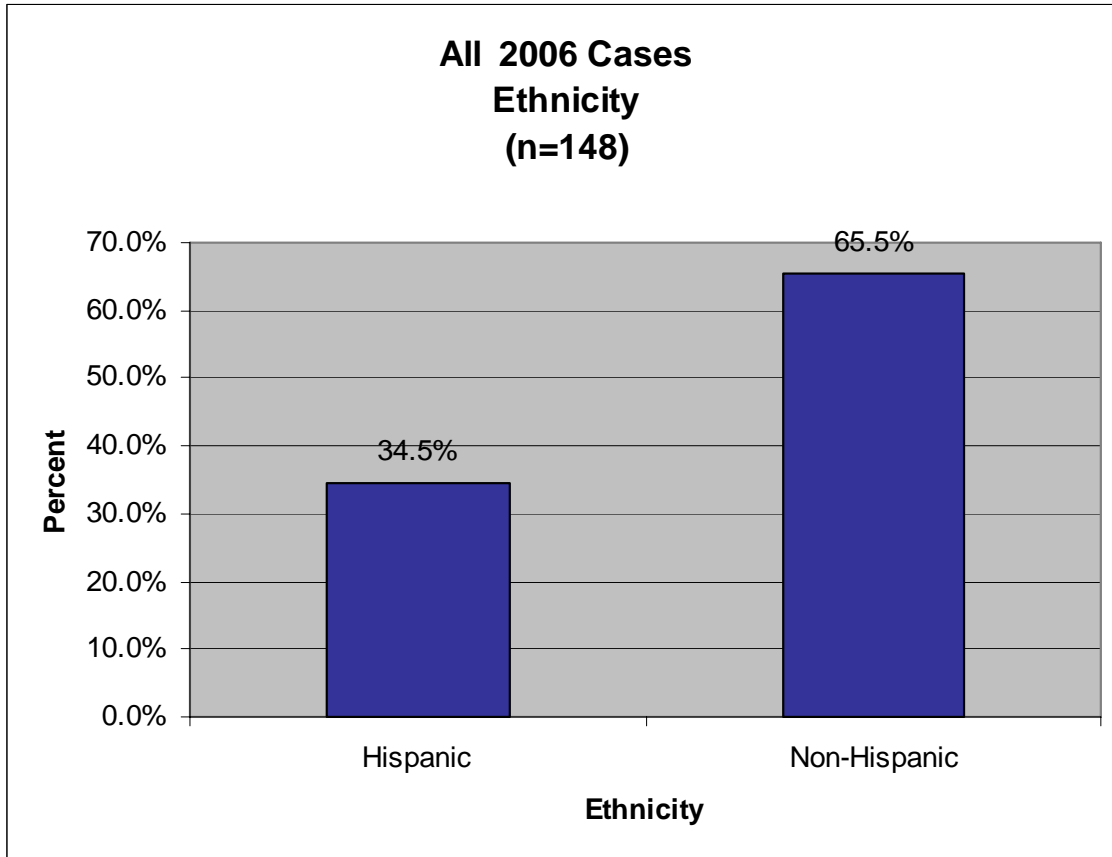
In 2006 the child’s race and ethnicity were recorded separately on the data tool in an effort to be consistent with methods used on the death certificate. First the child’s race was recorded (White, Black, Asian, Native American/Pacific Islander, Other), and then a separate question asks whether or not the child was of Hispanic or Latino ethnicity. Because of the way the questions are asked, many of the cases in the “Other” race category were those cases where a race was not listed but the ethnicity was listed as Hispanic. The data for all cases’ race and ethnicity is presented in the charts below.

Figure 1.3



A majority of the cases reviewed in 2006 were White children (60.1%), while one fourth of the cases reviewed were Black children. There were very few Asian, Pacific Islander, or Native American cases reviewed in 2006, all three categories combined add up to only 6.8% of all cases reviewed.

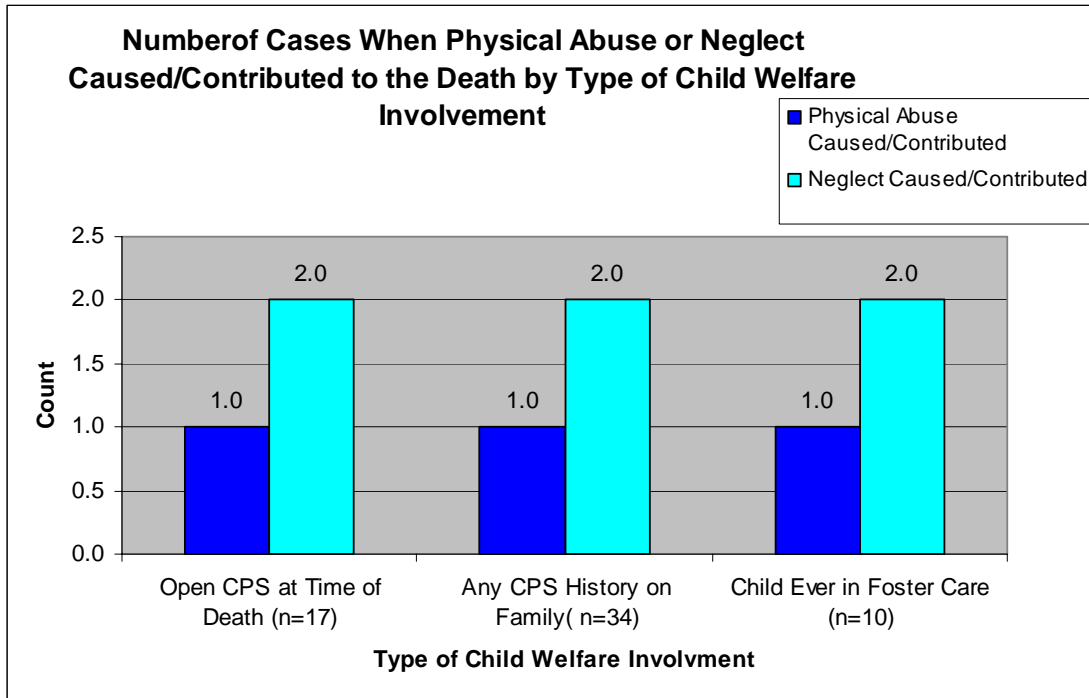
Figure 1.4



The majority of the cases reviewed were Non-Hispanic children (65.5%), and about a third of the cases reviewed involved children that were Hispanic or Latino. It is important to note that because of the way the data were collected, cases include both a race and an ethnicity, therefore these two variables are not mutually exclusive; therefore a child could be coded as both White and Hispanic.

Finally, data were collected about all children’s past involvement with the child welfare system. In 17 cases, there was an open CPS case at the time of the child’s death, in 10 of the cases reviewed the child had been in foster care at some point, and in 34 cases reviewed the family had some history of involvement with child protective services.

Figure 1.5



* These categories are not mutually exclusive meaning that one child could fall in each of these categories. For example a child’s family could have a history of involvement with CPS, been in foster care and the case was open at the time of their death.

** One case represents one child

The graph above illustrates that in cases where the child or family had involvement with the child welfare system, neglect was much more likely to be a factor in the child’s death than actual physical abuse. The graph represents cases where the child or family was involved with child protective services and then the number of those cases where either neglect or physical abuse either caused or contributed to the death of the child. These numbers may not accurately represent the cases reviewed because strict definitions for what constitutes “neglect” were not used in completing the collection tool. This means that circumstances may have been interpreted differently by staff completing the tool. In 2007 strict definitions will be created to ensure consistency in interpretation of the facts of each case. Additionally, the distribution of cases is the same in all categories, but this was simply by chance and is likely due to the fact that the categories are NOT mutually exclusive and the same child could logically fit into all categories.

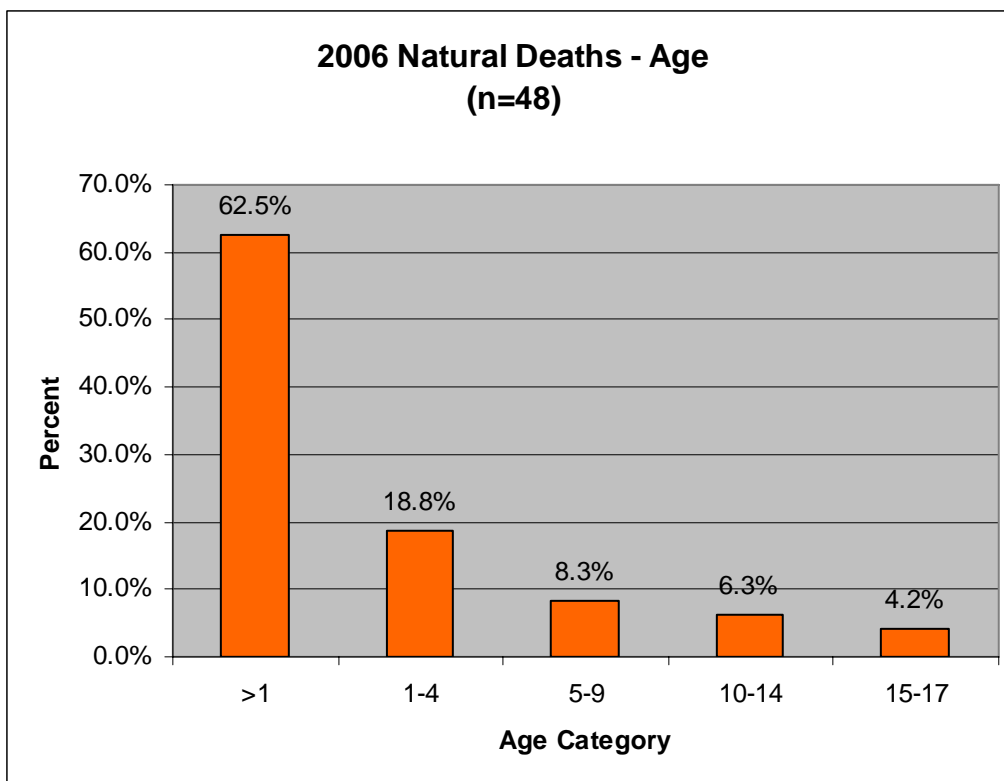
The following sections will discuss in more detail the factors surrounding cases as organized by their manner of death. Each section will begin with a brief description of what that manner of death means, then will present the demographics of the children assigned that manner of death. Finally, each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

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 Clark County in 2006 natural deaths comprised 32.4% (n=48) of all cases reviewed. However, it is important to note that this does not accurately represent the total number of natural deaths to children in Clark County because this is the only category of death where all cases are NOT reviewed. The following tables illustrate the demographic composition of children who died from natural causes for reviewed cases.

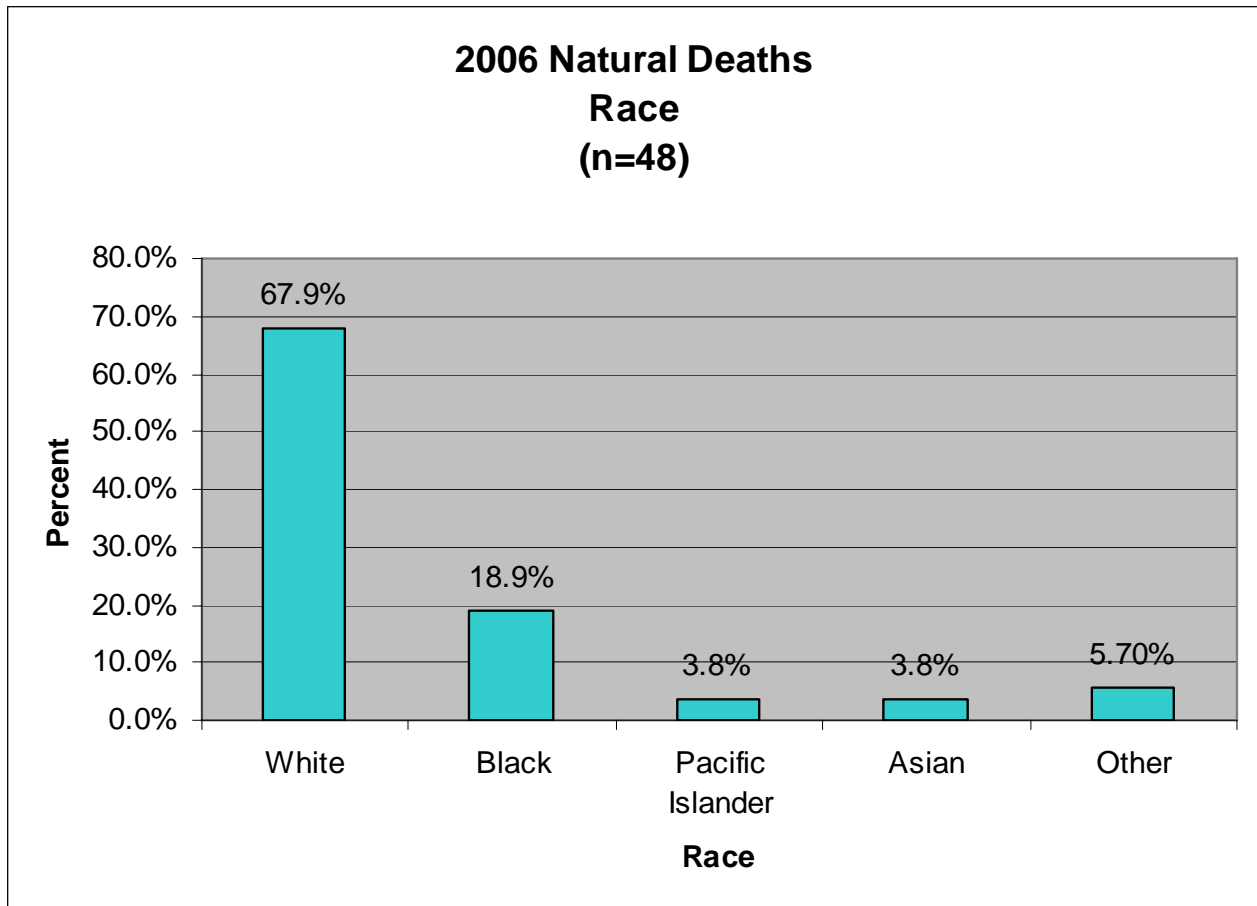
Figure 2.1



Well over half of children dying from natural causes were less than one year of age (62.5%). After that we see a sharp decrease in the frequencies as the children get older. When looking at the oldest category, only 4.2% of children aged 15 to 17 years died from natural causes. This supports the information from the National Center that most natural deaths occur among children less than one year of age.

