2021 Annual Report of Child Deaths in Clark County, Nevada

3/11/2024

A Report from the Child Death Review Team in Clark County

Nevada Institute For Children's Research & Policy

NICRP

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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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TABLE OF CONTENTS

Background 4
Purpose 5
Membership 7
Review Process 8
Cases included for review 8
Prior to the meeting 8
During the meeting 8
After the meeting 9
Data Overview 10
Confidentiality 11
Overview of Deaths 12
Deaths by Manner 15
Natural 15
Accident 16
Homicide 16
Suicide 17
Undetermined 17
Leading Manners and Causes of Child Death 18
Accidents caused by asphyxia (n = 18) 19
Motor vehicle accidents (n = 13) 21
Homicides caused by bodily force or weapon (n = 10) 24
Accidents caused by poisoning, overdose, or acute intoxication (n = 9) 27
Deaths in which there was Abuse or Neglect, Substance Use During Pregnancy, or CPS Involvement 29
Deaths in which abuse or neglect caused or contributed to the death 29
Infant deaths in which the childbearing parent used substances during pregnancy 33
Deaths in which the child was involved in the Child Protective Services (CPS) System 35
Local Prevention Efforts 37
2021 Recommendations to the State Executive Committee 38
APPENDIX A: 2021 Clark County Child Death Review Team Membership List 39
APPENDIX B: Nevada Revised Statutes for Child Death Review 41

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 2021 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 2021 is in Appendix A.

REVIEW PROCESS

CASES INCLUDED FOR REVIEW

In 2021, the Clark County Child Death Review Team reviewed 100% (n = 359) 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 2021, there was an average of 41 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. 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

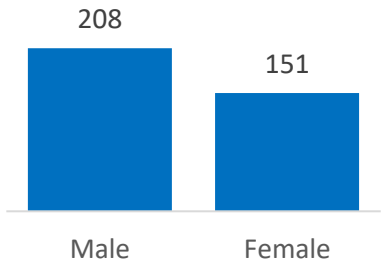
In 2021, the Clark County Child Death Review Team reviewed the deaths of 359 children under 18 years of age, which included fetal deaths of at least 20 weeks gestation. These deaths represent 100% of the cases referred to the team by the Clark County Office of the Coroner/Medical Examiner (CCOCME). In 2020, the team also reviewed 100% of the cases referred to them which included 334 deaths. This represents a 7.5% increase in child deaths in Clark County from 2020 to 2021.

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.

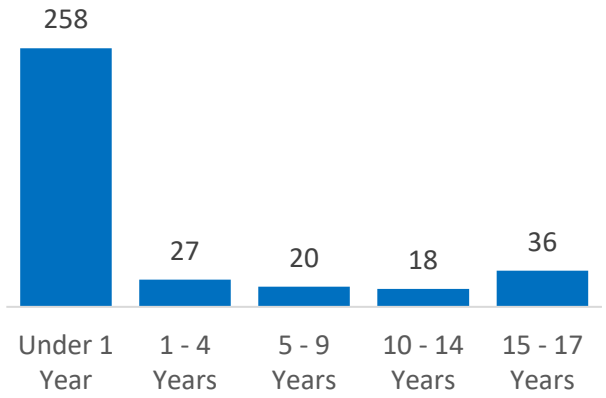
As seen in Figure 1, there were more child deaths in Clark County in 2021 among males as compared to females.

