STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

2011 STATEWIDE CHILD DEATH REPORT

Submitted by:

The Executive Committee to Review the Death of Children

Marla Morris and Peggy Rowe, Co-Chairs

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Acknowledgements

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Data Confidentiality

PLEASE NOTE: PORTIONS OF THE COLLECTIVE INFORMATION AND DATA CONTAINED IN THIS REPORT WERE COMPILED FROM CHILD RECORDS THAT ARE CONFIDENTIAL AND CONTAIN INFORMATION WHICH IS PROTECTED FROM DISCLOSURE TO THE PUBLIC, PURSUANT TO NEVADA REVISED STATUTES (NRS) AND FEDERAL LAWS AND REGULATIONS.

Executive Summary

Why is child death prevention important?

Ensuring child safety is critical to help reduce the risk of injury and death for infants, children, and adolescents. Each year in Nevada, over 100 children die from preventable causes of death. The four leading causes of child death are:

1. Non-motor vehicle accidents such as asphyxia (suffocation), drowning, gunshot wounds, and drug overdoses
2. Homicide
3. Suicide
4. Motor vehicle accidents, especially for children and adolescents who are passengers in vehicles

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. Sadly, they are also at greater risk of homicide by abuse and neglect. 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. In areas like Las Vegas where many homes and apartments have swimming pools and spas, it is very important for parents and caregivers to supervise their children and ensure pool and spa safety.

How does child death in Nevada compare with the rest of the United States?

Total Nevada child and adolescent deaths in 2011:
337 (ages birth through 17 years)[1]

↑ This is a 3% increase from Nevada child deaths in 2010:
327 (ages birth through 17 years)

Nevada infant mortality rate:
5.59 per 1,000 live births[2]

Largest subgroup of child deaths in Nevada:
Age group: Under 1
Causes: Natural[3]

Total national child and adolescent deaths in 2011:
[2011 federal comparison data unavailable][4]

↑ This is a ?%[5] increase from national child deaths in 2010:
38,908 (ages birth through 17 years)

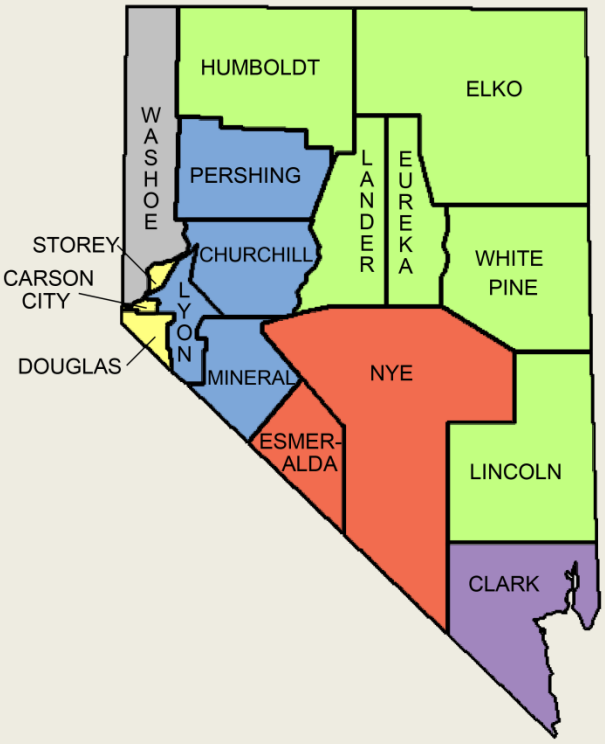
National infant mortality:
6.15 per 1,000 live births[6]

Largest subgroup of child deaths in the U.S.:
Age group: Under 1
Causes: Natural[7]

[1] DCFS. (2013). *CDR Case Reporting System*. Carson City, NV: Nevada Division of Child and Family Services.
[2] Murphy, S. et al. (2013). *NVSS Volume 61, Number 4 - Deaths: Final Data for 2010*. Hyattsville, MD: National Center for Health Statistics.
[3] Ibid.
[4] Due to the U.S. federal government shutdown from October 1 – 16, 2013, publication of 2011 national death statistics has been delayed.
[5] Ibid.
[6] Murphy, S. et al. (2013). *NVSS Volume 61, Number 4 - Deaths: Final Data for 2010*. Hyattsville, MD: National Center for Health Statistics.
[7] Ibid.

Where does Nevada's child death data come from?

2011 child deaths were reviewed by Nevada's regional child death review (CDR) teams, which are organized and operational based on Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 4095. There are currently six regional CDR teams in the state actively engaged in child death reviews:



- Washoe Team
- Elko Team
- Fallon Team
- Clark Team
- Carson Team
- Pahrump Team

The two urban teams, Clark and Washoe, review child deaths in the major population centers of the state, in the areas of Las Vegas and Reno, respectively. The four rural teams review child deaths in all other counties, which comprise Nevada's rural region. There is a seventh team located in Clark County, the Southern Nevada Child Fatality Task Force, which reviews select cases to promote process improvement for child death investigations. However, this team is not primarily responsible for child death reviews in Clark County.

The Executive Committee to Review the Death of Children is the statewide group which provides coordination and oversight for the review of child deaths in Nevada. The Executive Committee reviews reports and recommendations from the regional CDR teams and makes decisions regarding recommendations for improvements to laws, policies, and practices related to the prevention of child death. The Executive Committee also makes decisions about funding initiatives to prevent child death, which may be based on recommendations from the regional CDR teams and annual child death data analysis.

Additionally, the Executive Committee adopts statewide protocols for the review of the death of children; oversees training and development for the regional CDR teams; and compiles and distributes this statewide annual report.

How do the regional CDR teams work to prevent child deaths?

1. 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. Highlights of current and past prevention efforts are included in *Section 2*, within the detailed reviews for each leading cause of child death.

2. The regional CDR teams submit recommendations to the Executive Committee to improve to 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.

Section 1: Data Overview and General Analysis

Data Sources

All Nevada data in this report is derived from the regional CDR teams, which collect and enter data into an electronic case reporting system maintained by the National Maternal Child Health (MCH) Center for Child Death Review. Based on the multidisciplinary reviews conducted for child deaths that occurred in calendar year 2011, there were a total of 337 child and adolescent deaths in the state. These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data. National comparison and supplementary research data is primarily obtained from federal sources including the Centers for Disease Control and Prevention (CDC).

Data Limitations

- All child deaths may not be 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 does not get 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 this data is collected and how certain questions are answered.
- There may be data errors because of problems with a child's name. This most commonly occurs with infants who are not given a name at the time of their death and assigned a designation such as "baby boy" or "baby girl." When a death certificate is issued, in most cases a name is given, thus creating 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 because of 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.[8] For regional CDR team data, cause of death is entered as reported on the death certificate or based on findings from the multidisciplinary review process, which may differ from the coroner's or medical examiner's findings.
- Although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, the multidisciplinary reviews completed by the regional CDR teams may provide details that allow alternate classification of the death for the purposes of this report.

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 from 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.

[8] National Center for Health Statistics. (2013). *Classification of Diseases, Functioning, and Disability*. Retrieved October 16, 2011, from http://www.cdc.gov/nchs/icd.htm.

- Children who were adopted through a child welfare agency.
- Children who died from Sudden Infant Death Syndrome (SIDS).

Additional detail about the organization and functions of the seven regional CDR teams is included in Appendix A of this report.

Deaths reviewed versus deaths not reviewed

Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region with one exception: The Southern Nevada Child Fatality Task Force reviews only select cases in its work to improve the investigation of child deaths by stakeholders in the CDR process.

In Clark County, the team meets monthly because of its high caseload. The Southern Nevada Child Fatality Task Force meets every other month. 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 may meet less frequently if no child fatalities are reported in a given quarter.

Natural Deaths

Why are there so many natural deaths among infants?

In spite of advancements in medical practice and technology, newborn infants are at risk from a variety of natural disease mechanisms. Some of these result from genetic disorders, while others may relate to environmental factors and the health and wellbeing of mothers during pregnancy. Infant prematurity is a leading cause of natural death and may be associated with the following risk factors:[9]

- Prior pre-term delivery
- Previous infant or fetal loss
- Adequacy of prenatal care (early entry, missed appointments)
- Medical conditions of the mother
- Maternal age (under 20, over 35)
- Infections, including sexually transmitted
- Hypertension
- Diabetes
- Poor nutritional status
- Obesity
- Short inter-pregnancy interval
- Poverty
- Substance, alcohol and tobacco use
- Stressors and lack of social support
- Less than 12th grade education
- Unintended unplanned pregnancy
- Unmarried or lack of male involvement in pregnancy
- Physical and emotional abuse of mother

[9] National MCH Center for Child Death Review. *Natural Deaths to Infants Excluding SIDS - Fact Sheet*. Retrieved September 17, 2012, from: http://www.childdeathreview.org/causesNNS.htm.

Natural deaths in Nevada 2011

Natural deaths are the leading manner of child death in the state, accounting for 62.3% of all deaths in 2011 and occurring primarily in infants less than one year of age. Specific causes include the following:

Cause	Total Deaths	Percentage	Cause	Total Deaths	Percentage
Prematurity	77	22.8%	**Cardiovascular**	6	1.8%
Congenital anomaly	60	17.8%	**Infection**	2	0.6%
Other medical	19	5.6%	**Neurological**	2	0.6%
Cancer	13	3.9%	**Other**	2	0.6%
Perinatal condition	13	3.9%	**Influenza**	1	0.3%
Pneumonia	7	2.1%	**SIDS**	1	0.3%
Asthma	7	2.1%			
			TOTAL:	210	62.3%

All natural deaths are reviewed by the regional CDR teams, and certain natural causes are focused on as follows:

- Sudden Infant Death Syndrome (SIDS): Review of these deaths are mandated by NRS 432B.405.
- Natural deaths for children with a current or prior child protective services (CPS) history: Review of these deaths are mandated by NRS 432B.405.
- Natural causes that may be associated with abuse and/or neglect: Although a coroner or medical examiner may determine that a child death resulted from identifiable natural causes, investigation findings may suggest signs of abuse and/or neglect such as over-medication or medical neglect.
- Toxicology reports suggesting maternal drug use and drug exposure for infants: Again, although a coroner or medical examiner may determine that a child death resulted from identifiable natural causes, toxicology tests conducted at birth may suggest that drug exposure contributed to the fatality.

More detailed data for these types of deaths are available based on the regional CDR case review process and are discussed in detail below.

Leading Manners and Causes of Death

The four leading manners of child death statewide, excluding natural and undetermined deaths, are as follows:

Leading Manner	Total Deaths by Manner	Percentage of Total Deaths
1. Non-motor vehicle accidents	43	12.8%
2. Homicide	23	6.8%
3. Suicide	21	6.2%
4. Motor vehicle accidents	15	4.5%
TOTAL:	102	30.3%

These leading manners of death exclude undetermined deaths, which are sometimes difficult to target for prevention efforts due to lack of information. More detail about undetermined deaths is available based on the reviews conducted

by the regional CDR teams, and additional information on these deaths is provided below. These manners also exclude natural deaths, which are discussed separately above.

1. Non-motor vehicle accidents

Leading Manner and Causes	Total Deaths by Manner and Cause	Percentage of Total Deaths
1. Non-motor vehicle accidents	43	12.8%
• **Asphyxia**	13	3.9%
• **Overdose**	11	3.3%
• **Drowning**	10	3.0%
• **Fire**	3	0.9%
• **Drug exposed infant**	1	0.3%
• **Fall**	1	0.3%
• **Gunshot Wound (GSW)**	0	0.0%
• **Other weapon**	1	0.3%
• **Other**	2	0.6%
• **Unknown**	1	0.3%

Findings:

- Non-motor vehicle accidents (non-MVA) are the leading manner of accidental death for children and adolescents in Nevada. This is inconsistent with national mortality data, which shows motor vehicle accidents (MVA) as the leading cause of death for all American children and adolescents, ages one through 17.[10] However, recent National Highway Traffic Safety Administration (NHTSA) data shows a decline in MVA deaths nationally over the past seven years, beginning in 2005.[11] Nevada MVA deaths have reflected this downward trend since 2004.
- Asphyxia, drug overdose, and drowning deaths were the most common type of accidental deaths in 2011.
- Of the 13 asphyxia deaths, 11 were related to bed sharing and/or unsafe sleep environments. Data analysis below shows that many more child deaths likely involve bed sharing and/or unsafe sleep environments when investigative information from undetermined deaths is considered.

