FINAL approved 02-11-2008

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: [x] Washoe [ ] Clark [ ] Elko [ ] Carson [ ] Fallon [ ] Pahrump

Contact Person: ______________________________

Calendar Quarter:
[ ] QTR 1 (JAN – MAR) [ ] QTR 3 (JUL – SEP)
[ ] QTR 2 (APR – JUN) [x] QTR 4 (OCT – DEC)

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	16
Actual cases reviewed for the current quarter by manner of death:	
Natural	8
Accidental	5
Homicide	2
Suicide	
Undetermined	1
TOTAL cases reviewed:	16

Mandatory Reviews Per NRS 432B.405:

(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.	1
Cases for which more than one of the above apply:	1

— Recommendations to Administrative Team —

Recurring Recommendations:

Please indicate if there were cases reviewed in the previous quarter or ongoing concerns regarding leading causes of death in Nevada and targeted areas for CDR as follows:

Accidental	Comments:
MVA	Washoe County reviewed a case involving both the driver and the passenger of a vehicle in which they lost control of the vehicle and crashed. Neither was wearing a seatbelt and they died on impact. Washoe County reviewed another case involving a 13-year-old who stole a vehicle and crashed into another car while trying to evade the police, dying on impact. He was not wearing a seatbelt. Washoe County reviewed an accidental case involving a teen being thrown from an ATV and hitting his head on the cement. He was not wearing a helmet.
Drowning	Washoe County reviewed one case in which a 16-year-old drown while swimming in Lake Tahoe.
Asphyxia, co-sleeping or unsafe sleep environment	
Asphyxia, all others	
Accidents, all others	
Homicide	**Comments:**
GSW	Washoe County reviewed one case of murder suicide involving the mother shooting her daughter in the head.
Abuse	
Neglect	
Shaken Baby Syndrome	
Homicides, all others	Washoe County reviewed one case in which a 12-year-old was stabbed multiple times and then set on fire by the roommate.
Suicide	**Comments:**
Asphyxia	
GSW	
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	

Natural deaths, all others	Washoe County reviewed eight natural cases. Four fetal demise, 1 prematurity, 2 caused by severe brain disease known as Adrenoleukodystrophy and one due to infection.
Undetermined	Comments:
Undetermined	Washoe County reviewed one case of SIDS. Due to unsafe sleeping conditions, accidental asphyxia could not be excluded. However, the cause and manner of death was undetermined.

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter, or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 1:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

This is a summary of the concerns we have for ongoing safe sleep deaths within Washoe County. There have been multiple this year and ongoing communication with new parents who need to have this information repeated to them.

Define the problem by summarizing related risk factors and required protective factors:

Social media is impacting this problem by pictures on social media of parents co sleeping with their infants, especially media stars, influencers, actresses and singers who are showing it is ok to sleep with your baby.

Provide related case data: Is there more than one case or additional data that substantiates this problem?

Within the last quarter there have been 2.

Concisely state the recommendation for change:

Ongoing campaign that specifically targets social media with blasts to stop co sleeping with your baby.

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

This has not been discussed with the team at this time, however, will be at the next CDR meeting in Washoe County.

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Katie Metz, Tammi Williamson, Denise Tyre

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

OB doctors, St. Mary’s, Renown, public health, pregnancy center include more pamphlets.

Change focus: What type of change does this recommendation focus on?

X	Strengthening parent/caregiver knowledge and skills
X	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
X	Mobilizing neighborhoods and communities
X	Influencing laws and legislation

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 2:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Multiple incidents of youth not wearing seatbelt restraints in motor vehicles and all-terrain vehicles.

Define the problem by summarizing related risk factors and required protective factors:

Lack of awareness and impulsive decision making and youth's are going on "joy rides".

Provide related case data: Is there more than one case or additional data that substantiates this problem?

5 incidents within the last quarter (see above for specific information)

Concisely state the recommendation for change:

Awareness campaign within the schools to provide reminders, wear seatbelts at assemblies when they have a large youth audience. Reminders in school notices to the parents to encourage discussion and ongoing reinforcement of wearing seatbelts as a life saving decision.

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

This has not been discussed with the team at this time, however, will be at the next CDR meeting in Washoe County.