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



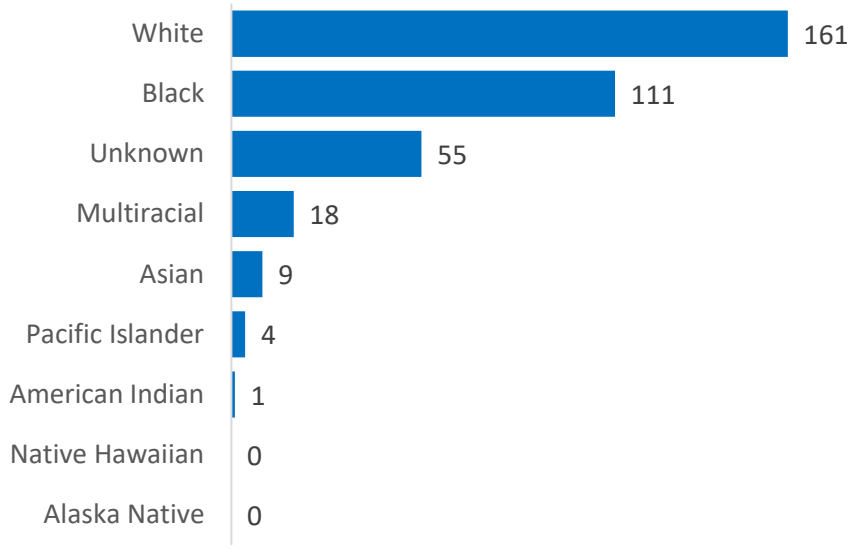
As seen in Figure 2, the majority of child deaths in Clark County in 2021 occurred among those less than one year of age (71.9%).

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



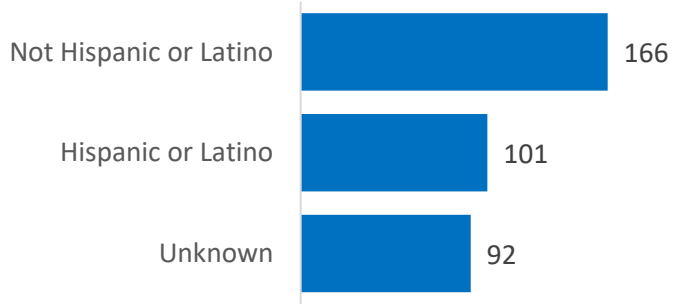
As seen in Figure 3, the largest percentage of child deaths in Clark County in 2021 occurred among White children (44.8%), followed by Black children (30.9%).

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



Finally, with regard to demographics, the largest percentage of child deaths in Clark County in 2021 were among children not of Hispanic or Latino ethnicity (46.2%). See Figure 4.

Figure 4. Number of child deaths in Clark County in 2021 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.

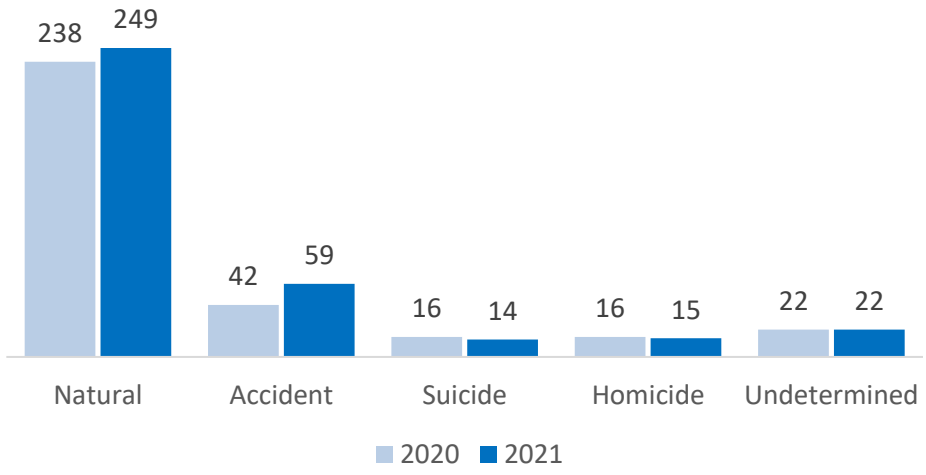
As seen in Table 2, the largest percentage of child deaths by manner in Clark County in 2021 were natural (69.4%), followed by accident (16.4%).

Table 2. Number and percent of child deaths in Clark County in 2021 by manner of death.

	Number	Percent
Natural	249	69.4%
Accident	59	16.4%
Suicide	14	3.9%
Homicide	15	4.2%
Undetermined	22	6.1%
Total	359	100%

As seen in Figure 5, the number of natural and accident manners of death increased in 2021 as compared to 2020 but there were slight decreases in the number of suicide and homicide manners of death.