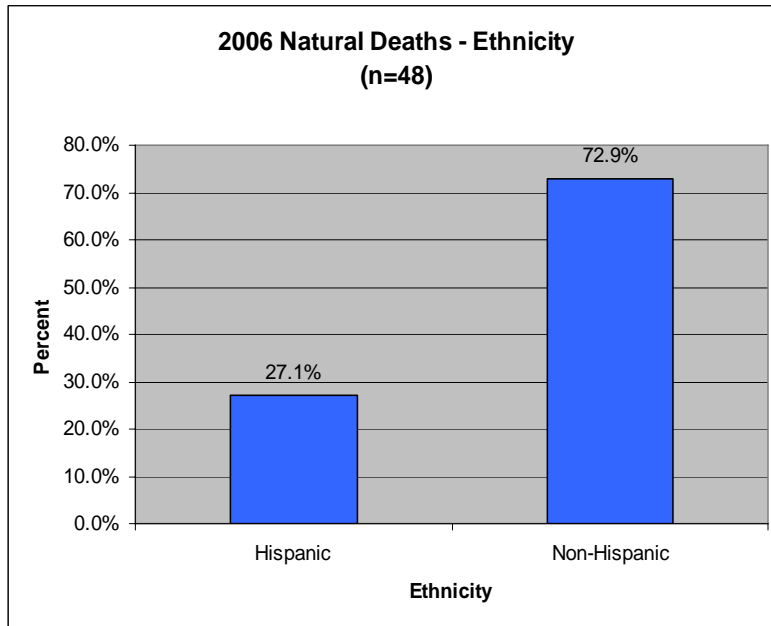
There is not a big difference in terms of the sex of children in this category. There were slightly more male children (58.3%) than female children (41.7%) dying of natural causes in 2006. The race and ethnicity of these children is presented in the figures below. Well over half of the children were White, with just under one fifth of the cases of natural deaths being Black children. These statistics are to be expected given that the majority of cases reviewed were White children and “natural” was the second most frequently occurring manner of death.

Figure 2.2



When examining ethnicity of these cases, just over one quarter of the natural cases (27.1%) reviewed were Hispanic or Latino in their ethnicity. This number is slightly higher than the general population, which is 26.1% Hispanic or Latino in Clark County (US Census Bureau Quick Facts, 2005).

Figure 2.3



Natural deaths have a variety of causes. In 2006, the top three causes of natural deaths were: Pneumonia (16.7%); Prematurity (14.6%); and SIDS (14.6%).

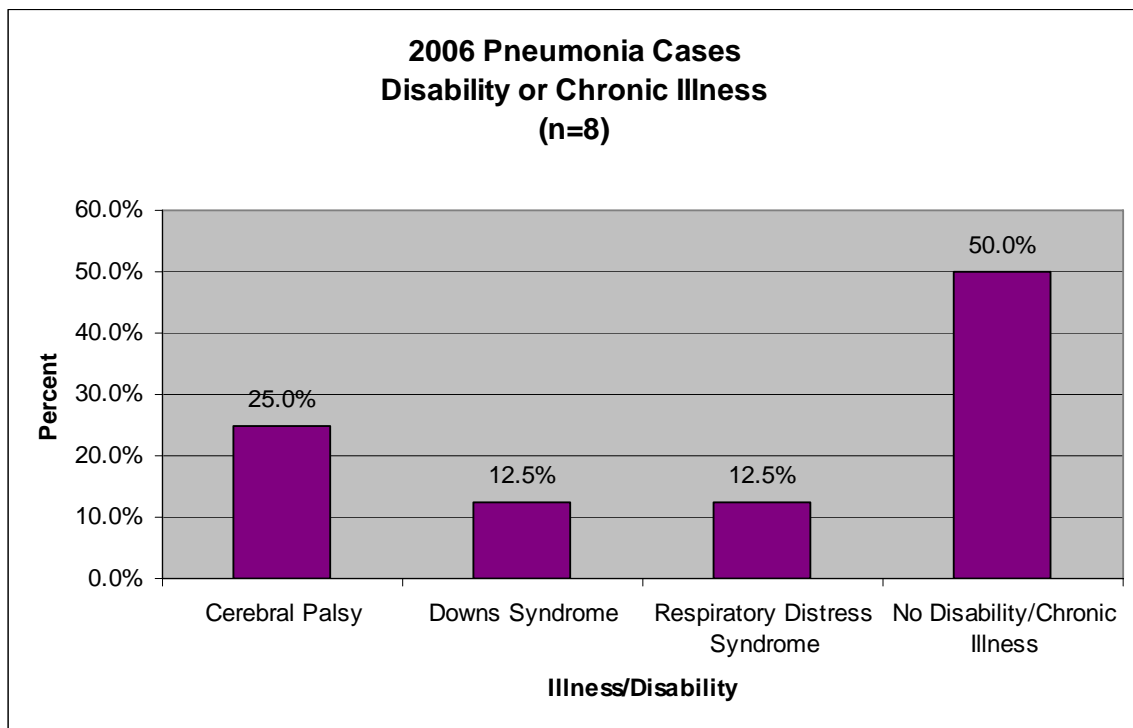
The following table presents all the causes of natural deaths among cases reviewed in 2006. Additionally, in 27.1% of natural deaths the mother used illicit drugs during her pregnancy.

Cause	Number	Percent
Cancer	1	2.1%
Cardiovascular	5	10.4% %
Congenital Anomaly	4	8.3%
Influenza	1	2.1%
Malnutrition/Dehydration	1	2.1%
Neurological/Seizure Disorder	3	6.3%
Pneumonia	8	16.7%
Prematurity	7	14.6%
SIDS	7	14.6%
Infection	4	8.3%
Other Perinatal Conditions	6	12.5%
Complications from diabetes	1	2.1%

Pneumonia

In 2006, 16.7% of natural deaths were caused by pneumonia. In 62.5% of cases the child was under one year of age, and in 75% of cases the child was White. Pneumonia is a lung infection that can be caused by a variety of microorganisms, including, viruses, bacteria, parasites, and fungi. According to the American Lung Association, “Pneumonia is often a complication of a pre-existing condition/infection and triggered when a patient's defense system is weakened”. This was also the case in these child fatalities. In 50% of natural deaths due to pneumonia the child had a disability or chronic illness. These included cerebral palsy, Down’s syndrome, and respiratory distress syndrome (See Figure 3.1 below). In 37% of cases the child was receiving medical care for their condition and in all 37% the family was compliant with prescribed care plans.

Figure 2.4



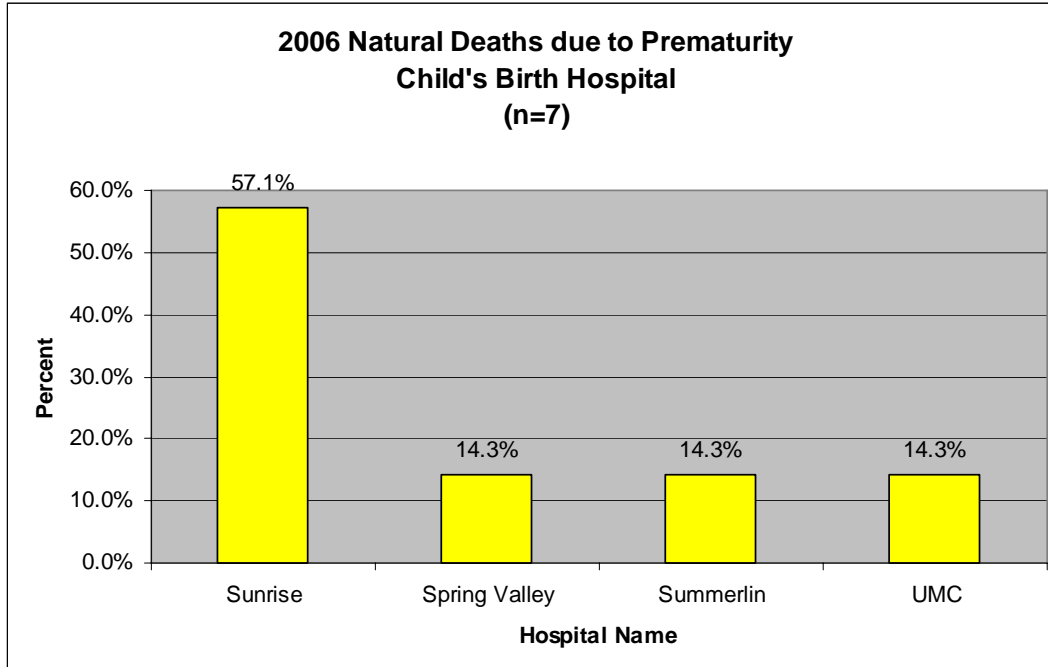
In 25% of deaths due to pneumonia the mother used illicit drugs during her pregnancy. However, this statistic could be low because in the remaining 75% of cases it is unknown whether the mother used drugs during her pregnancy. In 25% of these cases there was an open CPS case with the family at the time of the child’s death. In 50% of these cases the child or the child’s family had a history of CPS involvement.

Prematurity

According to the National MCH Center for Child Death Review, prematurity and low birth weight are the greatest predictors of infant mortality. While there are still many gaps in understanding why some women go into labor well ahead of schedule, there are some identified risk factors. These include cigarette smoking, disorders that raise blood pressure, prior pre-term birth and certain pregnancy complications increase the risk of prematurity. Other significant risks include genital tract infections, stress, anxiety, depression and other psychological factors. Adequate prenatal care is an effective intervention that improves pregnancy outcomes. Early access to quality prenatal care, including health promotion, risk assessment and appropriate interventions can prevent both pre-term births and ensure that babies are born at normal birth weights. (National MCH Center for Child Death Review, 2007).

In 2006 the team reviewed seven cases where the cause of death was listed as “prematurity”. These children were between 23 and 33 weeks gestation at the time of their death. Much of the information regarding the mother’s pregnancy was listed as “unknown”, however in one case there was reported drug use by the mother during pregnancy. Also, most (57.1%) of these children were born at Sunrise Hospital. The figure below illustrates the hospitals where the decedents were born. The ages for five of the seven mothers range from 16 to 36 with an average of 25.6 years.

Figure 2.5



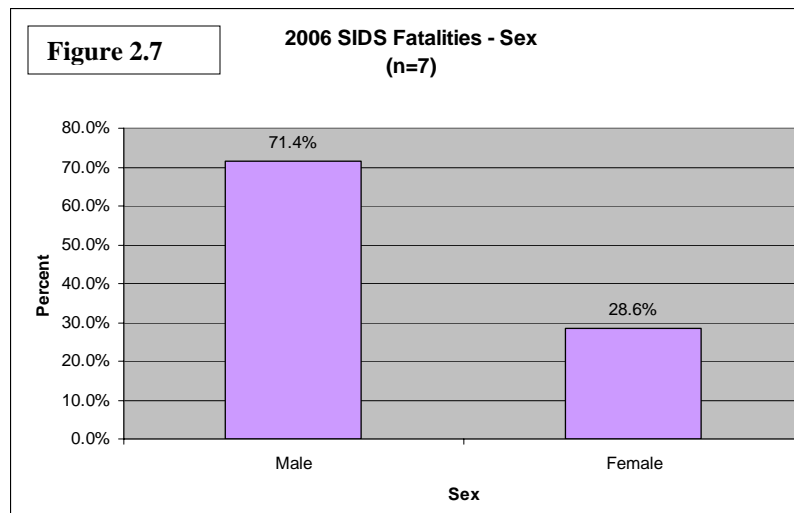
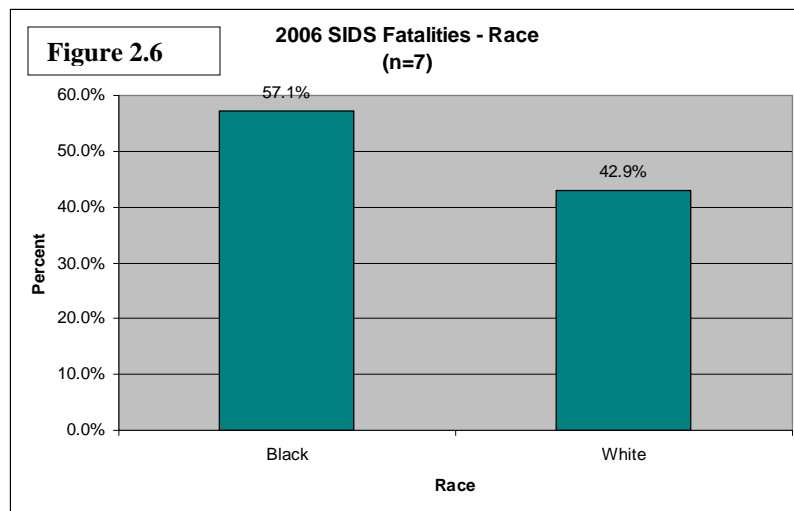
In 28.6% of cases there was an open child welfare case with the family at the time of death and in 71.4% of the cases the family had some history of child welfare involvement.

SIDS

According to the National Center for Child Death Review, “Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under one year of age which remains unexplained after completion of a full autopsy, examination of the death scene and review of the baby’s health history. If any of these three steps are not conducted, a SIDS diagnosis should not be made. A diagnosis of SIDS reflects the clear admission by medical examiners that an infant’s death remains completely unexplained” (<http://www.childdeathreview.org/causesSI.htm>, 2007). Due to the complex nature of SIDS, the Centers for Disease Control and Prevention (CDC) convened a multidisciplinary task force to improve the investigation and reporting of SIDS, and developed the Sudden Unexplained Infant Death Investigation Reporting Form¹ which is available for state and local death investigators to use. This form was released in March 2006, and the Clark County Coroner’s Office has worked in 2006 to add questions from the form to their new child death investigation checklist which will be implemented in 2007.

In 2006 there were seven cases ruled SIDS in Clark County. All SIDS cases are reviewed by the team, as the review is legally mandated by NRS statute. Among SIDS cases, all decedents were either White or Black and one child was Hispanic. Slightly more Black children died from SIDS than White children. (See Figure 2.6) Additionally, there were more than twice as many males (71.4%) than females (28.6%) in this category. (See Figure 2.7)

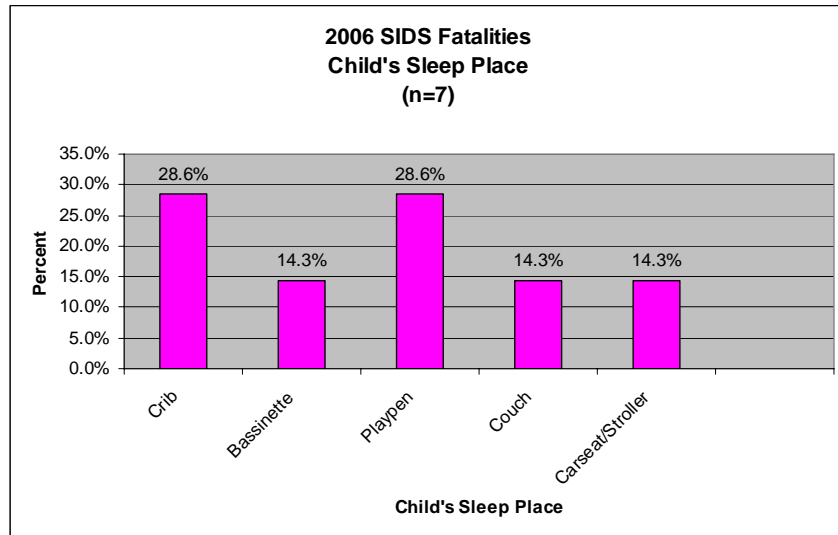
Among SIDS fatalities, in 28.6% of the cases the mother received prenatal care and just under one third (28.6%) of the children were exposed to second hand smoke either often or occasionally.