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

Washoe County School District counselors

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Washoe County School District, Tammi Williamson & Denise Tyre

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
X	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
X	Mobilizing neighborhoods and communities
	Influencing laws and legislation

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: ☐ Washoe ☒ Clark ☐ Elko ☐ Carson ☐ Fallon ☐ Pahrump

Contact Person: Dawn L Davidson

Calendar Quarter:
☐ QTR 1 (JAN – MAR) ☐ QTR 3 (JUL – SEP)
☐ QTR 2 (APR – JUN) ☒ QTR 4 (OCT – DEC)

Date Completed: January 12, 2021

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	70
Actual cases reviewed for the current quarter by manner of death:	
Natural	35
Accidental	15
Homicide	6
Suicide	6
Undetermined	8
TOTAL cases reviewed:	70

Mandatory Reviews Per NRS 432B.405:

(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;	0
(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;	0
(3) If the death is alleged to be from abuse or neglect of the child;	6
(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;	3
(5) If the child was adopted through an agency which provides child welfare services; or	0
(6) If the child died of Sudden Infant Death Syndrome.	0
Cases for which more than one of the above apply:	0

— Recommendations to Administrative Team —

Recurring Recommendations:

Please indicate if there were cases reviewed in the previous quarter or ongoing concerns regarding leading causes of death in Nevada and targeted areas for CDR as follows:

Accidental	Comments:
MVA	4 cases reviewed during this quarter were due to a motor vehicle accident.
Drowning	1 case during this quarter was due to drowning.
Asphyxia, co-sleeping or unsafe sleep environment	7 deaths reviewed during this quarter were due to unsafe sleep.
Asphyxia, all others	
Accidents, all others	3 cases reviewed during this quarter were due to Fentanyl Intoxication. The team is in contact with the Narcotics Task Force to track spike in Fentanyl deaths and trace sources of Fentanyl.
Homicide	Comments:
GSW	5 cases reviewed during this quarter were due to gunshot wounds.
Abuse	1 case reviewed during this quarter was due to blunt force injury.
Neglect	
Shaken Baby Syndrome	
Homicides, all others	
Suicide	Comments:
Asphyxia	1 case reviewed during this quarter used hanging as a mechanism.
GSW	5 cases reviewed during this quarter used a firearm as a mechanism. A firearm preliminary review was conducted to see if deaths could have been prevented by firearm training.
Overdose	
Suicides, all others	
Natural	Comments:
Maternal drug use	1 fetal demise was due to maternal drug use (methamphetamine).
Natural deaths, all others	
Undetermined	Comments:
Undetermined	5 of the 8 undetermined cases reviewed include infants that were placed in an unsafe sleep position and/or an unsafe sleep environment.

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter, or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 1:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

In July/August of 2020, a suicide case was reviewed in which the psychiatrist's notes indicated that the decedent was given a prescription for mental health issues but that it had not filled because the parents were waiting to hear back from their insurance and the pharmacy. Approximately two weeks later, the decedent died by suicide.

Define the problem by summarizing related risk factors and required protective factors:

Receiving psychotropic medication prescribed by a qualified physician for depression is protective against death by suicide.
Delay in receiving psychotropic medication prescribed by a qualified physician for depression is a risk factor for suicide.
Health insurance company policies that prevent individuals from receiving prescribed psychotropic medication in a timely manner are risk factors for suicide.
The cost of psychotropic medication which can prevent individuals from filling prescriptions without first receiving approval from their health insurance provider is a risk factor for suicide.

Provide related case data: Is there more than one case or additional data that substantiates this problem?

The team reports that this has been an issue in the past but has never been offered as a recommendation.

Concisely state the recommendation for change:

Health insurance policies should not prevent individuals from filling prescriptions for mental health or physical health issues.

Identify best practices or other solutions the Team believes are appropriate to help implement this change:

None

Identify existing community or statewide efforts the Team is aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:

None

Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Health insurance organizations and/or regulators/legislators

Change focus: What type of change does this recommendation focus on?