Figure 5. Number of child deaths in Clark County 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, 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 2021, the largest percentage of child deaths by manner reviewed by the team were natural (69.4%). As seen in Table 4 below, of the natural deaths reviewed, the majority occurred among children under one year of age (85.9%). Overall, the most common cause of natural death was due to "other perinatal condition" (41.8%), followed by prematurity (16.5%). "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 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	1	6
Cardiovascular	3	1	1	2	1	8
Congenital anomaly	19	2	1	0	0	22
COVID-19	1	1	0	1	0	3
Diabetes	0	0	0	0	1	1
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	0	0	1	1	0	2
Pneumonia	1	0	0	0	0	1
Prematurity	41	0	0	0	0	41
SIDS	0	0	0	0	0	0
Other infection	2	0	2	0	0	4
Other perinatal condition	104	0	0	0	0	104
Other medical condition	14	4	2	2	3	25
Unknown	25	0	0	0	0	25
Total	214	10	11	8	6	249

ACCIDENT

Accident deaths are deaths not caused by an intent to harm. In 2021, the Clark County Child Death Review Team reviewed 59 accident deaths. As seen in Table 5 below, asphyxia accidents were the most common cause of accident deaths among children in Clark County in 2021 (30.5%), occurring primarily among children under the age of one. Among all of the accident child deaths occurring in 2021, the largest percentage were among children under one year of age (40.7%).

Table 5. Number of accident child deaths in Clark County 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
Motor Vehicle and Other Transport	2	1	3	2	5	13
Fire, Burn, or Electrocution	1	3	0	0	0	4
Drowning	0	6	1	1	0	8
Asphyxia	17	0	1	0	0	18
Bodily Force or Weapon	0	0	0	1	0	1
Fall or Crush	0	1	0	0	0	1
Poisoning, Overdose, or Acute Intoxication	2	0	0	1	6	9
Other Injury	0	0	0	0	1	1
Unknown	0	0	0	0	1	1
Total	24	11	5	5	14	59

HOMICIDE

In 2021, the Clark County Child Death Review Team reviewed 15 homicide deaths. As seen in Table 6 below, the largest percentage of homicide deaths were caused by bodily force or a weapon (66.7%), followed by drowning (20.0%). One third (33.3%) of the homicide deaths occurred among children in the 15 – 17 Years age category with a slightly smaller percentage of deaths (26.7%) occurring among children in the 1 – 4 Years age category.

Table 6. Number of homicide child deaths in Clark County in 2021 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	2	1	0	0	3
Asphyxia	0	0	0	0	0	0
Bodily Force or Weapon	1	1	2	1	5	10
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	1	0	0	0	1
Unknown	1	0	0	0	0	1
Total	2	4	3	1	5	15

SUICIDE

In 2021, the Clark County Child Death Review Team reviewed 14 suicide deaths. As seen in Table 7, suicide deaths occurred among children in the 10 – 14 Years and the 15 – 17 Years age categories. With the exception of one suicide, the suicides occurred either by firearm (57.1%) or hanging (35.7%).

Table 7. Number of suicide child deaths in Clark County in 2021 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	1	1
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Asphyxia	0	0	0	3	2	5
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
Total	0	0	0	4	10	14

UNDETERMINED

In 2021, 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 2021 were among children under one year of age (81.8%). In all but one of the undetermined deaths (95.5%), the cause of death was also unknown.

Table 8. Number of undetermined child deaths in Clark County 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
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	0	1	1
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0
Unknown	18	2	1	0	0	21
Total	18	2	1	0	1	22

Leading Manners and Causes of Child Death

Excluding natural and undetermined manners of death, in Clark County in 2021, the four leading manners and causes of death included accidents caused by asphyxia (20.5%), motor vehicle accidents (14.8%), homicides caused by bodily force or a weapon (11.4%), and accidents caused by poisoning, overdose, or acute intoxication (10.2%). See Table 9 for the number and percent of manner and causes of child deaths in Clark County in 2021, excluding natural and undetermined manners of death.

Table 9. Number and percent of manner and causes of child deaths in Clark County in 2021 excluding natural and undetermined manners of death.