¹ More information about the SUID Initiative can be found on the CDC’s web site at <http://www.cdc.gov/SIDS/SUID.htm>

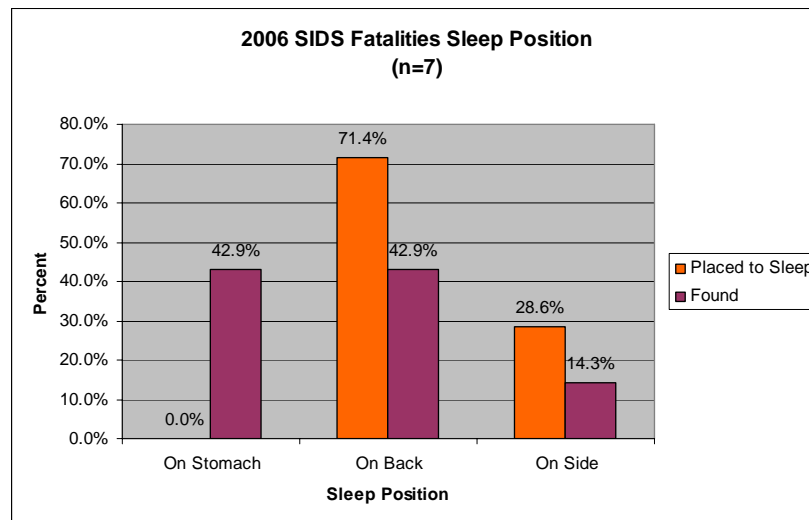
In all seven cases the child was in a sleep environment, with the most frequently occurring places being a crib or a playpen. (See figure 2.8).

Figure 2.8



Sleep position was also recorded in these cases and in all cases the child was placed either on their back (71.4%) or on their side (28.6%) to sleep. Although none of the children were reported as being placed to sleep on their stomach, 42.9% were found on their stomach, implying that the child rolled over from either their side or back.

Figure 2.9



In all but one case the child was in their own sleeping environment, but in all cases the child was not co-sleeping with another person. Additionally 42.9% of these children had an open child welfare case at the time of their death and over half (57.1%) of the families had some history of involvement with a child welfare agency.

Natural Deaths: Recommendations for Prevention

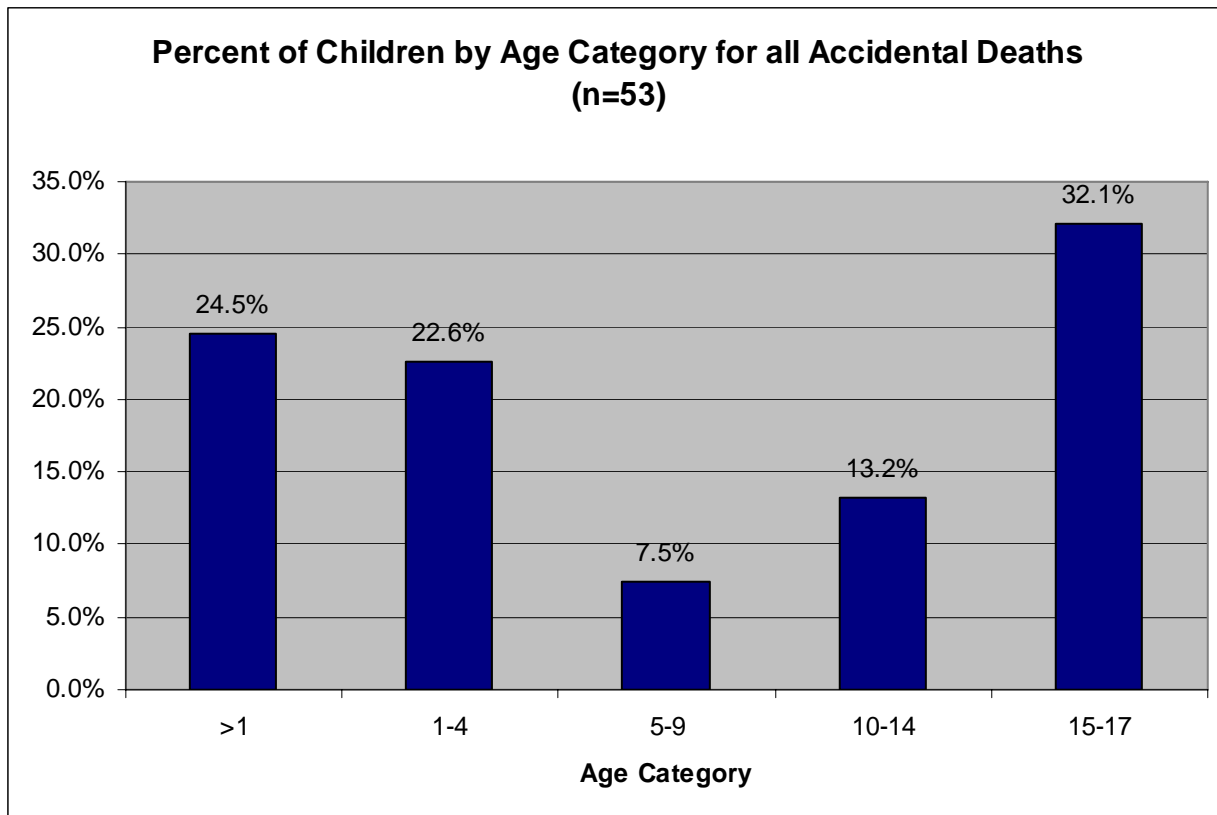
Natural deaths are some of the most difficult cases in which to identify preventative factors that could lead to recommendations for change to prevent future child deaths. By definition, natural deaths are those that occur from natural causes, leaving little room for prevention. The data does present,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

1. The majority (62.5%) of all natural deaths occurred in children less than one year of age. Additional data collection and/or research may be warranted to determine the level of prenatal care, exposure to prenatal substance abuse, as well as exposure to environmental pollutants to determine the effects of these factors on the overall health of the child. This additional data collection and/or research may lead to the identification of risk factors that contribute to infant deaths and for which preventative measures may be put in place to prevent future child deaths.
2. Nearly three-quarters (71.4 %) of all natural child deaths due to prematurity occurred in families that had some history of child welfare involvement. Prenatal care is a key factor in preventing preterm births and low birth weight babies. At prenatal visits, the health of both mother and fetus can be checked. Because maternal nutrition and weight gain are linked with fetal weight gain and birth weight, eating a healthy diet and gaining weight in pregnancy are essential. Prenatal care is also important in identifying problems and lifestyles that can increase the risks for preterm labor and birth. Thus, it is recommended that child welfare caseworkers provide education and resources on the importance of prenatal care to families that they come in contact with who are either planning on becoming pregnant or who may become pregnant even if the referral is unrelated.
3. Although the overall number of SIDS deaths in 2006 was relatively low (7), Black children, and particularly male Black children, were disproportionately affected by this cause of death. Education efforts regarding measures that may be taken to reduce the risk of SIDS should be targeted at this group.

Accidental Deaths

In 2006, there were 53 accidental deaths of children in Clark County. All were investigated by the coroner. Of those 53 accidental deaths, 66% of the decedents were male, and 34% were female. The majority of decedents (nearly one third) in this category were between the ages of 15 and 17, however nearly 25% of victims were under age 1, and slightly more than 20% were between the ages of 1-4.

Figure 3.1

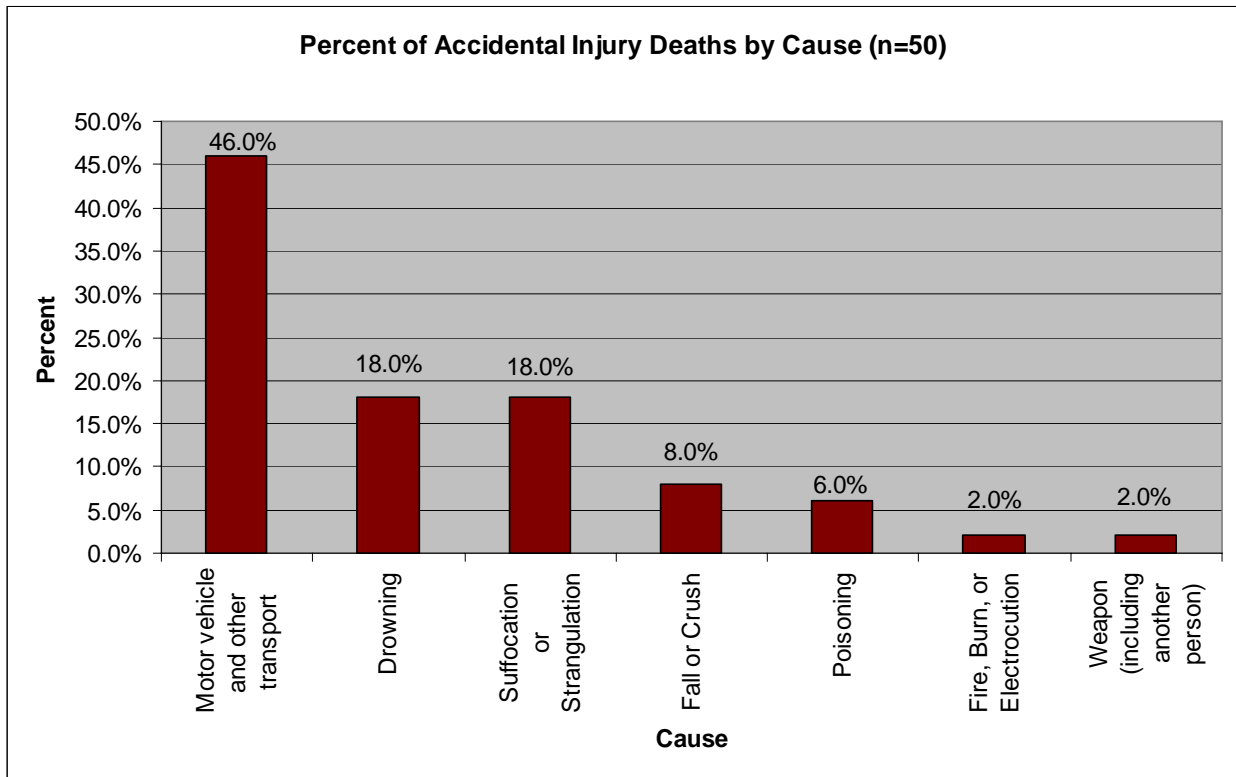


Slightly more than two-thirds of accident victims (67.9%) were Caucasian, less than one-fifth (18.9%) were Black, and 7.6% were Asian or Pacific Islander. There were no American Indians or Alaska Natives who died from accidental causes in Clark County in 2006. Nearly 40% of decedents were of Hispanic ethnicity.

Approximately 5 cases (10%) were not residents of Clark County. Home zip codes included California, Utah and Northern Nevada. All 5 of the non Clark County residents listed above died in motor vehicle accidents.

Of the 53 accidental death cases, 94.3% (50) were caused by an external injury, and 5.7% (3) were from a medical cause. Medical causes included prematurity (33%) and other medical conditions from which the child was not expected to die (67%). Nearly half of all accidental external injury deaths were due to motor vehicle accidents, followed by drowning and suffocation. The complete list of causes from an external injury is Figure 3.2.

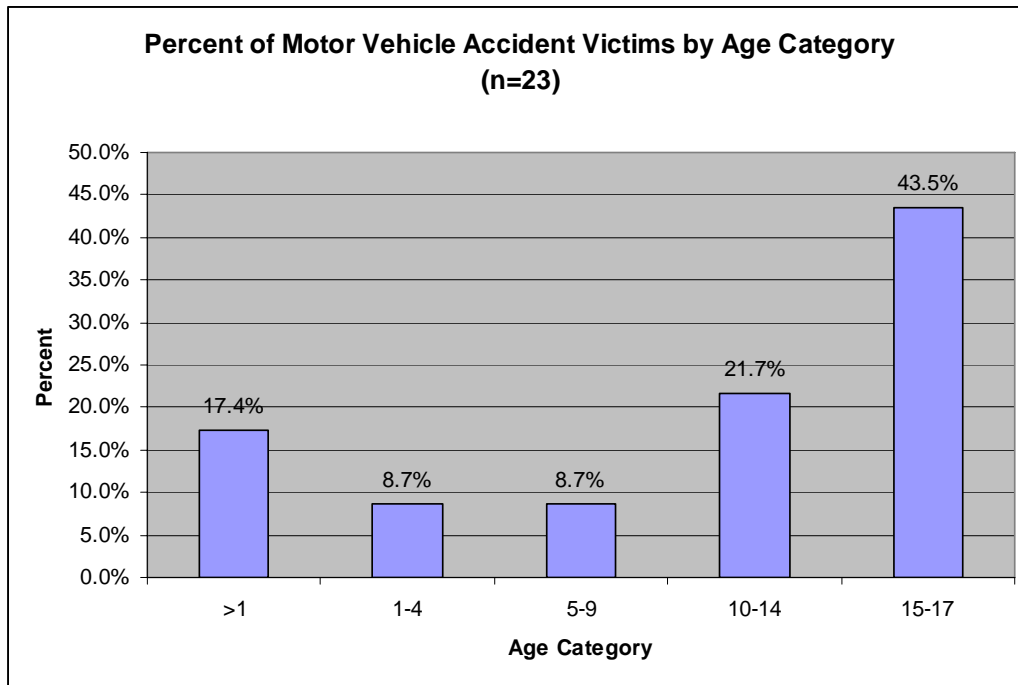
Figure 3.2



Motor Vehicle Accidents

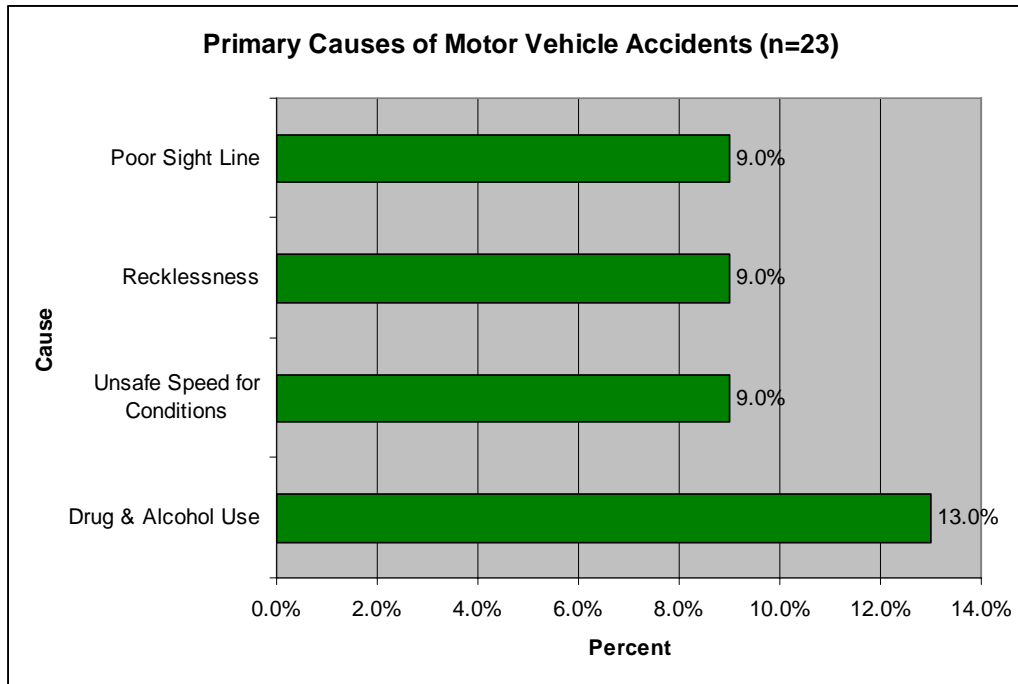
There were 23 deaths due to motor vehicle accidents (MVAs) in Clark County in 2006. More females (52.2%) than males (47.8%) died in MVAs, although the number is fairly evenly split. Nearly three quarters (73.9%) of decedents were Caucasian, and less than one-tenth (8.7%) were Black. Over half of the victims (52.2%) were of Hispanic ethnicity. Less than one in five decedents (13%) had a criminal or delinquent history, and less than 10% (8.7%) had a prior CPS history for the child or family. Almost half of the decedents were between the ages of 15-17 (43.5%), and nearly two-thirds (65.2%) were over the age of 10. Slightly less than 20% were under the age of 1 year (17.4%).