2. Homicide

Leading Manner and Causes:	Total Deaths by Manner and Cause	Percentage of Total Deaths
2. Homicide	23	6.8%
• **Abuse**	10	3.0%
• **Neglect**	1	0.3%
• **Gunshot wounds**	8	2.4%
• **Other weapon**	3	0.9%
• **Unknown causes**	1	0.3%

[10] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 18, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

[11] Fatality Analysis Reporting System (FARS). (2013). *Fatalities and Fatality Rates, 1994 – 2011*. Retrieved October 16, 2013, from http://www-fars.nhtsa.dot.gov/Trends/TrendsGeneral.aspx.

Findings:

- Homicides remained level with 23 in 2010 and 23 in 2011. Homicides from gunshot wounds increased slightly from 7 in 2010 to 8 in 2011. A high number of deaths by gunshot wounds is consistent with national data, which shows gunshot wounds as the leading cause of homicide deaths for children and adolescents ages one through 17.[12]
- Abuse deaths remained level between 2010 and 2011, with 10 each year. More detail on this critical and preventable cause of death is provided below.

3. Suicide

Leading Manner and Causes	Total Deaths by Manner and Cause	Percentage of Total Deaths
3. Suicide	21	6.2%
• **Gunshot wounds**	16	4.7%
• **Asphyxia**	4	1.2%
• **Overdose**	1	0.3%

Findings:

- Total deaths by suicide increased from 8 in 2010 to 21 in 2011.
- Deaths by suicide resulting from gunshot wounds increased significantly from 4 in 2010 to 16 in 2011, highlighting the problem with access to lethal means. More detail on this critical and preventable cause of death is provided below.

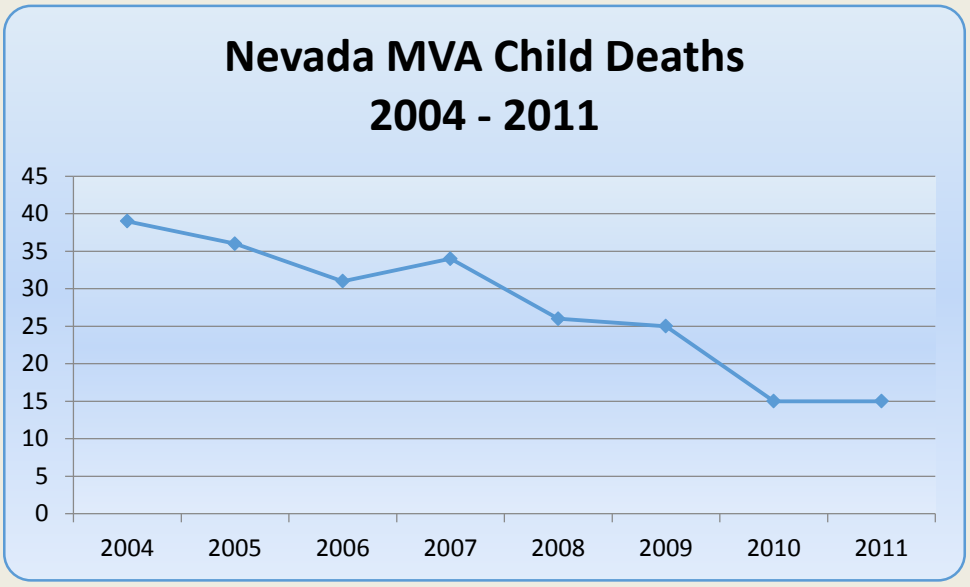
4. Motor vehicle accidents

Leading Manner and Causes:	Total Deaths by Manner and Cause	Percentage of Total Deaths
4. Motor vehicle accidents	15	4.5%
• **Driver**	2	0.6%
• **Passenger**	8	2.4%
• **Pedestrian**	4	1.2%
• **Motorcycle driver**	0	0.0%
• **Motorcycle passenger**	0	0.0%
• **Moped driver**	0	0.0%
• **Moped passenger**	0	0.0%
• **Bicycle**	1	0.3%
• **All-terrain vehicle (ATV)**	0	0.0%
• **Watercraft**	0	0.0%
• **Other**	0	0.0%
• **Unknown type**	0	0.0%

Findings:

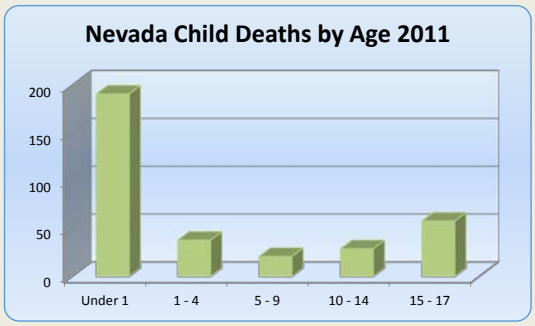
- As noted above, Nevada motor vehicle accident (MVA) deaths among children and adolescents have decreased considerably over the past seven years:

[12] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 18, 2012, from http://www.cdc.gov/injury/wisqars/index.html.



Basic Demographics: All Deaths

Age



Age Group	Total	%
Under 1	191	56.7%
1 – 4	38	11.3%
5 - 9	21	6.2%
10 - 14	29	8.6%
15 - 17	58	17.2%
TOTAL:	337	100.0%

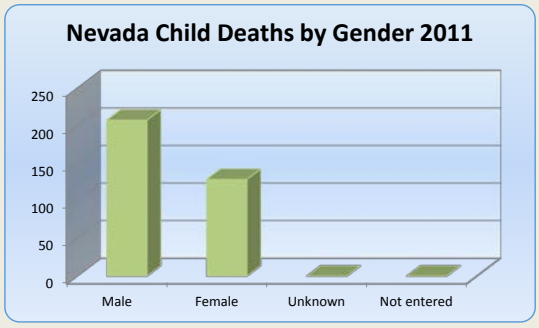
Deaths by Age Findings:

- The greatest number of child deaths in 2011 occurred among infants less than one year of age. This is consistent with national death rates for children and adolescents, which indicate the highest rate of deaths for infants ages birth to one year, at approximately 623.4 per 100,000 of the population.[13]
- Nevada child death rates in other age groups are considerably lower, with decreasing deaths through the 5 – 9 age group, and then increasing deaths as adolescents move through their pre-teen and teen years. This u-shaped data pattern is consistent with national death rates for the same age groups.

[13] Murphy, S. et al. (2013). *NVSS Volume 61, Number 4 - Deaths: Final Data for 2010*. Hyattsville, MD: National Center for Health Statistics.

Gender

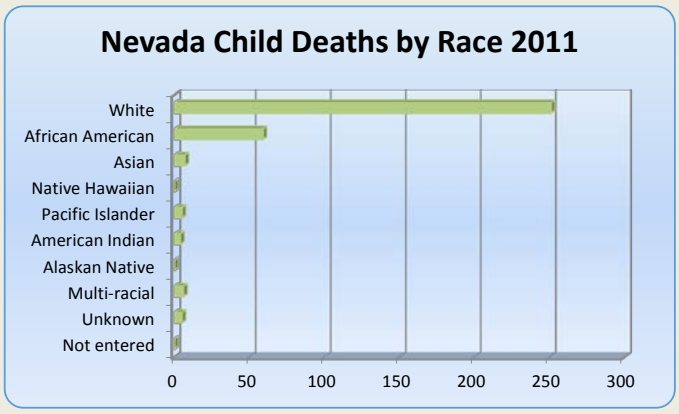
Gender	Total	%
Male	208	61.7%
Female	129	38.3%
Unknown	0	0.0%
Not entered	0	0.0%
TOTAL:	337	100.0%



Deaths by Gender Findings:

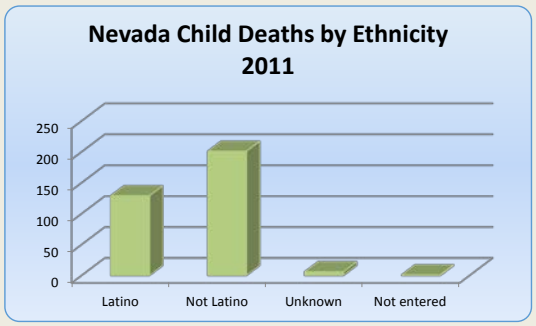
- Nevada child deaths in 2011 include more males than females. This is again consistent with national data, which indicates that male children and adolescents die at a higher rate than females.[14]

Race and Ethnicity



Race Group	Total	%
White	251	74.5%
African American	59	17.5%
Asian	7	2.1%
Native Hawaiian	0	0.0%
Pacific Islander	5	1.5%
American Indian	4	1.2%
Alaskan Native	0	0.0%
Multi-racial	6	1.8%
Unknown	5	1.5%
Not entered	0	0.0%
TOTAL:	337	100.0%

Ethnicity	Total	%
Latino	129	38.3%
Not Latino	201	59.6%
Unknown	6	1.8%
Not entered	1	0.3%
TOTAL:	337	100.0%



[14] Murphy, S. et al. (2013). *NVSS Volume 61, Number 4 - Deaths: Final Data for 2010*. Hyattsville, MD: National Center for Health Statistics.

Comparison: Statewide Population and Child Death by Race and Ethnicity

STATEWIDE POPULATION (0 – 17)[15]		
Race Group	Total	%
White	309,959	45.6%
Hispanic/Latino	256,653	37.8%
African American	56,938	8.4%
Asian/Pacific Islander	47,673	7.0%
American Indian	8,610	1.3%
Other	-	-
Unknown	-	-
TOTAL:	679,833	100.0%

STATEWIDE CHILD DEATHS		
Race Group	Total	%
White	251	74.5%
African American	59	17.5%
Asian	7	2.1%
Native Hawaiian	0	0.0%
Pacific Islander	5	1.5%
American Indian	4	1.2%
Alaskan Native	0	0.0%
Multi-racial	6	1.8%
Unknown	5	1.5%
Not entered	0	0.0%
Ethnicity	Total	%
Hispanic/Latino	129	38.3%
Not Hisp/Latino	201	59.6%
Unknown	6	1.8%
Not entered	1	0.3%

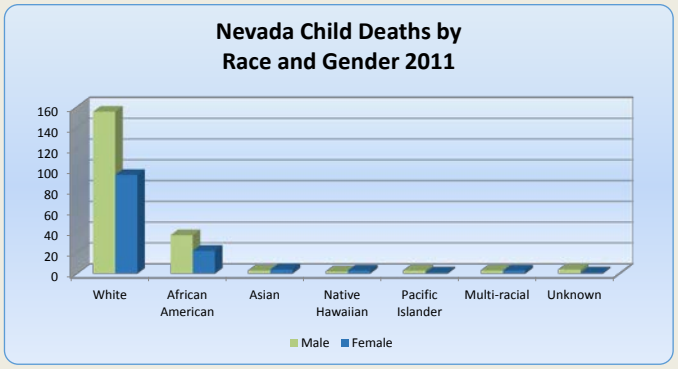
Findings:

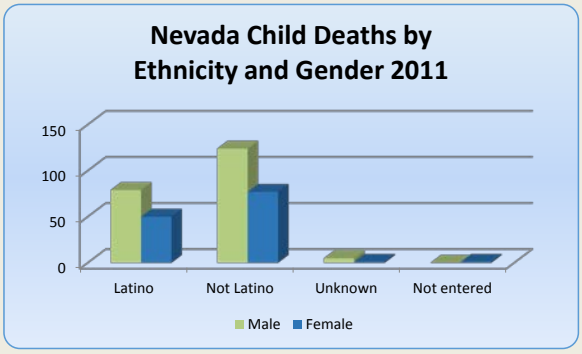
- For whites and Latinos, comparison data is confounded because the State Demographer counts Latinos as a race category, whereas child death data follows federal standards and separates Latinos out as an ethnicity. To accommodate this comparison, white and Latino race categories can be combined from the statewide population data, yielding a total white population of 83.4%. This indicates that child deaths among whites are less frequent at 74.5%, which is consistent with data from prior years. Likewise, child deaths among Latinos are slightly above the statewide population distribution when comparing the race and ethnicity data at 38.3% (CDR) versus 37.8% (statewide).
- For African Americans, 2011 child deaths are disproportionately higher at 17.5% versus the statewide population distribution at 8.4%. In terms of infant mortality, this consistent with national data, which shows that African Americans have a higher overall infant mortality rate than whites (11.63 deaths per 1,000 live births for African Americans versus 5.20 deaths per 1,000 live births for whites).[16] However, for some specific causes of death detailed in *Section 2*, African American deaths are disproportionately higher, which indicates that child deaths among African Americans are more frequent for certain causes and may benefit from increased prevention efforts.