Manner	Cause	Number	Percent
Accident	Asphyxia	18	20.5%
Accident	Motor Vehicle	13	14.8%
Homicide	Bodily Force or Weapon	10	11.4%
Accident	Poisoning, Overdose, or Acute Intoxication	9	10.2%
Suicide	Bodily Force or Weapon	8	9.1%
Accident	Drowning	8	9.1%
Suicide	Asphyxia	5	5.7%
Accident	Fire, Burn, or Electrocution	4	4.5%
Homicide	Drowning	3	3.4%
Accident	Any Medical Cause	3	3.4%
Suicide	Motor Vehicle	1	1.1%
Homicide	Undetermined Injury	1	1.1%
Homicide	Unknown Injury	1	1.1%
Accident	Bodily Force or Weapon	1	1.1%
Accident	Fall or Crush	1	1.1%
Accident	Other Injury	1	1.1%
Accident	Unknown	1	1.1%
	Total	88	100%

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

ACCIDENTS CAUSED BY ASPHYXIA (N = 18)

With the exception of one case, all of the accident child deaths caused by asphyxia in Clark County in 2021 were sleep-related. As seen in Table 10, there were more male children (66.7%) that died of asphyxia accidents in 2021 as compared to female children (33.3%).

Table 10. Number and percent of accident child deaths caused by asphyxia in Clark County in 2021 by sex of the decedent.

	Number	Percent
Male	12	66.7%
Female	6	33.3%
Unknown	0	0.0%
Total	18	100%

As seen in Table 11, with the exception of one death, all of the accident child deaths caused by asphyxia were among children under one year of age (94.4%).

Table 11. Number and percent of accident child deaths caused by asphyxia in Clark County in 2021 by age category of the decedent.

	Number	Percent
<1 Year	17	94.4%
1 - 4 Years	0	0.0%
5 - 9 Years	1	5.6%
10 - 14 Years	0	0.0%
15 - 17 Years	0	0.0%
Total	18	100%

As seen in Table 12, the majority of accident child deaths caused by asphyxia in Clark County in 2021 were among children that were Black (38.9%) or White (38.9%).

Table 12. Number and percent of accident child deaths caused by asphyxia in Clark County in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	1	5.6%
Black	7	38.9%
Native Hawaiian	0	0.0%
Pacific Islander	2	11.1%
White	7	38.9%
Multiracial	1	5.6%
Unknown	0	0.0%
Total	18	100%

As seen in Table 13, the majority of accident child deaths caused by asphyxia in Clark County in 2021 were among children not of Hispanic or Latino ethnicity (72.2%).

Table 13. Number and percent of accident child deaths caused by asphyxia in Clark County in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	27.8%
Not Hispanic or Latino	13	72.2%
Unknown	0	0.0%
Total	18	100%

Some of the circumstances of the accident child deaths caused by asphyxia in Clark County 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 14.

Table 14. Circumstances of accident child deaths caused by asphyxia in Clark County in 2021.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	7
	Child(ren)	2
	Animal(s)	1
	Comforter, quilt, or other	9
	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
	Wall	2
	Toys	2
	Other	6
Child placed to sleep	With a pacifier	1
	On stomach	4
	On side	0
	In adult bed	12
	On couch	1
	Wrapped or swaddled in blanket	4
	On floor	0
	In car seat	0
	Bouncy chair	1
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 = 13)

As seen in Table 15, there were more male children (76.9%) that died of motor vehicle accidents in Clark County in 2021 as compared to female children (23.1%).

Table 15. Number and percent of motor vehicle accident child deaths in Clark County in 2021 by sex of the decedent.

	Number	Percent
Male	10	76.9%
Female	3	23.1%
Unknown	0	0.0%
Total	13	100%

As seen in Table 16, the largest percentage of motor vehicle accident child deaths (38.5%) were among children in the 15 – 17 Years age category.

Table 16. Number and percent of motor vehicle accident child deaths in Clark County in 2021 by age category of the decedent.

	Number	Percent
<1 Year	2	15.4%
1 - 4 Years	1	7.7%
5 - 9 Years	3	23.1%
10 - 14 Years	2	15.4%
15 - 17 Years	5	38.5%
Total	13	100%

As seen in Table 17, all of the motor vehicle accident child deaths occurred among White (69.2%) and Black (30.8%) children.