Figure 3.3



In 90% of the cases, there were either one or two cars involved in the accident. In the remaining 10% there were more than two cars involved in the accident. The majority of accidents happened on city streets (43.5%), followed by accidents occurring on highways (30.4%), and residential streets (13%). Primary causes of the accident included: drug or alcohol use (13%), unsafe speed for conditions (9%), recklessness (9%), and poor sight line (9%). At the time of death, 13% of decedents were alcohol- or drug-impaired.

Figure 3.4

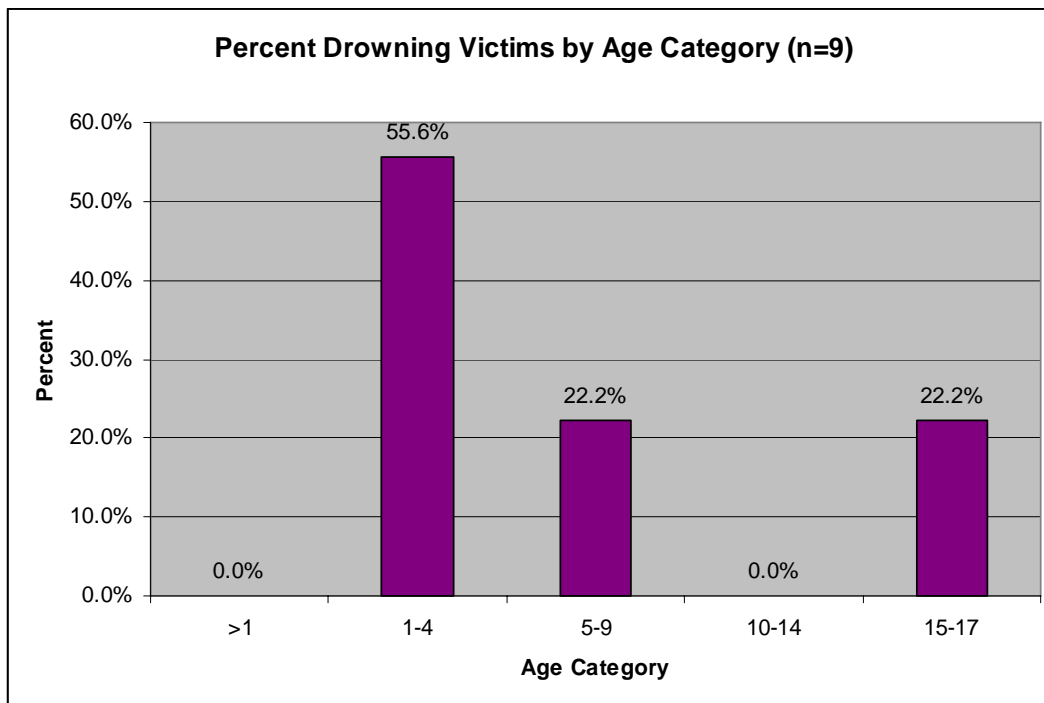


The child was a passenger in all of the cases where an infant under age 1 died, and all of the children between ages 1 and 4 were pedestrian fatalities. The remaining pedestrian fatalities were between the ages of 10-17. In 26.1% of the cases, the child was the driver of his or her vehicle. In those cases where the decedent was driving, one half (50%) of incidents occurred on city streets. Approximately 13% of the vehicles operated by children were bicycles or motor scooters, and in two cases, there was no helmet used by the decedent. In one case, there was a helmet used correctly, but it was not enough to prevent death. Over half (56%) of the vehicles involved were cars, vans, SUVs, or trucks. In 27% of the cases, a seatbelt was available to the decedent, as either a driver or passenger, but was not used. Nearly four-fifths (78.3%) of victims died on the same day as their accident. 911 was called in over 90% of cases. Autopsies were not conducted in 87% of cases, and toxicology screens were conducted in 34% of cases. CPS action was taken as a result of the death in less than 5% of cases.

Drowning

There were nine drownings that occurred in 2006. Over half (55.6%) were children ages 1-4, while approximately one in five (22.2%) were aged 5-9. Another 22.2% were ages 15-17. No infants under age 1 drowned in 2006. Over three quarters (77.8%) were Caucasian, and 22.2% were Black. Two thirds (66.7%) of children who drowned were listed with Hispanic ethnicity. Over half (55.6%) were male, while the remaining 44.4% were female. Over half (55.6%) of the children had siblings. In none of the cases was there a history of substance abuse nor was the decedent drug- or alcohol-impaired. Approximately 1 in 10 (11.1%) children had an open child welfare case at the time of death, 11.1% of decedents had been in foster care, and 11.1% of the children had a family or personal history with a child welfare agency.

Figure 3.5



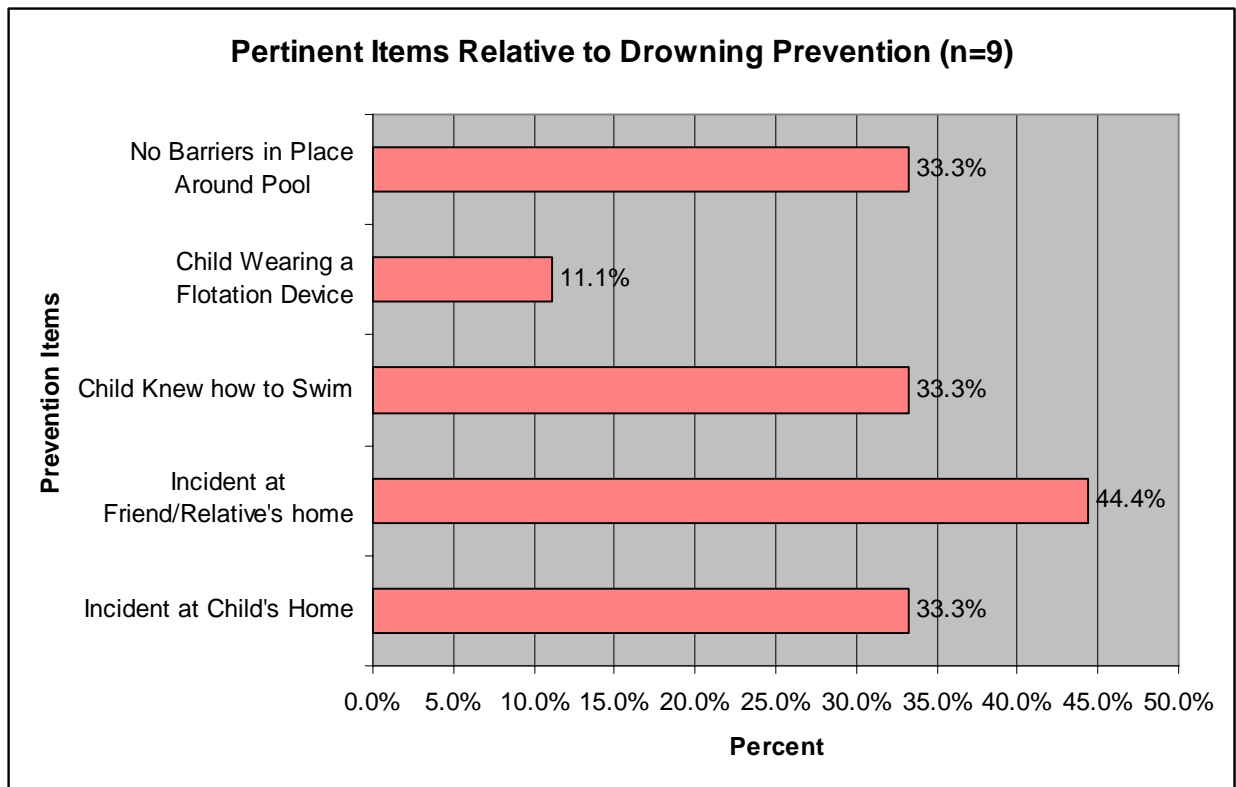
Approximately three quarters (77.8%) of the children were supervised at the time of the incident – the remaining 22.2% did not need supervision due to their age. Nearly all (85.7%) of the supervised decedents were under the supervision of their biological parent, and 15% were under the supervision of a sibling. Nearly all (85.7%) supervisors reported that it had been minutes since they had last seen the child, with approximately 80% reporting that it had been 10 minutes or less.

Nearly four-fifths (77.8%) of victims died on the same day as their accident. In 89% of cases, 911 was called, and CPR was performed until EMS arrived. In 22.2% of cases, CPS action was taken as a result of the death.

Over three quarters (77.8%) of the incidents occurred in a pool or hot tub, while the remaining 22.2% occurred in open water. According to the zip codes of the drownings, the majority are

taking place in older parts of Las Vegas and North Las Vegas. This fact suggests that the drownings may be occurring in pools that may not be up to current County safety codes. However, only one third (33.3%) of cases are taking place at the child's home – nearly half (44.4%) are occurring at a friend or relative's home. Only 33.3% of the children knew how to swim, and only 11.1% of the children were wearing a personal flotation device. In one third of the cases (33.3%), there were no barriers in place to keep children out of the pool, while one half of cases had a fence and gate.

Figure 3.6



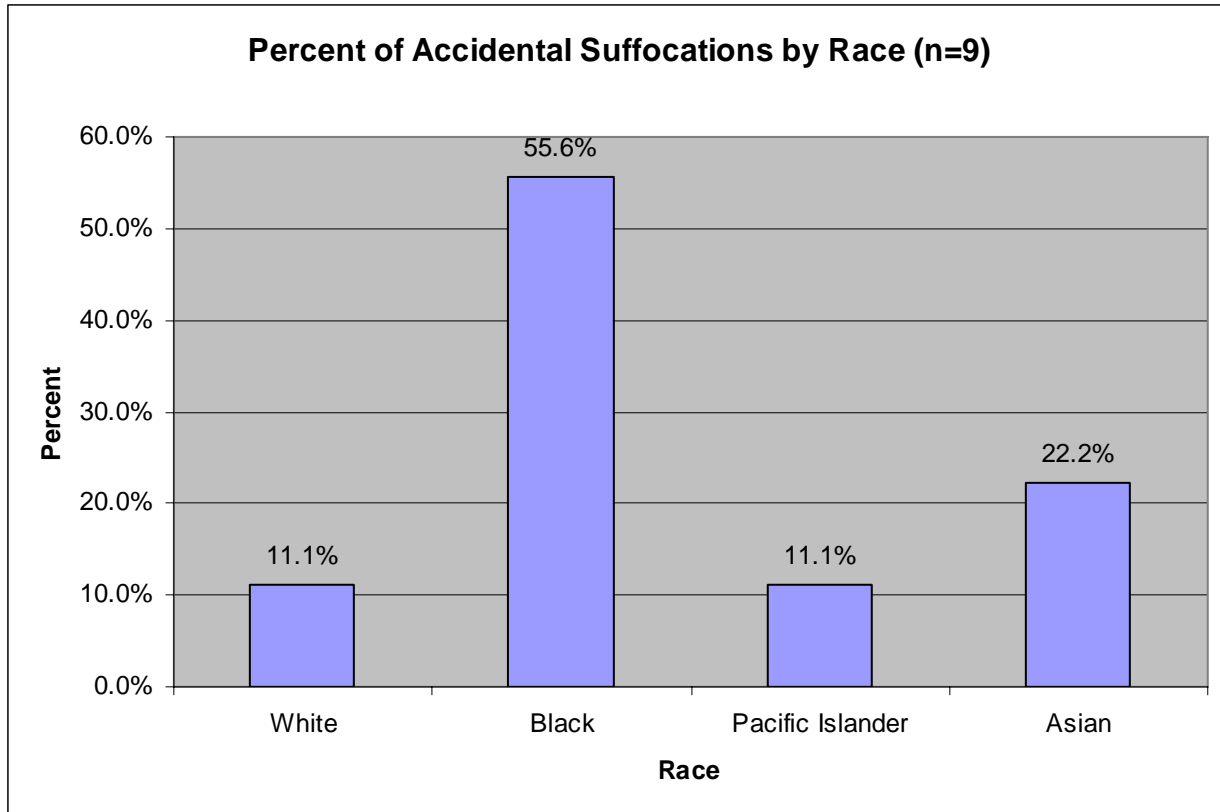
* Note: These percentages do not add up to 100% - the data is from different questions.

According to a Journal of Pediatrics study quoted by the National Center for Child Death Review, children of different ages tend to drown in different locations. The study found that babies most often drown in bathtubs when left unattended, even for a few minutes. Toddler drownings most often occur in swimming pools or backyard ponds. Older children more often drown in open bodies of water (lakes, rivers, oceans, gravel pits). According to Clark County data, all the toddlers between the ages of 1-4 drowned in pools, 80% of which were not at the child's home. For the children ages 5-9, half drowned in open water and half drowned in a pool that was not at their home. For the teens ages 15-17, one half drowned in open water and the other half drowned in a pool that was at their home. All the open water deaths occurred in a lake.

Suffocation or Strangulation

There were nine accidental suffocations that occurred in 2006 in Clark County. More than three-quarters (77.8%) were babies under one year old, with 11.1% between the ages of one and four, and 11.1% between the ages of 10 and 14. Nearly all were male (88.9%), and only 11.1% were female. Over half (55.6%) of the victims were Black, and slightly more than one in five (22.2%) were Asian. These two racial categories comprised all the deaths to infants under one year. None of the victims were listed with Hispanic ethnicity.

Figure 3.7



None of the children had an open CPS case at the time of their deaths, though one child had a prior CPS history. None of them were acutely ill in the two weeks before their deaths. The majority (55.6%) were born full term, and 22% were born slightly premature at approximately 32 weeks gestation. Approximately half of the mothers received prenatal care while pregnant. None of the infants were born drug-exposed.

