STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

2021 STATEWIDE CHILD DEATH REPORT

Submitted by:

The Executive Committee to Review the Death of Children

Special thanks go to the following who contributed to complete the 2021 Statewide Child Death Report:

2021 Executive Committee to Review Death of Children

2023 Executive Committee to Review Death of Children

Division of Child and Family Services (DCFS)

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EXECUTIVE SUMMARY

The purpose of this report is to provide comprehensive information regarding the circumstances by which children die in Nevada in order to prevent future child deaths and improve the health and safety of children in the state.

WHY IS CHILD DEATH PREVENTION IMPORTANT?

Most child deaths, with the exception of natural and undetermined deaths, are preventable. A child's death is a tragic loss to the family and the community and can also be an indicator regarding the health of the community. Understanding why a child dies can help prevent the deaths of other children and improve health outcomes and overall child safety.

Different age groups of children and adolescents are at risk for different types of death. Infants and young children are at greater risk of accidental asphyxia deaths, which often result from unsafe sleeping environments and parents sharing a bed with their children. Adolescents are at greater risk of motor vehicle accidents, suicide, and drug overdoses. All age groups are at risk of drowning, especially children between ages one and four.

WHERE DOES NEVADA'S CHILD DEATH DATA COME FROM?

The 2021 child deaths were reviewed by Nevada's regional child death review (CDR) teams, which are organized and operational pursuant to Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 4095. (See Appendix D.) In 2021, there were seven regional CDR teams in the state that conducted child death reviews.

The two urban teams, Clark and Washoe, reviewed child deaths in the major population centers of the state, in the areas of Las Vegas and Reno, respectively. The teams in the rural areas reviewed child deaths in all other counties.

The Executive Committee to Review the Death of Children (Executive Committee) is the statewide group that provides coordination, oversight, and training to the regional CDR teams. The Executive Committee reviews reports and recommendations from the regional teams and advocates for improvements to laws, policies, protocols, and practices related to the prevention of child deaths. Additionally, the Executive Committee compiles and distributes this statewide annual report. Finally, the Executive Committee makes decisions about funding initiatives to prevent child deaths based on the analyses of the annual data.

HOW DO THE REGIONAL CDR TEAMS AND THE EXECUTIVE COMMITTEE WORK TO PREVENT CHILD DEATHS?

The regional CDR teams submit recommendations to the Executive Committee to improve laws, policies, and practices that may help prevent child death. The Executive Committee primarily works with state, county, and local agencies to make internal or systemic changes that focus on increased safety for children.

The Executive Committee funds annual public awareness campaigns for the prevention of child death in cooperation with community-based organizations, focused on the leading preventable causes of death.

WHAT ARE THE LEADING CAUSES OF CHILD DEATH IN NEVADA?

Excluding natural and undetermined deaths, in 2021, the four leading causes of death were:

1. Accidents caused by asphyxia
2. Motor vehicle accidents
3. Drowning accidents
4. Homicides caused by bodily force or weapon

HOW DOES CHILD DEATH IN NEVADA COMPARE WITH THE UNITED STATES AS A WHOLE?

	Nevada	United States
Number of child deaths in 2021	278	35,654[1]
Number of child deaths in 2020	244	34,088[1]
Change in number of child deaths from 2020 to 2021	Increase of 34 (13.9%)	Increase of 1566 (4.6%)
Infant mortality rate per 1,000 live births in 2021[2]	5.76	5.4
Age group experiencing largest number of child deaths in 2021[1]	Under 1 year	Under 1 year
Leading manner of child death in 2021	Natural	Natural

[1] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2023). *Web-based Injury Statistics Query and Reporting System: Leading Causes of Deaths* [custom data query]. Retrieved November 15, 2023 from https://www.cdc.gov/injury/wisqars/LeadingCauses.html

[2] Centers for Disease Control (2023). *Infant Mortality*. Retrieved September 26, 2023 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

DATA OVERVIEW

DATA SOURCES

All Nevada data in this report are derived from the regional CDR teams, which collect and enter data into an electronic case reporting system maintained by the National Center for Fatality Review and Prevention (CFRP). Based on the multidisciplinary reviews conducted for child deaths that occurred in calendar year 2021, there were a total of 278 child deaths that were reviewed in the state. These fatalities include children and adolescents from birth through 17 years of age.

DATA CONFIDENTIALITY

Portions of the collective information and data contained in this report were compiled from child records that are confidential and contain information that is protected from disclosure to the public, pursuant to Nevada Revised Statutes (NRS) and federal laws and regulations.

DATA LIMITATIONS

- Some child deaths are not reviewed by the regional CDR teams. While the teams review all coroner-referred deaths, there may be some cases where the death certificate is issued by a private attending physician (non-coroner-referred) and is not referred to a team for review. Additionally, some deaths of out-of-state residents may not be processed through a Nevada coroner or medical examiner.

- Although a national data instrument is used for the collection of data, there may be inconsistencies at the regional CDR team level in terms of how these data are collected and entered.

- The data entered into the database are based on the documentation provided to the teams and information obtained during the review process. Unfortunately, for some cases, this information is very limited which leads to several variables in the data system being recorded as “unknown” or “missing”.

- There may be data errors due to problems with a child’s name. The most common issue occurs with infants who are not given a name at the time of their death and are assigned a designation such as “baby boy” or “baby girl.” When a death certificate is issued, in most cases, a name is given, which creates discrepancies in the data. These cases are examined, and attempts are made to reconcile these differences, but not all discrepancies can be corrected.

- There may be data errors due to coding for the cause of death. For coroner and medical examiner data, groupings are made based on International Classification of Diseases (ICD)-10 codes and information grouping details. The ICD-10 classification system is developed and published by the World Health Organization (WHO) and used to code and classify mortality

data from death certificates.[3] Typically, the cause of death is entered as reported on the death certificate. However, if during the review process, additional information is obtained, the team has the ability to reclassify the cause of death. In these instances, the cause of death decided by the team would be recorded in the database.

- Similarly, although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, if during the review process, additional information is obtained, the team has the ability to reclassify the manner of death. In these instances, the manner of death decided by the team would be recorded in the database.

Review Requirements

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 4095. State-mandated child death reviews include the following:

- Reviews requested by adults related to the child within one year of the date of death.
- Children who were in the custody of a child welfare agency or whose family received services from such an agency.
- Children who died from alleged abuse or neglect.
- Children whose siblings, household members, or day care providers were subject to an abuse or neglect investigation within the previous 12 months.
- Children who were adopted through a child welfare agency.
- Children who died from Sudden Infant Death Syndrome (SIDS).

Deaths Reviewed vs. Deaths not Reviewed

Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region that meet the above criteria. In Clark County, the team meets monthly due to their high caseload. In Washoe County, the team meets every other month. In the rural areas, most of the regional CDR teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. However, the rural regional teams might meet less frequently if no child fatalities are reported in a given quarter.

[3] National Center for Health Statistics. (2021). *International Classification of Diseases, Tenth Revision (ICD-10)*. Retrieved September 27, 2022 from https://www.cdc.gov/nchs/icd/icd10.htm

Overview of Deaths

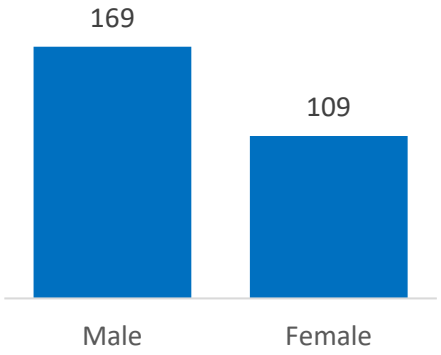
In 2021, the Nevada regional CDR teams reviewed the deaths of 278 children under 18 years of age. In the sections that follow, the overall demographics and manner of these deaths are reviewed.

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 regional CDR teams. 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.

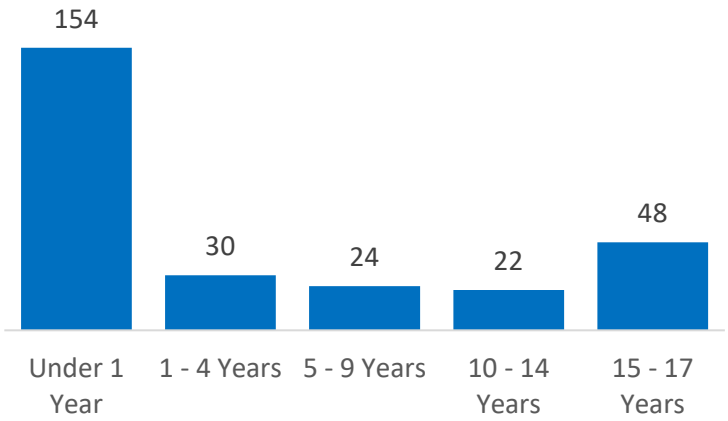
As seen in Figure 1, there were more child deaths in Nevada in 2021 among males as compared to females.

Figure 1. Number of child deaths in Nevada in 2021 by sex of decedent.



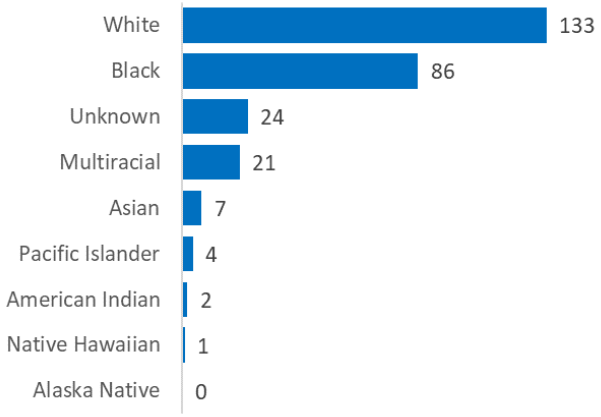
As seen in Figure 2, the largest percentage of child deaths in Nevada in 2021 occurred among those less than one year of age (55.4%).