Table 17. Number and percent of motor vehicle accident child deaths in Clark County 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	30.8%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	9	69.2%
Multiracial	0	0.0%
Unknown	0	0.0%
Total	13	100%

As seen in Table 18, the largest percentage of motor vehicle accident child deaths in Clark County in 2021 were among children of Hispanic or Latino ethnicity (69.2%).

Table 18. Number and percent of motor vehicle accident child deaths in Clark County in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	9	69.2%
Not Hispanic or Latino	4	30.8%
Unknown	0	0.0%
Total	13	100%

The largest percentage of motor vehicle accident child deaths in Clark County in 2021 occurred among those who were passengers in the motor vehicle (38.5%) and among pedestrians (38.5%). See Table 19.

Table 19. Number and percent of motor vehicle accident child deaths in Clark County in 2021 by position of child during the accident.

	Number	Percent
Driver	1	7.7%
Passenger	5	38.5%
On bicycle	0	0.0%
Pedestrian	5	38.5%
Unknown	1	7.7%
Missing	1	7.7%
Total	13	100%

Details regarding the factors associated with the motor vehicle accident child deaths in Clark County in 2021 can be seen in Table 20.

Table 20. Factors associated with the motor vehicle accident child deaths in Clark County in 2021.

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

Among the motor vehicle accident child deaths that occurred in Clark County in 2021, the child was responsible in two cases, the child's driver was responsible in two cases, the other driver was responsible in six cases, and in two cases, multiple drivers were responsible for the accident. In two cases, the driver responsible for the incident was unknown. Table 21 identifies some of the factors contributing to the motor vehicle accident child deaths based on who was responsible.

Table 21. Number of cases in which the following were contributing factors in motor vehicle accident child deaths in Clark County 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				

HOMICIDES CAUSED BY BODILY FORCE OR WEAPON (N = 10)

As seen in Table 22, in all but one case, the homicides caused by bodily force or weapon in Clark County in 2021 were among male children (90.0%).

Table 22. Number and percent of child homicides caused by bodily force or a weapon in Clark County in 2021 by sex of the decedent.

	Number	Percent
Male	9	90.0%
Female	1	10.0%
Unknown	0	0.0%
Total	10	100%

Half (50.0%) of child homicides caused by bodily force or a weapon were among children in the 15 – 17 Years age category. See Table 23.

Table 23. Number and percent of child homicides caused by bodily force or a weapon in Clark County in 2021 by age category of the decedent.

	Number	Percent
<1 Year	1	10.0%
1 - 4 Years	1	10.0%
5 - 9 Years	2	20.0%
10 - 14 Years	1	10.0%
15 - 17 Years	5	50.0%
Total	10	100%

The majority of the child homicides caused by bodily harm or a weapon in Clark County in 2021 were among children that were Black (40.0%) or White (40.0%). See Table 24.

Table 24. Number and percent of child homicides caused by bodily harm or a weapon in Clark County 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	40.0%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	4	40.0%
Multiracial	1	10.0%
Unknown	1	10.0%
Total	10	100%

As seen in Table 25, half (50.0%) of child homicides caused by bodily harm or a weapon in Clark County in 2021 were among children not of Hispanic or Latino ethnicity.

Table 25. Number and percent of child homicides caused by bodily harm or a weapon in Clark County in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	4	40.0%
Not Hispanic or Latino	5	50.0%
Unknown	1	10.0%
Total	10	100%

As seen in Table 26, all of the child homicides caused by bodily harm or a weapon in Clark County in 2021 were the result of a firearm (70.0%) or bodily force (30.0%).

Table 26. Number and percent of child homicides caused by bodily harm or a weapon in Clark County in 2021 by type of weapon used.

	Number	Percent
Firearm	7	70.0%
Bodily Force	3	30.0%
Knife/Sharp instrument	0	0.0%
Rope	0	0.0%
Other	0	0.0%
Total	10	100%

With regard to the seven child homicides caused by a firearm, in one of the homicides, the owner of the firearm was a family member and in one of the homicides, the owner of the firearm was a rival gang

member. For five homicides caused by a firearm, the owner of the firearm was unknown. In one of the homicides, the firearm was kept loaded. In the remaining six cases, it is unknown whether or not the firearm was kept loaded. In one of the homicides, the firearm was not kept locked. In the remaining six cases, it is unknown whether or not the firearm was kept locked.