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
X	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
X	Influencing laws and legislation

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: [ ] Washoe [ ] Clark [x] Elko [ ] Carson [ ] Fallon [ ] Pahrump

Contact Person: ______________________

Calendar Quarter: [ ] QTR 1 (JAN – MAR) [ ] QTR 3 (JUL – SEP)

[ ] QTR 2 (APR – JUN) [X] QTR 4 (OCT – DEC)

Date Completed: 1.9.2021

Quarterly Statistics:

Total cases referred to the team for review for the current quarter: 0

Actual cases reviewed for the current quarter by manner of death:

- Natural ______
- Accidental ______
- Homicide ______
- Suicide ______
- Undetermined ______

TOTAL cases reviewed: 0

Mandatory Reviews Per NRS 432B.405:

(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. ______

Cases for which more than one of the above apply: ______

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: [ ] Washoe [ ] Clark [ ] Elko [X] Carson [ ] Fallon [ ] Pahrump

Contact Person: Andrea Valenzuela

Calendar Quarter: [ ] QTR 1 (JAN – MAR) [ ] QTR 3 (JUL – SEP)

[ ] QTR 2 (APR – JUN) [x] QTR 4 (OCT – DEC)

Date Completed: ______________

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	3
Actual cases reviewed for the current quarter by manner of death:	
Natural	1
Accidental	
Homicide	
Suicide	
Undetermined	1
TOTAL cases reviewed:	3 (1 manner pending)

Mandatory Reviews Per NRS 432B.405:

(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;	1
(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;	1
(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.	
Cases for which more than one of the above apply:	0

— Recommendations to Administrative Team —

Recurring Recommendations:

Please indicate if there were cases reviewed in the previous quarter or ongoing concerns regarding leading causes of death in Nevada and targeted areas for CDR as follows:

Accidental	Comments:
MVA	
Drowning	
Asphyxia, co-sleeping or unsafe sleep environment	
Asphyxia, all others	
Accidents, all others	
Homicide	**Comments:**
GSW	
Abuse	
Neglect	
Shaken Baby Syndrome	
Homicides, all others	
Suicide	**Comments:**
Asphyxia	
GSW	
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	The mother took illegal medication to abort her child in third trimester of pregnancy. It cannot be determined if the child was born alive and drown in the bathtub or born deceased.
Natural deaths, all others	
Undetermined	**Comments:**
Undetermined	At this time the medical examiner’s report has not been received. The cause of death is unknown

Recommendation format based on: Wirtz, Steve Ph.D. (2006). *Developing Effective Recommendations: Taking Findings to Action*. Sacramento, CA: Epidemiology and Prevention for Injury Control (EPIC) Branch – California Department of Health Services.

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: ☐ Washoe ☐ Clark ☐ Elko ☐ Carson [x] Fallon ☐ Pahrump

Contact Person: Kelli Weishaupt

Quarter:
☐ QTR 1 (JAN – MAR) ☐ QTR 3 (JUL – SEP)
☐ QTR 2 (APR – JUN) [x] QTR 4 (OCT – DEC)

Date Completed: 1/29/21

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	1
Actual cases reviewed for the current quarter by manner of death:	
Natural	1
Accidental	
Homicide	
Suicide	
Undetermined	
TOTAL cases reviewed:	1

Mandatory Reviews Per NRS 432B.405:

(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;	1
(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.	
Cases for which more than one of the above apply:	0

NEVADA CHILD DEATH REVIEW
REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: ☐ Washoe ☐ Clark ☐ Elko ☐ Carson ☐ Fallon ☒ Pahrump

Contact Person: ____________________

Quarter:
☐ QTR 1 (JAN – MAR) ☐ QTR 3 (JUL – SEP)
☐ QTR 2 (APR – JUN) ☒ QTR 4 (OCT – DEC)

Date Completed: 12-30-2020

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	0
Actual cases reviewed for the current quarter by manner of death:	
Natural	0
Accidental	0
Homicide	0
Suicide	0
Undetermined	0
TOTAL cases reviewed:	0

Mandatory Reviews Per NRS 432B.405:

(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.	
Cases for which more than one of the above apply:	

Recommendation format based on: Wirtz, Steve Ph.D. (2006). *Developing Effective Recommendations: Taking Findings to Action*. Sacramento, CA: Epidemiology and Prevention for Injury Control (EPIC) Branch – California Department of Health Services.