Figure 2. Number of child deaths in Nevada in 2021 by age category of decedent.



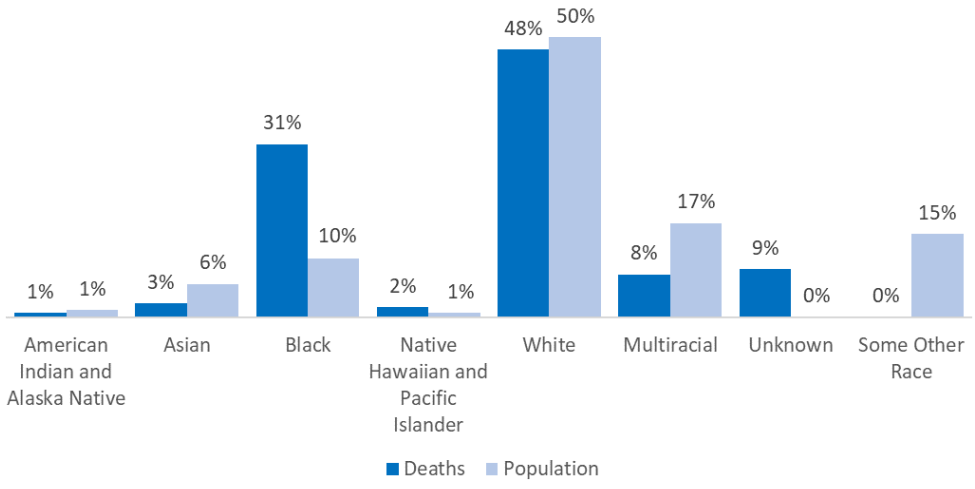
With regard to race, as seen in Figure 3, the largest percentage of child deaths in Nevada in 2021 occurred among White (47.8%) and Black children (30.9%).

Figure 3. Number of child deaths in Nevada in 2021 by race of decedent.



As seen in Figure 4, in comparing the percentage of child deaths in Nevada in 2021 by race to the population estimates of the race of children in Nevada in 2021, the percentage of deaths among Black and Native Hawaiian and Pacific Islander children is overrepresented.[4] Specifically, according to population estimates, Black children made up 10 percent of the child population in Nevada in 2021 but accounted for 31 percent of the deaths reviewed for this report. Native Hawaiian and Pacific Islander children made up 1 percent of the population but accounted for 2 percent of the deaths.

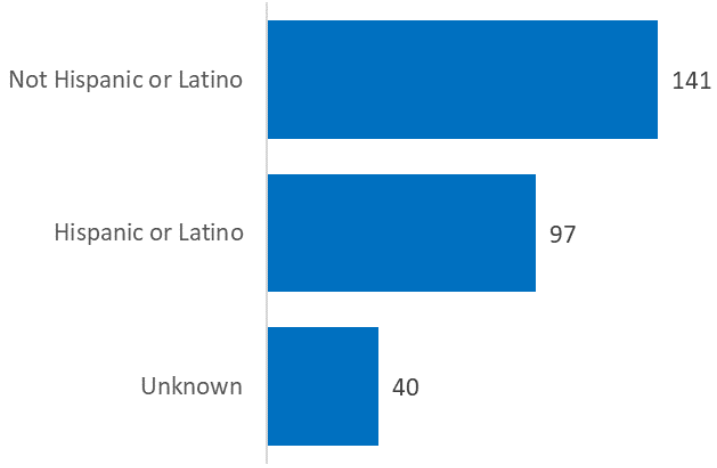
Figure 4. Percent of child deaths in Nevada in 2021 by race of decedent and the race of the population under 18 years of age in Nevada in 2021.



[4] U.S. Census Bureau. (2021). CHILDREN CHARACTERISTICS. *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0901*. Retrieved November 16, 2023, from https://data.census.gov/table/ACSST5Y2021.S0901?q=Nevada&t=Children&y=2021.

With regard to ethnicity, the largest percentage of child deaths in Nevada in 2021 were among children not of Hispanic or Latino ethnicity (50.7%). See Figure 5.

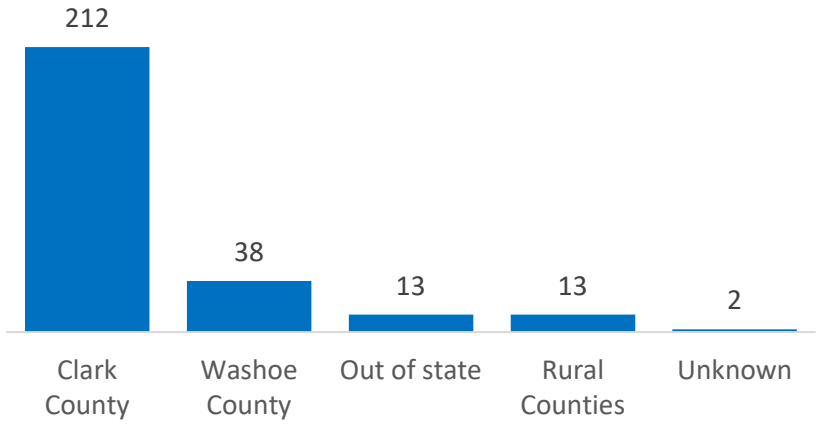
Figure 5. Number of child deaths in Nevada in 2021 by Hispanic or Latino ethnicity of decedent.



Due to the small number of child deaths that occur among children who are residents of the counties of Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine, and to maintain confidentiality, the number of child deaths that occurred in these counties in 2021 have been combined for this report and the county of residence is referred to as the Rural Counties.

As seen in Figure 6, the largest percentage of child deaths in Nevada in 2021 occurred among those who were residents of Clark County (76.3%).

Figure 6. Number of child deaths in Nevada in 2021 by county of residence of the decedent.



Manner of Death

A coroner or medical examiner lists one of five manners of death on the death certificate as follows:

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.

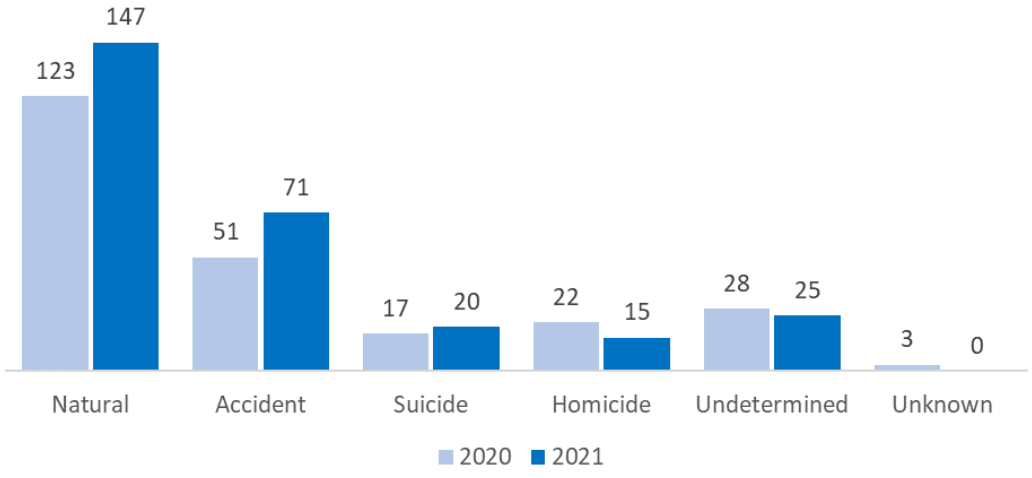
As seen in Table 1, the largest percentage of child deaths by manner in Nevada in 2021 were natural (52.9%), followed by accident (25.5%).

Table 1. Number and percent of child deaths in Nevada in 2021 by manner of death.

	Number	Percent
Natural	147	52.9%
Accident	71	25.5%
Suicide	20	7.2%
Homicide	15	5.4%
Undetermined	25	9.0%
Unknown	0	0.0%
Total	278	100%

As seen in Figure 7, there were fewer homicide and undetermined child deaths in Nevada in 2021 as compared to 2020 but more natural, accident, and suicide child deaths.

Figure 7. Number of child deaths in Nevada in 2020 and 2021 by manner of death.



DEATHS BY MANNER

NATURAL

Natural deaths are those deaths that result from natural disease mechanisms and include prematurity, and Sudden Infant Death Syndrome (SIDS) cases. In 2021, the largest percentage of child deaths by manner in Nevada were natural (52.9%). As seen in Table 2 below, the majority of natural deaths occurred among children under one year of age (70.8%). Overall, the most common cause of natural death was due to prematurity (18.4%), followed by congenital anomaly and "other medical condition" (both at 17.0%), and "other perinatal condition" (14.3%). "Other medical condition" and "other perinatal condition" are response options in the data collection tool and include natural deaths in which the primary cause of death was due to a medical condition other than those listed in Table 2.

Table 2. Number of natural child deaths in Nevada in 2021 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asthma/Respiratory	3	1	1	1	0	6
Cancer	0	1	3	1	2	7
Cardiovascular	4	1	1	2	1	9
Congenital anomaly	18	4	3	0	0	25
COVID-19	1	1	0	1	0	3
Diabetes	0	0	0	1	1	2
HIV/AIDS	0	0	0	0	0	0
Influenza	1	0	0	0	0	1
Low birth weight	0	0	0	0	0	0
Malnutrition/dehydration	0	0	0	0	0	0
Neurological/seizure	1	0	1	1	0	3
Pneumonia	1	0	0	0	0	1
Prematurity	27	0	0	0	0	27
SIDS	0	0	0	0	0	0
Other infection	3	1	2	0	0	6
Other perinatal condition	21	0	0	0	0	21
Other medical condition	13	4	2	2	4	25
Unknown	11	0	0	0	0	11
Total	104	13	13	9	8	147

ACCIDENT

Accident deaths are deaths not caused by an intent to harm. In 2021, there were 71 accident child deaths reviewed in Nevada. As seen in Table 3 below, the largest percentage of accident deaths (40.9%) occurred among children under one year of age. Overall, asphyxia accidents were the most common cause of accident deaths among children in Nevada in 2021 (29.6%) with all but one of those deaths occurring among children under one year of age. The next most common causes of accident child deaths in Nevada in 2021 were motor vehicle accidents (23.9%), drowning (12.7%), and poisoning, overdose, or acute intoxication (11.3%).