Table 27 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 2021.

Table 27. 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 2021.

	Number of Cases
Commission of a crime	6
Gang-related activity	3
Random violence	2
Showing the gun to others	1
Playing with the weapon	1
Self-defense	1
Self-injury	0
Child was a bystander	0
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
Argument	0
Jealousy	0
Cleaning the weapon	0
Murder-suicide	0
Note: More than one use can apply to a case	

ACCIDENTS CAUSED BY POISONING, OVERDOSE, OR ACUTE INTOXICATION (N = 9)

As seen in Table 28, there were slightly more male children (55.6%) that died of accidents caused by poisoning, overdose, or acute intoxication in Clark County in 2021 as compared to female children (44.4%).

Table 28. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021 by sex of the decedent.

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

The majority (66.7%) of the accident child deaths caused by poisoning, overdose, or acute intoxication were among children in the 15 – 17 Years age category. See Table 29.

Table 29. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021 by age category of the decedent.

	Number	Percent
<1 Year	2	22.2%
1 - 4 Years	0	0.0%
5 - 9 Years	0	0.0%
10 - 14 Years	1	11.1%
15 - 17 Years	6	66.7%
Total	9	100%

All but two of the accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021 were among White children (77.8%). The remaining two deaths were among Black (11.1%) and Multiracial (11.1%) children. See Table 30.

Table 30. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	1	11.1%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	7	77.8%
Multiracial	1	11.1%
Unknown	0	0.0%
Total	9	100%

As seen in Table 31, there were slightly more children not of Hispanic or Latino ethnicity (55.6%) that died of accidents caused by poisoning, overdose, or acute intoxication in Clark County in 2021 as compared to children of Hispanic or Latino ethnicity (44.4%).

Table 31. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County 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%

As seen in Table 32 below, most of the substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021 were obtained from unknown sources.

Table 32. Type and source of substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Clark County in 2021.

	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	0	0
Prescription opioid pain medication	0	1	0	0	1
Over the counter cold medicine	0	0	0	0	0
Cocaine	0	0	0	1	1
Fentanyl/Fentanyl analogs	0	0	0	3	3
Marijuana/THC	0	0	0	0	0
Alcohol	0	0	1	1	2
Methamphetamine	0	0	0	2	2
Other Illicit Substance	0	0	0	2	2
Total	0	1	1	9	11
Note: More than one substance can apply to a case					

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 Clark County in 2021, there were 77 deaths in which abuse (n = 10), neglect (n = 37), poor/absent supervision (n = 5), or exposure to hazards (n = 25) 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 less than half (48.1%) were accidents followed by undetermined deaths (20.8%).

Table 1. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 by manner of death.

	Number	Percent
Natural	7	9.1%
Accident	37	48.1%
Suicide	6	7.8%
Homicide	11	14.3%
Undetermined	16	20.8%
Total	77	100%

As seen in Table 34, there were more deaths of male children (67.5%) than of female children (32.5%) in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death.

Table 2. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 by sex of the decedent.

	Number	Percent
Male	52	67.5%
Female	25	32.5%
Unknown	0	0.0%
Total	77	100%

In Clark County in 2021, more than half (53.2%) 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 3. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 by age category of the decedent.

	Number	Percent
<1 Year	41	53.2%
1 - 4 Years	14	18.2%
5 - 9 Years	8	10.4%
10 - 14 Years	4	5.2%
15 - 17 Years	10	13.0%
Total	77	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 (46.8%) followed by Black children (33.8%).

Table 4. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	3	3.9%
Black	26	33.8%
Native Hawaiian	0	0.0%
Pacific Islander	2	2.6%
White	36	46.8%
Multiracial	9	11.7%
Unknown	1	1.3%
Total	77	100%

The majority of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 were among children not of Hispanic or Latino ethnicity (58.4%). See Table 37.