[15] Hardcastle, J. (2011). *Nevada's Age, Sex, Race, and Hispanic Origin Estimates For 2011 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

[16] Murphy, S. et al. (2013). *NVSS Volume 61, Number 4 - Deaths: Final Data for 2010*. Hyattsville, MD: National Center for Health Statistics.

Comparison: Race, Ethnicity, and Gender





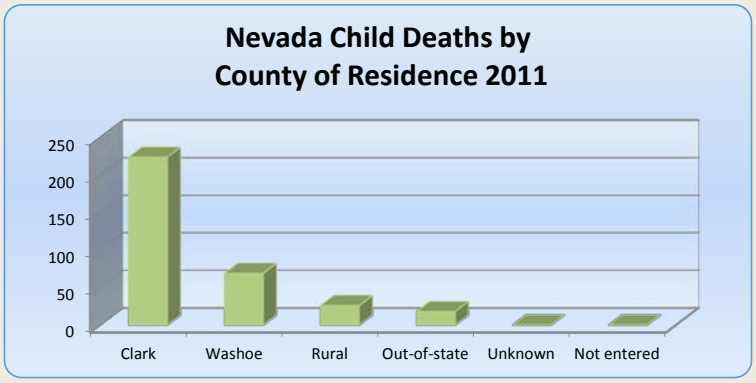
Race Group	Male	Female	Male %	Female %
White	156	95	75.0%	73.6%
African American	37	22	17.8%	17.1%
Asian	3	4	1.4%	3.1%
Native Hawaiian	0	0	0.0%	0.0%
Pacific Islander	2	3	1.4%	0.8%
American Indian	3	1	0.0%	0.0%
Alaskan Native	0	0	0.0%	0.0%
Multi-racial	3	3	1.4%	2.3%
Unknown	4	1	1.9%	0.8%
Not entered	0	0	0.0%	0.0%
TOTAL:	208	129	100.0%	100.0%

Ethnic Group	Male	Female	Male %	Female %
Hispanic/Latino	79	50	38.0%	38.8%
Not Hispanic/Latino	124	77	59.6%	59.7%
Unknown	5	1	2.4%	0.8%
Not entered	0	1	0.0%	0.8%
TOTAL:	208	129	100.0%	100.0%

Findings:

- Comparison by race, ethnicity, and gender again demonstrates that in general, males die more frequently than females (based on raw numbers).
- Asian females die more frequently than Asian males.

County of Residence



County	Total	%	County	Total	%
Clark	224	66.5%	Lincoln	0	0.0%
Washoe	69	20.5%	Lyon	1	0.3%
Carson City	4	1.2%	Mineral	0	0.0%
Churchill	4	1.2%	Nye	7	2.1%
Douglas	3	0.9%	Pershing	2	0.6%
Elko	4	1.2%	Storey	0	0.0%
Esmeralda	0	0.0%	White Pine	1	0.3%
Eureka	0	0.0%	Out-of-state	18	5.3%
Humboldt	0	0.0%	Unknown	0	0.0%
Lander	0	0.0%	Not entered	0	0.0%
			TOTAL:	337	100.0%

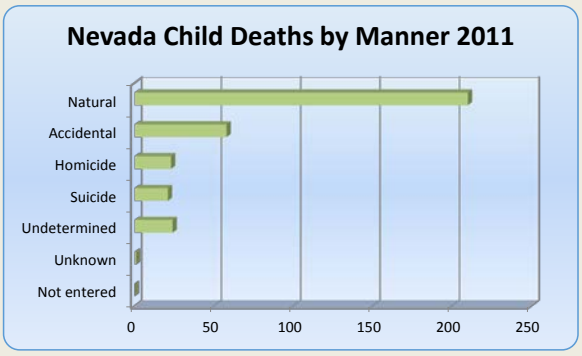
Findings:

- The highest number of child deaths occurred among residents of Nevada's two largest counties, Clark and Washoe.
- Clark County's child and adolescent population accounts for 74.2% of the statewide child and adolescent population. With Clark County child deaths at 66.5% of total deaths in 2011, this means the proportion of child deaths in Clark County is below the average based on the total child and adolescent population.
- Washoe County's child and adolescent population accounts for 15.1% of the statewide child and adolescent population. With Washoe County child deaths at 20.5% of total deaths in 2011, this means the proportion of child deaths in Washoe County is above the average based on the total child and adolescent population.
- Out-of-state deaths include children who are not Nevada residents that die while they are visiting the state.

Manner of Death

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

1. **Natural**: These are deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases.
2. **Accidental**: These are deaths where there was not any intent to cause harm to another person and include causes such as motor vehicle accidents, asphyxia, and drowning.
3. **Homicide**: Homicide is the killing of one human by another.
4. **Suicide**: Suicide is the taking of one's own life voluntarily and intentionally.
5. **Undetermined**: These are deaths where sufficient evidence or information cannot be deduced during the initial investigation, usually about intent, to assign a manner of death.



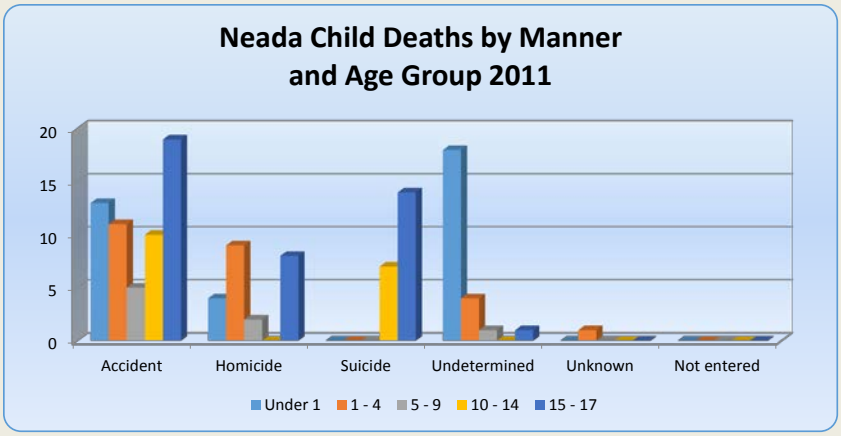
Manner	Total	%
Natural	210	62.3%
Accidental	58	17.2%
Homicide	23	6.8%
Suicide	21	6.2%
Undetermined	24	7.1%
Unknown	1	0.3%
Not entered	0	0.0%
TOTAL:	337	100.0%

Findings:

- The greatest number of child deaths in 2011 was natural, largely due to the high incidence of natural deaths among infants less than one year of age, as discussed earlier in this section.
- The second most common manner of death is accidental, accounting for over 17% of child deaths in Nevada. When infants less than one year of age are separated out, accidents become the most common manner of death for children and adolescents ages one through 17. This is consistent with national data, which shows that accidents (unintentional injuries) are the leading cause of death for all age groups except infants less than one year of age.[17]
- Accidental deaths represent the type of deaths where prevention efforts would most likely contribute to a reduction in fatalities. Leading causes of accidental death are discussed in more detail below in *Section 2* of this report.

[17] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 19, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

Comparison: Manner of Death and Age



*This chart excludes natural deaths to facilitate a more meaningful comparison across other manners of death

Manner	Less than 1	1 – 4	5 – 9	10 – 14	15 – 17
Natural	156	13	13	12	16
Accidental	13	11	5	10	19
Homicide	4	9	2	0	8
Suicide	0	0	0	7	14
Undetermined	18	4	1	0	1
Unknown	0	1	0	0	0
Not entered	0	0	0	0	0
TOTAL:	191	38	21	29	58

Findings:

Natural Deaths

- As noted above, the greatest number of child deaths in 2011 was natural deaths of infants less than one year of age. This is consistent with national data, which indicates that the top four causes of infant death are natural, and these natural deaths represent approximately 52% of infant deaths nationwide.[18]

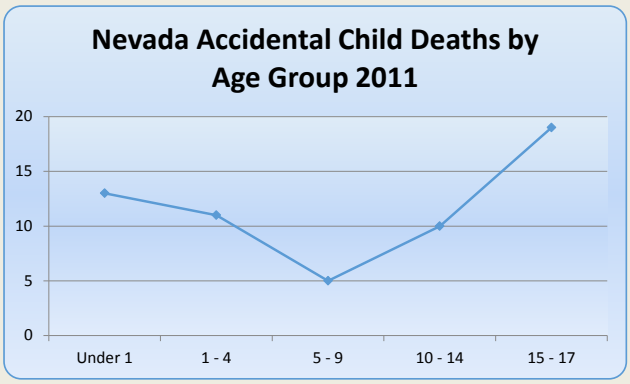
Undetermined Deaths

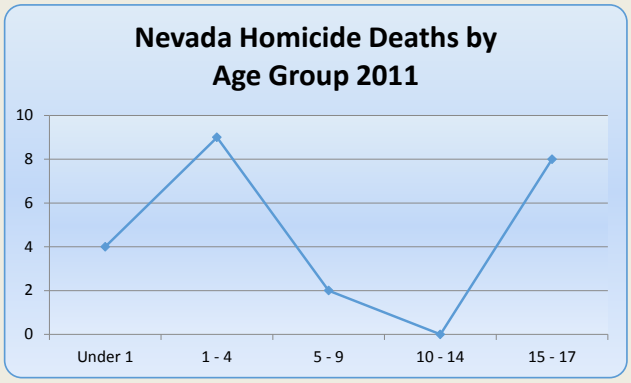
- Undetermined deaths are also most common in infants less than one year of age, likely due to the broad array of possible infant mortality causes, difficulty identifying causes for sudden unexplained infant deaths (SUIDs), and uncertain circumstances surrounding accidental, abuse, and neglect deaths.

[18] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010, Under 1* [custom data query]. Retrieved September 20, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

Accidental Deaths

- Accidental deaths tend to follow a u-shaped pattern across age groups, with the highest number of deaths in the age groups of under 1 and 15 – 17, and the lowest in the age group of 5 – 9. Accidental deaths also tend to increase with age as children move into adolescence. This is consistent with national data, which shows that the leading causes of death are accidental for all child and adolescent age groups over one-year, the highest number of accidental deaths is in the age groups of 1 – 4 and 15 – 17, and the lowest in the age groups of 5 – 9 and 10 – 14. National data also shows that accidental deaths tend to increase with age.[19]



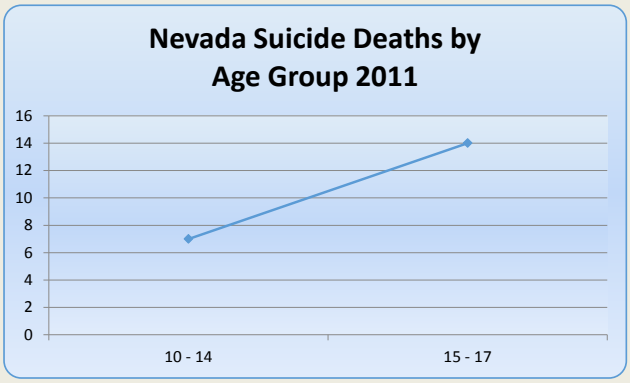


Homicide Deaths

- Homicides in 2011 occurred in all age groups except 10 – 14. Over time, homicide deaths in Nevada have also tended to follow a u-shaped pattern across age groups, with the highest in the age groups of under 1 and 15 – 17. During 2011, however, there were a lower number of homicide deaths in the under 1 age group.
- Homicide deaths tend to increase with age as children move through their adolescent years, which is consistent with national data.[20]

Suicide Deaths

- Suicides in 2011 occurred only within the age groups of 10 – 14 and 15 – 17, and demonstrate a sharp increase with age. This is consistent with national data, which shows suicide as the fourth leading cause of death for the 10 – 14 and 15 – 17 age groups, and a substantial increase in suicides with age.[21]



[19] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 20, 2012, from http://www.cdc.gov/injury/wisqars/index.html.
[20] Ibid.
[21] Ibid.