Table 3. Number of accident child deaths in Nevada in 2021 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	2	0	0	0	1	3
Asphyxia	20	0	1	0	0	21
Motor Vehicle	2	1	5	3	6	17
Fire, Burn, or Electrocution	1	3	0	0	0	4
Drowning	1	6	1	1	0	9
Bodily Force or Weapon	0	0	0	1	0	1
Fall or Crush	0	1	0	0	0	1
Poisoning, Overdose, or Acute Intoxication	1	0	0	1	6	8
Undetermined if Injury or Medical Cause	0	0	0	0	0	0
Other Injury	0	0	0	0	1	1
Unknown	0	0	0	0	1	1
Missing	2	0	0	0	3	5
Total	29	11	7	6	18	71

HOMICIDE

In 2021, there were 15 homicide child deaths reviewed in Nevada. As seen in Table 4 below, more than half (60.0%) of the homicides were caused by bodily force or weapon and the largest percentage of homicide child deaths (40.0%) were among children in the 15 – 17 Years age category.

Table 4. Number of homicide child deaths in Nevada in 2021 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
Asphyxia	0	0	0	0	0	0
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	2	1	0	0	3
Bodily Force or Weapon	0	1	2	1	5	9
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined Injury	0	1	0	0	0	1
Other Injury	0	0	0	0	0	0
Unknown Injury	1	0	0	0	0	1
Missing	0	0	0	0	1	1
Total	1	4	3	1	6	15

SUICIDE

In 2021, there were 20 suicide child deaths reviewed in Nevada. As seen in Table 5, all of the suicide deaths occurred among children in the 10 – 14 Years and 15 – 17 Years age categories. The largest percentage of suicide child deaths were the result of bodily force or a weapon (40.0%), followed by asphyxia (30.0%).

Table 5. Number of suicide child deaths in Nevada in 2021 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
Asphyxia	0	0	0	3	3	6
Motor Vehicle	0	0	0	0	1	1
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	1	7	8
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	0	0	1	0	1
Other Injury	0	0	0	1	3	4
Unknown	0	0	0	0	0	0
Total	0	0	0	6	14	20

UNDETERMINED

In 2021, there were 25 child deaths reviewed in Nevada in which the manner of death was undetermined. Undetermined deaths are deaths in which there is lack of sufficient evidence or information during the initial investigation, usually about intent, to assign a different manner of death. As seen in Table 6 below, the majority of the undetermined child deaths were among children under one year of age (80.0%). Further, in the majority of the undetermined child deaths (72.0%), it was undetermined if they were caused by an injury or due to a medical reason.

Table 6. Number of undetermined child deaths in Nevada in 2021 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	1	0	0	0	0	1
Asphyxia	0	0	0	0	0	0
Motor Vehicle	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	0	1	1
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined if Injury or Medical Cause	16	2	0	0	0	18
Other Injury	0	0	0	0	0	0
Unknown	3	0	1	0	1	5
Total	20	2	1	0	2	25

For details regarding the age, gender, race, Hispanic or Latino ethnicity, and county of residence for all of the 2021 Nevada child decedents by manner, see Appendix A.

Leading Manners and Causes of Child Death

Excluding natural and undetermined manners of death, in Nevada in 2021, the four leading manners and causes of death included accident caused by asphyxia (19.8%), motor vehicle accidents (16.0%), accidents caused by drowning (8.5%), and homicide caused by bodily force or weapon (8.5%). See Table 7 for the number and percent of manner and causes of child deaths in Nevada in 2021, excluding natural and undetermined manners of death.

Table 7. Number and percent of manner and causes of child deaths in Nevada in 2021 excluding natural and undetermined manners of death.

Manner	Cause	Number	Percent
Accident	Asphyxia	21	19.8%
Accident	Motor Vehicle	17	16.0%
Accident	Drowning	9	8.5%
Homicide	Bodily Force or Weapon	9	8.5%
Accident	Poisoning, Overdose, or Acute Intoxication	8	7.6%
Suicide	Bodily Force or Weapon	8	7.6%
Suicide	Asphyxia	6	5.7%
Accident	Missing	5	4.7%
Accident	Fire, Burn, or Electrocution	4	3.8%
Suicide	Other Injury	4	3.8%
Homicide	Drowning	3	2.8%
Accident	Any Medical Cause	3	2.8%
Accident	Bodily Force or Weapon	1	0.9%
Accident	Fall or Crush	1	0.9%
Suicide	Motor Vehicle	1	0.9%
Accident	Other Injury	1	0.9%
Accident	Unknown	1	0.9%
Homicide	Undetermined Injury	1	0.9%
Homicide	Unknown Injury	1	0.9%
Homicide	Missing	1	0.9%
Suicide	Undetermined	1	0.9%
	Total	106	100%

ACCIDENTS CAUSED BY ASPHYXIA (N = 21)

All but one of the accident child deaths caused by asphyxia in Nevada in 2021 were sleep-related. As seen in Table 8, there were more male children that died of asphyxia accidents in Nevada in 2021 as compared to female children.

Table 8. Number and percent of accident child deaths caused asphyxia in Nevada in 2021 by sex of the decedent.

	Number	Percent
Male	13	61.9%
Female	8	38.1%
Unknown	0	0.0%
Total	21	100%

All but one of the accident child deaths caused by asphyxia were among children under one year of age (95.2%). There was one child in the 5 – 9 Years age category that died due to accidental asphyxia (4.8%).

As seen in Table 9, the majority of accident child deaths caused by asphyxia in Nevada in 2021 were among children that were White (42.9%) or Black (38.1%).

Table 9. Number and percent of accident child deaths in Nevada in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	1	4.8%
Black	8	38.1%
Native Hawaiian	0	0.0%
Pacific Islander	2	9.5%
White	9	42.9%
Multiracial	1	4.8%
Unknown	0	0.0%
Total	21	100%

As seen in Table 10, the majority of accident child deaths caused by asphyxia in Nevada in 2021 were among children not of Hispanic or Latino ethnicity (66.7%).

Table 10. Number and percent of accident child deaths caused by asphyxia in Nevada in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	23.8%
Not Hispanic or Latino	14	66.7%
Unknown	2	9.5%
Total	21	100%

Some of the circumstances of the accident child deaths caused by asphyxia in Nevada in 2021, 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 11.

Table 11. Circumstances of accident child deaths caused by asphyxia in Nevada in 2021.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	8
	Child(ren)	2
	Animal(s)	1
	Comforter, quilt, or other	10
	Thin blanket/flat sheet	0
	Pillow	9
	Cushion	1
	Nursing or U-shaped pillow	2
	Sleep positioner	0
	Bumper pads	0
	Clothing	0
	Crib railing/side	1
	Bottle	2
	Wall	2
	Toys	2
	Other	6
Child placed to sleep	With a pacifier	1
	On stomach	5
	On side	0
	In adult bed	14
	On couch	1
	Wrapped or swaddled in blanket	5
	On floor	1
	In car seat	0
Caregiver/supervisor fell asleep	Bottle feeding child	1
	Breastfeeding child	0
Note: More than one circumstance can apply to a case.		

MOTOR VEHICLE ACCIDENTS (N = 17)

As seen in Table 12, there were more male children (70.6%) that died of motor vehicle accidents in Nevada in 2021 as compared to female children (29.4%).

Table 12. Number and percent of motor vehicle accident child deaths in Nevada in 2021 by sex of the decedent.

	Number	Percent
Male	12	70.6%
Female	5	29.4%
Unknown	0	0.0%
Total	17	100%

The largest percentage of motor vehicle accident child deaths were among children in the 15 – 17 Years age category (35.3%), followed by those in the 5 - 9 Years age category (29.4%). See Table 13.

Table 13. Number and percent of motor vehicle accident child deaths in Nevada in 2021 by age category of the decedent.

	Number	Percent
<1 Year	2	11.8%
1 - 4 Years	1	5.9%
5 - 9 Years	5	29.4%
10 - 14 Years	3	17.7%
15 - 17 Years	6	35.3%
Total	17	100%

As seen in Table 14, all of the motor vehicle accident child deaths, in which the race of the child was known, occurred among White (64.7%) and Black children (29.4%).

Table 14. Number and percent of motor vehicle accident child deaths in Nevada in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	5	29.4%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	11	64.7%
Multiracial	0	0.0%
Unknown	1	5.9%
Total	17	100%

As seen in Table 15, more than half (58.8%) of the motor vehicle accident child deaths in Nevada in 2021 were among children of Hispanic or Latino ethnicity.

Table 15. Number and percent of motor vehicle accident child deaths in Nevada in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	10	58.8%
Not Hispanic or Latino	5	29.4%
Unknown	2	11.8%
Total	17	100%

Approximately half (47.1%) of the motor vehicle accident child deaths in Nevada in 2021 occurred among those who were a passenger in the motor vehicle. The next largest percentage of deaths occurred among those who were pedestrians (29.4%). See Table 16.

Table 16. Number and percent of motor vehicle accident child deaths in Nevada in 2021 by position of child during the accident.

	Number	Percent
Driver	2	11.8%
Passenger	8	47.1%
On bicycle	0	0.0%
Pedestrian	5	29.4%
Unknown	2	11.8%
Total	17	100%

Details regarding the causes of the motor vehicle accident child deaths in Nevada in 2021 can be seen in Table 17.