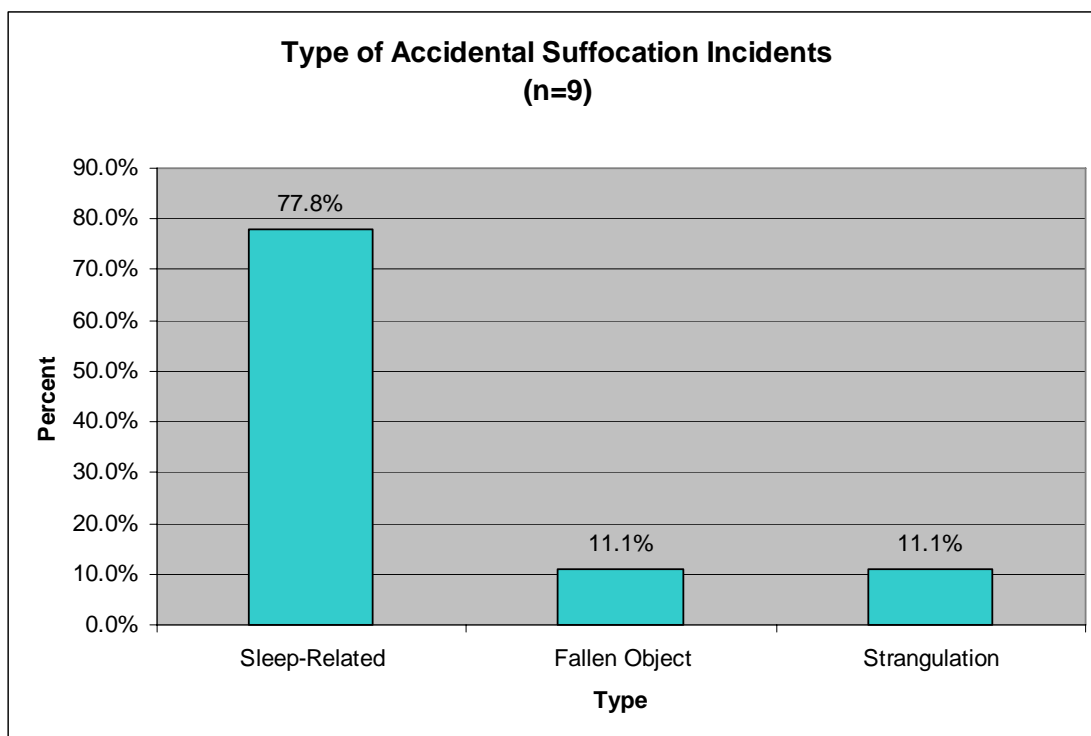
All children were primarily cared for by a biological parent. With the exception of 11.1% of cases, where supervision was not needed due to developmental age, all children had supervision, although not necessarily direct supervision, at the time of the incident. In more than three quarters (87.5%) of the cases, the supervisor was the biological parent, and in 12.5% of cases, supervision was provided by a babysitter. For two thirds of the cases, the child was in sight of the supervisor or it had only been minutes since the child had been seen. In 22.2% of cases, it had been hours since the supervisor had seen the child. All incidents occurred in the child's home,

and nearly all (88.9%) died on the same day as the incident. 911 was called in 88.9% of cases, and CPR was performed in all cases.

In 11.1% of cases, the child’s suffocation was not sleep related, and was caused due to a large object on top of the child which obstructed the child’s airway and caused the suffocation. In 11.1% of cases the child was strangled by a rope/string. In reviewing the accidental strangulation the team suspected that this death may have occurred as an attempt at the “choking game”, which is increasing in popularity among teenagers and pre-teens across the nation².

All incidents involving infants under one year occurred in a sleeping environment, which accounts for 77.8% of all accidental suffocations. None of these children had a history of sleep apnea or seizure.

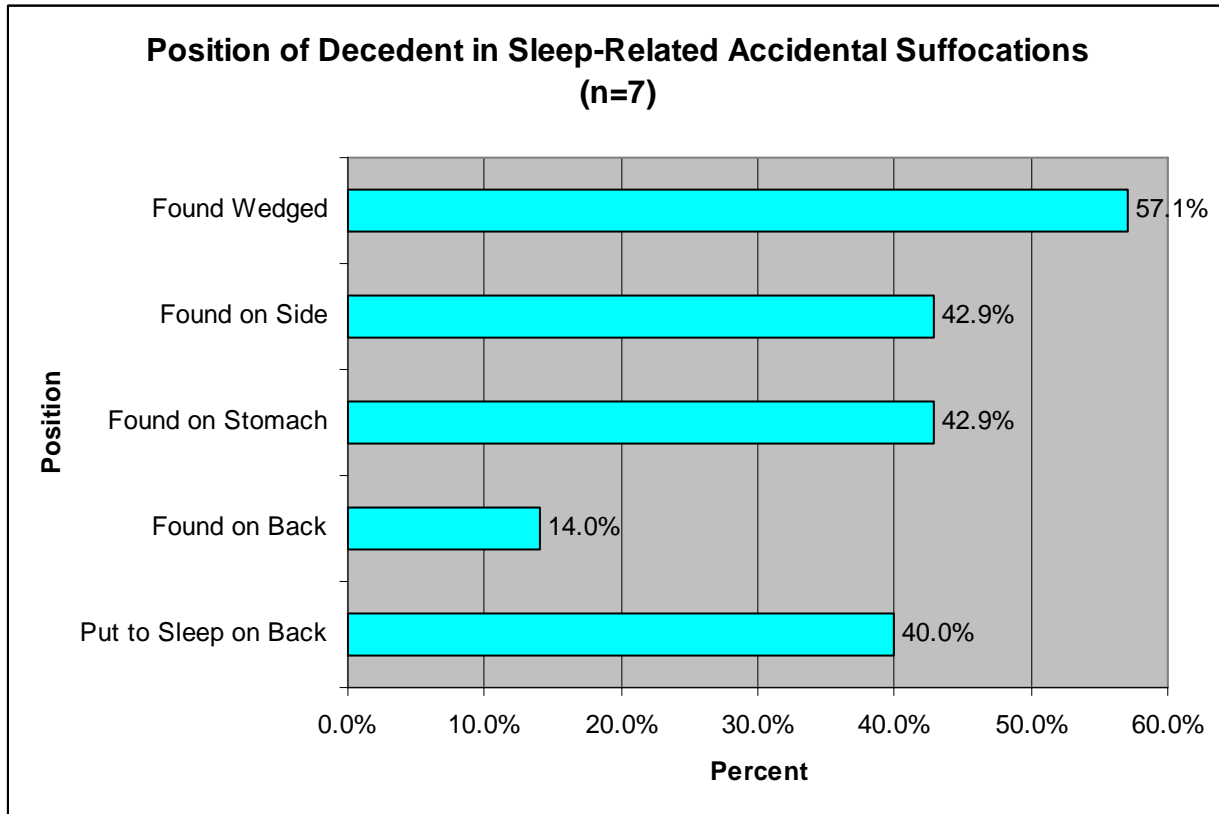
Figure 3.8



In less than one third (28.6%) of sleeping cases, the child had been placed in a crib or bassinette. The remainder of the cases occurred on adult mattresses, chairs, or couches. For all cases, the sleeping location where the child was found was listed as the child’s normal sleeping place. Approximately 40% of infants were placed to sleep on their backs, yet only 14% were found on their backs. Approximately 85% were found on their stomachs or on their sides. Over half (57%) of the cases involved the infant being wedged between adults, mattresses, and chairs; the remainder were pressed into pillows.

² More information about the choking game can be found at: <http://thedbfoundation.com/>

Figure 3.9



* Note: These percentages do not add up to 100% - the data is from different questions.

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 2006 were due to motor vehicle accidents, drowning and suffocation/strangulation. By their nature, all accidental deaths are preventable and thus provide ample data to make recommendations aimed at preventing future child deaths.

1. Nearly half (46%) of all accidental deaths that occurred among children in Clark County in 2006 were the result of some type of motor vehicle accident.
 - 43.5% involved children between the ages of 15 and 17 years old and 13% of those were alcohol and/or drug impaired at the time of the incident. Prevention efforts should focus on working with parents, young drivers and possibly insurance companies to provide incentives for participation in driver education/safety courses and implement stiff penalties for young drivers that are driving while impaired.
 - 27% involved children who had access, either as a driver or passenger, to a seatbelt, but did not use it. Prevention activities should include education regarding the importance of using a seatbelt, as well as the penalties currently in place for failure to comply with seatbelt laws.
 - 13% involved children who were on either bicycles or motor scooters. Only one of these children was wearing a helmet. Prevention efforts should educate children and parents on the importance of wearing safety helmets while riding bicycles, motor scooters and other similar vehicles.

2. The majority of drowning victims in 2006 were between the ages of one and four. 77.8% were reported to have been supervised at the time of the incident and 85.7% of those reported that it had been only “minutes” since they had last seen the child, with 80% reporting that it had been 10 minutes or less. 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 2006 took place in older areas of Las Vegas 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 code by providing gates, alarms, covers and other safety features to prevent drowning.
 - Most drowning incidents occurred at a home where the decedent did not primarily reside – usually either a friend or family member’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.

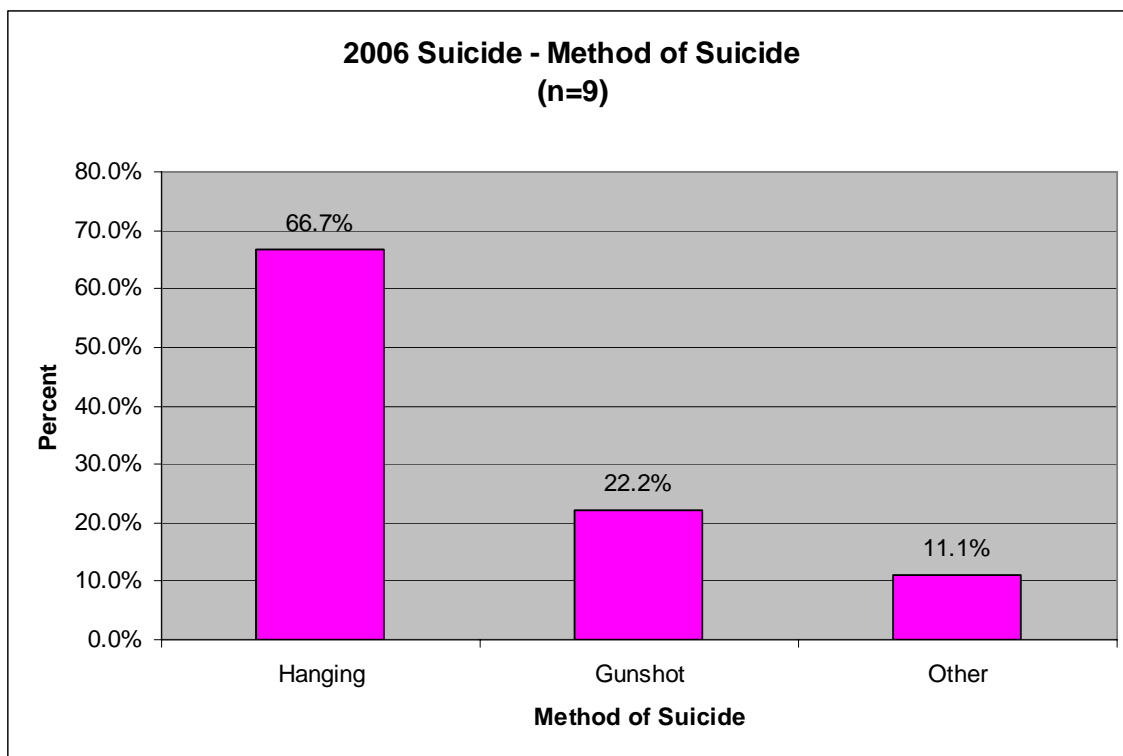
3. More than three-quarters (77.8%) of children who died from suffocation were under one year old. Additionally, the majority (77.8%) of all suffocation cases were sleep related, meaning that the incident occurred while the child was sleeping and/or was in their

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.

Suicide

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 2006, the Clark County team reviewed nine suicides and all decedents were between the ages of 15 and 17. In only 11.1% of suicides was there an open CPS case at the time of death, and in less than one quarter of cases the family had a history of involvement with Child Protective Services. The method of suicide is listed in Figure 4.1 below. The majority (66.7%) of teen suicides were hangings, followed by fatal firearm injuries at 22.2%. In only 22.2% of cases did investigators find a suicide note.

Figure 4.1



There were virtually equal numbers of males and females and almost all decedents were White. According to the National Center on Child Death Review, White males make up the greatest percentage of suicides among youth ages 15-24 years. Interestingly, in 2006, 44% of suicide cases reviewed by the Clark County Child Death Review Team involved Hispanic decedents, which is not illustrated in the national statistics. The percentages for sex, race and ethnicity for all 2006 suicide cases is listed in the Figures below.

Figure 4.2

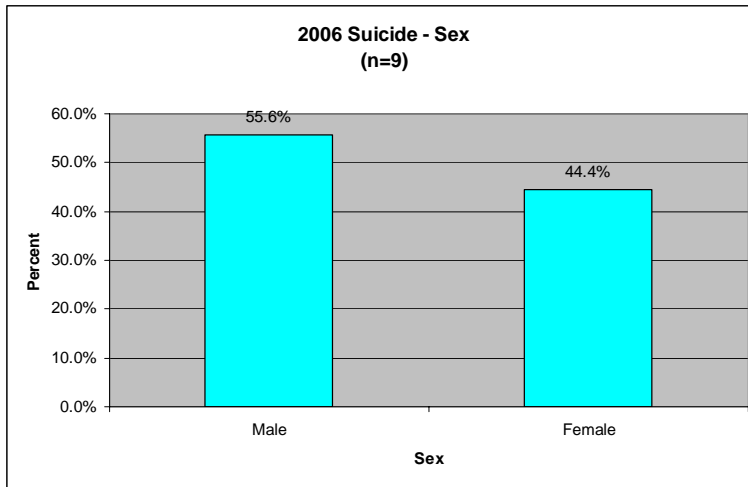
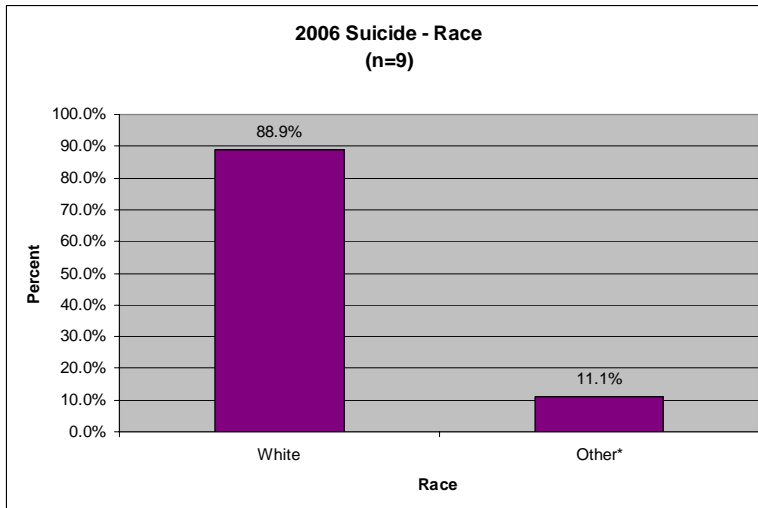
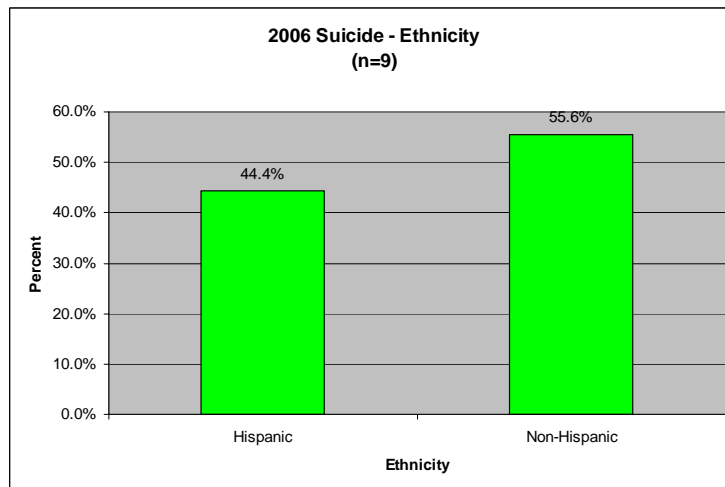