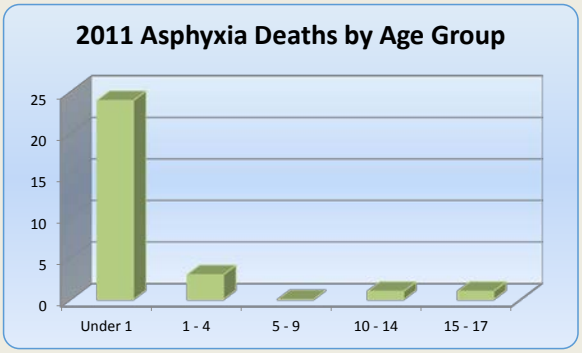
Section 2: Detailed Review of Target Causes of Death

Review: Accidents and Other Deaths Involving Asphyxia

In addition to 13 asphyxia deaths determined to be accidental based on manner of death, this section of the report includes an additional 16 undetermined deaths with circumstances indicating that these deaths were likely due to asphyxia. This determination was made during analysis completed for this report.

Reviewed by Team	Total	County of Residence	Total
Carson	0	**Churchill**	1
Clark	17	**Clark**	18
Elko	1	**Elko**	1
Fallon	1	**Nye**	1
Pahrump	1	**Washoe**	8
Washoe	9	**Out-of-state**	0
		Not entered	0
TOTAL:	29	**TOTAL:**	29

Basic Demographics



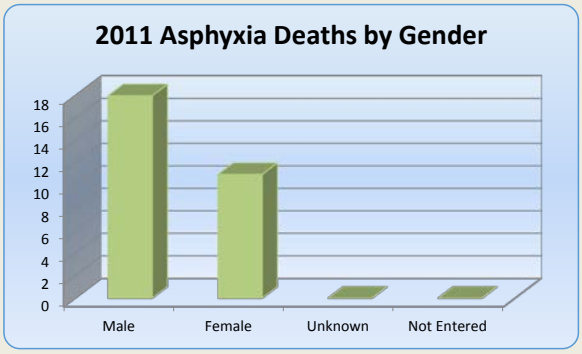
Age Group	Total
Under 1	24
1 - 4	3
5 - 9	0
10 - 14	1
15 - 17	1

Findings:

- Approximately 83% (24 of 29) of asphyxia deaths in 2011 occurred among infants less than one year of age. This is consistent with national data, and this age group presents the highest risk for death by asphyxia.[22]

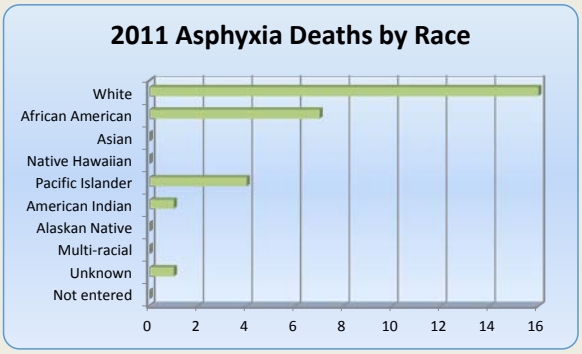
[22] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 20, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

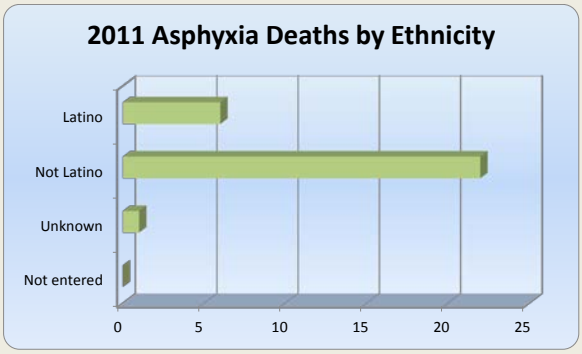
Gender	Total
Male	18
Female	11
Unknown	0
Not Entered	0



Findings:

- Over 60% (18 of 29) of asphyxia deaths in 2011 occurred among males. This is a consistent with prior years' data, which typically demonstrates a higher rate of asphyxia deaths among males.





Race Group	Total	Race Group	Total
White	16	**American Indian**	1
African American	7	**Alaskan Native**	0
Asian	0	**Multi-racial**	0
Native Hawaiian	0	**Unknown**	1
Pacific Islander	4	**Not entered**	0

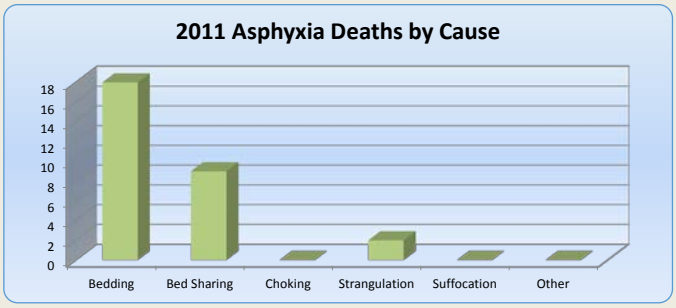
Ethnicity	Total	Ethnicity	Total
Latino	6	**Unknown**	1
Not Latino	22	**Not entered**	0

Findings:

- Approximately 24% (7 of 29) of asphyxia deaths in 2011 occurred among African Americans. This considerably higher than the statewide population distribution for African Americans at 8.3%, and suggests that African-American families may benefit from increased prevention efforts related to asphyxia dangers in the home.
- Approximately 21% (6 of 29) of asphyxia deaths in 2011 occurred among Hispanics and Latinos. This is lower than the statewide population distribution for Hispanics and Latinos at 38.3%.

Contributing Factors

Cause	Total
Bedding	18
Bed sharing	9
Choking	0
Strangulation	2
Suffocation	0
Other	0



Findings:

- 93% (27 of 29) of asphyxia deaths in 2011 were caused by unsafe sleeping environments due to excessive bedding, wedging, or adults/children sharing a bed with children, which can result in rolling over or onto the child and causing suffocation (overlay). 62% (18 of 29) of these unsafe sleeping deaths were caused by excessive bedding, inappropriate bedding, or objects placed with children in their sleeping environment. 31% (9 of 29) of these unsafe sleeping deaths were caused by adults or children sharing a bed with children.

Unsafe Sleeping Death Risk Factors

More than one cause may apply to more than one case, therefore total causes exceed the total of 29 asphyxia cases reviewed.

Factor	Total
Child put to sleep in an adult bed	12
Child put to sleep in a carseat	1
Child put to sleep on a couch	3
Child put to sleep on the floor	1
Child put to sleep on stomach	7
Child found with blanket	3
Child found with pillow	4
Child found with comforter	1
Child found with bumper pads	2
Child sharing a bed with another adult	7
Child sharing a bed with another child	2
Child sharing a bed with an animal	0

Other Asphyxia Death Detail

Detail	Total
Strangulation: Airway cutoff	1
Strangulation: Accidental hanging	1

Related Public Awareness Efforts by the Executive Committee

Starting in SFY 2007, the Executive Committee contributed funding to the printing of bilingual brochures intended to educate parents of newborn infants and young children about safe sleeping environments. These were distributed to 30 hospitals statewide for inclusion in new birth packets and/or distribution through labor and delivery units. During SFY 2009, distribution was expanded to child welfare agencies and foster parents, as well as Family Resource Centers, Family-to-Family programs, and Women, Infants, and Children (WIC) Offices statewide. The safe sleeping brochure is also available through partner websites.

During SFY 2010, the Executive Committee contributed funding to a *Cribs for Kids* pilot project through the Nevada State Health Division, which worked in partnership with the WIC Program, Washoe County Health District (WCHD), and St. Mary's Hospital. Safe Kids Washoe County, a chapter of the national Safe Kids prevention group, was accepted as the provider for the related curriculum training curriculum. The goal was to provide new moms with pack-and-play cribs and information on safe sleeping for new babies, along with SIDS prevention.

During SFY 2011, the Executive Committee partnered with Immunize Nevada to include a variety of prevention materials in new-baby information packets distributed through hospitals statewide. These packets included the existing safe sleeping brochure, along with a bilingual choking prevention brochure developed in partnership with DCFS.

During SFY 2012, the Executive Committee partnered with Safe Kids Washoe County and the Nevada State Health Division to revise the safe sleeping brochure in order to update portions of the information provided, and bring the brochure into alignment with the national model provided by Safe Kids. Distribution to hospitals will continue based on the existing partnership with Immunize Nevada, which provides new-baby information packets to hospitals statewide, as well as through the expanded *Cribs for Kids* program being implemented by Safe Kids Washoe County.

Additionally, the Executive Committee funded a safe sleep campaign through the Washoe County Department of Social Services (WCDSS). This campaign included instructional messages delivered through an existing volunteer program, billboards focused on the prevention of bed sharing, printing and distribution of informational materials, and the provision of cribs for low-income families.

During SFY 2013, the Executive Committee continued funding the inclusion of the updated safe sleeping brochure in new-baby information packets distributed through hospitals statewide, through the partnership with Immunize Nevada.

During SFY 2014, the Executive Committee partnered again with Safe Kids Washoe County to support the ongoing *Cribs for Kids* program, which targets underserved communities through a comprehensive educational campaign that promotes healthy sleep conditions for infants. This includes three primary components:

1. A Train-the-Trainer program with partner agencies that provides direct education on SIDS and safe sleep information to clients, families, and caregivers.
2. Targeting families who would not have a safe sleep environment to assist them with a Safe Sleep Survival Kit, which includes a portable crib, a sleep sack, a fitted crib sheet, a pacifier, and additional educational materials.
3. Collaborative efforts to create a larger professional and public awareness and education campaign to serve the Nevada community.

Review: Undetermined Deaths

Although a coroner or medical examiner may conclude that the manner of death is undetermined in some cases, the reviews completed by the regional CDR teams may result in the classification of a cause of death based on the additional case details obtained by the team and/or the consensus of the multidisciplinary partners. This difference of opinion regarding cause of death is expected given the multidisciplinary approach to death reviews implemented by the regional CDR teams.

There were a total of 24 deaths with an undetermined manner reviewed in 2011. As noted above, 16 of these were likely asphyxia deaths related to unsafe sleeping environments. The remaining 8 deaths have likely causes as follows:

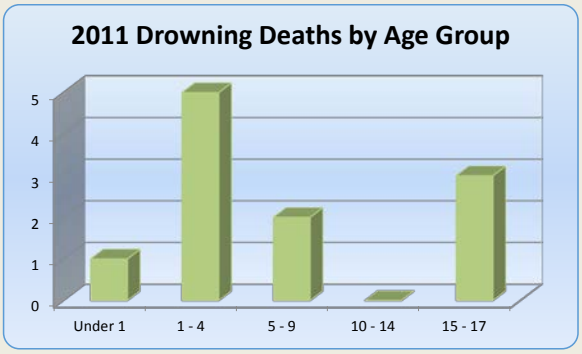
Manner	Likely Cause	Detail	Total
Undetermined	Asphyxia related to bed sharing or unsafe sleep environments	Outlined above	16
Undetermined	Suicide	-	1
Undetermined	Sudden Unexplained Infant Death (SUID)	-	1
Undetermined	Sudden Infant Death Syndrome (SIDS)	-	1
Undetermined	Undetermined	-	5

Review: Accidents Involving Drowning

In addition to the 10 accidental drowning deaths that occurred in 2011, this section includes a homicide by drowning, which is also included in the homicide review section.