Table 17. Causes of motor vehicle accident child deaths in Nevada in 2021.

	Number of cases
Speeding over limit	3
Unsafe speed for conditions	0
Recklessness	4
Ran stop sign/red light	2
Driver distraction	0
Inexperienced driver	0
Poor weather	0
Poor visibility	1
Drug/alcohol use	1
Vehicle ran over child	4
Vehicle flipped over	1
Poor sightline	0
Car changing lanes	0
Road hazard	0
Electronic use	0
Racing	0
Other driver error	2
Other cause	4
Unknown	3
Note: More than one cause may apply to a case.	

Among the motor vehicle accident child deaths that occurred in Nevada in 2021, the child was responsible in two cases, the child's driver was responsible in three cases, and the other driver was responsible in six cases. Multiple drivers were responsible in one case and there were five cases in which the driver responsible for the incident was unknown. Table 18 identifies some of the factors contributing to the motor vehicle accident child deaths based on who was responsible.

Table 18. Number of cases in which the following were contributing factors in motor vehicle accident child deaths in Nevada in 2021 by person responsible for the accident.

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

ACCIDENTS CAUSED BY DROWNING (N = 9)

As seen in Table 19, there was one more male child that died of an accident caused by drowning in Nevada in 2021 than female children.

Table 19. Number and percent of accident child deaths caused by drowning in Nevada in 2021 by sex of the decedent.

	Number	Percent
Male	5	55.6%
Female	4	44.4%
Unknown	0	0.0%
Total	9	100%

In Nevada in 2021, the majority of accident child deaths caused by drowning were among children in the 1 – 4 years age category. See Table 20.

Table 20. Number and percent of accident child deaths caused by drowning in Nevada in 2021 by age category of the decedent.

	Number	Percent
<1 Year	1	11.1%
1 - 4 Years	6	66.7%
5 - 9 Years	1	11.1%
10 - 14 Years	1	11.1%
15 - 17 Years	0	0.0%
Total	9	100%

As seen in Table 21, the largest percentage of accident child deaths caused by drowning in Nevada in 2021 were among children that were Multiracial (44.4%), followed by children that were White (33.3%), and children that were Black (22.2%).

Table 21. Number and percent of accident child deaths caused by drowning in Nevada in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	2	22.2%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	3	33.3%
Multiracial	4	44.4%
Unknown	0	0.0%
Total	9	100%

The majority of accident child deaths caused by drowning in Nevada in 2021 were among children not of Hispanic or Latino ethnicity (66.7%). See Table 22.

Table 22. Number and percent of accident child deaths caused by drowning in Nevada in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	3	33.3%
Not Hispanic or Latino	6	66.7%
Unknown	0	0.0%
Total	9	100%

As seen in Table 23, in all but two of the accident child deaths caused by drowning in Nevada in 2021, the drowning location was a pool, hot tub, or spa.

Table 23. Number and percent of accident child deaths caused by drowning in Nevada in 2021 by drowning location.

	Number	Percent
Open water	1	11.1%
Pool, hot tub, spa	7	77.8%
Bathtub	1	11.1%
Other	0	0.0%
Total	9	100%

As seen in Table 24, in the majority of the accident child deaths caused by drowning in Nevada in 2021, the child was not able to swim (66.7%). The swimming ability of the children in the other drowning accidents was unknown, missing, or not applicable (i.e., the drowning location was in a bathtub).

Table 24. Swimming ability of children that died in Nevada in 2021 in accidents caused by drowning.

	Number	Percent
Child was able to swim	0	0.0%
Child was not able to swim	6	66.7%
Child's swimming ability was unknown	1	11.1%
Missing	1	11.1%
N/A	1	11.1%
Total	9	100%

As seen in Table 29, the majority of child homicides caused by bodily harm or a weapon in Nevada in 2020 were among children not of Hispanic or Latino ethnicity (55.6%).

Table 29. Number and percent of child homicides caused by bodily harm or a weapon in Nevada in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	4	44.4%
Not Hispanic or Latino	5	55.6%
Unknown	0	0.0%
Total	9	100%

Of all of the child homicides in Nevada in 2021 in which the weapon type is known, they were all the result of a firearm. See Table 30.

Table 30. Number and percent of child homicides caused by bodily harm or a weapon in Nevada in 2021 by type of weapon used.

	Number	Percent
Firearm	6	66.7%
Knife/Sharp instrument	0	0.0%
Bodily Force	0	0.0%
Rope	0	0.0%
Other	0	0.0%
Unknown	3	33.3%
Total	9	100%

As seen in Table 31, in one of the child homicides caused by a firearm, the owner of the firearm was not the caregiver but another family member.

Table 31. Circumstances related to child homicides caused by a firearm in Nevada in 2021.

Storage	Firearm loaded	0
	Firearm kept locked	0
Owner of firearm	Caregiver	0
	Other family member	1
	Stranger	0
	Other	1
	Unknown	4
Note: More than one circumstance can apply to a case.		

Table 32 identifies how the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Nevada in 2021.

HOMICIDES CAUSED BY BODILY FORCE OR WEAPON (N = 9)

In Nevada in 2021, all but one of the child homicides caused by bodily force or a weapon occurred among male children (88.9%). See Table 26.

Table 26. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2021 by sex of the decedent.

	Number	Percent
Male	8	88.9%
Female	1	11.1%
Unknown	0	0.0%
Total	9	100%

More than half (55.6%) of child homicides caused by bodily force or a weapon were among children in the 15 – 17 Years age category. See Table 27.

Table 27. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2021 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	1	11.1%
5 - 9 Years	2	22.2%
10 - 14 Years	1	11.1%
15 - 17 Years	5	55.6%
Total	9	100%

In Nevada in 2021, there was an equal number of Black children and White children that died of homicide caused by bodily harm or a weapon (n = 4). There was one Multiracial child that died of homicide caused by bodily harm or a weapon. See Table 28.

Table 28. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	4	44.4%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	4	44.4%
Multiracial	1	11.1%
Unknown	0	0.0%
Total	9	100%

Table 32. How the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Nevada in 2021.

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

Table 38. Types of abuse and neglect in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021.

		Number of Cases
Type of Abuse	Abusive head trauma	4
	Chronic Battered Child Syndrome	2
	Beating/kicking	2
	Scalding/burning	0
	Munchausen Syndrome by Proxy	0
	Sexual assault	0
	Other abuse*	3
	Unknown abuse	2
Type of Neglect	Failure to provide necessities – Food	0
	Failure to provide necessities – Shelter	0
	Failure to provide necessities – Other	1
	Failure to seek/follow treatment	3
	Failure to provide supervision	6
	Emotional	1
	Abandonment	1
	Exposure to hazards**	28
Note: More than one type of abuse or neglect can occur in a case. *Cases included drowning (2) and strangulation (1) **Cases included sleep environment hazards (23), firearm hazards (3), and water hazards (2)		

Details regarding the reported events that prompted the physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021 can be seen in Table 39. In one case, the physical abuse was reported to be prompted by crying and in another case, it was reported to be prompted by a toilet training mishap.

Table 39. Events reported as prompting physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021.

	Number of Cases
Crying	1
Toilet training mishap	1
Disobedience	0
Feeding problems	0
Domestic argument	0
None	0
Other	1
Unknown	1
Note: More than one event can be reported for a case.	

The historical type of abuse or neglect experienced by the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021 can be seen in Table 40.

Deaths in which there was Abuse or Neglect, Substance Use During Pregnancy, or CPS Involvement

Deaths in which abuse or neglect caused or contributed to the death

In Nevada in 2021, there were 78 deaths in which abuse (n = 10), neglect (n = 38), poor/absent supervision (n = 9), or exposure to hazards (n = 21) caused or contributed to the death. Abuse is any injury inflicted on a child by a parent or caregiver. The parent or caretaker may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment. Neglect is failure on the part of a parent, caregiver, or supervisor to provide for the shelter, safety, supervision and nutritional needs of the child that results in harm to the child. Poor/absent supervision is failure on the part of the parent, caregiver, or supervisor to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death. Exposure to hazards refers to behavior by a parent, caregiver, or supervisor that exposes a child to a hazard that poses a threat of harm to the child, but does not meet the criteria to be classified as child neglect.

As seen in Table 33, for child deaths in which abuse, neglect, poor/absent supervision, or exposure to hazards caused or contributed to the death, slightly more than half (51.3%) were accidents followed by undetermined deaths (23.1%).

Table 33. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 by manner of death.

	Number	Percent
Natural	3	3.9%
Accident	40	51.3%
Suicide	6	7.7%
Homicide	11	14.1%
Undetermined	18	23.1%
Unknown	0	0.0%
Total	78	100%

As seen in Table 34, there were more deaths of male children (64.1%) than of female children (35.9%) in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death.

Table 34. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 by sex of the decedent.

	Number	Percent
Male	50	64.1%
Female	28	35.9%
Unknown	0	0.0%
Total	78	100%

In Nevada in 2021, more than half (52.6%) of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among children under one year of age. See Table 35.

Table 35. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 by age category of the decedent.

	Number	Percent
<1 Year	41	52.6%
1 - 4 Years	14	18.0%
5 - 9 Years	8	10.3%
10 - 14 Years	5	6.4%
15 - 17 Years	10	12.8%
Total	78	100%

As seen in Table 36 below, the largest percentage of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among White children (43.6%) followed by Black children (34.6%).

Table 36. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	3	3.9%
Black	27	34.6%
Native Hawaiian	0	0.0%
Pacific Islander	2	2.6%
White	34	43.6%
Multiracial	11	14.1%
Unknown	1	1.3%
Total	78	100%

The majority of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 were among children not of Hispanic or Latino ethnicity (60.3%). See Table 37.

