

# Summary of Findings from the 2012 Child Death Review Annual Report

The 2012 Annual Report of Child Deaths in Clark County, Nevada provides data regarding all infant, child, and fetal (over 20 weeks gestation) deaths occurring in Clark County in 2012. Since 2008, the Child Death Review Team in Clark County has reviewed 100% of the child deaths referred to the team by the Clark County Office of the Coroner/Medical Examiner. This includes all natural deaths, as well as all accidents, homicides, suicides, and undetermined cases.

## Overall 2012 Child Death Statistics

### Manners of Death in 2012

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

### Causes of Death in 2012

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

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

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

### Recommendations:

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

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

### Recommendations:

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

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

Recommendations:

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

**Homicide**- In 2012, 3.6% (8 cases) of child deaths were categorized as homicides. This is a decrease from 19 deaths in 2011, nearly half of what we have seen since 2008, and the smallest number recorded since 2006. In 2012, youth 10-14 years was the most frequent age group at 37.5%, followed by children ages 5-9 at 25%. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2012 there were far more non-firearm homicides (n=7) than firearm homicides (n=1). For non-firearm homicides (n=7), 85.7% were a result of child abuse or neglect (n=6). In four of those cases the perpetrator a parent’s partner (boyfriend/girlfriend or step parent) and two cases the perpetrator was the biological parent. In the remaining case the perpetrator was a stranger. More than half (n=4) of the decedents’ families had a history of involvement with the child welfare system.

Recommendations:

- Firearm Homicides: Focus on addressing the needs of youth (especially minority youth) through community based outreach and violence prevention activities.
- Non-Firearm Homicides: Develop and promote networks of services to help families most at risk to prevent incidents before they start. Parenting/stress management training should be targeted toward parents as well as other adults living in the home that may be responsible for caregiving.

**Undetermined** – 7.20% (16 cases) of child deaths were ruled undetermined, which is a decrease from 2008 (n=18). This ruling is used by the Office of the Coroner/Medical Examiner when information regarding the circumstances of the death makes it difficult for the medical examiner to make a distinct determination about the manner of the death. 8 of these 16 cases (50%) were infants less than 1 year of age. Among those children less than 1 year of age (n=8), 75% (n=6) died in a sleeping environment and in 4 of those 6 cases the child was sleeping with other adults.

### **Summary of Child Welfare History for all 2012 Child Deaths**

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

- 53 of the 222 cases reviewed had some family history of involvement with DFS prior to the child’s death – an increase of 2 cases from 2011 (n=51).
- In 8 cases the child/family had an open case with DFS at the time of the child’s death (decrease of 2 cases from 2011)
- In 2 cases the child was in foster/shelter care at the time of their death (an increase from 2010).
- In 2012 there were 9 substantiated death allegations of abuse or neglect.
- Of the 9 substantiated death allegations (4.1% of all child deaths in Clark County), three were homicides, four undetermined, and two accidental. In nearly half (n=4) of these cases the decedents’ and their family did not have any prior history with DFS.

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## 2012 CDR Team Prevention Activities

### COMMUNITY COLLABORATION

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

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

### CHILD ABUSE AND NEGLECT PREVENTION

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

### DROWNING PREVENTION

Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. The Southern Nevada Drowning Prevention Coalition continues to coordinate efforts, and ensure consistent prevention messaging related to water safety and drowning prevention. There are three members of the Clark County CDRT that continue to serve on this coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County. This year the collaboration celebrated April Pools Day with a joint press conference, as well as several local events where information was distributed to attendees. In 2012 the coalition focused efforts on the Hispanic population due to disproportionate numbers of Hispanic children victims of both fatal and non-fatal drowning incidents.

### SAFE SLEEP – SUFFOCATION PREVENTION

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

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