2020 Annual Report of Child Deaths in Clark County, Nevada

12/23/2022

A Report from the Child Death Review Team in Clark County

Nevada Institute For Children's Research & Policy

NICRP

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

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About the Nevada Institute for Children's Research and Policy

The Nevada Institute for Children's Research and Policy (NICRP) is a not-for-profit, non-partisan organization whose primary goal is to advance the well-being of children in Nevada. As a research center in the School of Public Health at the University of Nevada Las Vegas, NICRP is dedicated to conducting academic and community-based research that helps guide the development of policies, practices, and programs which serve to enhance the health and well-being of children and their families. For more information about NICRP, please contact us or visit our website at http://nic.unlv.edu.

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BACKGROUND

In 1992, Nevada joined many other states in mandating child death review teams to act to prevent future child deaths. 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 child death review teams in Nevada has been on addressing fatalities related to child maltreatment and/or involvement with the child welfare system, the teams have expanded their focus to address risk factors and preventability in a wide variety of cases. Given that approximately 75% of the state's population under 18 years of age (US Census Bureau Quick Facts 2020 Estimates, Retrieved October 2022) resides in Clark County, 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.

Clark County has contracted with the Nevada Institute for Children's Research and Policy (NICRP) in the School of Public Health at the University of Nevada, Las Vegas to collect case specific data from cases reviewed by the Clark County Child Death Review Team and compile this 2020 Annual Report of Child Deaths in Clark County, Nevada. This report is a result of Clark County's commitment to make this information more visible and available to the public. The Clark County Child Death Review Team is a multidisciplinary team that conducts independent reviews of child deaths. The team does not report to any county official.

> *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**

PURPOSE

The primary goal of all child death review teams is to prevent future child deaths. The child death review process enables jurisdictions to come together in a collaborative, multidisciplinary forum to openly discuss detailed circumstances of specific cases in an effort to gain a better understanding of child deaths. The team provides a venue for representatives from a variety of both public and private agencies as well as community organizations to share information in a confidential and non-threatening environment. The National Center for Child Death Review (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" (Program Manual) to assist states in developing and conducting child death reviews. Many of the recommendations provided in the Program Manual have been adopted by the regional child death review teams in Nevada.

What are Child Death Review Teams?

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.

Child Death Review Operating Principles

All Nevada child death review teams have adopted the following operating principles established by the National Center.

- 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.

Case Review 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 serve as guidelines for all regional child death review teams in Nevada and are focused on preventing future child deaths.

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every child death.
2. Improve communication and linkages among local and state agencies and enhance coordination of efforts.

3. Improve agency responses in the investigation of child deaths.
4. Improve agency response to protect siblings and other children in the homes of deceased children.
5. Improve criminal investigations and the prosecution of child homicides.
6. Improve delivery of services to children, families, providers, and community members.
7. Identify specific barriers and system issues involved in the deaths of children.
8. Identify significant risk factors and trends in child deaths.
9. Identify and advocate for needed changes in legislation, policy, and practices and expand 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.

MEMBERSHIP

In an effort to gain a holistic perspective of risk factors that may have contributed to the death of a child, child death review teams are organized to include representatives from a variety of both public and private entities. The collaborative nature of this process allows the teams to understand the child and family in a more global perspective, providing more insight into circumstances which might have led to the fatality. The ultimate goal of the review process is to identify preventative measures that could 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 is not 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 Clark County Department of Juvenile Justice, local fire departments, Southern Nevada Health District, Nevada Highway Patrol, Nevada Office of Suicide Prevention, and others.

A complete list of the Clark County Child Death Review Team members for 2020 is in Appendix A.

REVIEW PROCESS

CASES INCLUDED FOR REVIEW

In 2020, the Clark County Child Death Review Team reviewed 100% (n = 334) of the child deaths referred to them by the Clark County Office of the Coroner/Medical Examiner (CCOCME); these included natural deaths, accidents, homicides, suicides, and undetermined deaths. Fetal deaths over 20 weeks gestation were included in the reviews because 20 weeks gestation was determined by the team to be a conservative gestational age for viability of a fetus. Although fetal death certificates do not indicate a manner of death, for purposes of the case reviews and this report, fetal deaths were classified based on the manner reported by the CCOCME.

PRIOR TO THE MEETING

Each month, the CCOCME provides NICRP with case information on the fetal and child deaths to be reviewed by the Clark County Child Death Review Team. NICRP uses this information to develop the monthly team agenda. For each case on the agenda, a summary sheet is created that contains basic demographic information about the decedent and a short description regarding the circumstances of the death. Follow-up cases, those cases that were on a previous agenda but their review was not completed because the team requested additional information, are listed first on the agenda. The remaining pages of the agenda include new cases organized by manner of death and by cause of death within each manner. Only cases that have been officially assigned a cause and manner of death by the CCOCME or the attending physician signing the death certificate are placed on the monthly agenda.

The monthly agenda also includes an overview page which lists the number of deaths by manner by year of death for the last several years so that the team can easily determine any trends. In December of 2019, NICRP began including a similar overview page in the agenda that is specific to suicide deaths. This overview page includes information regarding history of suicide, substance abuse, mental health, and child welfare involvement by year of death for the suicide cases reviewed by the team since 2016.

NICRP provides the team members with the agenda one week prior to the monthly meeting so that they can gather pertinent case information for the review. During 2020, there was an average of 25 cases on each monthly agenda for the team to review, including new and follow-up cases.