Figure 4.3



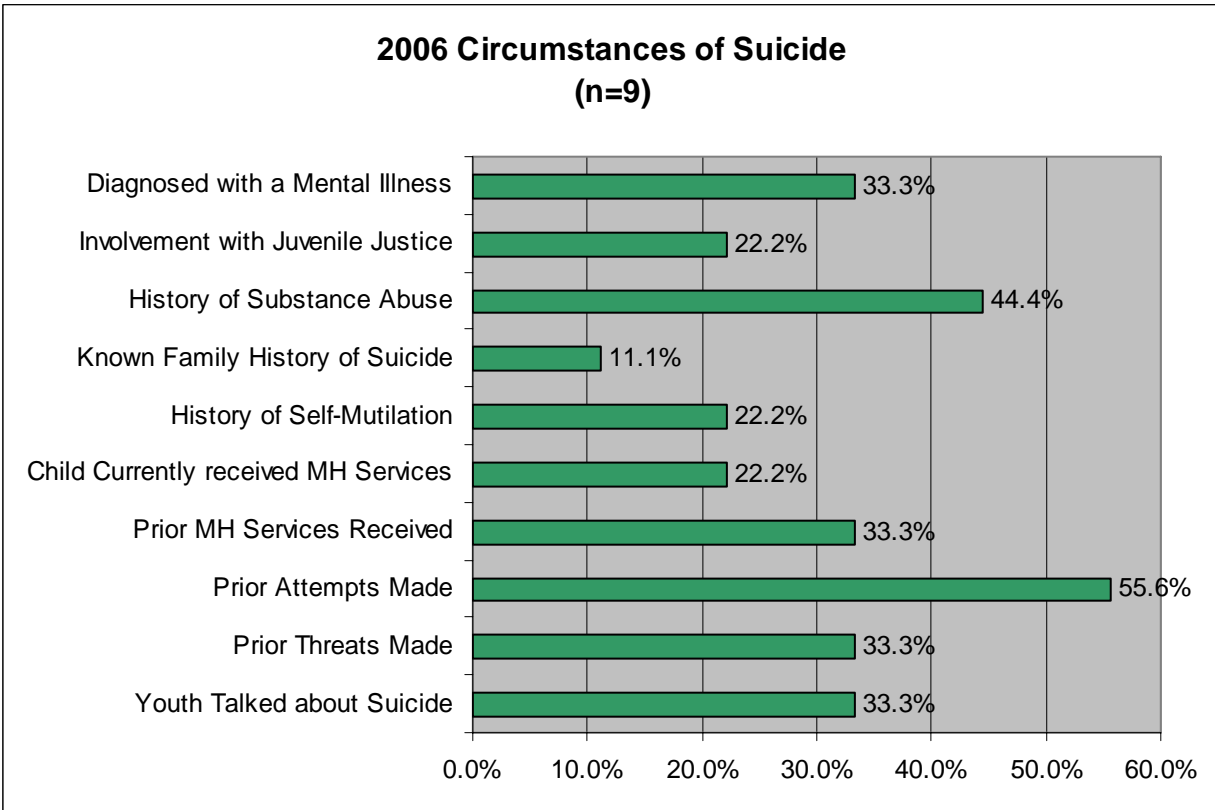
"Other" race in this instance was a person who did not list a race, but listed ethnicity as Hispanic

Figure 4.4



There are several factors that have been identified as risk factors for suicide. The circumstances that were present in the cases reviewed are listed in Figure 4.5 below.

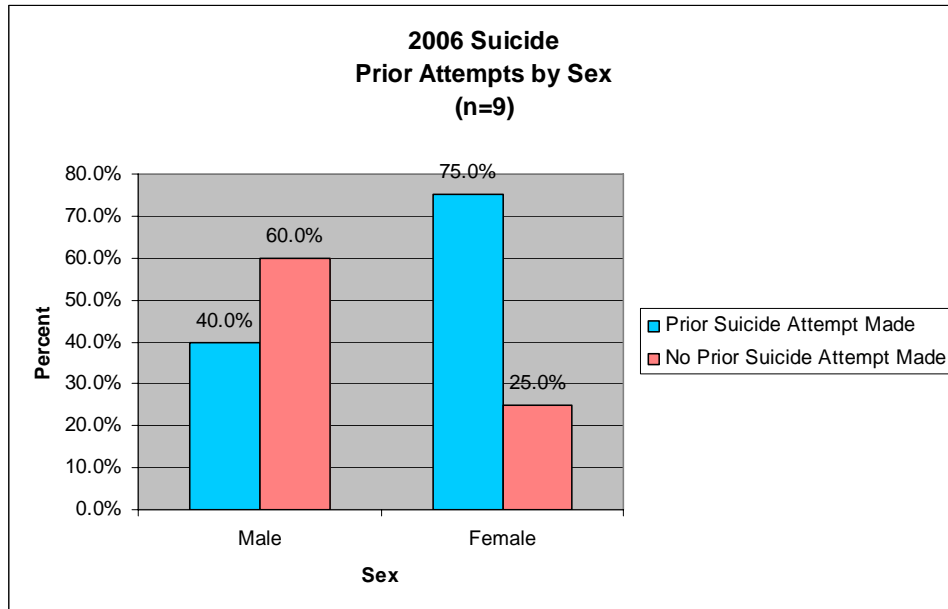
Figure 4.5



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 data does not support this trend. Data shows that (44.4%) of the suicide cases were using drugs or alcohol in the time leading up to the death, and those cases were evenly split by sex (50% of those cases were boys and 50% were girls). These two factors alone point to areas where prevention campaigns could be targeted as they are the circumstances that surround nearly half of these local cases.

According to literature on risk factors associated with suicide, prior attempts are one of the best predictors of future attempts of suicide (www.KidsHealth.org, Retrieved June 25, 2007). In 2006, over half (55.6%) of suicide victims had prior attempts. 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. Clark County data shows that females have a greater percentage of prior attempts than do males. As Figure 4.6 illustrates, 75% of females had prior suicide attempts, while only 40% of males had previously attempted suicide. Again these are important distinctions when crafting prevention campaigns.

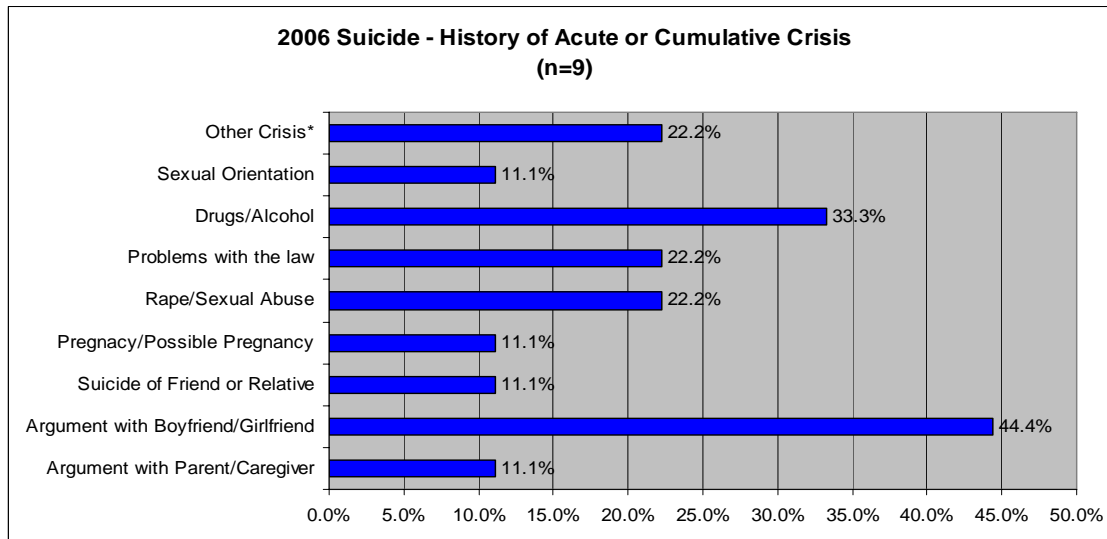
Figure 4.6



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 2006 cases, both the coroner and 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 for the 2007 data.

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. Almost one half of victims (44.4%) had recently had a fight with their boyfriend or girlfriend, while almost one third (33.3%) had been involved with drugs or alcohol. All of these factors are presented in Figure 4.7.

Figure 4.7



*"Other Crisis" includes a youth whose brother had been recently incarcerated, as well as a recent school dropout.

Method of Suicide

According to childdeathreview.org (2007), firearms (60%) and hanging (26%) were the most common methods of suicide used by young people in the U.S. 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 (<http://www.sprc.org/library/YouthSuicideFactSheet.pdf>). Regardless of the actual order, firearms and hanging appear to be the most common methods of suicide for teens.

In Clark County, hanging was by far the number one method of suicide. Youth used a variety of implements to carry out their suicide. These included, belts (33.3%), ropes (16.7%), straps (16.7%) and other clothing. It seems that youth used what was available to them indicating that parents and other caregivers need to be vigilant in recognizing any signs of suicide ideation because according to these statistics youth have constant access to this viable method of suicide.

In 22.2% of suicide cases reviewed a firearm was used as the means for suicide. These cases involved one male and one female and in both cases the firearm was a handgun. Also in both cases the firearm was locked in a cabinet, but the decedent had access to the keys. In one case the decedent had taken gun safety courses and was a trained shooter. In the other case, the decedent had a history of mental illness and another youth at school had recently committed suicide.

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, and to provide appropriate resources for youth who are suicidal. The 2006 data does, however, indicate some areas where suicide prevention efforts should be focused:

1. Nearly half (44.4%) of youth suicide cases involved Hispanic youth. Prevention efforts should take into consideration the language and cultural differences of Hispanic youth. Materials and resources should be available in both English and Spanish.
2. More than half (55.6%) of all youth who committed suicide in 2006 had made a prior suicide attempt and 75% of all female youth who committed suicide in 2006 had made a prior suicide attempt. Prior attempts is one of the highest risk factors for suicide completion. While prevention efforts should attempt to minimize suicide attempts, serious interventions should be available for all youth who have attempted suicide in an effort to prevent future attempts/completions.
3. Nearly half (44.4%) of all youth who committed suicide in 2006 had drugs and/or alcohol in their system at the time of death. Prevention efforts should focus on reducing youth access to substances which may impair their ability to think rationally, particularly if other risk factors exist, such as: prior attempts (55.6%), history of substance abuse (44.4%), diagnosed mental illness (33.3%), prior suicide threats (33.3%), or history of self-mutilation (22.2%).
4. Nearly half (44.4%) of all youth who committed suicide in 2006 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.

Homicide Deaths

In 2006, there were 20 homicides of children and youth. They fell into two primary categories – those that were committed using a firearm (55%) and those that were committed without a firearm (45%). Overall, victims were four times more likely to be male (80%) than female (20%), and primarily between the ages of 15-17 (40%). Nearly two thirds of the victims (60%) were White, one quarter (25%) of victims were Black, and 40% were listed as having Hispanic ethnicity. Clearly, this data shows that Black and Hispanic teens are disproportionately victimized by homicide. It is also interesting to note the bimodality of the age distribution – no children between the ages of 5-9 were homicide victims in 2006, and the oldest group (ages 15-17) and the youngest group (infants <1 year) demonstrated the highest percentages of victims. Age groups are shown in the chart below:

Figure 5.1

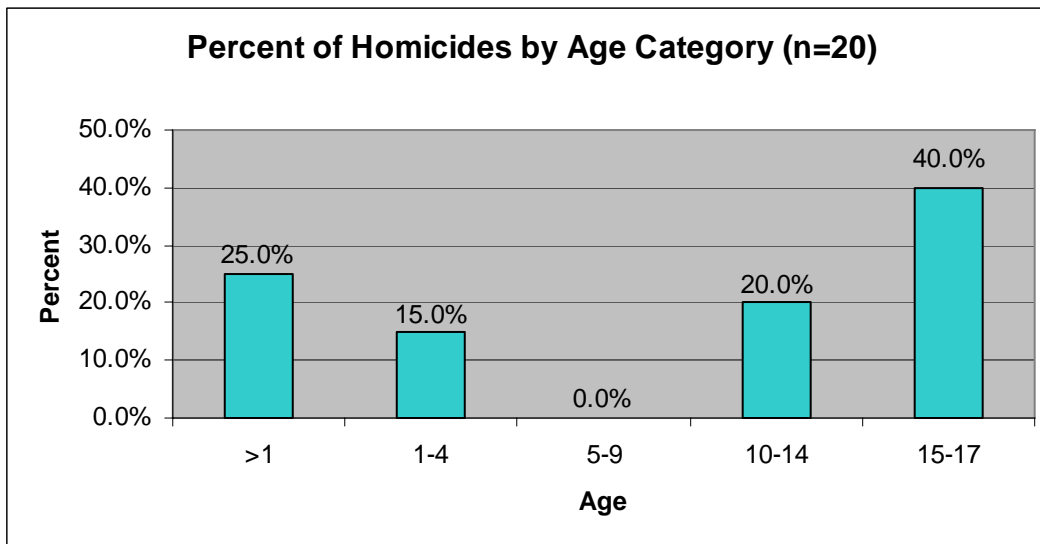
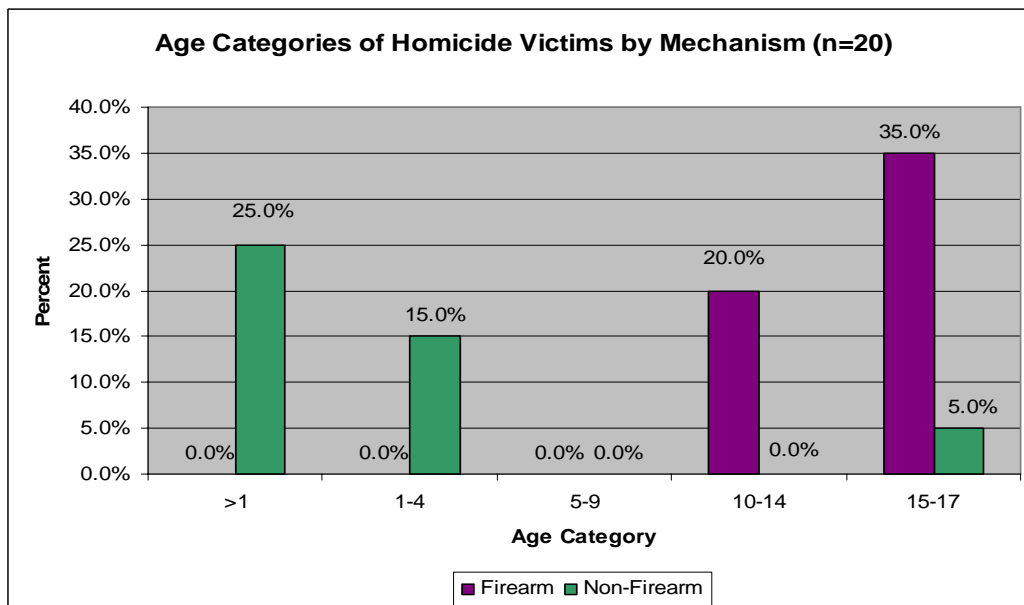


Figure 5.2



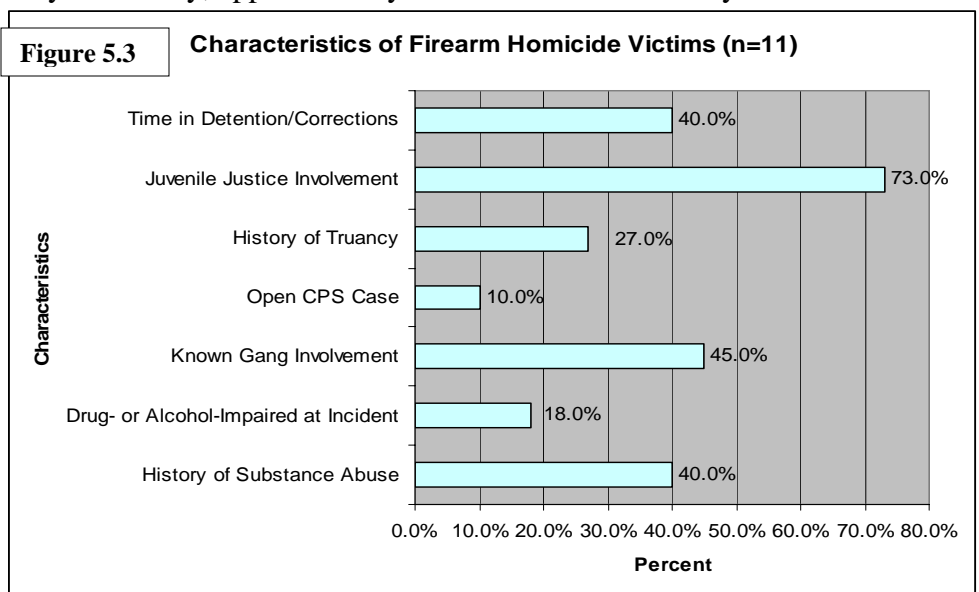
The mechanism of homicide clearly divides the age categories, showing different trends in victimization by age.