Table 37. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	28	35.9%
Not Hispanic or Latino	47	60.3%
Unknown	3	3.9%
Total	78	100%

The types of abuse and neglect indicated in the child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2021 are shown in Table 38. Neglect by exposure to hazards was indicated in 28 deaths. These hazards included sleep environment hazards, firearm hazards, and water hazards. Neglect by failure to provide supervision was indicated in six deaths. Abusive head trauma was indicated in four deaths and other abuse was indicated in three deaths. “Other abuse” is a response option in the data collection tool and includes types of abuse not listed in Table 38. In Nevada in 2021, these types of abuse specifically included drowning and strangulation.

Finally, as seen in Table 25, in six of the child accident deaths caused by drowning in Nevada in 2021, there were no barriers to the swimming area. In eight of the deaths, no barrier was breached, and in seven of the deaths, rescue attempts were made to save the child.

Table 25. Number of accident child deaths involving drowning in Nevada in 2021 with the listed contributing factors.

		Number of cases
Safety Factors	Child had a personal flotation device	1
	No barriers to swimming area	6
	Fence around swimming area	1
	Gate to swimming area	0
	Door to swimming area	1
	Alarm for swimming area	1
	Cover for swimming pool, hot tub, or spa	0
Safety Breaches	No barrier breached	8
	Gate left open	0
	Gate unlocked	0
	Gate latch failure	0
	Gap in gate	0
	Child climbed fence to access swimming area	0
	Gap in fence	0
	Damaged fence	0
	Fence too short	0
	Door left open	1
	Door unlocked	0
	Door broken	0
	Door screen torn	0
	Door closer failure	0
	Alarm not working	1
	Alarm not answered	0
	Cover left off	0
	Cover not locked	0
Rescue Efforts	Rescue attempt made	7
	Rescue attempt made by parent/relative	7
	Rescue attempt made by other child	0
	Rescue attempt made by lifeguard	0
	Rescue attempt made by bystander	1
	Rescue attempt made by other	0
	Appropriate rescue equipment present	0
Note: More than one factor can apply to a case.		

Table 40. History of abuse and neglect of the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021.

	Number of Cases
History of physical maltreatment	3
History of neglect	7
History of sexual maltreatment	1
History of emotional maltreatment	1
Note: More than one type of abuse or neglect can occur for a case.	

Table 41 details the CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021.

Table 41. CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2021.

	Number of Cases
CPS action taken as a result of the death	41
Open CPS case with child at time of death	3
Child ever placed in foster care	1
Note: More than one type of involvement can apply to a case.	

In four of the child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2021, there was child abuse in the form of abusive head trauma. The impact of this abusive trauma is noted in Table 42.

Table 42. Abusive head trauma in cases of homicide child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2021.

	Number of Cases with a yes response
For abusive head trauma, were there retinal hemorrhages?	2
For abusive head trauma, was the child shaken?	0
If the child was shaken, was there impact?	N/A
Note: More than one condition can apply to a case.	

INFANT DEATHS IN WHICH THE CHILDBEARING PARENT USED SUBSTANCES DURING PREGNANCY

There were 22 deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy. The manner of these deaths included natural (36.4%), undetermined (36.4%), and accident (27.3%).

More than half (54.6%) of the deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy were among males. See Table 43.

Table 43. Number and percent of deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy by gender of decedent.

	Number	Percent
Male	12	54.6%
Female	10	45.5%
Unknown	0	0.0%
Missing	0	0.0%
Total	22	100%

As seen in Table 44, the largest percentage of deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy were among Black children (54.6%) and White children (27.3%).

Table 44. Number and percent of deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	12	54.6%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	6	27.3%
Multiracial	3	13.6%
Unknown	0	0.0%
Missing	1	4.6%
Total	22	100%

As seen in Table 45, the majority of deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy were among children that were not Hispanic or Latino (68.2%).

Table 45. Number and percent of deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	6	27.3%
Not Hispanic or Latino	15	68.2%
Unknown	0	0.0%
Missing	1	4.6%
Total	22	100%

Risk factors associated with deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances can be seen in Table 46. The types of risk factors shown include those that occurred prior to pregnancy, during pregnancy, and indicate exposure to the child.

Table 46. Risk factors associated with deaths of children under 1 year of age in Nevada in 2021 in which the childbearing parent used substances during pregnancy.

		Number of Cases
Prior to Pregnancy	Childbearing parent was a prior victim of child maltreatment	0
	Childbearing parent was a prior perpetrator of child maltreatment	11
	Childbearing parent's history included a prior child death	1
During Pregnancy	Childbearing parent smoked	6
	Childbearing parent used alcohol	1
	Childbearing parent used cocaine	1
	Childbearing parent used heroin	2
	Childbearing parent used marijuana	16
	Childbearing parent used methamphetamines	5
	Childbearing parent used opiates	3
Child Exposure	Toxicology screen completed on child	17
	Toxicology screen was negative	6
	Child tested positive for alcohol	0
	Child tested positive for cocaine	0
	Child tested positive for marijuana	1
	Child tested positive for methamphetamines	2
	Child tested positive for opiates	0
	Child tested positive for prescription drugs	0
	Child tested positive for other drugs	0
	Child test results unknown	8
Note: More than one risk factor can apply to a case.		

DEATHS IN WHICH THE CHILD WAS INVOLVED IN THE CHILD PROTECTIVE SERVICES (CPS) SYSTEM

Of the 278 child deaths reviewed in Nevada in 2021, there were 27 in which the child had been involved with the Child Protective Services (CPS) System. In 25 of these deaths, there was a past history of child maltreatment of the decedent as identified through CPS. See Table 47 for information regarding the status of the involvement of CPS with the decedent.

Table 47. Status of the involvement of Child Protective Services (CPS) System in which there was CPS involvement in Nevada in 2021.

	Number	Percent
Past history of child maltreatment as identified through CPS	18	66.7%
Past history of child maltreatment as identified through CPS and open CPS case at time of death	7	25.9%
Open CPS case at time of death	2	7.4%
Total	27	100%

As seen in Table 48, slightly more than half of child deaths in Nevada with CPS involvement in 2021 included homicides (25.9%) and natural deaths (25.9%).

Table 48. Number and percent of child deaths in Nevada with CPS involvement in 2021 by manner of death.

	Number	Percent
Natural	7	25.9%
Accident	6	22.2%
Suicide	2	7.4%
Homicide	7	25.9%
Undetermined	5	18.5%
Unknown	0	0.0%
Total	27	100%

In the deaths of children in which there was CPS involvement in Nevada in 2021, two-thirds were male (66.7%) and one-third were female (33.3%).

In Nevada in 2021, the largest percentage of child deaths with CPS involvement occurred among those less than one year of age (33.3%). See Table 49.

Table 49. Number and percent of child deaths with CPS involvement in Nevada in 2021 by age category of decedent.

	Number	Percent
<1 Year	9	33.3%
1 - 4 Years	5	18.5%
5 - 9 Years	4	14.8%
10 - 14 Years	3	11.1%
15 - 17 Years	6	22.2%
Total	27	100%

Almost half (48.1%) of the child deaths with CPS involvement in Nevada in 2021 occurred among Black children. See Table 50.

Table 50. Number and percent of child deaths with CPS involvement in Nevada in 2021 by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	1	3.7%
Asian	0	0.0%
Black	13	48.1%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	9	33.3%
Multiracial	4	14.8%
Unknown	0	0.0%
Missing	0	0.0%
Total	27	100%

Two-thirds of child deaths with CPS involvement in Nevada in 2021 occurred among those that were not Hispanic or Latino (66.7%). See Table 51.

Table 51. Number and percent of child deaths with CPS involvement in Nevada in 2021 by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	9	33.3%
Not Hispanic or Latino	18	66.7%
Unknown	0	0.0%
Missing	0	0.0%
Total	27	100%

REGIONAL TEAM RECOMMENDATIONS

Each of the regional child death review teams in Nevada are responsible for completing and submitting a quarterly report form to the Executive Committee to Review of the Death of Children (Executive Committee). The form requires the team to report 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 aimed at improving laws, policies, and practices to support the safety of children and prevent future child deaths. In submitting recommendations, teams are instructed to:

> (1) Submit recommendations related to specific observations and conclusions drawn from the case review process,
> (2) Prioritize recommendations based on case trends (three or more cases within the quarter or cumulatively), and
> (3) Not submit recommendations that have already been made unless additional gaps are identified.

The Executive Committee reviews the regional team recommendations quarterly, determines whether and how to take action on the recommendations, and notifies the regional team making the recommendation of the outcome of their recommendation.

RECOMMENDATIONS RECEIVED

There were seven recommendations made to the Executive Committee by the regional teams in 2021. The recommendations are listed below and the action taken on each is described in the next section.

1) Gun locks and gun safety classes should be required for gun owners, particularly those with children in the home. Additionally, children should participate in gun safety classes.
2) Children younger than 12 years of age should be routinely assessed for depression, suicidal ideation, and suicide attempts by mental health and medical professionals.
3) Collaboration with gun shop owners should occur to ensure that individuals who purchase firearms, particularly those with children, receive proper firearms training and are made aware of NRS 202.300.
4) Medical professionals should be educated on when to notify child protective services (CPS) when a parent/guardian is diagnosed with severe postpartum depression/psychosis.
5) Hospitals and drug testing facilities should begin testing for fentanyl as part of their standard drug testing panels, Narcan should be made more accessible to the at-risk teen populations, and hospitals should test for fentanyl when withdrawal signs are present in mothers and infants.
6) Information about safe sleep when traveling should be in included in the safe sleep education and literature information.
7) A public service announcement and community education should be developed regarding minors operating all-terrain vehicles (ATVs).

ACTION TAKEN ON RECOMMENDATIONS

Below are the actions taken to date by the Executive Committee regarding each recommendation received in 2021.