DURING THE MEETING

The Clark County Child Death Review Team meets for approximately three hours once a month. At the beginning of each meeting, the team chair reminds the members and any guest attendees of the confidential nature of the review process and ensures that any new members or guest attendees have signed a confidentiality agreement. Team members and all meeting attendees are required to sign an annual confidentiality agreement in which they agree that they will not discuss or share any of the information presented during the meetings with anyone outside of the meeting. After the review of confidentiality, the team chair requests that the police department with jurisdiction over the first case on the agenda begin presenting the case details. Next, Clark County Department of Family Services and Clark County Department of Juvenile Justice share any information they have regarding the family or the decedent. Then, agencies with any additional information about the case are asked to share it with the group. The team members then have the opportunity to ask clarifying questions and engage in discussion

regarding the circumstances of the case. Next, the team votes on whether abuse and/or neglect caused or contributed to the death using the definitions in Table 1 which come from the National Center for the Review & Prevention of Child Deaths Data Dictionary and do not represent the legal definition of any specific agency or jurisdiction.

Table 1. Definitions used during the review process in determining whether abuse and/or neglect caused or contributed to the child death.

Abuse	**Neglect**
Physical abuse is any *non-accidental act* that results in physical injury or the imminent risk of harm. Emotional abuse refers to such acts as verbal assault, belittling, threats and blaming. Sexual abuse is a single or series of sexual assault(s) or sexual exploitation(s).	Neglect occurs if a child has been abandoned; is without proper care, control, and supervision; or lacks the subsistence, education, shelter, medical care, or other care *necessary for the well-being of the child* because of the faults or habits of the person responsible for his or her welfare or because of that person's neglect or refusal to provide care when able to do so.
Caused	**Contributed**
The direct cause of death refers to an act that was the *primary event leading directly to the death*. It describes a specific act of commission or omission that, in and of itself, led to the physiological processes precipitating the child's death. Generally, the act in question was both *necessary and sufficient* to kill the child.	The contributing cause of death refers to an act that *plays a role, but not the primary role*, in the death. The contributing (or indirect) cause of death describes a *necessary but not sufficient* act of commission or omission that contributed in a substantial manner to the death of the child. The act did not, in and of itself, precipitate or lead inevitably to the physiological processes leading to death.

Finally, based on the case review, team members have the opportunity to make and discuss recommendations for improvements to laws, policies, and practices to support the safety of children and prevent future child deaths. Occasionally, the team decides to request additional information on a case and bring it back for further review at the next meeting. These cases become follow-up cases on the next monthly agenda.

AFTER THE MEETING

Following the meeting, NICRP makes note of any additional case information that the team requested during the meeting (e.g., hospital records, school records, or mental health treatment notes) and follows up with the appropriate agencies or individuals to try to obtain the information prior to the next monthly meeting. NICRP also summarizes any recommendations that the team proposed so that they can be included in the quarterly report that is sent to the Executive Committee for the Review of the Death of Children (Executive Committee). If there are any recommendations that the team has decided to implement locally and not send to the Executive Committee, NICRP works to develop a plan to implement the recommendation and provides updates regarding the plan at the next meeting for further action by the team.

DATA OVERVIEW

Based on the information provided to NICRP by the CCOCME to create the agenda and the information collected during the monthly review meetings, NICRP enters case level data into an electronic case reporting system maintained by the National Center for Fatality Review and Prevention (CFRP). The data for the current report were exported from the CFRP reporting system.

Prior to analyses, the data were cleaned by reviewing a 10% random sample of cases for data entry errors. If errors were found in the sample, they were corrected and another 10% random sample of the remaining cases were reviewed. This process continued until a sample was found to have no data entry errors. During data cleaning, no additional case information was requested. Therefore, if specific case information was not received by the CCOCME or was not provided during the review process, it was coded as "unknown" in the CFRP reporting system.

CONFIDENTIALITY

All cases reviewed by the Clark County Child Death Review Team are kept completely confidential. Information shared in the meetings is protected under NRS 432B.407 and cannot be shared with anyone outside the meeting. NRS also states that any team member who discloses confidential information is personally liable for a civil penalty of up to $500.

NICRP keeps all of the child death review records confidential and securely stored in a locked cabinet in a locked office. In addition, only Clark County Child Death Review team members are sent the full agenda with case details prior to the review meeting. Because this information is confidential, every effort was made in this report to discuss cases in general terms and not refer to any specific details of one case. Therefore, in instances where only one case fits specific criteria, details are not provided in this report.

OVERVIEW OF DEATHS

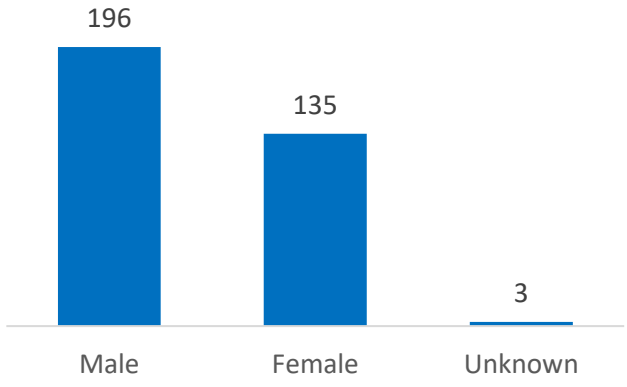
In 2020, the Clark County Child Death Review Team reviewed the deaths of 334 children under 18 years of age, which included fetal deaths of at least 20 weeks gestation. These deaths represent 100% of the cases referred to the team by the Clark County Office of the Coroner/Medical Examiner (CCOCME). In 2019, the team also reviewed 100% of the cases referred to them which included 347 deaths. This represents a 3.7% decrease in child deaths in Clark County from 2019 to 2020.