Reviewed by Team	Total	County of Residence	Total
Carson	2	**Carson**	2
Clark	8	**Clark**	8
Elko	0	**Nye**	1
Fallon	0	**Out-of-state**	0
Pahrump	1	**Not entered**	0
Washoe	0		
TOTAL:	11	**TOTAL:**	11

Basic Demographics

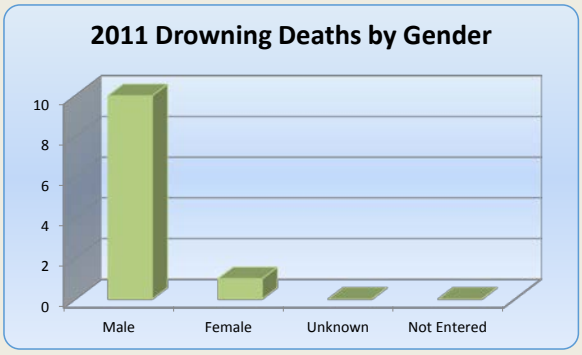


Age Group	Total
Under 1	1
1 - 4	5
5 - 9	2
10 - 14	0
15 - 17	3

Findings:

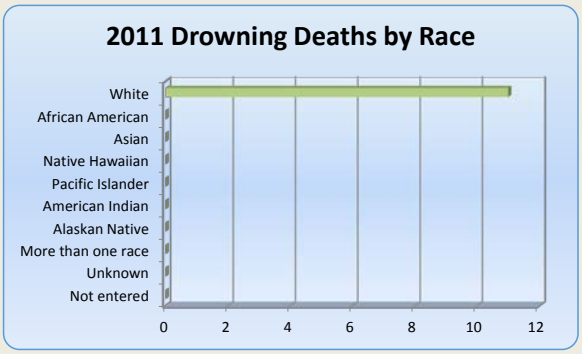
- 45% (5 of 11) of all drownings in 2011 occurred among children 1 to 4 years of age. This underscores the importance of public awareness efforts regarding pool and water safety for parents and other caregivers with young children.

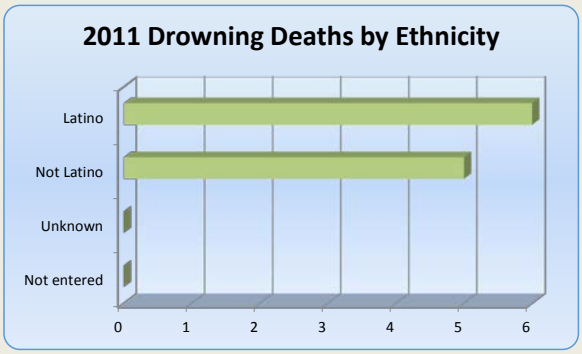
Gender	Total
Male	10
Female	1
Unknown	0
Not Entered	0



Findings:

- Almost all drownings in 2011 occurred among males. This is consistent with prior years' data, which shows that males are more likely to die by drowning than females.





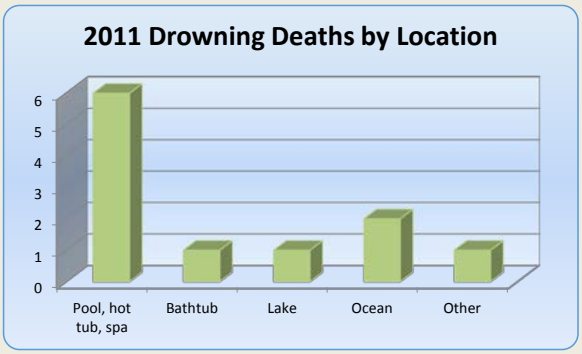
Race Group	Total	Race Group	Total
White	11	**American Indian**	0
African American	0	**Alaskan Native**	0
Asian	0	**Multi-racial**	0
Native Hawaiian	0	**Unknown**	0
Pacific Islander	0	**Not entered**	0

Ethnicity	Total	Ethnicity	Total
Latino	6	**Unknown**	0
Not Latino	5	**Not entered**	0

Findings:

- Over half of drownings in 2011 occurred among Latinos. This is consistent with data from the Southern Nevada Health District (SNHD), which shows increased drowning incidents within the Latino Community. This is being addressed directly by current prevention campaigns, detailed at the end of this section.

Location of Drowning



Location	Total
Pool, hot tub, spa	6
Bathtub	1
Lake	1
Ocean	2
Other	1

Findings:

- Most drownings occur in man-made swimming locations such as a pool, hot tub, or spa. This is consistent with prior years' data and again underscores the importance of public awareness efforts regarding pool and water safety for parents and other caregivers with young children.

Contributing Factors

Safety Factors

Factor	Total
Child was able to swim	3
Child was not able to swim	7
Child's swimming ability was unknown	0
Child's swimming ability was not entered	1
Child had a personal flotation device	0
No barriers to swimming area	5
Fence around swimming area	2
Gate to swimming area	3
Door to swimming area	4
Alarm for swimming area	1
Cover for swimming pool, hot tub, or spa	0

Safety Breaches

Breach	Total
No barrier breached	3
Gate left open	1
Gate unlocked	2
Gate latch failed	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	3
Door unlocked	1
Door broken	0
Door screen torn	0
Door closer failed	0
Window left open	0
Alarm not working	0
Alarm not answered	0
Cover left off	0
Cover not locked	0

Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee contributed funding to the production of 10,000 refrigerator magnets intended to educate parents and caregivers about water and pool safety as part of drowning prevention efforts. These were distributed along with brochures printed courtesy of the Southern Nevada Health District (SNHD). In the southern region, about 6,000 magnets were distributed through the Association of Pool and Spa Professionals (APSP) to businesses who are members of the group. These businesses were then able to distribute the magnets to pool and spa consumers. In the northern region, about 4,000 magnets were distributed as part of the Reno River Festival, a 3-day event held at the Truckee River in Downtown Reno. Additionally, the magnets were included in a direct mail to 800 child care facilities statewide, done in partnership with the Children's Trust Fund (CTF). The prevention message printed on the magnets focused on the *ABCDs of Drowning Prevention* campaign developed by SNHD: www.gethealthyclarkcounty.org/be-safe/drowning-prevention-abcd.php

During SFY 2011, a revised bilingual drowning brochure was developed by the Executive Committee in partnership with DCFS, which is based on the *ABCDs of Drowning Prevention* campaign. This brochure was distributed statewide through the new-baby information packets produced by Immunize Nevada.

During SFY 2012, the Executive Committee awarded funds directly to SNHD to update the *ABCDs of Drowning Prevention* brochure to comply with the federal Virginia Graeme Baker Law, and to complete translation of the updated brochure into Spanish. An updated refrigerator magnet was also developed and distributed through the Southern Nevada Child Drowning Prevention Coalition. Additionally, production was completed for a 30-second Spanish-language public service announcement to be broadcast through regional Spanish television stations.

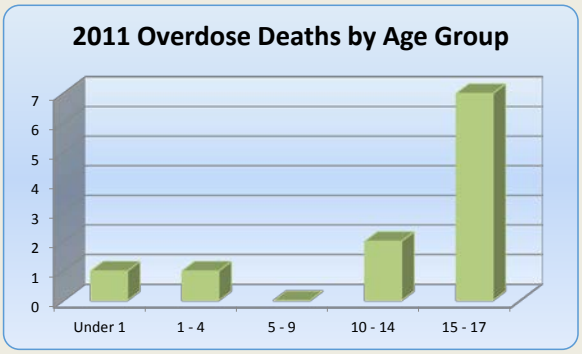
During SFY 2013, the Executive Committee awarded funds directly to SNHD again to print additional copies of the *ABCDs of Drowning Prevention* brochure in Spanish based on high demand. A Water Watcher Card project was implemented that identified and promoted responsibility among adults who agree to supervise children while swimming. Additional broadcast time was purchased for the 30-second Spanish-language public service announcement completed during the SFY 2012 grant cycle.

During SFY 2014, the Executive Committee awarded funds directly to SNHD again to develop an *ABCDs of Drowning Prevention* hand fan in Spanish. This specialized approach resulted from focus groups which indicated that a useful item repeatedly used in warm weather, like a hand fan, would likely increase impressions of the prevention message. Also, more media time was purchased to continue broadcast of the 30-second Spanish-language public service announcement, to be distributed through regional Spanish television stations. Additionally, the Executive Committee awarded funds directly to the Southern Nevada Child Drowning Prevention Coalition (SNCDPC) to print bilingual brochures and posters with drowning prevention messages, to be distributed at public events, businesses, and doctors' offices in the southern region.

Review: Accidents Involving Drug Overdose

Reviewed by Team	Total	County of Residence	Total
Carson	0	**Clark**	7
Clark	7	**Washoe**	4
Elko	0	**Out-of-state**	0
Fallon	0	**Not entered**	0
Pahrump	0		
Washoe	4		
TOTAL:	11	**TOTAL:**	11

Basic Demographics

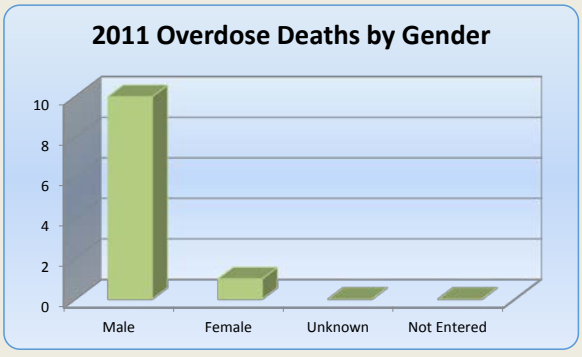


Age Group	Total
Under 1	1
1 - 4	1
5 - 9	0
10 - 14	2
15 - 17	7

Findings:

- All self-administered overdose deaths in 2011 occurred among older youth and teens in the 10 – 14 and 15 to 17 age groups. This underscores the high risk posed to teens through excessive use of alcohol and other drugs.
- Two deaths occurred among children in the under 1 and 1 – 4 age groups. In these cases, excessive or improper medication was administered by caregivers.

Gender	Total
Male	10
Female	1
Unknown	0
Not Entered	0



Findings:

- Almost all self-administered overdose deaths in 2011 occurred among males. This is consistent with prior years' data and suggests that males are at greater risk of drug overdose.

Drug Types

For decedents with a known history of drug use, following are the types of drugs known to be previously used:

Drug	Total
Child had a history of substance abuse	8
Alcohol	5
Cocaine	0
Marijuana	5
Methamphetamines	1
Opiates	3
Prescription drugs	5
Over-the-counter (OTC) drugs	1
Other drugs	3

Findings:

- More than half (5 of 9) of adolescents involved in self-administered overdose deaths in 2011 had a history of abusing prescription drugs. This underscores the importance of restricting access to prescription drugs in the home.

Contributing Factors

Prescription/OTC Drug Access

Factor	Total
Drugs were stored in an open cabinet	0
Drugs were stored in an open area	1
Drugs were stored in other accessible areas	3
Prescription antidepressants involved in death	1
Prescription pain killers involved in death	7
Over-the-counter cough medicine involved in death	1
Over-the-counter pain medicine involved in death	1
Alcohol involved in death	1
Other substance involved in death	1

Findings:

- 77% (7 of 9) self-administered overdose deaths in 2011 involved the use of prescription pain killers. This underscores the importance of restricting access to prescription drugs in the home.

Mental Health and Disability

Factor	Total
Child had a prior disability or chronic illness	4
Prior disability was physical	3
Prior disability was mental	1
Prior disability was sensory	0

Prior disability was unknown	0
Child received prior mental health services	2
Child was receiving current mental health services	2
Child was on medications for mental illness	2
Issues prevented child receiving mental health services	0

Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee contributed funding to a collaboration between CAN Prevent and Join Together Northern Nevada (JTNN) to produce 10,000 magnets focused on the *I Am One of Many* campaign. JTNN sponsored a prescription drug roundup event during 2010 that resulted in the return of over 95,000 un-used prescription pills. Additionally, CAN Prevent and JTNN partnered to broadcast movie theater and radio public service announcements (PSAs) about the risks of drug overdose. A total of approximately 160,000 message impressions were made through the movie theater ads, and approximately 260,000 impressions through radio PSAs.