Firearm Homicides

According to childdeathreview.org (2007), youth homicides represent the greatest proportion of all firearm deaths. 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.” (www.childdeathreview.org, 2007) Clark County’s data supports these factors, particularly the substance abuse history, gang involvement, and school failure. Although no specific socio-economic status or family environment information is collected by the tool, the zip codes in which these youth homicides occur tend to be low-income areas. 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” (www.childdeathreview.org, 2007).

Although the percent of firearm homicides (55%) is nearly equal to the percent of non-firearm homicides (45%), there are some unique characteristics. The age distribution clearly shows that these are older children, with two thirds (63%) in the 15-17 age group, and one third (36%) in the 10-14 age group. None of the babies and toddlers were killed using firearms. Racially, 73% were White, and 27% were Black. Nearly half (45%) of the victims listed Hispanic ethnicity. All (100%) firearm homicide victims were male. None of the victims had a known disability or chronic illness.

Firearm homicide victims also demonstrated other common characteristics. More than one quarter (27%) had a known history of truancy, approximately 40% had a known history of substance abuse, and nearly one in five (18%) was drug- or alcohol-impaired at the time of the incident. Approximately 10% of victims had an open CPS case at the time of death, and 10% had ever been in foster care. Not surprisingly, approximately three quarters (73%) had a prior criminal or delinquent history, and 40% had spent time in juvenile detention/corrections.



The majority of victims (81%) died on the same day as the incident. 911 was called in 90% of the incidents. Almost half (46%) of the shootings occurred at a friend's home, and another third of the shootings (27%) occurred on a sidewalk in front of a home or apartment. Other locations included roadways and parking areas.

Over half (55%) of the firearms used in these homicides were handguns. While 10% were sawed-off shotguns and 10% were hunting rifles, the remaining 25% of firearms were unknown or unidentified by investigators at the time of the review. More than one third (36%) of firearms involved in the homicide were owned by known gang members, with other owners listed as Friend/Acquaintance (20%), Neighbor (10%), and Unknown (20%).

Consistent with national trends, nearly half (44%) of firearm homicides occurred during an argument or fight. Approximately 10% occurred while showing the gun to others or playing with it, and 10% occurred during the commission of a crime. Approximately half (45%) were known to be gang-related. The team determined that poor/absent supervision contributed to 22% of firearm homicide cases, and that child neglect was a contributing factor in just under 10% of cases.

Non-Firearm Homicides

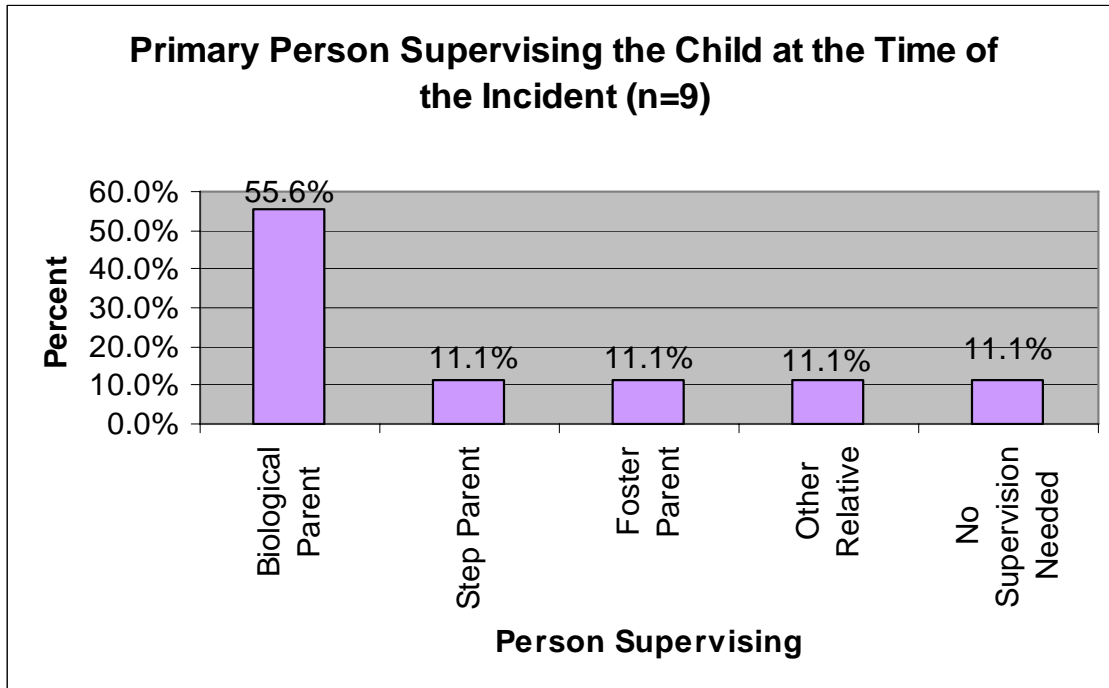
Non-firearm homicides demonstrated an entirely different pattern of circumstances. Over half (55%) of the victims in this group were infants under age one, and another third (33%) were between the ages of one and four years old. Only 11% of victims were between the ages of 15-17. Victims were primarily White (55%) and Black (22%), and Asian (11%) with 33% reporting Hispanic ethnicity. The sex of non-firearm homicide victims was much more evenly split, with 55% being male and 45% being female. Contrary to the firearm homicide victims, where none of the victims had a known disability or chronic illness, 22% of non-firearm homicide victims had a known disability or chronic illness.

Due to the age of the majority (88.9%) of the victims, school history is not applicable, therefore there is little concern about truancy. However, the older homicide victim did have a known history of substance abuse. There was no known juvenile justice history for any of the victims. However, 22% of cases had an individual or family history with CPS, 10% had an open CPS case at the time of their death, and 10% had ever been in foster care.

Nearly all (88.9%) were in the custody of their biological parent at the time of their deaths, and 11% of cases were in the custody of a foster parent. For all young children, supervision was provided at the time of death, although it may have been minutes or hours since the supervisor had seen the child in 66% of cases.

In over half (55.6%) of cases the person supervising the child was a biological parent, and the remaining cases were evenly distributed among foster parents, step parents, other relatives and those children not requiring direct supervision due to their age. This information is illustrated in Figure 5.4 below.

Figure 5.4



Much of the information about the caregiver/supervisor's history of substance abuse, intimate partner violence, criminal or delinquent history, and child abuse/neglect history was undetermined from the records available to the team at the time of review. However, it is known that 11% of supervisors had a history of substance abuse, and 11% were the victims of intimate partner violence.

Over half (62.5%) of the incidents took place in the child's home, while other incidents occurred in a relative's home (12.5%), a friend's home (12.5%), and a licensed foster home (12.5%). 911 was called in 77% of cases, and CPR was performed in 55% of cases. CPS action was taken in 77% of these cases. Only 33% of children died on the same day as the incident – slightly more than half died at a later date. Approximately 10% of cases occurred during an argument, and the 89% occurred in an abusive situation.

*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. Many children who die from physical abuse have been abused over time, but a one-time event often causes a death. **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

The team determined that poor/absent supervision caused the fatality in 11% of cases, that physical abuse caused the fatality in 67% of cases, and that child neglect was a causative factor in 22% of cases and a contributing factor in 11% of cases. The autopsy found abusive head trauma in 44% of cases, and chronic battered child syndrome in 22% of cases. The decedent was shaken in 11% of cases.

Homicide Deaths: Recommendations for Prevention

Homicide, by definition, is the intentional killing of another human being. Twenty children were the victims of homicide in Clark County in 2006. The data indicates two distinct categories for child homicides: firearm related and non-firearm related.

Firearm Homicides:

1. Nearly all youth homicide victims age 10 to 17 in 2006 were shot by a firearm, and all were male. The data indicates that Black (25%) and Hispanic (40%) male youth are disproportionately represented in this category. The data also shows that 73% of the victims had a prior juvenile justice history and that nearly half of incidents were gang related. Prevention efforts aimed at reducing firearm related youth homicides should focus on addressing the needs of these youth through community based outreach programs and gang prevention activities. All efforts should take into consideration the language and cultural needs of the populations most at risk.

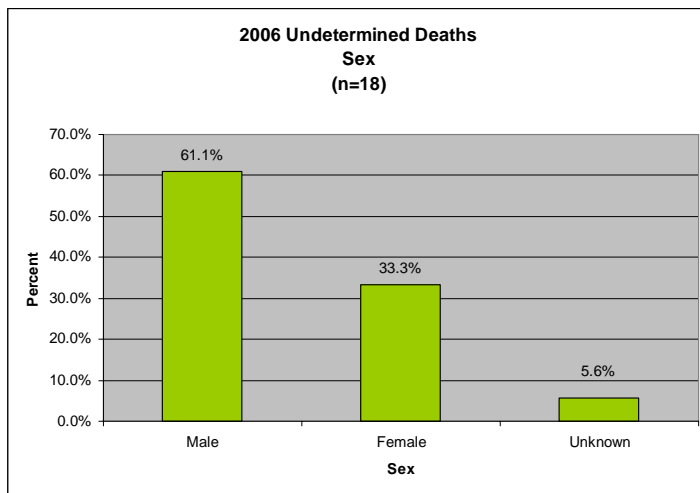
Non-Firearm Homicides:

1. All homicide victims aged less than one to four years in 2006 were the victims of non-firearm related homicides. Two-thirds (67%) of these homicides involved physical abuse and in 44% of the cases abusive head trauma was noted in the autopsy. Neglect was identified as a causative factor in 22% of the cases and as a contributing factor in 11%. Only 11% were noted as having indications of Shaken Baby Syndrome. Over 62% of these children were in the care of their biological parent at the time of death, and the remaining children had been supervised by either a step-parent, foster-parent or other relative. 22% of the families involved had a history of involvement with the child welfare system. Prevention efforts should focus on providing services and resources to parents of young children that educate parents on how to handle stress and anger. In an effort to gain better perspectives on these deaths, the CDR data collection tool should be expanded to capture more information which could inform prevention initiatives.

Undetermined Deaths

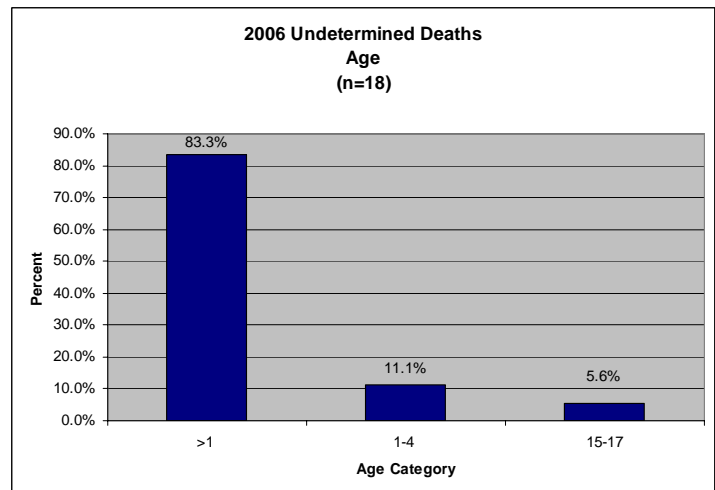
In 2006 Clark County reviewed 18³ cases where the death was ruled “undetermined”. This ruling is used by the Coroner’s office when information regarding the circumstances of the death make it difficult for the medical examiner to make a distinct determination about the manner of the death. The coroner may rule a death “undetermined” when sufficient evidence or information cannot be obtained, usually about intent, to assign a manner of death. In all eighteen cases, the cause of death was also listed as “undetermined”. Additionally, 16.7% of these cases had an open CPS case with the family at the time of the death, and in one third of these cases the family had some previous history with Child Protective Services. Information on the sex, age and race/ethnicity of these cases is provided in the Figures 6.1-6.4.

Figure 6.1



There were almost twice as many male undetermined deaths (61.1%) as there were females (33.3%). There was also one case where the sex of a fetus could not be determined.