Demographics

The data used for this report come from the National Fatality Review Case Reporting System, which is the case reporting system used by the Clark County Child Death Review Team. The response options in the system to report on a child's "sex" include, "Male," "Female," and "Unknown." Based on the available data, the terms sex, male, female, and unknown will be used in the current report.

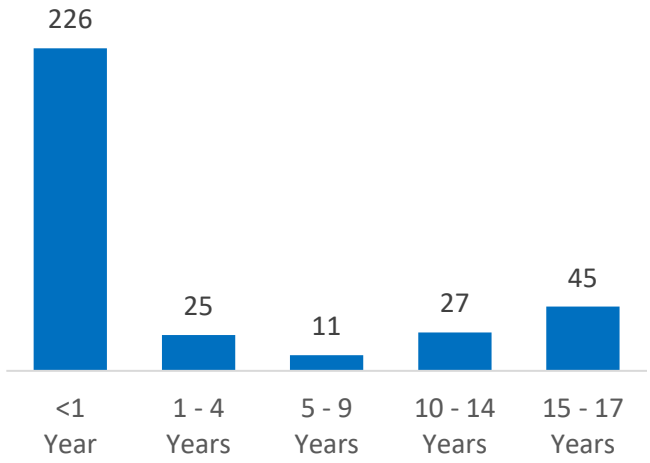
As seen in Figure 1, there were more child deaths in Clark County in 2020 among males as compared to females.

Figure 1. Number of child deaths in Clark County in 2020 by sex of decedent.



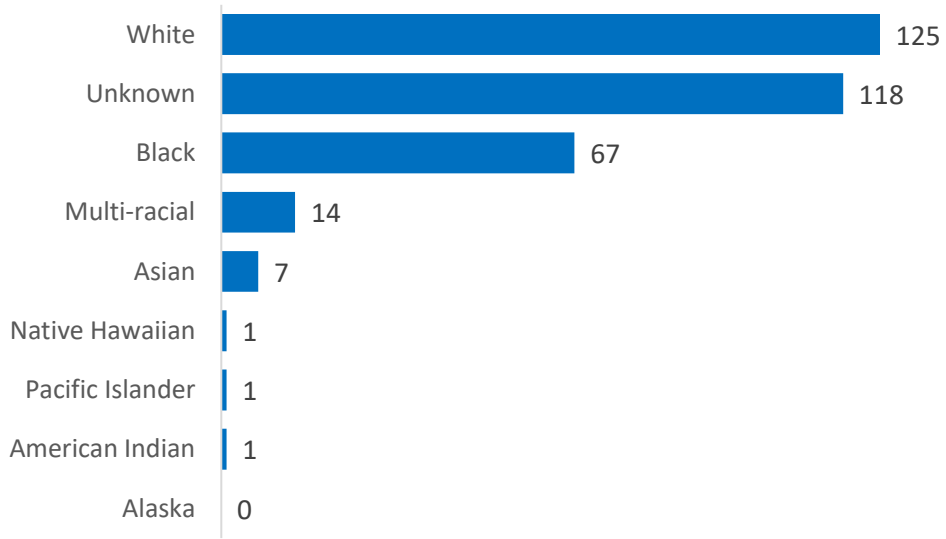
As seen in Figure 2, the majority of child deaths in Clark County in 2020 occurred among those less than one year of age (67.7%).

Figure 2. Number of child deaths in Clark County in 2020 by age category of decedent.



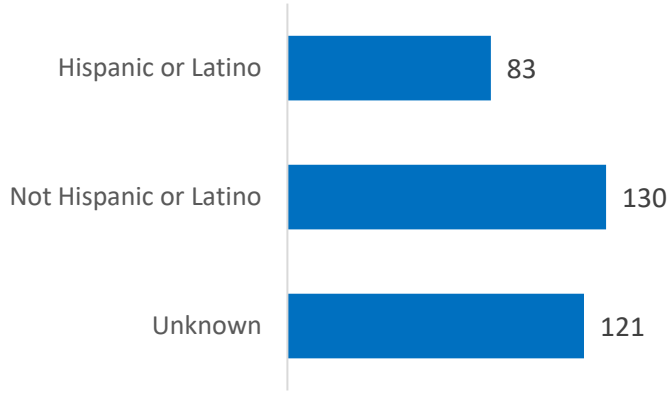
As seen in Figure 3, the largest percentage of child deaths in Clark County in 2020 occurred among White children (37.4%), followed by children of an unknown race (35.3%).

Figure 3. Number of child deaths in Clark County in 2020 by race of decedent.



Finally, with regard to demographics, the largest percentage of child deaths in Clark County in 2020 were among children not of Hispanic or Latino ethnicity (38.9%). See Figure 4.

Figure 4. Number of child deaths in Clark County in 2020 by Hispanic or Latino ethnicity of decedent.



Manner of Death

Manner of death classifications are determined by the CCOCME during an investigation or by the physician signing the death certificate in the hospital. When a physician signs a death certificate, it is because the circumstances of the death do not warrant an investigation. Death certificates list one of the following five manners of death:

1. **Natural**: Deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases.
2. **Accident**: Deaths not caused by an intent to harm.
3. **Homicide**: The killing of one human by another.
4. **Suicide**: Taking of one's own life voluntarily and intentionally.
5. **Undetermined**: Deaths where sufficient evidence or information cannot be deduced during the initial investigation, usually about intent, to assign a manner of death.