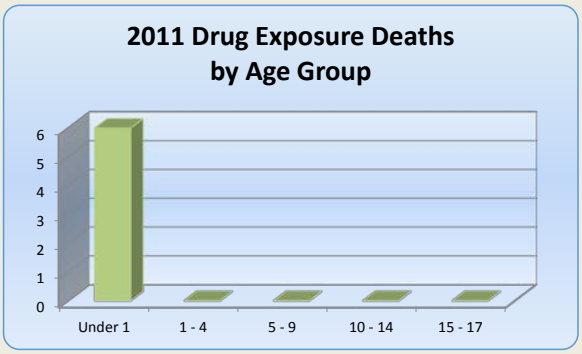
During SFY 2011, a revised medication safety brochure was developed by the Executive Committee in partnership with DCFS, which is based on drug safety information published by the Centers for Disease Control and Prevention (CDC). This brochure was distributed statewide through the new-baby information packets produced by Immunize Nevada through SFY 2013.

Review: Accidents Involving Drug Exposed Infants

This section focuses on drug related deaths among young children where maternal drug use was a primary or likely factor. In addition to deaths determined to be accidental based on manner of death, this section of the report includes 4 natural deaths with circumstances indicating that these deaths involved infant drug exposure. This determination was made during analysis completed for this report.

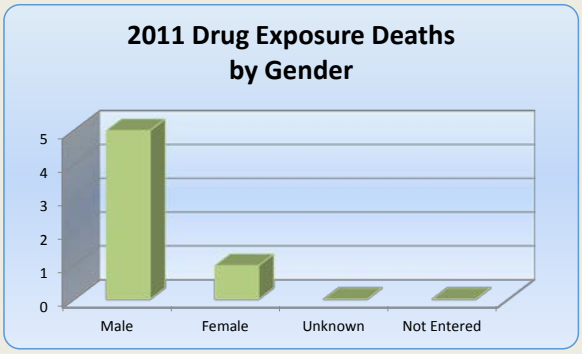
Reviewed by Team	Total	County of Residence	Total
Carson	0	**Clark**	4
Clark	4	**Elko**	1
Elko	1	**Washoe**	1
Fallon	0	**Out-of-state**	0
Pahrump	0	**Not entered**	0
Washoe	1		
TOTAL:	6	**TOTAL:**	6

Basic Demographics



Age Group	Total
Under 1	6
1 - 4	0
5 - 9	0
10 - 14	0
15 - 17	0

Gender	Total
Male	5
Female	1
Unknown	0
Not Entered	0



Findings:

- All infants who died from drug exposure in 2011 were less than one year of age.
- Almost all (5 of 6) drug exposure deaths in 2011 were among males.

Maternal Risk Factors

Prior to Pregnancy

Factor	Total
Mother had a history of drug abuse	5
Drug abuse included alcohol	1
Drug abuse included cocaine	0
Drug abuse included marijuana	2
Drug abuse included methamphetamines	2
Drug abuse included opiates	0
Drug abuse included prescription drugs	1
Mother was prior victim of child maltreatment	0
Mother was a prior perpetrator of child maltreatment	3
Mother's history included a prior child death	0

During Pregnancy

Factor	Total
Mother smoked during pregnancy	2
Mother engaged in heavy alcohol use during pregnancy	0
Mother misused over-the-counter drugs during pregnancy	2
Mother used illegal drugs during pregnancy	4

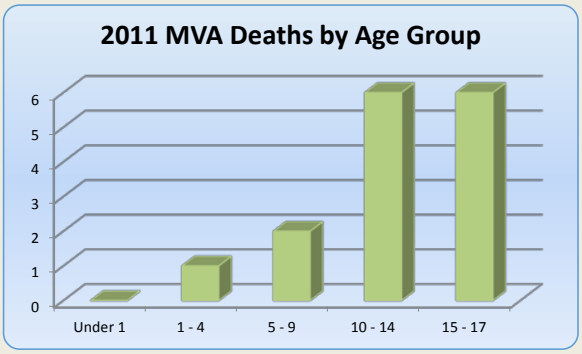
Drug Exposure

Factor	Total
Toxicology screen was completed on child	3
Child tested positive for alcohol	0
Child tested positive for cocaine	0
Child tested positive for marijuana	0
Child tested positive for methamphetamines	1
Child tested positive for opiates	0
Child tested positive for prescription drugs	0
Child tested positive for other drugs	1

Review: Motor Vehicle Accidents (MVA)

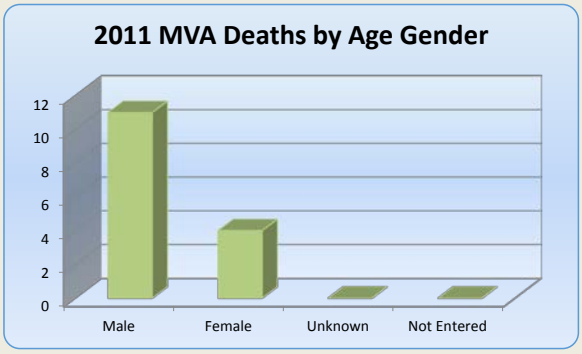
Reviewed by Team	Total	County of Residence	Total
Carson	3	Churchill	1
Clark	9	Clark	6
Elko	0	Douglas	2
Fallon	1	Washoe	1
Pahrump	1	Out-of-state	5
Washoe	1	Not entered	0
TOTAL:	15	TOTAL:	15

Basic Demographics



Age Group	Total
Under 1	0
1 - 4	1
5 - 9	2
10 - 14	6
15 - 17	6

Gender	Total
Male	11
Female	4
Unknown	0
Not Entered	0



Findings:

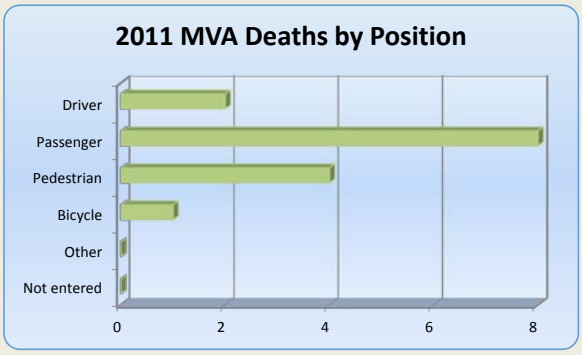
- Consistent with national data, the risk of death from MVA generally increases with age for children in Nevada. [23]
- Teens are at the greatest risk of MVA deaths.
- In 2011 cases reviewed, male deaths from MVA (11) are almost three times that of females (4). This consistent with national data, which shows that males typically die at more than twice the rate of females in motor vehicle accidents across the lifespan (18.8 per 100,000 versus 7.3 per 100,000). [24]

[23] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 20, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

[24] National Center for Health Statistics. (2012). *Health, United States, 2011, With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: National Center for Health Statistics.

Position of Child in Accident

Position	Total
Driver	2
Passenger	8
Pedestrian	4
Bicycle	1
Other	0
Not entered	0



Findings:

- 53% (8 of 15) of children who died in motor vehicle accidents were passengers in vehicles.
- Of the 8 passengers, 4 were in cars, 2 were in sport utility vehicles, and 2 were in trucks.
- Of the 2 drivers, 1 was driving a dirt bike and 1 was driving a go-cart.

Position of Child by Age Group

Age Group	Driver	Passenger	Pedestrian	On Bicycle	Unknown	Not Entered	Total
Less than 1	0	0	0	0	0	0	0
1 – 4	0	1	0	0	0	0	1
5 – 9	0	1	1	0	0	0	2
10 – 14	2	3	1	0	0	0	6
15 – 17	0	3	2	1	0	0	6
TOTAL:	2	8	4	1	0	0	15

Findings:

- 75% of passenger deaths (6 of 8) in 2011 occurred in the 10 – 14 and 15 – 17 age groups.

Contributing Factors

Causes of Accidents for All Cases

More than one cause may apply to more than one case, therefore total causes exceed the total of cases reviewed.

Cause	Total	Cause	Total
Speeding over limit	5	**Medical event**	0
Unsafe speed for conditions	1	**Back over**	0
Recklessness	2	**Rollover**	2
Ran stop sign/red light	0	**Poor sightline**	1
Driver distraction	1	**Car changing lanes**	1

Cause	Total	Cause	Total
Inexperienced driver	0	Road hazard	0
Mechanical failure	0	Animal in road	0
Poor tires	1	Cell phone use while driving	0
Poor weather	0	Racing	0
Poor visibility	2	Other driver error	1
Drug or alcohol use	6	Other cause	3
Fatigue/sleeping	0	Unknown	0

Causes of Accidents When Child Was Responsible for Accident

Cause	Total
Child responsible for causing accident	2
Child was alcohol or drug impaired	0
Child had no license	1
Child had a learners permit	0
Child had a graduated license	0
Child had full license, not graduated	0
Child had a full license, restricted	0
Child had suspended license	0
If recreational vehicle, child had driver safety certificate	0
Child was violating graduated license rules	0

Causes of Accidents When Child's Driver Was Responsible for Accident

Cause	Total
Child's driver responsible for accident	7
Child's driver was alcohol or drug impaired	4
Child's driver had no license	1
Child's driver had a learners permit	0
Child's driver had a graduated license	0
Child's driver had full license, not graduated	5
Child's driver had full license, restricted	0
Child's driver had suspended license	0
If recreational vehicle, child's driver had driver safety certificate	0
Child's driver was violating graduated license rules	0

Causes of Accidents When Another Driver Was Responsible for Accident

Cause	Total
Another driver responsible for accident	2
Another driver was alcohol or drug impaired	2
Another driver had no license	0
Another driver had a learners permit	0
Another driver had a graduated license	0

Cause	Total
Another driver had a full license, not graduated	2
Another driver had full license, restricted	0
Another driver had suspended license	0
If recreational vehicle, other driver had driver safety certificate	0
Another driver was violating graduated license rules	0

Related Public Awareness Efforts by the Executive Committee

Traffic safety campaigns, including child seat safety, are managed and implemented by the Nevada Department of Public Safety (DPS) through the Office of Traffic Safety (OTS). In general, the Executive Committee avoids duplication of effort when other state or county agencies have well-established campaigns in place for safety and child death prevention.

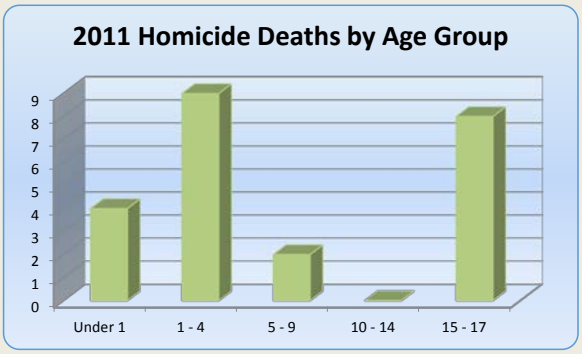
During SFY 2013, the Executive Committee provided funds to support the purchase of computer equipment used as part of the Driving Responsibly Includes Vehicle Education (DRIVE) training program implemented by DPS. This program is currently offered in rural areas including Douglas County, Carson City, Fernley, and the Fallon Juvenile courts. The program also expanded into Washoe County during SFY 2013.

During SFY 2014, the Executive Committee again provided funds to support the purchase of computer equipment used as part of the DRIVE training program implemented by DPS. This program continues to be offered in rural areas and Washoe County, and is planned to expand into Clark County during SFY 2014.