1) **Gun locks and gun safety classes should be required for gun owners, particularly those with children in the home. Additionally, children should participate in gun safety classes.**

During the first meeting at which this recommendation was presented, the Executive Committee asked for clarification from the regional team submitting it. The team revised their recommendation to: **Gun safety classes should be offered to children.** They also indicated that they would reach out to the Nevada Department of Wildlife, as they offer a hunter safety class that provides general information on gun safety. However, the regional team requested suggestions from the Executive Committee for curricula, appropriate ages for training, and appropriate trainers.

The Executive Committee sent the regional team a letter providing them with the resources listed below and the recommendation was closed.

- Information regarding 4-H Shooting Sports Program which includes the safe use of firearms: 4-H Shooting Sports | Extension | University of Nevada, Reno (unr.edu)
- Information to promote gun safety: Gun Safety (for Parents) - Nemours KidsHealth
- Parent's Firearm Safety Checklist: Microsoft Word - FirearmInjuryPreventionChecklist.doc (injuryfree.org)

2) **Children younger than 12 years of age should be routinely assessed for depression, suicidal ideation, and suicide attempts by mental health and medical professionals.**

The Executive Committee sent a letter to Nevada Medicaid, the Nevada Insurance Commissioner, and the Nevada State Board of Medical Examiners with resources and information about children's mental health, including a link to a suicide screening tool appropriate for children as young as 8 years old. The recipients of the letter were asked to share the resources with their healthcare providers and the recommendation was closed.

3) **Collaboration with gun shop owners should occur to ensure that individuals who purchase firearms, particularly those with children, receive proper firearms training and are made aware of NRS 202.300.**

The team submitting this recommendation indicated that they were not requesting assistance with the recommendation. The team had already reached out to gun shop owners but wanted to make sure that the Executive Committee was aware of their actions.

4) **Medical professionals should be educated on when to notify child protective services (CPS) when a parent/guardian is diagnosed with severe postpartum depression/psychosis.**

In review of this recommendation, the Executive Committee agreed that it might deter birthing parents from seeking help for postpartum depression/psychosis. Therefore, the Executive Committee suggested distributing postpartum depression/psychosis education and resources to medical professionals that provide care to birthing parents. They also suggested distributing this information to pediatricians as new parents/guardians are more likely to schedule and keep these appointments than their own. When the regional team that made this recommendation was presented with these suggestions, they indicated that the medical professionals involved in the incident resulting in the recommendation did

provide the family with education and resources. Therefore, the regional team indicated that no action was needed from the Executive Committee and the recommendation was closed.

5) **Hospitals and drug testing facilities should begin testing for fentanyl as part of their standard drug testing panels, Narcan should be made more accessible to the at-risk teen populations, and hospitals should test for fentanyl when withdrawal signs are present in mothers and infants.**

During discussions of this recommendation, the regional team revised the recommendation to: **Hospitals and drug testing facilities should begin testing for fentanyl as part of their standard drug testing panels and Narcan should be made more accessible to the at-risk teen populations.** To address the first part of the recommendation, the Executive Committee sent a letter to the Bureau of Health Care Quality and Compliance (HCQC) seeking collaboration to include fentanyl in standard drug testing panels. To address the second part of the recommendation, the Executive Committee sent a letter to the regional team letting them know about the passage of NV AB205 which allows schools to store and administer naloxone. The letter also provided them with the following resources found on the Nevada State Opioid Response website:

- Naloxone Finder
- Media Campaigns & Outreach
- Perinatal Health 2021 Media Toolkit

HCQC responded to the letter sent to them, stating that they do not have the authority to place requirements on hospitals/medical facilities/physicians to run specific drug panels. Therefore, the Executive Committee decided to send a letter to hospitals in the state encouraging them to include fentanyl as part of their standard drug testing panels. The letter also included the following educational materials to facilitate provider-patient conversations about the dangers of fentanyl:

- Training/Education - Nevada State Opioid Response (nvopioidresponse.org)
- Resources - Nevada State Opioid Response (nvopioidresponse.org)
- THE FACTS ABOUT FENTANYL (cdc.gov)
- Drug Fact Sheet: Fentanyl (dea.gov)
- heroin-fentanyl-other-opioids-ebook-partnership-for-drug-free-kids.pdf (nvopioidresponse.org)

Next, the Executive Committee sent a letter to the Division of Public and Behavioral Health (DPBH) informing them of the letter that was sent to the hospitals and asking DPBH to assist the Executive Committee by:

- Encouraging hospitals and drug testing facilities to implement this recommendation,
- Developing and releasing a technical bulletin for hospitals and drug testing facilities on the topic of fentanyl and drug test panels,
- Putting forth local legislation similar to Tyler's Law in California , and/or
- Collaborating with the Executive Committee to implement this recommendation.

On December 14, 2022, Fox5 published an article about the work of the Executive Committee on this recommendation. This recommendation is currently open.

6) Information about safe sleep when traveling should be included in the safe sleep education and literature information.

Upon receipt of this recommendation, the Executive Committee reviewed the current safe sleep materials distributed within the state. The materials instruct that safe sleep practices be followed "every time". Therefore the Executive Committee sent a letter to the regional team that made this recommendation and let them know that the materials state this. In the letter, the Executive Committee also suggested that the regional team consider a press release before peak family travel times (e.g., mid-December and the start of summer) to remind families of safe sleep practices. Further, it was suggested that the press release include a reminder to families to plan for safe sleep prior to arriving at their destination. The regional team was notified in the letter that no further action would be taken on the recommendation and that it would be closed.

7) A public service announcement and community education should be developed regarding minors operating all-terrain vehicles (ATVs).

Following discussions of this recommendation, the Executive Committee invited the Nevada Offroad Association (NVORA) to speak at the August 17, 2022 Executive Committee meeting. During this meeting, NVORA discussed their current efforts relevant to this recommendation and provided information regarding a summit and camps they were promoting that include ATV and off-highway vehicle (OHV) safety training for children. NVORA also expressed interest in promoting helmet wearing as children in Nevada are currently not required to wear helmets when operating ATVs or OHVs. Following this meeting, the Executive Committee sent letters to all of the regional teams providing them with the resources shared by the NVORA as well as their contact information. In a subsequent Executive Committee meeting, Safe Kids presented statistics regarding 2021 OHV crashes involving those under the age of 18. At the August 16, 2023 Executive Committee meeting, a letter was approved to be sent to NVORA expressing support for their efforts and offering to collaborate with them in the future to advance policies to protect children as it relates to the use of ATVs. This recommendation is currently open.

PUBLIC AWARENESS EFFORTS FUNDED BY THE EXECUTIVE COMMITTEE

NRS 432B.409 establishes the creation of the Review of Death of Children Account in the State General Fund. One dollar of the fee associated with the purchase of a certificate of death through the state registrar funds this account. The Executive Committee to Review the Death of Children (Executive Committee) uses these funds to support efforts to prevent child deaths. Each year, the Executive Committee posts a Notice of Funding Opportunity (NOFO) for competitive applications to prevent the death of children with funding priorities based on the leading causes of death in Nevada. The NOFO for State Fiscal Year 2021 (7/2020 – 6/2021) prioritized drowning and near drowning prevention, safe sleep, and suicide prevention efforts. The NOFO for State Fiscal Year 2022 (7/2021 – 6/2022) prioritized safe sleep and suicide prevention efforts. Below are the programs that were awarded funding in State Fiscal Years 2021 and 2022 by the Executive Committee.

SFY 2021 (7/2020 – 6/2021)

- NyE Community ($19,584.00) – Work with community partners to provide water safety education and focus on safe sleep initiatives and suicide prevention
- Baby's Bounty ($25,000.00) – Continue to provide safe sleep education and expand services by funding two additional staff positions
- Washoe County HAS ($14,200.00) – Launch a multi-faceted safe sleep awareness community outreach campaign
- Renown ($40,033.00) – Training for the administration of the Youth Risk Behavior Survey which is one of the primary sources of information about high school students' health risk behaviors, such as bullying, depression, and suicide
- Nevada Medical Center ($12,500.00) – Improve Nevada's healthcare system by promoting collaboration and innovation in the community and establish performance metrics and health indicators to identify priorities and measure community success
- Crisis Support Center ($21,989.74) – Suicide prevention and services by way of the text line

SFY 2022 (7/2021 – 6/2022)

- Community Chest ($26,716.00) – Provide programming and services to youth to increase protective factors and reduce the risk of depression and suicide and provide home visiting to rural families to promote safe sleep
- Crisis Call Center ($22,007.00) – Expand the current texting and call line and provide follow-up calls to youth who consent to follow-up services
- NyE Communities Coalition ($32,290.00) – Work with community partners to provide parents, especially teens or young adults, with safe sleep education, provide brief safe sleep interventions in the community, educate the community about suicide prevention and mental health, and expand suicide prevention clubs in schools

- Washoe County HSA ($35,000.00) – Raise awareness about infant safe sleep practices, with an emphasis on younger parents and parents-to-be through billboards, social media, movie theater ads, and a month-long awareness campaign in October
- Suicide Prevention Network ($35,000.00) – Increase protective factors to reduce the risk of suicide among youth and hold town hall sessions to develop community competence in suicide awareness, prevention, intervention, mental wellness, positivity, resilience, and coping skills
- Nevada Medical Center ($66,850.00) – Increase the awareness of comprehensive mental health and suicide prevention information and resources accessible by youth/teens and their families and enhance awareness of crisis intervention, mental health therapeutic and support services, and counseling service information by disseminating mental health information and resources
- Children's Cabinet ($82,137.00) – Expand programming to prevent youth suicide by providing parents of those identified as at-risk with support and education and training school staff to facilitate suicide prevention workshops