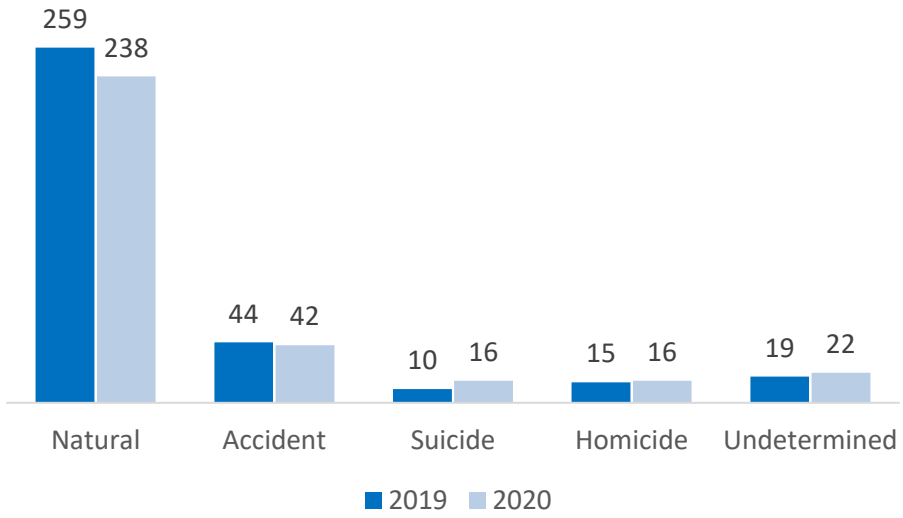
As seen in Table 2, the largest percentage of child deaths by manner in Clark County in 2020 were natural (71.3%), followed by accident (12.6%).

Table 2. Number and percent of child deaths in Clark County in 2020 by manner of death.

	Number	Percent
Natural	238	71.3%
Accident	42	12.6%
Suicide	16	4.8%
Homicide	16	4.8%
Undetermined	22	6.6%
Total	334	100%

As seen in Figure 5, the number of natural and accident manners of death decreased in 2020 as compared to 2019 but there were increases in the number of suicide, homicide, and undetermined manners of death.

Figure 5. Number of child deaths in Clark County in 2019 and 2020 by manner of death.



Abuse and/or Neglect Caused or Contributed

As noted in the Review Process section of the current report, during the Clark County Child Death Review Team meetings, the team votes on whether abuse and/or neglect caused or contributed to each child death reviewed. (See Table 1 for the definitions used for voting.) Of the 334 cases reviewed in 2020, the team voted that abuse and/or neglect caused or contributed to the death in 65 of the cases (19.5%). As seen in Table 3 below, the team voted that neglect contributed to the largest percentage of these deaths.

Table 3. Number and percent of child deaths in Clark County in 2020 in which abuse and/or neglect caused or contributed to death as voted on by the team.

	Number	Percent
Abuse Caused	5	7.7%
Neglect Caused	13	20.0%
Abuse Contributed	2	3.1%
Neglect Contributed	37	56.9%
Abuse and Neglect Caused	3	4.6%
Abuse and Neglect Contributed	0	0.0%
Abuse Caused and Neglect Contributed	5	7.7%
Abuse Contributed and Neglect Caused	0	0.0%
Total	65	100%

DEATHS BY MANNER

NATURAL

Natural deaths are those deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases. Since 2008, the Clark County Child Death Review Team has been reviewing all natural deaths including fetal deaths over 20 weeks gestation. In 2020, the largest percentage of child deaths by manner reviewed by the team were natural (71.3%). As seen in Table 4 below, of the natural deaths reviewed, the majority occurred among children under one year of age (81.5%). Overall, the most common cause of natural death was due to "other perinatal condition" (51.7%), followed by prematurity (12.2%). "Other perinatal condition" is a response option in the data collection tool and includes natural deaths in which the primary cause of death was due to a perinatal condition other than those listed in Table 4.

Table 4. Number of natural child deaths in Clark County in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asthma/Respiratory	2	0	2	3	0	7
Cancer	1	2	3	2	5	13
Cardiovascular	3	1	0	0	2	6
Congenital anomaly	26	0	0	0	0	26
COVID-19	0	0	1	0	0	1
Diabetes	0	0	0	0	2	2
HIV/AIDS	0	0	0	0	0	0
Influenza	0	0	0	0	0	0
Low birth weight	0	0	0	0	0	0
Malnutrition/dehydration	0	0	0	0	0	0
Neurological/seizure	0	1	0	1	1	3
Pneumonia	0	1	0	0	0	1
Prematurity	28	1	0	0	0	29
SIDS	0	0	0	0	0	0
Other infection	0	0	0	1	0	1
Other perinatal condition	123	0	0	0	0	123
Other medical condition	11	6	0	8	1	26
Total	194	12	6	15	11	238

ACCIDENT

Accident deaths are deaths not caused by an intent to harm. In 2020, the Clark County Child Death Review Team reviewed 42 accident deaths. As seen in Table 5 below, overall, motor vehicle accidents were the most common cause of accident deaths among children in Clark County in 2020 (33.3%), occurring among children of all age categories. Among all of the accident child deaths occurring in 2020, the largest percentage were among children in the 15 – 17 Years age category (38.1%).

Table 5. Number of accident child deaths in Clark County in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	0	0	0	0	0	0
Motor Vehicle and Other Transport	1	1	1	4	7	14
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	4	0	0	0	4
Asphyxia	8	2	0	0	0	10
Bodily Force or Weapon	0	0	0	0	0	0
Fall or Crush	0	0	0	0	1	1
Poisoning, Overdose, or Acute Intoxication	0	0	1	1	8	10
Undetermined	0	0	0	0	0	0
Other Injury	1	1	0	1	0	3
Unknown	0	0	0	0	0	0
Total	10	8	2	6	16	42

HOMICIDE

In 2020, the Clark County Child Death Review Team reviewed 16 homicide deaths. As seen in Table 6 below, all of the homicide deaths were caused by bodily force or a weapon (87.5%) or a fall or crush (12.5%). Half (50.0%) of the homicide deaths reviewed by the team were among children in the 15 – 17 Years age category.