Table 5. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Clark County in 2021 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	27	35.1%
Not Hispanic or Latino	45	58.4%
Unknown	5	6.5%
Total	77	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 Clark County in 2021 are shown in Table 38. Neglect by exposure to hazards was indicated in 29 deaths. These hazards included sleep environment hazards, firearm hazards, water hazards, and unknown other hazards. Neglect by failure to provide supervision was indicated in five 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 Clark County in 2021, these types of abuse specifically included drowning and strangulation.

Table 6. 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 Clark County 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	0
	Failure to seek/follow treatment	3
	Failure to provide supervision	5
	Emotional	0
	Abandonment	1
	Exposure to hazards**	29
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), water hazards (2), and unknown other (1)		

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 Clark County 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 7. 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 Clark County in 2021.

	Number of Cases
Crying	1
Toilet training mishap	1
Disobedience	0
Feeding problems	0
Domestic argument	0
None	0
Other	1
Unknown	6
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 Clark County in 2021 can be seen in Table 40.

Table 8. 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 Clark County in 2021.

	Number of Cases
History of physical maltreatment	3
History of neglect	6
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 Clark County in 2021.

Table 9. CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Clark County in 2021.

	Number of Cases
CPS action taken as a result of the death	40
Open CPS case with child at time of death	2
Child ever placed in foster care	1
Note: More than one type of involvement can apply to a case.	

In two of the child deaths in which abuse or neglect caused or contributed to the death in Clark County 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 10. Abusive head trauma in cases of homicide child deaths in which abuse or neglect caused or contributed to the death in Clark County 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 40 deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy. The manner of these deaths included natural (70.0%), undetermined (17.5%), and accident (12.5%).

More than half (62.5%) of the deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy were among males. See Table 43.

Table 11. Number and percent of deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy by gender of decedent.

	Number	Percent
Male	25	62.5%
Female	15	37.5%
Unknown	0	0.0%
Total	40	100%

As seen in Table 44, the largest percentage of deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy were among Black children (47.5%) and White children (37.5%).

Table 12. Number and percent of deaths of children under 1 year of age in Clark County 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	19	47.5%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	15	37.5%
Multiracial	1	2.5%
Unknown	5	12.5%
Total	40	100%

As seen in Table 45, the largest percentage of deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy were among children that were not Hispanic or Latino (55.0%).

Table 13. Number and percent of deaths of children under 1 year of age in Clark County in 2021 in which the childbearing parent used substances during pregnancy by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	5	12.5%
Not Hispanic or Latino	22	55.0%
Unknown	13	32.5%
Total	40	100%

Risk factors associated with deaths of children under 1 year of age in Clark County 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 14. Risk factors associated with deaths of children under 1 year of age in Clark County 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	0
During Pregnancy	Childbearing parent smoked	6
	Childbearing parent used alcohol	1
	Childbearing parent used cocaine	2
	Childbearing parent used heroin	4
	Childbearing parent used marijuana	31
	Childbearing parent used methamphetamines	10
	Childbearing parent used opiates	7
Child Exposure	Toxicology screen completed on child	23
	Toxicology screen was negative	5
	Child tested positive for alcohol	0
	Child tested positive for cocaine	1
	Child tested positive for marijuana	5
	Child tested positive for methamphetamines	4
	Child tested positive for opiates	2
	Child tested positive for prescription drugs	0
	Child tested positive for other drugs	0
	Child test results unknown	10
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 359 child deaths reviewed in Clark County in 2021, there were 25 in which the child had been involved with the Child Protective Services (CPS) System. In 24 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 15. Status of the involvement of Child Protective Services (CPS) System in which there was CPS involvement in Clark County in 2021.

	Number	Percent
Past history of child maltreatment as identified through CPS	17	68.0%
Past history of child maltreatment as identified through CPS and open CPS case at time of death	7	28.0%
Open CPS case at time of death	1	4.0%
Total	25	100%

As seen in Table 48, the largest percentage of child deaths in Clark County with CPS involvement in 2021 were homicides (28.0%) and natural deaths (24.0%).

Table 16. Number and percent of child deaths in Clark County with CPS involvement in 2021 by manner of death.