APPENDIX A: DEMOGRAPHICS OF DECEDENTS BY MANNER OF DEATH

Age Category	Natural	Accident	Suicide	Homicide	Undetermined	Unknown	Total
Under 1 Year	104	29	0	1	20	0	154
1 - 4 Years	13	11	0	4	2	0	30
5 - 9 Years	13	7	0	3	1	0	24
10 - 14 Years	9	6	6	1	0	0	22
15 - 17 Years	8	18	14	6	2	0	48
Total	147	71	20	15	25	0	278
Gender	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Male	80	47	16	13	13	0	169
Female	67	24	4	2	12	0	109
Unknown	0	0	0	0	0	0	0
Total	147	71	20	15	25	0	278
Race	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Alaska Native	0	0	0	0	0	0	0
American Indian	2	0	0	0	0	0	2
Asian	3	3	1	0	0	0	7
Black	42	20	6	6	12	0	86
Native Hawaiian	1	0	0	0	0	0	1
Pacific Islander	2	2	0	0	0	0	4
White	70	37	11	5	10	0	133
Multiracial	7	6	2	3	3	0	21
Unknown	20	3	0	1	0	0	24
Total	147	71	20	15	25	0	278
Hispanic or Latino Ethnicity	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Hispanic or Latino	45	27	8	8	9	0	97
Not Hispanic or Latino	71	38	10	7	15	0	141
Unknown	31	6	2	0	1	0	40
Total	147	71	20	15	25	0	278
County of Residence	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Clark	113	53	13	12	21	0	212
Washoe	21	9	5	1	2	0	38
Rural	8	3	1	0	1	0	13
Out of state	3	6	1	2	1	0	13
Unknown	2	0	0	0	0	0	2
Total	147	71	20	15	25	0	278

APPENDIX B: DEMOGRAPHICS OF DECEDENTS FOR EACH MANNER OF DEATH BY YEAR

Natural Deaths

	Year				
Age Category	**2021**	**2020**	**2019**	**2018**	**2017**
Under 1 Year	104 (70.8%)	72 (58.5%)	111 (70.3%)	104 (73.8%)	191 (78.9%)
1 - 4 Years	13 (8.8%)	13 (10.6%)	16 (10.1%)	13 (9.2%)	20 (8.3%)
5 - 9 Years	13 (8.8%)	9 (7.3%)	12 (7.6%)	15 (10.6%)	12 (5.0%)
10 - 14 Years	9 (6.1%)	17 (13.8%)	11 (7.0%)	3 (2.1%)	10 (4.1%)
15 - 17 Years	8 (5.4%)	12 (9.8%)	8 (5.1%)	6 (4.3%)	9 (3.7%)
Total	147 (100%)	123 (100%)	158 (100%)	141 (100%)	242 (100%)
Gender	**2021**	**2020**	**2019**	**2018**	**2017**
Male	80 (54.4%)	73 (59.3%)	89 (56.3%)	86 (61.0%)	133 (55.0%)
Female	67 (45.6%)	49 (39.8%)	69 (43.7%)	54 (38.3%)	106 (43.8%)
Unknown	0 (0.0%)	1 (0.8%)	0 (0.0%)	1 (0.7%)	3 (1.2%)
Total	147 (100%)	123 (100%)	158 (100%)	141 (100%)	242 (100%)
Race	**2021**	**2020**	**2019**	**2018**	**2017**
White	70 (47.6%)	64 (52.0%)	86 (54.4%)	96 (68.1%)	107 (44.2%)
Black	42 (28.6%)	35 (28.5%)	37 (23.4%)	24 (17.0%)	43 (17.8%)
Asian	3 (2.0%)	5 (4.1%)	10 (6.3%)	5 (3.5%)	17 (7.0%)
Native Hawaiian	1 (0.7%)	1 (0.8%)	0 (0.0%)	1 (0.7%)	2 (0.8%)
Pacific Islander	2 (1.4%)	1 (0.8%)	3 (1.9%)	0 (0.0%)	0 (0.0%)
American Indian	2 (1.4%)	2 (1.6%)	0 (0.0%)	1 (0.7%)	2 (0.8%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	7 (4.8%)	7 (5.7%)	13 (8.2%)	10 (7.1%)	24 (9.9%)
Unknown	20 (13.6%)	8 (6.5%)	9 (5.7%)	4 (2.8%)	47 (19.4%)
Total	147 (100%)	123 (100%)	158 (100%)	141 (100%)	242 (100%)
Hispanic or Latino Ethnicity	**2021**	**2020**	**2019**	**2018**	**2017**
Hispanic or Latino	45 (30.6%)	46 (37.4%)	64 (40.5%)	62 (44.0%)	74 (30.6%)
Not Hispanic or Latino	71 (48.3%)	70 (56.9%)	86 (54.4%)	74 (52.5%)	124 (51.2%)
Unknown	31 (21.1%)	7 (5.7%)	8 (5.1%)	5 (3.5%)	44 (18.2%)
Total	147 (100%)	123 (100%)	158 (100%)	141 (100%)	242 (100%)
County of Residence	**2021**	**2020**	**2019**	**2018**	**2017**
Clark	113 (76.9%)	99 (80.5%)	126 (79.7%)	120 (85.1%)	192 (79.3%)
Washoe	21 (14.3%)	18 (14.6%)	25 (15.8%)	18 (12.8%)	26 (10.7%)
Rural	8 (5.4%)	0 (0.0%)	2 (1.3%)	1 (0.7%)	11 (4.5%)
Out of state	3 (2.0%)	6 (4.9%)	5 (3.2%)	2 (1.4%)	12 (5.0%)
Unknown	2 (1.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Total	147 (100%)	123 (100%)	158 (100%)	141 (100%)	242 (100%)

Accident Deaths

	Year				
Age Category	**2021**	**2020**	**2019**	**2018**	**2017**
Under 1 Year	29 (40.9%)	10 (19.6%)	29 (55.8%)	28 (47.5%)	22 (37.3%)
1 - 4 Years	11 (15.5%)	9 (17.6%)	9 (17.3%)	10 (16.9%)	12 (20.3%)
5 - 9 Years	7 (9.9%)	3 (5.9%)	7 (13.5%)	5 (8.5%)	5 (8.5%)
10 - 14 Years	6 (8.5%)	7 (13.7%)	4 (7.7%)	4 (6.8%)	9 (15.3%)
15 - 17 Years	18 (25.4%)	22 (43.1%)	3 (5.8%)	12 (20.3%)	11 (18.6%)
Total	71 (100%)	51 (100%)	52 (100%)	59 (100%)	59 (100%)
Gender	**2021**	**2020**	**2019**	**2018**	**2017**
Male	47 (66.2%)	36 (70.6%)	29 (55.8%)	43 (72.9%)	30 (50.8%)
Female	24 (33.8%)	15 (29.4%)	23 (44.2%)	16 (27.1%)	29 (49.2%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	71 (100%)	51 (100%)	52 (100%)	59 (100%)	59 (100%)
Race	**2021**	**2020**	**2019**	**2018**	**2017**
White	37 (52.1%)	36 (70.6%)	24 (46.2%)	37 (62.7%)	33 (55.9%)
Black	20 (28.2%)	10 (19.6%)	15 (28.8%)	11 (18.6%)	11 (18.6%)
Asian	3 (4.2%)	2 (3.9%)	3 (5.8%)	0 (0.0%)	5 (8.5%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	2 (2.8%)	0 (0.0%)	2 (3.8%)	1 (1.7%)	0 (0.0%)
American Indian	0 (0.0%)	1 (2.0%)	2 (3.8%)	1 (1.7%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	6 (8.5%)	1 (2.0%)	6 (11.5%)	9 (15.3%)	6 (10.2%)
Unknown	3 (4.2%)	1 (2.0%)	0 (0.0%)	0 (0.0%)	4 (6.8%)
Total	71 (100%)	51 (100%)	52 (100%)	59 (100%)	59 (100%)
Hispanic or Latino Ethnicity	**2021**	**2020**	**2019**	**2018**	**2017**
Hispanic or Latino	27 (38.0%)	16 (31.4%)	13 (25.0%)	15 (25.4%)	18 (30.5%)
Not Hispanic or Latino	38 (53.5%)	34 (66.7%)	39 (75.0%)	43 (72.9%)	38 (64.4%)
Unknown	6 (8.5%)	1 (2.0%)	0 (0.0%)	1 (1.7%)	3 (5.1%)
Total	71 (100%)	51 (100%)	52 (100%)	59 (100%)	59 (100%)
County of Residence	**2021**	**2020**	**2019**	**2018**	**2017**
Clark	53 (74.7%)	34 (66.7%)	40 (76.9%)	50 (84.7%)	42 (71.2%)
Washoe	9 (12.7%)	7 (13.7%)	7 (13.5%)	5 (8.5%)	5 (8.5%)
Rural	3 (4.2%)	1 (2.0%)	1 (1.9%)	4 (6.8%)	7 (11.9%)
Out of state	6 (8.5%)	8 (15.7%)	4 (7.7%)	0 (0.0%)	5 (8.5%)
Unknown	0 (0.0%)	1 (2.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	71 (100%)	51 (100%)	52 (100%)	59 (100%)	59 (100%)