Table 6. Number of homicide child deaths in Clark County in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle and Other Transport	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Asphyxia	0	0	0	0	0	0
Bodily Force or Weapon	2	2	1	1	8	14
Fall or Crush	2	0	0	0	0	2
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0
Total	4	2	1	1	8	16

SUICIDE

In 2020, the Clark County Child Death Review Team reviewed 16 suicide deaths. As seen in Table 7, suicide deaths occurred among children in the 5 – 9, 10 – 14, and 15 -17 Years age categories. Half (50.0%) of the suicide deaths reviewed by the team were the result of bodily force or a weapon. The next largest percentage of suicide deaths (37.5%) were caused by “other injury”. A review of these cases indicates that they were all suicide by hanging.

Table 7. Number of suicide child deaths in Clark County in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle and Other Transport	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	3	5	8
Fall or Crush	0	0	0	0	1	1
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	1	1
Other Injury*	0	0	2	1	3	6
Total	0	0	2	4	10	16
* All suicide deaths caused by other injury were suicide deaths by hanging.						

UNDETERMINED

In 2020, the Clark County Child Death Review Team reviewed 22 deaths in which the manner of death was undetermined. Undetermined deaths are deaths in which there is a lack of sufficient evidence or information during the initial investigation, usually about intent, to assign a different manner of death. As seen in Table 8 below, the majority of the undetermined deaths reviewed by the team in 2020 were among children under one year of age (81.8%). In 20 of the undetermined deaths (90.9%), the cause of death was unknown.

Table 8. Number of undetermined child deaths in Clark County in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	0	0	0	0	0	0
Motor Vehicle and Other Transport	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Asphyxia	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	1	0	1
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	1	0	0	0	0	1
Undetermined	0	0	0	0	0	0
Unknown	17	3	0	0	0	20
Total	18	3	0	1	0	22

LEADING MANNERS AND CAUSES OF CHILD DEATH

Excluding natural and undetermined manners of death, in Clark County in 2020, the four leading manners and causes of death included motor vehicle accidents (18.9%), homicides caused by bodily force or a weapon (18.9%), accidents caused by asphyxia (13.5%), and accidents caused by poisoning, overdose, or acute intoxication (13.5%). See Table 9 for the number and percent of manner and causes of child deaths in Clark County in 2020, excluding natural and undetermined manners of death.

Table 9. Number and percent of manner and causes of child deaths in Clark County in 2020 excluding natural and undetermined manners of death.

Manner	Cause	Number	Percent
Accident	Motor Vehicle and Other Transport	14	18.9%
Homicide	Bodily Force or Weapon	14	18.9%
Accident	Asphyxia	10	13.5%
Accident	Poisoning, Overdose, or Acute Intoxication	10	13.5%
Suicide	Bodily Force or Weapon	8	10.8%
Suicide	Other Injury	6	8.1%
Accident	Drowning	4	5.4%
Accident	Other Injury	3	4.1%
Homicide	Fall or Crush	2	2.7%
Accident	Fall or Crush	1	1.4%
Suicide	Fall or Crush	1	1.4%
Suicide	Poisoning, Overdose, or Acute Intoxication	1	1.4%
	Total	74	100%

An in-depth review of the top four manner and causes of death follow.

MOTOR VEHICLE ACCIDENTS (N = 14)

As seen in Table 10, there were more male children (57.1%) that died of motor vehicle accidents in Clark County in 2020 as compared to female children (42.9%).

Table 10. Number and percent of motor vehicle accident child deaths in Clark County in 2020 by sex of the decedent.

	Number	Percent
Male	8	57.1%
Female	6	42.9%
Unknown	0	0.0%
Total	14	100%

Half (50.0%) of the motor vehicle accident child deaths were among children in the 15 – 17 Years age category. See Table 11.

Table 11. Number and percent of motor vehicle accident child deaths in Clark County in 2020 by age category of the decedent.

	Number	Percent
<1 Year	1	7.1%
1 - 4 Years	1	7.1%
5 - 9 Years	1	7.1%
10 - 14 Years	4	28.6%
15 - 17 Years	7	50.0%
Total	14	100%

As seen in Table 12, the majority of motor vehicle accident child deaths were among White children (78.6%).

Table 12. Number and percent of motor vehicle accident child deaths in Clark County in 2020 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	1	7.1%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	11	78.6%
Multiracial	1	7.1%
Unknown	1	7.1%
Total	14	100%

As seen in Table 13, the largest percentage of motor vehicle accident child deaths in Clark County in 2020 were among children not of Hispanic or Latino ethnicity (64.3%).

Table 13. Number and percent of motor vehicle accident child deaths in Clark County in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	4	28.6%
Not Hispanic or Latino	9	64.3%
Unknown	1	7.1%
Total	14	100%

Half (50.0%) of the motor vehicle accident child deaths in Clark County in 2020 occurred among those who were a passenger in the motor vehicle. The next largest percentage of deaths occurred among those who were pedestrians (42.9%). See Table 14.

Table 14. Number and percent of motor vehicle accident child deaths in Clark County in 2020 by position of child during the accident.

	Number	Percent
Driver	1	7.1%
Passenger	7	50.0%
On bicycle	0	0.0%
Pedestrian	6	42.9%
Unknown	0	0.0%
Total	14	100%

Details regarding the factors associated with the motor vehicle accident child deaths in Clark County in 2020 can be seen in Table 15.

Table 15. Factors associated with the motor vehicle accident child deaths in Clark County in 2020.