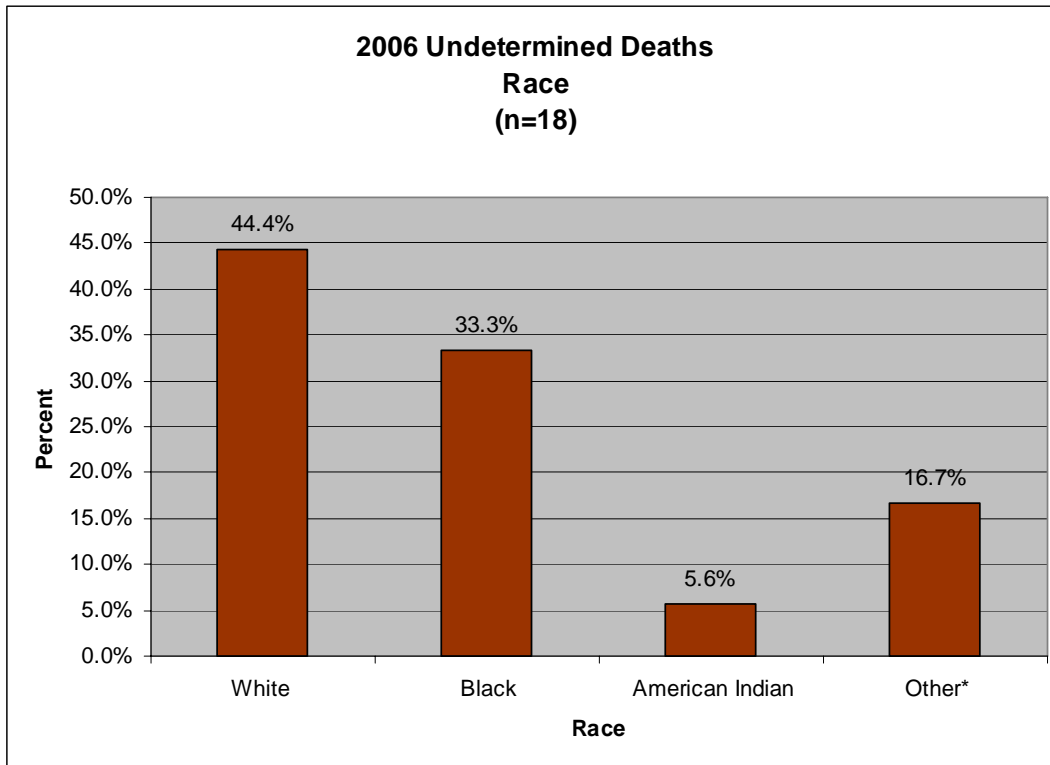
Figure 6.2



Nearly all (94.4%) of the cases of undetermined deaths were infants under one year of age (83.3%) and toddlers between the ages of one and four (11.1). A very low percentage (5.6%) of cases were teens between 15 and 17 years old.

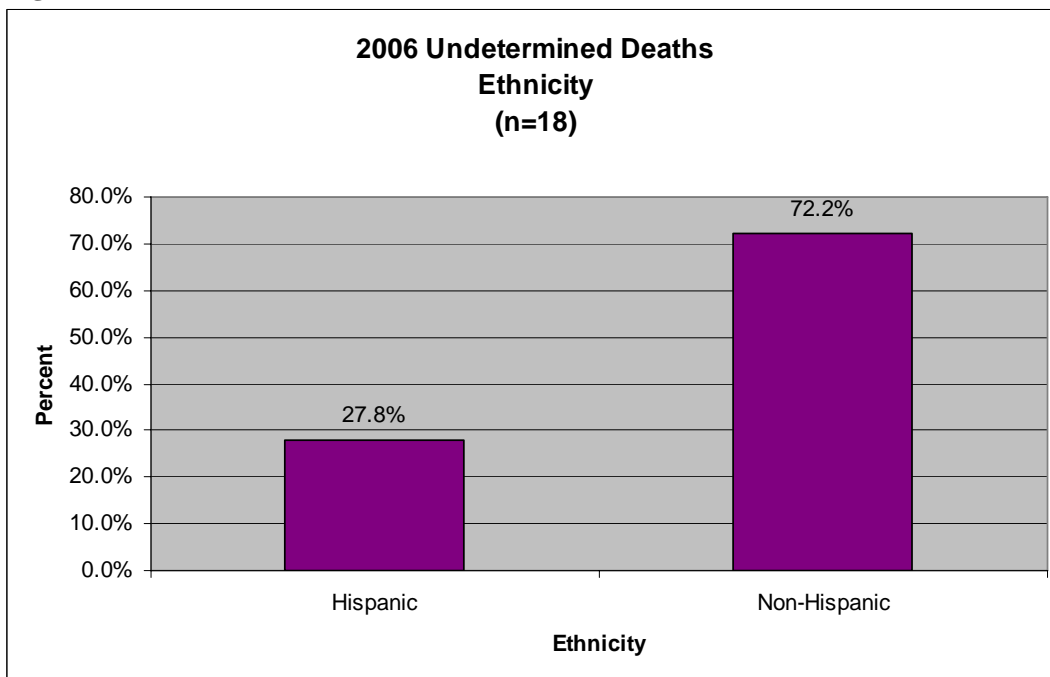
³ According to numbers provided by the Clark County Coroner’s Office, there were only 17 undetermined child deaths in 2006. An attempt was made to reconcile this discrepancy, but NICRP did not receive a response and therefore maintains that the team reviewed 18 undetermined child deaths.

Figure 6.3



* There were two cases where the race of the child was not listed, but the child's ethnicity was listed as "Hispanic" in both cases.

Figure 6.4



Undetermined Death – Less than One Year of Age

Almost all (83.3%) of these cases were children less than one year of age. In 26.7% of children less than one year the child was exposed to second hand smoke, often or occasionally. The death occurred in a sleeping environment in 86.7% of children less than one year. Children were sleeping in a number of different locations, most prevalent were mattresses (30.8%) and cribs (30.8%). Information on sleep environment and location is illustrated in Figures 6.5-6.6.

Figure 6.5

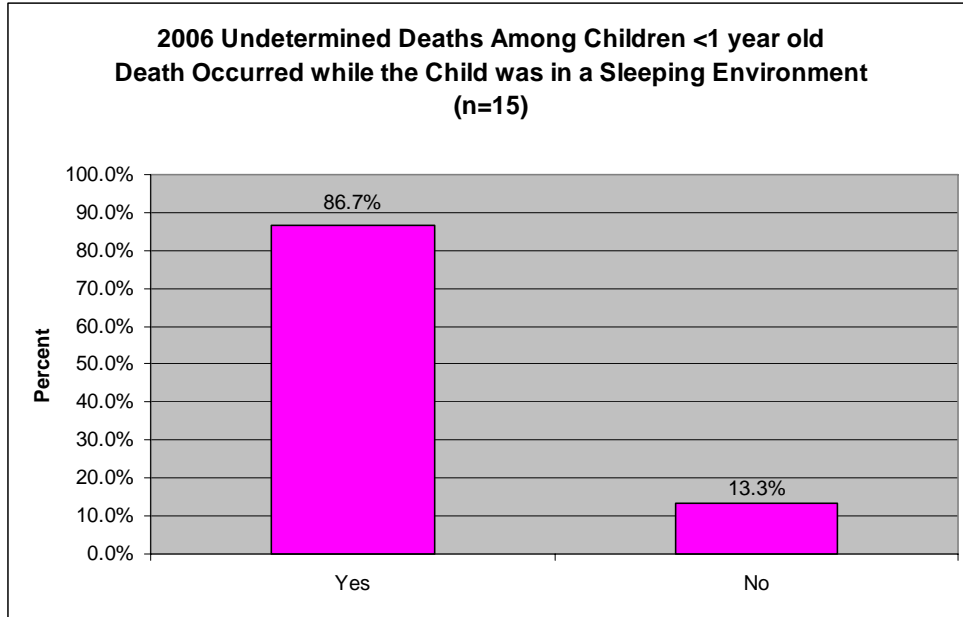
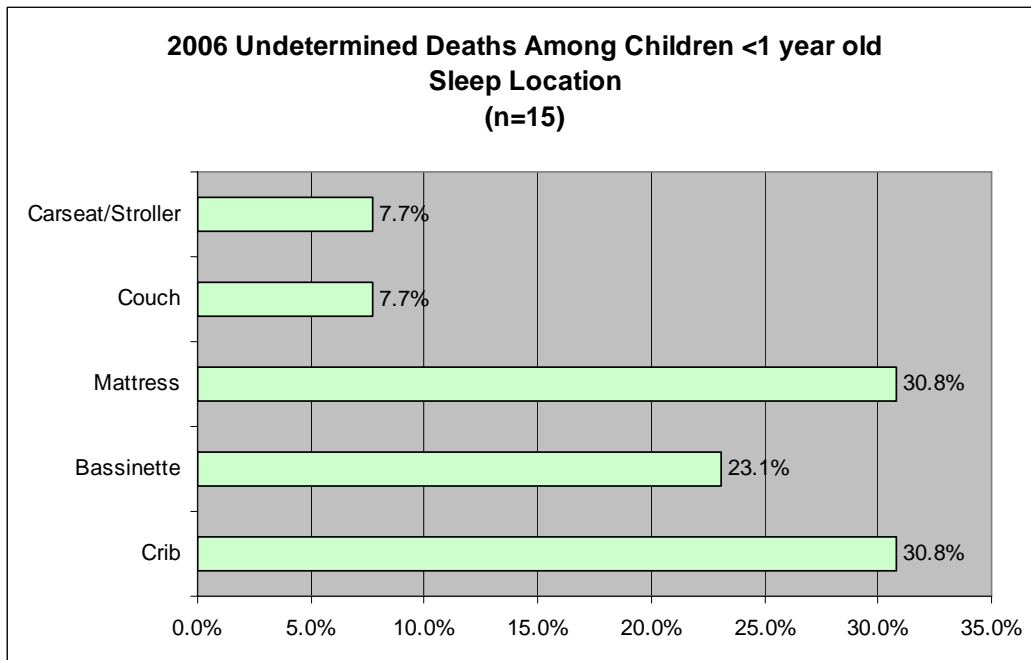


Figure 6.6



Among these deaths that occurred in sleeping environments, children were most often put to sleep on either their back (46.7%) or on their side (26.7%) and then found on either their back (46.7%) or on their stomach (26.7%). About one third (33.3%) of children less than one year in a sleep environment at the time of death were found with their faces obstructed in some way. Infants were found with faces pressed into a pillow, tangled in sheets, rolled off the bed where they were put to sleep, or rolled into a stuffed animal. There were only two children less than one year who were not in a sleep environment at the time of their death.

Undetermined Deaths – Over One Year of Age

There were only three cases where the child was over one year of age. Two were between the ages of 1 and 4 years and the other was between 15 and 17 years old. Two of these cases were children who were one year old and were found unresponsive in their sleeping environments. One was sleeping in her own crib, while the other was co-sleeping with his parents. Neither of the children had any history of serious medical conditions and both were reported as in good health on the day of their deaths. Neither child had any history of involvement with the child welfare system. The other case involved a 16 year old who was found unresponsive in his bed by a parent and investigation failed to pinpoint an exact cause of death.

Appendix A:
Clark County Child Death Review Team Membership List

Atkinson, Kelvin	Clark County Coroner's Office
Baltz, Rebecca	LVMPD Abuse & Neglect
Barter, Debbie	Area Health Education Center of Southern Nevada
Bolton, Julie	Clark County School District
Campbell-Dolinar, Hiedi	LVMPD Abuse & Neglect
Carroll, Tom	Clark County District Attorney
Coleman, Cathy	University Medical Center
Connor, Erin	Southern Nevada Health District
Cosgrove, Jeanne	Sunrise Hospital
Dupuis, Lynn	Clark County Department of Family Services
Dwitt, Daphne	North Vista Hospital
Eisen, Andrew	Touro University
Fitzgerald, Mark	Clark County Department of Family Services
Flatt, Linda	Nevada State Office of Suicide Prevention
Fudenberg, John	Clark County Coroner's Office
Fulbrook, Thomas	University Medical Center
Gazza, William	Clark County Coroner's Office
Hancock, Marion	Sunrise Hospital
Harpin, Nancy	University Medical Center
Hatch, Troy	Henderson Police Department
Hosaka, Mark	Henderson Police Department
Hull, Cynthia	University Medical Center
Koch, Doug	University Medical Center
Kreml, Sandy	Clark County Department of Juvenile Justice Services
Larsen, Kevin	DPS – Nevada Highway Patrol
Lattin, Edward	DPS – Nevada Highway Patrol
Lebegern, Holly	LVMPD Abuse & Neglect
Lipscomb, Diane	Sunrise Hospital
Lowry, Teresa	Clark County District Attorney
Lyon, Doug	Clark County Manager's Office
Magleby, Suzanne	Clark County Social Services
Mankey, Carol	Southern Nevada Health District
Marek, Beth	Clark County Department of Juvenile Justice Services
Mehta, Neha	Sunrise Hospital
Molnar, Dave	North Las Vegas Police Department
Monroe, Vicki	Clark County District Attorney
Murphy, Mike	Clark County Coroner's Office
Myk, Lisa	LVMPD Abuse & Neglect
Olson, Alane	Clark County Coroner's Office
Rubin, Ann	Clark County Department of Family Services
Sauchak, Cyndi	LVMPD Abuse & Neglect

Schmidt, Edith	Sunrise Hospital
Schulze, Victor	Nevada State Attorney General's Office
Swanson, Tara	UNLV - NICRP
Tanata, Denise	UNLV - NICRP
Tavarez, Teresa	LVMPD Abuse & Neglect
Teele, Lisa	LVMPD Abuse & Neglect
Thompson, Fred	Henderson Police Department
Tudor, Judy	Clark County Department of Family Services
Virtuoso, Rosemary	Clark County School District
Washington, Eboni	Clark County Department of Family Services
Zipoy, Jennifer	UNLV - NICRP

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](#))

Appendix C: Summary of Recommendations and Accomplishments Reported to the State Administrative Team for 2006 Child Deaths

Recommendations

Gun Safety: Law enforcement agencies should train investigators to inquire about gun security with suicide by gun shot wound cases and implement the suicide investigation checklist to increase data collection for suicide cases.

Prenatal Substance Abuse: Recommend to State Legislature to conduct a study on the feasibility of enacting laws which allows prosecution of mothers whose child dies due to maternal drug use.

Car Seat Safety: Child welfare agencies should provide and require car seat safety and installation education/training to all foster and shelter parents, as well as staff, before they are allowed to drive with an infant. Collaborate with Safe Kids Coalition to set up.

Teen Driving: Enact graduated licensing which restricts juvenile drivers from having other youth in their vehicle.

Medical Care:

- Require medical providers at urgent care facilities and other drop-in clinics to check all vital signs, especially when a child has a history of respiratory problems and presents with respiratory systems. Additionally, for these facilities, require that a pediatrician is on duty at all times and/or create a checklist for seeing pediatric cases.
- Collaborate with Spanish-speaking media outlets across the state to put out messages regarding how to access health care without medical insurance.

Mental Health Services: The State should implement appropriate levels of mental health facilities to ensure that youth receive appropriate treatment for their condition.

Medical Care for Children in the Child Welfare System:

- Child welfare agencies should collaborate with public health and hospitals to develop a “medical passport” for children in foster care, which would include complete discharge instructions, that goes with the child and is provided to whoever is caring for the child.
- Child welfare agencies should arrange for a public health nurse to provide in-home, child specific training to foster/shelter parents caring for medically fragile or at-risk children.

Public Education Campaigns Regarding:

- The dangers of overmedication of young children with over the counter medications and the importance of following instruction labels and doctor’s orders.
- Safe sleeping conditions for infants including placing the child to sleep on their back as well as asphyxia related to co-sleeping and having unsafe items in or around the sleeping area (pillows, blankets, stuffed animals, etc.). Also warn about the dangers of wedging (child’s head becoming “wedged” between mattress and head/foot board, couch/chair cushions, etc.).

- Youth suicide and identifying symptoms of suicidal ideation as well as available resources.
- Recognizing youth substance abuse and possible overdose situations.
- The need to properly store and secure drugs and alcohol in the home to protect both young children and teenagers, especially if there is a history of substance abuse, depression or suicidal ideation.
- Pool safety and drowning, encouraging all pool owners and pool users to supervise children, lock gates and use other available safety measures.
- The need to properly store items and to secure furniture to avoid having items fall on and crush a child.
- Safe driving practices for teens including warnings about wearing safety belts and the danger of distractions such as other youth in the vehicle, cell phones, radios, etc.
- Fire safety education and the importance of supervision of young children.