Suicide Deaths

	Year				
Age Category	**2021**	**2020**	**2019**	**2018**	**2017**
Under 1 Year	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
1 - 4 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
5 - 9 Years	0 (0.0%)	2 (11.8%	0 (0.0%)	0 (0.0%)	0 (0.0%)
10 - 14 Years	6 (30.0%)	5 (29.4%)	6 (37.5%)	9 (39.1%)	3 (18.8%)
15 - 17 Years	14 (70.0%)	10 (58.8%)	10 (62.5%)	14 (60.9%)	13 (81.3%)
Total	20 (100%)	17 (100%)	16 (100%)	23 (100%)	16 (100%)
Gender	**2021**	**2020**	**2019**	**2018**	**2017**
Male	16 (80.0%)	15 (88.2%)	10 (62.5%)	15 (65.2%)	14 (87.5%)
Female	14 (20.0%)	2 (11.8%)	6 (37.5%)	8 (34.8%)	2 (12.5%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	20 (100%)	17 (100%)	16 (100%)	23 (100%)	16 (100%)
Race	**2021**	**2020**	**2019**	**2018**	**2017**
White	11 (55.0%)	12 (70.6%)	13 (81.3%)	15 (65.2%)	11 (68.8%)
Black	6 (30.0%)	2 (11.8%	1 (6.3%)	4 (17.4%)	2 (12.5%)
Asian	1 (5.0%)	1 (5.9%)	0 (0.0%)	3 (13.0%)	1 (6.3%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	1 (6.3%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	2 (10.0%)	2 (11.8%)	1 (6.3%)	0 (0.0%)	2 (12.5%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)
Total	20 (100%)	17 (100%)	16 (100%)	23 (100%)	16 (100%)
Hispanic or Latino Ethnicity	**2021**	**2020**	**2019**	**2018**	**2017**
Hispanic or Latino	8 (40.0%)	8 (47.1%)	4 (25.0%)	7 (30.4%)	6 (37.5%)
Not Hispanic or Latino	10 (50.0%)	9 (52.9%)	10 (62.5%)	16 (69.6%)	10 (62.5%)
Unknown	2 (10.0%)	0 (0.0%)	2 (12.5%)	0 (0.0%)	0 (0.0%)
Total	20 (100%)	17 (100%)	16 (100%)	23 (100%)	16 (100%)
County of Residence	**2021**	**2020**	**2019**	**2018**	**2017**
Clark	13 (65.0%)	15 (88.2%)	9 (56.3%)	19 (82.6%)	11 (68.8%)
Washoe	5 (25.0%)	1 (5.9%)	5 (31.3%)	2 (8.7%)	3 (18.8%)
Rural	1 (5.0%)	0 (0.0%)	1 (6.3%)	1 (4.3%)	2 (12.5%)
Out of state	1 (5.0%)	1 (5.9%)	1 (6.3%)	1 (4.3%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	20 (100%)	17 (100%)	16 (100%)	23 (100%)	16 (100%)

Homicide Deaths

	Year				
Age Category	**2021**	**2020**	**2019**	**2018**	**2017**
Under 1 Year	1 (6.7%)	5 (22.7%)	1 (6.3%)	7 (25.9%)	7 (29.2%)
1 - 4 Years	4 (26.7%)	2 (9.1%)	6 (37.5%)	9 (33.3%)	10 (41.7%)
5 - 9 Years	3 (20.0%)	1 (4.5%)	3 (18.8%)	2 (7.4%)	0 (0.0%)
10 - 14 Years	1 (6.7%)	3 (13.6%)	1 (6.3%)	1 (3.7%)	2 (8.3%)
15 - 17 Years	6 (40.0%)	11 (50.0%)	5 (31.3%)	8 (29.6%)	5 (20.8%)
Total	15 (100%)	22 (100%)	16 (100%)	27 (100%)	24 (100%)
Gender	**2021**	**2020**	**2019**	**2018**	**2017**
Male	13 (86.7%)	17 (77.3%)	11 (68.8%)	18 (66.7%)	18 (75.0%)
Female	2 (13.3%)	5 (22.7%)	5 (31.3%)	9 (33.3%)	6 (25.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	15 (100%)	22 (100%)	16 (100%)	27 (100%)	24 (100%)
Race	**2021**	**2020**	**2019**	**2018**	**2017**
White	5 (33.3%)	12 (54.5%)	8 (50.0%)	10 (37.0%)	13 (54.2%)
Black	6 (40.0%)	10 (45.5%)	8 (50.0%)	16 (59.3%)	9 (37.5%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	3 (20.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)	2 (8.3%)
Unknown	1 (6.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	15 (100%)	22 (100%)	16 (100%)	27 (100%)	24 (100%)
Hispanic or Latino Ethnicity	**2021**	**2020**	**2019**	**2018**	**2017**
Hispanic or Latino	8 (53.3%)	4 (18.2%)	5 (31.3%)	8 (29.6%)	10 (41.7%)
Not Hispanic or Latino	7 (46.7%)	18 (81.8%)	11 (68.8%)	18 (66.7%)	13 (54.2%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)	1 (4.2%)
Total	15 (100%)	22 (100%)	16 (100%)	27 (100%)	24 (100%)
County of Residence	**2021**	**2020**	**2019**	**2018**	**2017**
Clark	12 (80.0%)	16 (72.7%)	14 (87.5%)	23 (85.2%)	17 (70.8%)
Washoe	1 (6.7%)	6 (27.3%)	1 (6.3%)	1 (3.7%)	2 (8.3%)
Rural	0 (0.0%	0 (0.0%)	0 (0.0%)	1 (3.7%)	3 (12.5%)
Out of state	2 (13.3%)	0 (0.0%)	0 (0.0%)	2 (7.4%)	2 (8.3%)
Unknown	0 (0.0%)	0 (0.0%)	1 (6.3%)	0 (0.0%)	0 (0.0%)
Total	15 (100%)	22 (100%)	16 (100%)	27 (100%)	24 (100%)

Undetermined Deaths

	Year				
Age Category	**2021**	**2020**	**2019**	**2018**	**2017**
Under 1 Year	20 (80.0%)	23 (82.1%)	21 (84.0%)	16 (72.7%)	13 (76.5%)
1 - 4 Years	2 (8.0%)	3 (10.7%)	1 (4.0%)	3 (13.6%)	1 (5.9%)
5 - 9 Years	1 (4.0%)	0 (0.0%)	0 (0.0%)	1 (4.5%)	0 (0.0%)
10 - 14 Years	0 (0.0%)	1 (3.6%)	0 (0.0%)	1 (4.5%)	1 (5.9%)
15 - 17 Years	2 (8.0%	1 (3.6%)	3 (12.0%)	1 (4.5%)	2 (11.8%)
Total	25 (100%)	28 (100%)	25 (100%)	22 (100%)	17 (100%)
Gender	**2021**	**2020**	**2019**	**2018**	**2017**
Male	13 (52.0%)	17 (60.7%)	17 (68.0%)	12 (54.5%)	12 (70.6%)
Female	12 (48.0%)	11 (39.3%)	8 (32.0%)	10 (45.5%)	5 (29.4%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	25 (100%)	28 (100%)	25 (100%)	22 (100%)	17 (100%)
Race	**2021**	**2020**	**2019**	**2018**	**2017**
White	10 (40.0%)	18 (64.3%)	13 (52.0%)	12 (54.5%)	11 (64.7%)
Black	12 (48.0%)	8 (28.6%)	10 (40.0%)	9 (40.9%)	5 (29.4%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	1 (4.0%)	0 (0.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	3 (12.0%)	1 (3.6%)	1 (4.0%)	1 (4.5%)	1 (5.9%)
Unknown	0 (0.0%)	1 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	25 (100%)	28 (100%)	25 (100%)	22 (100%)	17 (100%)
Hispanic or Latino Ethnicity	**2021**	**2020**	**2019**	**2018**	**2017**
Hispanic or Latino	9 (36.0%)	9 (32.1%)	8 (32.0%)	8 (36.4%)	3 (17.6%)
Not Hispanic or Latino	15 (60.0%)	19 (67.9%)	17 (68.0%)	14 (63.6%)	13 (76.5%)
Unknown	1 (4.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (5.9%)
Total	25 (100%)	28 (100%)	25 (100%)	22 (100%)	17 (100%)
County of Residence	**2021**	**2020**	**2019**	**2018**	**2017**
Clark	21 (84.0%)	19 (67.9%)	15 (60.0%)	16 (72.7%)	13 (76.5%)
Washoe	2 (8.0%)	5 (17.9%)	5 (20.0%)	5 (22.7%)	1 (5.9%)
Rural	1 (4.0%)	1 (3.6%)	1 (4.0%)	0 (0.0%)	1 (5.9%)
Out of state	1 (4.0%)	2 (7.1%)	1 (4.0%)	0 (0.0%)	1 (5.9%)
Unknown	0 (0.0%)	1 (3.6%)	3 (12.0%)	1 (4.5%)	1 (5.9%)
Total	25 (100%)	28 (100%)	25 (100%)	22 (100%)	17 (100%)

APPENDIX C: NUMBER AND PERCENT OF CHILD DEATHS IN NEVADA IN 2021 BY DECEDENT'S COUNTY OF RESIDENCE FOR CATEGORIES OF DEATHS REVIEWED IN THIS REPORT

	Clark County	Washoe County	Rural Counties	Out of State	Unknown	Total
Accidents caused by asphyxia	17 (81.0%)	3 (14.3%)	0 (0.0%)	1 (4.8%)	0 (0.0%)	21 (100%)
Motor vehicle accidents	11 (64.7%)	2 (11.8%)	1 (5.9%)	3 (17.7%)	0 (0.0%)	17 (100%)
Accidents caused drowning	7 (77.8%)	0 (0.0%)	1 (11.1%)	1 (11.1%)	0 (0.0%)	9 (100%)
Homicides caused by bodily force or weapon	7 (77.8%)	0 (0.0%)	0 (0.0%)	2 (22.2%)	0 (0.0%)	9 (100%)
Deaths in which abuse or neglect caused or contributed to the death	64 (82.1%)	5 (6.4%)	3 (3.9%)	6 (7.7%)	0 (0.0%)	78 (100%)
Infant deaths in which the childbearing parent used substances during pregnancy	16 (72.7%)	4 (18.2%)	2 (9.1%)	0 (5.0%)	0 (0.0%)	22 (100%)
Deaths in which the child was involved in the Child Protective Services (CPS) System	18 (81.8%)	1 (4.6%)	3 (13.6%)	0 (0.0%)	0 (0.0%)	22 (100%)

APPENDIX D: 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)