	Number of cases
Speeding over limit	7
Recklessness	7
Drug/alcohol use	4
Unknown	4
Other cause	2
Unsafe speed for conditions	1
Poor weather	1
Poor visibility	1
Vehicle flipped over	1
Electronic use	1
Racing	1
Ran stop sign/red light	0
Driver distraction	0
Inexperienced driver	0
Vehicle ran over child	0
Poor sightline	0
Car changing lanes	0
Road hazard	0
Other driver error	0
Note: More than one factor may apply to a case	

Among the motor vehicle accident child deaths that occurred in Clark County in 2020, the child was responsible in one case, the child's driver was responsible in six cases, and the other driver was responsible in five cases. There were two cases in which the driver responsible for the incident was unknown. Table 16 identifies some of the factors contributing to the motor vehicle accident child deaths based on who was responsible.

Table 16. Number of cases in which the following were contributing factors in motor vehicle accident child deaths in Clark County in 2020 by person responsible for the accident.

	Child Responsible	Child's Driver Responsible	Other Driver Responsible
No license	0	0	0
Learners permit	0	0	0
Graduated license	0	0	0
Full license, not graduated	0	1	1
Full license, restricted	0	0	0
Suspended license	0	0	0
In violation of graduated license rules	0	0	0
Note: More than one contributing factor may apply to a case			

HOMICIDES CAUSED BY BODILY FORCE OR WEAPON (N = 14)

As seen in Table 17, there were more male children (71.4%) that died of homicide caused by bodily force or a weapon in Clark County in 2020 as compared to female children (28.6%).

Table 17. Number and percent of child homicides caused by bodily force or a weapon in Clark County in 2020 by sex of the decedent.

	Number	Percent
Male	10	71.4%
Female	4	28.6%
Unknown	0	0.0%
Total	14	100%

More than half (57.1%) of child homicides caused by bodily force or a weapon were among children in the 15 – 17 Years age category. See Table 18.

Table 18. Number and percent of child homicides caused by bodily force or a weapon in Clark County in 2020 by age category of the decedent.

	Number	Percent
<1 Year	2	14.3%
1 - 4 Years	2	14.3%
5 - 9 Years	1	7.1%
10 - 14 Years	1	7.1%
15 - 17 Years	8	57.1%
Total	14	100%

All of the child homicides caused by bodily harm or a weapon in Clark County in 2020 were among children that were Black (64.3%) or White (35.7%). As seen in Table 19, the majority of child homicides caused by bodily harm or a weapon in Clark County in 2020 were among children not of Hispanic or Latino ethnicity (78.6%).

Table 19. Number and percent of child homicides caused by bodily harm or a weapon in Clark County in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	3	21.4%
Not Hispanic or Latino	11	78.6%
Unknown	0	0.0%
Total	14	100%

As seen in Table 20, the majority of child homicides caused by bodily harm or a weapon in Clark County in 2020 were the result of a firearm (71.4%).

Table 20. Number and percent of child homicides caused by bodily harm or a weapon in Clark County in 2020 by type of weapon used.

	Number	Percent
Firearm	10	71.4%
Bodily Force	3	21.4%
Knife/Sharp instrument	0	5.0%
Rope	0	0.0%
Other	0	0.0%
Unknown	1	7.1%
Total	14	100%

As seen in Table 21, in three of the child homicides caused by a firearm, the owner of the firearm was a caregiver and in three of the child homicides caused by a firearm, the firearm was stored loaded.

Table 21. Circumstances related to child homicides caused by a firearm in Clark County in 2020.

Storage	Firearm loaded	3
	Firearm kept locked	0
Owner of firearm	Caregiver	3
	Other family member	2
	Stranger	1
	Other	1
	Unknown	3
Note: More than one circumstance can apply to a case		

Table 22 identifies how the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Clark County in 2020.

Table 22. How the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Clark County in 2020.

	Number of Cases
Commission of a crime	6
Argument	3
Showing the gun to others	3
Self-injury	2
Random violence	2
Playing with the weapon	2
Self-defense	2
Other	2
Child was a bystander	1
Weapon mistaken for a toy	1
Intimate partner violence	0
Hate crime	0
Bullying	0
Hunting	0
Target shooting	0
Drive-by shooting	0
Drug dealing/trading	0
Russian Roulette	0
Gang-related activity	0
Jealousy	0
Cleaning the weapon	0
Murder-suicide	0
Unknown	0
Note: More than one use can apply to a case	

ACCIDENTS CAUSED BY ASPHYXIA (N = 10)

All of the accident child deaths caused by asphyxia in Clark County in 2020 were sleep-related. As seen in Table 23, there were more male children (60.0%) that died of asphyxia accidents in 2020 as compared to female children (40.0%).

Table 23. Number and percent of accident child deaths caused by asphyxia in Clark County in 2020 by sex of the decedent.

	Number	Percent
Male	6	60.0%
Female	4	40.0%
Unknown	0	0.0%
Total	10	100%

As seen in Table 24, the majority of accident child deaths caused by asphyxia were among children under one year of age (80.0%).

Table 24. Number and percent of accident child deaths caused by asphyxia in Clark County in 2020 by age category of the decedent.

	Number	Percent
<1 Year	8	80.0%
1 - 4 Years	2	20.0%
5 - 9 Years	0	0.0%
10 - 14 Years	0	0.0%
15 - 17 Years	0	0.0%
Total	10	100%

All of the accident child deaths caused by asphyxia in Clark County in 2020 were among children that were White (50.0%) or Black (50.0%). As seen in Table 25, the majority of accident child deaths caused by asphyxia in Clark County in 2020 were among children not of Hispanic or Latino ethnicity (80.0%).