Review: Homicides

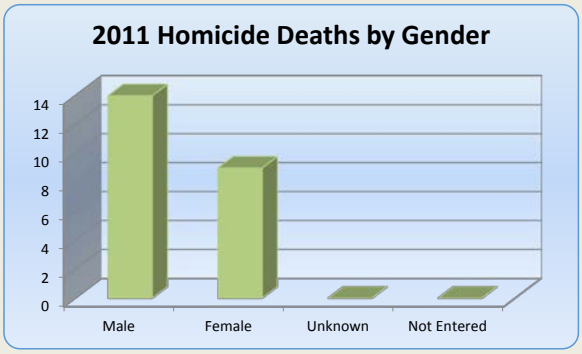
Reviewed by Team	Total	County of Residence	Total
Carson	0	Clark	17
Clark	19	Washoe	4
Elko	0	Out-of-state	2
Fallon	0	Not entered	0
Pahrump	0		
Washoe	4		
TOTAL:	23	TOTAL:	23

Basic Demographics



Age Group	Total
Under 1	4
1 - 4	9
5 - 9	2
10 - 14	0
15 - 17	8

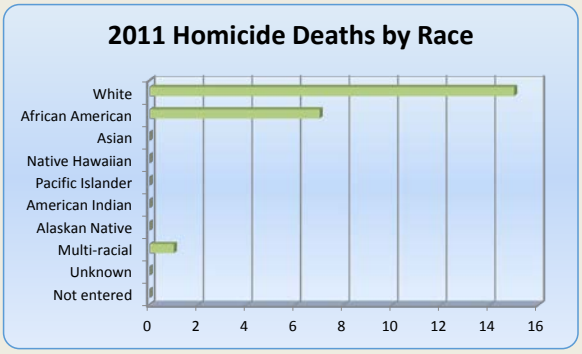
Gender	Total
Male	14
Female	9
Unknown	0
Not Entered	0

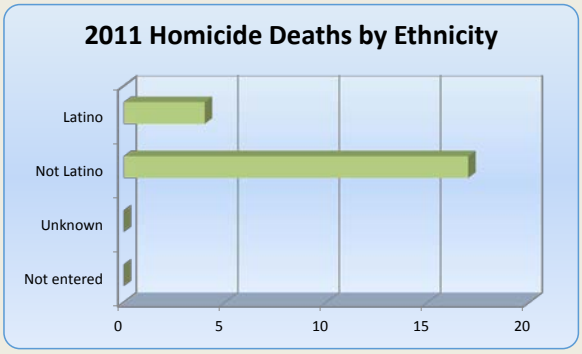


Findings:

- More than half (13 of 23) of homicide deaths in 2011 occurred among infants and children less than five years of age. Almost all of these deaths were caused by child abuse or neglect, and are reviewed in more detail below.
- Almost 35% (8 of 23) of homicide deaths in 2011 occurred among adolescents ages 15 to 17.
- 61% (14 of 23) of homicide deaths in 2011 occurred among males. This is consistent with national data that shows male homicide death rates are nearly four times that of females across the lifespan (9.3 per 100,000 versus 2.4 per 100,000).[25]

[25] National Center for Health Statistics. (2012). *Health, United States, 2011, With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: National Center for Health Statistics.





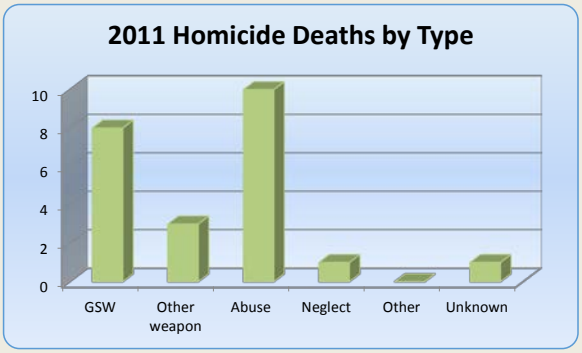
Race Group	Total	Race Group	Total
White	15	**American Indian**	0
African American	7	**Alaskan Native**	0
Asian	1	**Multi-racial**	0
Native Hawaiian	0	**Unknown**	0
Pacific Islander	0	**Not entered**	0

Ethnicity	Total	Ethnicity	Total
Latino	7	**Unknown**	0
Not Latino	16	**Not entered**	0

Findings:

- 30% (7 of 23) of homicide deaths in 2011 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%.
- Approximately 30% (7 of 23) of homicide deaths in 2011 occurred among Hispanics and Latinos. This is lower than the statewide population distribution for Hispanics and Latinos at 37.8%, and marks a change from prior years where homicide deaths among Latinos were disproportionately higher.

Homicides by Type



Type	Total
Gunshot wounds	8
Other weapon	3
Abuse	10
Neglect	1
Other	0
Unknown	1

Findings:

- Almost half (11 of 23) of homicide deaths in 2011 were cause by abuse or neglect. Abuse and neglect deaths are reviewed in the next section of this report.
- 35% (8 of 23) of homicide deaths in 2011 were caused by gunshot wounds (GSW). Additional information on GSW deaths is provided below.

Homicides by Gunshot Wound (GSW)

Most homicide deaths by gunshot wound in 2011 occurred among the 15 – 17 age group. This is consistent with national data, which shows that deaths from firearm-related injuries increase considerably in the 15 – 19 age group.[26] [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

GSW Deaths: Incident Detail

Detail	Total
Person handling fatal weapon was the decedent (self)	0
Person handling fatal weapon was a biological parent	0
Person handling fatal weapon was the mother's partner	0
Person handling fatal weapon was another relative	1
Person handling fatal weapon was a friend	0
Person handling fatal weapon was a rival gang member	2
Person handling fatal weapon was a stranger	1
Person handling fatal weapon was other	1

GSW Deaths: Criminal Activity Detail

Detail	Total
Use of fatal weapon involved commission of a crime	1
Use of fatal weapon involved a drive-by shooting	1
Use of fatal weapon involved child as a bystander	2
Use of fatal weapon involved an argument	1
Use of fatal weapon involved a hate crime	0
Use of fatal weapon involved target shooting	1
Use of fatal weapon involved playing with the gun	0
Use of fatal weapon involved weapon mistaken for toy	1
Use of fatal weapon involved showing the gun to others	1
Use of fatal weapon involved gang-related activity	3
Use of fatal weapon involved decedent assisting crime victim	1

[26] National Center for Health Statistics. (2012). *Health, United States, 2011, With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: National Center for Health Statistics.

Related Public Awareness Efforts by the Executive Committee

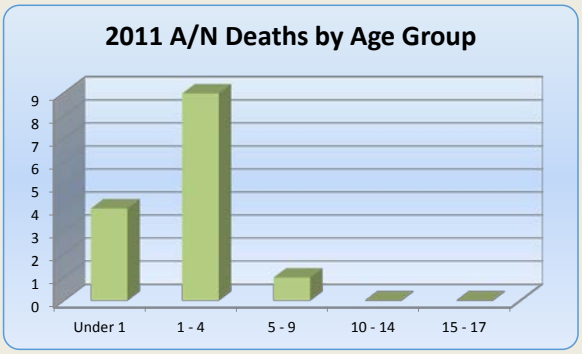
During SFY 2010, the Executive Committee funded the placement of gunshot wound prevention information on eight billboards statewide: 1 in Elko, 1 in Ely, 2 in Reno, and 4 in Las Vegas. The prevention message was based on the *Bullets Leave Holes* campaign formerly developed in Illinois. The billboard messages were contracted for a minimum of 30 days, which resulted in approximately 70,000 exposures per day in Las Vegas, and approximately 40,000 exposures per day in Reno.

During SFY 2011, the Executive Committee partnered with Immunize Nevada to include a variety of prevention materials in new-baby information packets distributed through hospitals statewide. These packets included a bilingual firearm safety brochure developed in partnership with DCFS.

Review: Deaths Caused by Abuse, Neglect, and Other Negligence

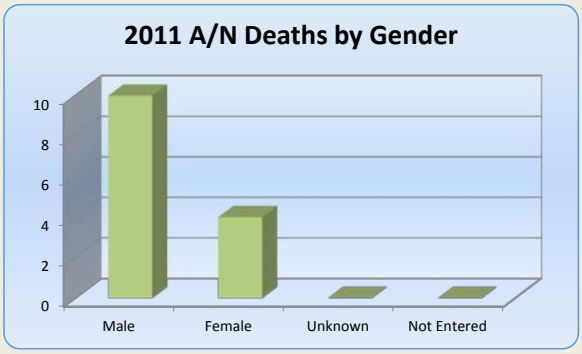
Reviewed by Team	Total	County of Residence	Total
Carson	0	Clark	12
Clark	12	Washoe	2
Elko	0	Out-of-state	0
Fallon	0	Not entered	0
Pahrump	0		
Washoe	2		
TOTAL:	14	TOTAL:	14

Basic Demographics



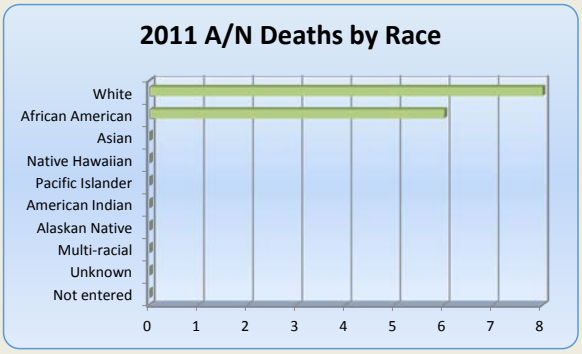
Age Group	Total
Under 1	4
1 - 4	9
5 - 9	1
10 - 14	0
15 - 17	0

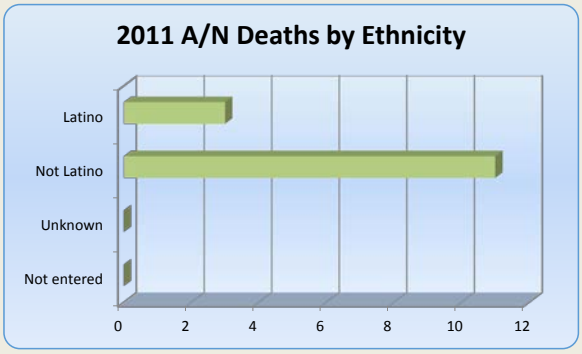
Gender	Total
Male	10
Female	4
Unknown	0
Not Entered	0



Findings:

- 93% (13 of 14) of deaths caused by abuse and neglect occurred among infants and children less than five years of age.
- 71% (10 of 14) of deaths caused by abuse and neglect occurred among males. This is consistent with prior years' data, which shows a higher rate of abuse/neglect deaths among males.





Race Group	Total	Race Group	Total
White	8	**American Indian**	0
African American	6	**Alaskan Native**	0
Asian	0	**Multi-racial**	0
Native Hawaiian	0	**Unknown**	0
Pacific Islander	0	**Not entered**	0

Ethnicity	Total	Ethnicity	Total
Latino	3	**Unknown**	0
Not Latino	11	**Not entered**	0

Findings:

- 43% (6 of 14) of deaths caused by abuse and neglect occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%.

Deaths by Cause

Abuse

Of the 11 deaths caused by abuse, 10 were homicides and 1 was an accidental overdose involving improper medication administered by the child's caregiver.

Neglect

Of the 3 deaths caused by neglect, 1 was a homicide, 1 was an accidental drowning, and 1 was undetermined. For the accidental drowning, family members were present but apparently distracted from supervision. For the undetermined death, this resulted from apparent medical neglect.

Contributing Factors

These contributing factors apply only to cases of direct abuse and neglect, not other negligence.

Type of Abuse or Neglect

Type of Abuse	Case Total
Physical abuse	11
Emotional abuse	0
Sexual abuse	0
Abusive head trauma	8
Chronic battered child syndrome	1
Beating/kicking	2
Scalding/burning	0
Munchausen syndrome by proxy	0
Other physical abuse	1
Unknown physical abuse	0

Triggering Events

Trigger	Case Total
Crying	1
Toilet training problem	0
Disobedience	2
Feeding problems	0
Domestic argument	0
Failure to protect child from hazards	4
Failure to provide child necessities	0
Failure to provide child necessities – food	0
Failure to provide child necessities – shelter	0
Other negligence	0
No triggering event	0
Other triggering event	3
Unknown triggering event	7
Not entered	0

Term of Abuse or Neglect

Term	Case Total
Chronic with child	0
Pattern in family or with perpetrator	5
Isolated incident	6
Unknown	3
Not entered	0

Prior Abuse or Neglect

Factor	Case Total
Child had a history of physical maltreatment	4
Child had a history of neglect	3
Child had a history of sexual maltreatment	0
Child had a history of emotional maltreatment	1
Unknown	0
Not entered	0

Drug or Alcohol Exposure

Factor	Case Total
Toxicology screen completed	3
Toxicology screen outcome: positive	0
Toxicology screen outcome: negative	3

CPS Involvement

Factor	Case Total
CPS record check conducted	9
Evidence of prior abuse	3
CPS action taken as a result of the death	7
Open CPS case on child at time of death	1
Was the child ever placed in foster care?	2

Abusive Head Trauma

In 2011, 8 of 11 homicide cases where children died from abuse included the discovery of abusive head injuries, and 2 of these cases were reported to involve shaking. These deaths highlight the importance of public awareness campaigns and other prevention activities related to Shaken Baby Syndrome (SBS).