	Number	Percent
Natural	6	24.0%
Accident	5	20.0%
Suicide	2	8.0%
Homicide	7	28.0%
Undetermined	5	20.0%
Total	25	100%

In the deaths of children in which there was CPS involvement in Clark County in 2021, approximately two-thirds were male (68.0%) and one-third were female (32.0%). In all but one of the homicide deaths, the child was male.

As seen in Table 49, in Clark County in 2021, the largest percentage of child deaths with CPS involvement occurred among those less than one year of age (32.0%). Of these deaths, half (50.0%) were due to an undetermined manner and one quarter (25%) were natural deaths.

Table 17. Number and percent of child deaths with CPS involvement in Clark County in 2021 by age category of decedent.

	Number	Percent
<1 Year	8	32.0%
1 - 4 Years	5	20.0%
5 - 9 Years	4	16.0%
10 - 14 Years	3	12.0%
15 - 17 Years	5	20.0%
Total	25	100%

All of the child deaths with CPS involvement in Clark County in 2021 occurred among Black children (52.0%), White children (32.0%) and Multiracial children (16.0%). See Table 50.

Table 18. Number and percent of child deaths with CPS involvement in Clark County in 2021 by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	13	52.0%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	8	32.0%
Multiracial	4	16.0%
Unknown	0	0.0%
Total	25	100%

The majority of child deaths with CPS involvement in Clark County in 2021 occurred among those that were not Hispanic or Latino (64.0%). See Table 51.

Table 19. Number and percent of child deaths with CPS involvement in Clark County in 2021 by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	9	36.0%
Not Hispanic or Latino	16	64.0%
Unknown	0	0.0%
Total	25	100%

LOCAL PREVENTION EFFORTS

The Clark County Child Death Review Team tries to act locally to prevent child deaths. Prevention activities that occurred in 2021 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 2021 virtually on a very limited basis as funding for this was not available. 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 offers a train the trainer class 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.

PREVENTION OF DEATHS BY FIREARM

At the request of the Clark County Child Death Review Team, NICRP examined cases previously reviewed by the team in which the decedent died by firearm. Through this review, NICRP identified 71 firearm related deaths occurring between 2015 and 2020. With the help of team members, it was determined that 40 of these deaths might have been prevented if the individual discharging the firearm had received firearms training. Therefore, the team reached out to all gun shop owners in Clark County via letter to learn about community training efforts and opportunities for collaboration. The letter explained the goal of the team, that the team had been discussing recommendations related to NRS 202.300 and firearms training, and that the team was interested in learning more about the firearms safety information being provided in trainings. Finally, the letter invited them to contact NICRP if they were interested in partnering with the team to prevent firearm deaths to children in the community. Letters were mailed out to 326 gun shop owners and NICRP heard back from six that were interested in collaborating. One of the core team members with firearms knowledge volunteered to follow-up with the six gun shop owners. Unfortunately, per this core team member, they reached out to the gun shop owners and were met with no response.

2021 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 were two recommendations submitted to the Executive Committee by the Clark County Child Death Review Team in 2021. Below are both of the recommendations and the actions taken on them by the Executive Committee.

1) **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 by the Executive Committee.

2) **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 determined 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. However, when the team 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 team informed the Executive Committee that no action was necessary and the Executive Committee closed the recommendation.

APPENDIX A: 2021 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
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
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
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
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.
Michelle Jobe	Clark County District Attorney's Office
Fernando Juarez	Las Vegas Metropolitan Police Department
Matthew Manning	US Consumer Product Safety Commission

Sara Owen	Henderson Police Department
Lisa Price	North Las Vegas Fire Department
Jennifer Pritchett	Clark County Department of Family Services
Wayne Prosser	Nevada Highway Patrol
Melinda Rhoades	Positively Kids
Joe Roberts	Clark County School District
Abby Shields	Las Vegas Fire and Rescue
Frank Simone	North Las Vegas Fire Department
Shane Splinter	Henderson Fire Department
Dean Steiner	Department of Juvenile Justice Services
Heather Strasser	Clark County School District Health Services
Steven Taulbee	Las Vegas Fire and Rescue
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)