Table 25. Number and percent of accident child deaths caused by asphyxia in Clark County in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	2	20.0%
Not Hispanic or Latino	8	80.0%
Unknown	0	0.0%
Total	10	100%

Some of the circumstances of the accident child deaths caused by asphyxia in Clark County in 2020, including the objects found in the sleeping area, how the child was placed to sleep, and if the caregiver fell asleep feeding the child, are identified in Table 26.

Table 26. Circumstances of accident child deaths caused by asphyxia in Clark County in 2020.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	6
	Child(ren)	2
	Animal(s)	0
	Comforter, quilt, or other	2
	Thin blanket/flat sheet	2
	Pillow	3
	Cushion	0
	Nursing or U-shaped pillow	0
	Sleep positioner	0
	Bumper pads	0
	Clothing	0
	Crib railing/side	0
	Wall	1
	Toys	0
	Other	1
Child placed to sleep	With a pacifier	0
	On stomach	3
	On side	1
	In adult bed	8
	On couch	0
	Wrapped or swaddled in blanket	1
	On floor	0
	In car seat	1
Caregiver/supervisor fell asleep	Bottle feeding child	0
	Breastfeeding child	0
Note: More than one circumstance can apply to a case		

ACCIDENTS CAUSED BY POISONING, OVERDOSE, OR ACUTE INTOXICATION (N = 10)

As seen in Table 27, there were more male children (80.0%) that died of accidents caused by poisoning, overdose, or acute intoxication in Clark County in 2020 as compared to female children (20.0%).

Table 27. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020 by sex of the decedent.

	Number	Percent
Male	8	80.0%
Female	2	20.0%
Unknown	0	0.0%
Total	10	100%

The majority (80.0%) of the accident child deaths caused by poisoning, overdose, or acute intoxication were among children in the 15 – 17 Years age category. See Table 28.

Table 28. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	0	0.0%
5 - 9 Years	1	10.0%
10 - 14 Years	1	10.0%
15 - 17 Years	8	80.0%
Total	10	100%

All of the accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020 were among White (80.0%) and Black (20.0%) children. As seen in Table 29, half (50.0%) of the accident child deaths caused by poisoning, overdose, or acute intoxication were among children not of Hispanic or Latino ethnicity and half (50.0%) were among children of Hispanic or Latino ethnicity.

Table 29. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	50.0%
Not Hispanic or Latino	5	50.0%
Unknown	0	0.0%
Total	10	100%

As seen in Table 30 below, most of the substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020 were obtained from unknown sources.

Table 30. Type and source of substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2020.

	Source of Substance				
	Bought from Dealer or Stranger	Took from Friend or Relative	From Friend or Relative for Free	Unknown Source	Total
Benzodiazepines	0	0	0	5	5
Prescription opioid pain medication	0	0	0	4	4
Over the counter cold medicine	0	1	0	0	1
Cocaine	0	0	0	2	2
Fentanyl/Fentanyl analogs	0	0	0	7	7
Marijuana/THC	0	0	1	0	1
Alcohol	0	0	1	0	1
Other	0	0	0	0	0
Total	0	1	2	18	21
Note: More than one substance can apply to a case					

LOCAL PREVENTION EFFORTS

The Clark County Child Death Review Team tries to act locally to prevent child deaths. Prevention activities that occurred in 2020 are highlighted below. As has occurred in previous years, some initiatives were carried out by the team itself while others were local agency efforts initiated by team members. These are examples of how the local annual report, as well as multidisciplinary participation in the review meetings, have had an impact on the community through improved policy and practice as well as prevention activities.

CHILD ABUSE AND NEGLECT PREVENTION

NICRP, the home of Prevent Child Abuse Nevada (PCANV), continued to provide Choose Your Partner Carefully training for parents and caregivers in 2020. The training focuses on how parents and primary caregivers can select appropriate alternate caregivers for their children by identifying red flags and asking questions. The training also provides information on childcare resource and referral agencies. PCANV also provided train the trainer classes so that other providers can offer this training in the community.

Prevent Child Abuse Nevada also continued to provide training to parents and professionals on recognizing and reporting child maltreatment and supporting healthy communities.

SUICIDE PREVENTION

In 2020, the Clark County Child Death Review Team released a report based on an in-depth review of suicides that occurred between 2016 and 2018. The report included the following recommendations for suicide prevention.

1. Support efforts related to enforcing the legal consequences of unsafe storage of firearms.
2. Increase research and dissemination of research findings related to the impact of electronic device addiction in adolescents and its relationship to youth suicide.
3. Improve public awareness of Adverse Childhood Experiences (ACES) and their impact.
4. Develop a social media campaign aimed at either parents or youth which would include the following:
    - Messaging focused on key risk factors
    - Messaging translated into Spanish
    - Visual materials, as opposed to print, that include a clear message and call to action
    - Information for youth on how to recognize the signs, verbalizations, and ideation of suicide in their peers and what to do if they recognize it
5. Provide resources to youth serving organizations about self-harm or cutting.

2020 Recommendations To The State Executive Committee

Each quarter, the Clark County Child Death Review Team completes a form for the state Executive Committee for the Review of the Death of Children (Executive Committee) identifying the number of cases reviewed each quarter by manner and leading cause of death, and the number of cases requiring a mandatory review as outlined in NRS 432B.405. The form also allows the team to submit recommendations, based on the cases reviewed that quarter, aimed at improving laws, policies, and practices to support the safety of children and prevent future child deaths. These recommendations are reviewed by the Executive Committee and some action or response is generated. There was one recommendation submitted to the Executive Committee by the Clark County Child Death Review Team in 2020. The recommendation was that health insurance policies should not prevent individuals from filling prescriptions for mental or physical health issues.

Below are the actions taken to date by the Executive Committee regarding the recommendation that health insurance policies should not prevent individuals from filling prescriptions for mental or physical health individuals.

- After discussing the recommendation, the Executive Committee decided to reach out to the Nevada State Board of Pharmacy to request a list of medications that are critical for suicide prevention. It was decided that, after receiving the list, the Executive Committee would send letters to the Nevada Insurance Commissioner and Nevada Medicaid to notify them of the recommendation and include the list of medications received by the Nevada State Board of Pharmacy.
- After receiving a short presentation on the policies that Medicaid has in place to protect vulnerable children from polypharmacy, the Executive Committee discussed revising some of the language in the letters to the Nevada State Board of Pharmacy, the Nevada Insurance Commissioner, and Nevada Medicaid. The Executive Committee also decided to specify asthma as the physical health issue of concern with the request that asthma medication be dispensed prior to patients leaving the hospital. These letters were sent to the respective agencies.
- A representative from the Nevada Insurance Commissioner's office reached out to the Executive Committee and indicated that although the mental health of Nevadans is of great concern to their office, they lack the regulatory authority necessary to gain compliance from insurance agencies to carry the recommendation forward. The Executive Committee was encouraged to reach out to the Interim Health Committee to see if the recommendation fit with their legislative priorities. The Executive Committee sent a letter to the Interim Health Committee, but was told the letter lacked necessary information, including possible barriers and solutions, and therefore would not be passed onto the committee.
- The Executive Committee learned that the Nevada Chapter for the American Academy of Pediatrics would be highlighting this recommendation as a legislative priority, therefore this recommendation was closed.

APPENDIX A: 2020 CLARK COUNTY CHILD DEATH REVIEW TEAM MEMBERSHIP LIST

Name	Agency
Dina Bailey	University Medical Center
Kathryn Barker	Southern Nevada Health District
Marion Biron	Clark County Department of Family Services
Devon Butts	Clark County Department of Family Services
Candace Caterer	Clark County Office of the Coroner/Medical Examiner
Jorge Correa	North Las Vegas Police Department
Stacie Dastrup	Clark County Department of Family Services
Dawn L Davidson	Nevada Institute for Children's Research and Policy, UNLV
Margarita DeSantos	Southern Nevada Health District
Leon Desimone	Las Vegas Metropolitan Police Department
Jennifer Ditto Kocis	Sunrise Hospital – Safe Kids
Brigid Duffy	Clark County District Attorney's Office – Child Welfare
Craig Dunn	Las Vegas Metropolitan Police Department
Richard Egan	Nevada Department of Public and Behavioral Health – Office of Suicide Prevention
Dr. Andrew Eisen	Valley Health Systems
Dr. Rachell Ekroos	University of Nevada, Las Vegas
Alissa Engler	Nevada Attorney General's Office
Jessica Freeman	Division of Child and Family Services
Paul Gambini	Las Vegas Metropolitan Police Department
Dr. Lisa Gavin	Clark County Office of the Coroner/Medical Examiner
Lisa Gibson	Clark County Department of Family Services
Natalie Guesman	Clark County Department of Family Services
Paula Hammack	Clark County Department of Family Services
Marion Hancock	Sunrise Hospital

Janne Hanrahan	Clark County District Attorney's Office
Elizabeth Holka	Nevada Institute for Children's Research and Policy
Kathryn Hooper	Henderson Fire Dept.
Hayley Jarolimek	Division of Child and Family Services
Fernando Juarez	Las Vegas Metropolitan Police Department
Michelle Jobe	Clark County District Attorney's Office
Troyce Krumme	Las Vegas Metropolitan Police Department- Abuse and Neglect Detail
Matthew Manning	US Consumer Product Safety Commission
Mary Martinat	University Medical Center
Bianca McCall	Desert Rose Counseling
Victor Montecerin	North Las Vegas Fire Department
Sara Owen	Henderson Police Department
Mari Parlade	Clark County Department of Family Services
Raya Peters	Division of Child and Family Services
Lisa Price	North Las Vegas Fire Department
Wayne Prosser	Nevada Highway Patrol
Dena Rinetti	Clark County District Attorney's Office
Joe Roberts	Clark County School District
R. D. Smith	St. Rose Siena
Cheri Sotelo	Legacy Health Centers
Shane Splinter	Henderson Fire Department
Dean Steiner	Department of Juvenile Justice Services
Steven Taulbee	Las Vegas Fire Rescue
Yvette Wintermute	Clark County School District
Susan Zannis	Southern Nevada Heath District

APPENDIX B: NEVADA REVISED STATUTES FOR 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 for review to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409.
2. The Executive Committee 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; A 2013, 438)

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:
    a. Representatives from multidisciplinary teams formed pursuant to paragraph (a) of subsection 1 of NRS 432B.405 and NRS 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.
    b. Administrators of agencies which provide child welfare services, and agencies responsible for mental health and public safety, to the extent that such administrators are not already appointed pursuant to paragraph (a). Members of the Executive Committee who are appointed pursuant to this paragraph shall serve as nonvoting members.
2. The Executive Committee shall:
    a. Adopt statewide protocols for the review of the death of a child;
    b. Adopt regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;
    c. Adopt bylaws to govern the management and operation of the Executive Committee;
    d. Appoint one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS 432B.405;
    e. Oversee training and development of multidisciplinary teams to review the death of children;
    f. Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes; and
    g. Carry out the duties specified in NRS 432B.408.
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.4095, inclusive.

(Added to NRS by 2003, 864; A 2007, 1509; 2013, 439)