Factor	Case Total
For abusive head trauma, were there retinal hemorrhages?	2
For abusive head trauma, was the child shaken?	2
If the child was shaken, was there impact?	0

Related Public Awareness Efforts by the Executive Committee

Primary prevention efforts for deaths caused by abuse and neglect are undertaken by the Nevada Children's Trust Fund (CTF), which engages in annual public awareness and prevention campaigns.

During SFY 2012, the Executive Committee provided funds to a Clark County collaborative group for the *Choose Your Partner Carefully* campaign. This campaign targeted prevention efforts based on the fact that in over half of substantiated abuse and neglect cases in Clark County, the perpetrator is identified as the primary caregiver's partner, typically the mother's boyfriend. This multimedia campaign included the printing and distribution of campaign brochures and postcards, direct dissemination of information at community events, bus stop advertisements in high-risk areas of the county, publication of web-based information resources, and distribution of an electronic newsletter to parents and professionals who work with families.

During SFY 2013, the Executive Committee provided funds again for the *Choose Your Partner Carefully* campaign, with the goals of additional expansion into Washoe County and the rural areas.

Review: Abuse and Neglect Related Deaths

In addition to deaths where abuse and neglect were the primary cause, there are other deaths where abuse and neglect contributed to the cause of death. It is useful to review these deaths to understand the impact that abuse and neglect have on child fatalities.

Related Deaths – Child Neglect

Manner	Cause	Case Total
Accident	MVA – passenger	1
Suicide	GSW	4
Undetermined	Asphyxia – bed sharing	1

Related Deaths – Other Negligence

Manner	Cause	Case Total
Suicide	Suicide – asphyxia	1
Undetermined	Asphyxia – bed sharing	1

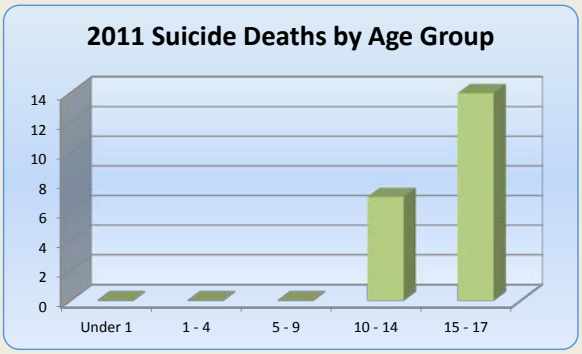
Related Deaths – Poor or Absent Supervision

Manner	Cause	Case Total
Accident	Asphyxia – bedding	2
Accident	Asphyxia – bed sharing	1
Accident	Overdose	2
Accident	MVA – pedestrian	1

Review: Suicides

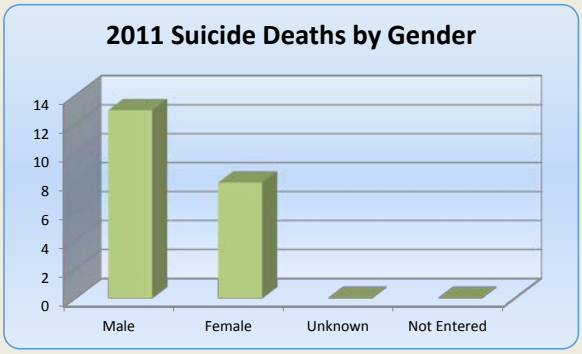
Reviewed by Team	Total	County of Residence	Total
Carson	0	**Clark**	15
Clark	16	**Washoe**	4
Elko	0	**Out-of-state**	1
Fallon	1	**Not entered**	0
Pahrump	0		
Washoe	4		
TOTAL:	21	**TOTAL:**	21

Basic Demographics



Age Group	Total
Under 1	0
1 - 4	0
5 - 9	0
10 - 14	7
15 - 17	14

Gender	Total
Male	13
Female	8
Unknown	0
Not Entered	0

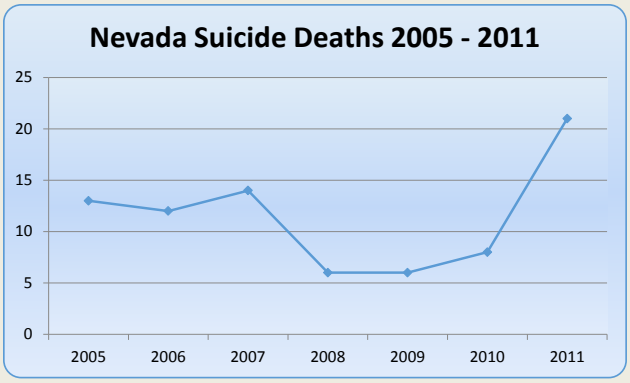


Findings:

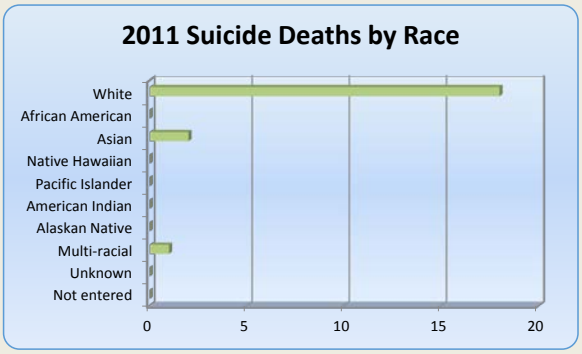
- Deaths by suicide occurred exclusively in the 10 – 14 and 15 – 17 age groups. This is consistent with national data, which shows that deaths from suicide increase considerably in the pre-teen and teen years.[27]

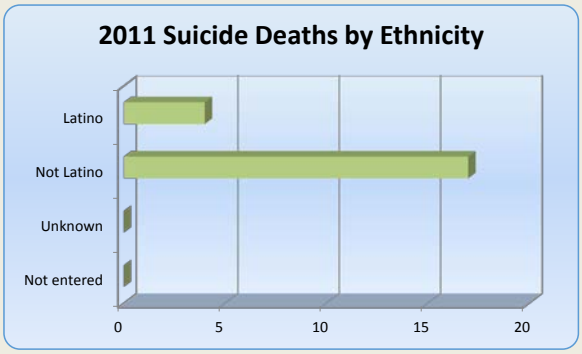
[27] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 20, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

- Deaths by suicide in Nevada demonstrated a general downward trend between 2005 and 2010, and then demonstrated a significant increase in 2011:



- Males die by suicide at a much higher rate than females. This is consistent with national data, which shows the rate of male deaths by suicide in the 15 – 19 age group at nearly four times that of females (11.6 per 100,000 population for male suicides compared with 3.1 per 100,000 for female suicides).[28] Other national research shows that adolescent males are much more likely to complete suicide, while adolescent females are much more likely to attempt suicide.[29] [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]





Race Group	Total	Race Group	Total
White	18	**American Indian**	0
African American	0	**Alaskan Native**	0
Asian	2	**Multi-racial**	1
Native Hawaiian	0	**Unknown**	0
Pacific Islander	0	**Not entered**	0

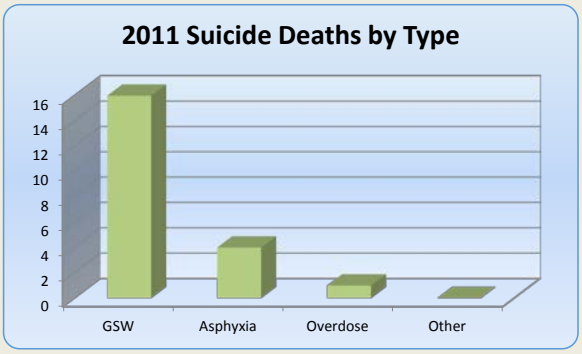
Ethnicity	Total	Ethnicity	Total
Latino	4	**Unknown**	0
Not Latino	17	**Not entered**	0

[28] National Center for Health Statistics. (2012). *Health, United States, 2011, With Special Feature on Socioeconomic Status and Health*. Hyattsville, MD: National Center for Health Statistics.
[29] National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Findings:

- Suicide occurs most frequently among whites in Nevada. This is generally consistent with national data, which shows that whites account for the second highest suicide rate within race categories.[30]
- National data shows that the highest suicide rates for both males and females are among American Indians and Alaskan Natives.[31] Given Nevada's indigenous American Indian population, the fact that there were no reported suicides among American Indians in 2011 may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported.

Suicides by Type



Type	Total
Gunshot wound (GSW)	16
Asphyxia	4
Overdose	1
Other	0

Findings:

- Gunshot wounds (GSW) were the most common method of death by suicide, accounting for 16 of 21 deaths reviewed. Asphyxia accounted for 4 deaths by suicide, and the remaining death resulted from a drug overdose. This is consistent with national suicide mechanism trends among males, which indicate that suicide by GSW is the most common method, accounting for almost half of all deaths by suicide among males in 2010.[32]

[30] National Center for Injury Prevention and Control. (2012). *Suicide Rates Among Persons Ages 10 Years and Older, by Race/Ethnicity, United States, 2005–2009*. Retrieved September 27, 2012, from: http://www.cdc.gov/violenceprevention/suicide/statistics/rates01.html.
[31] Ibid.
[32] National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System: Suicide Ages 10 – 17, All Races, Males, United States, 2010* [custom data query]. Retrieved September 27, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

Contributing Factors

More than one factor may apply to more than one case, therefore total factors exceed the total of cases reviewed.

Child History

Factor	Total
History of mental illness	3
Child previously received mental health services	8
Child was currently receiving mental health services	2
Child was taking psychotropic medications	3
History of substance abuse	3
History of homelessness	0
History of child abuse – physical	1
History of child abuse – neglect	1
History of child abuse – sexual	1
History of child abuse – emotional	0
History of child abuse – unknown	0
History of delinquent or criminal behavior	1
Child spent time in juvenile detention	0
Child was gay, lesbian, bisexual, or questioning orientation	0
Child had problems in school – academic	3
Child had problems in school – truancy	0
Child had problems in school – suspensions	1
Child had problems in school – behavioral	2
Child had problems in school – expulsion	1
Child had problems in school – other	2

Circumstances Surrounding Event

Factor	Total
Child left a note	7
Child talked about suicide	5
Prior suicide threats were made	3
Prior suicide attempts were made	4
Suicide was completely unexpected	12
Child had a history of running away	2
Child had a history of self-mutilation	4
History of suicides in family	1
Suicide was part of a murder-suicide	0
Suicide was part of a suicide pact	0
Suicide was part of a suicide cluster	0

Recent History of Personal Crisis

Factor	Number
Family discord	1
Parents divorced or separated	2
Argument with parents or caregivers	5
Argument with boyfriend or girlfriend	1
Breakup with boyfriend or girlfriend	0
Argument with other friends	2
Rumor mongering	0
Suicide by friend or relative	2
Other death of friend or relative	0
Victim of bullying	1
Perpetrator of bullying	0
School failure	3
Child entered new school	0
Other serious school problems	2
Pregnancy	1
Physical abuse or assault	0
Rape or sexual abuse	1
Problems with law enforcement	0
Problems with drugs or alcohol	2
Sexual orientation issues	1
Religious or cultural issues	0
Employment problems	0
Financial problems	0
Gambling problems	0
Involvement in cult activities	0
Involvement in computer or video gaming	0
Involvement with the Internet	1
Other crisis	4
Unknown crisis	0

Access to Lethal Means

Factor	Total
Child used a handgun	12
Child used a shotgun	3
Child had access to unsecured weapons in the home	11

CPS Involvement

Factor	Total
Open CPS case on child at time of death	0
Was the child ever placed in foster care?	1

Related Public Awareness Efforts by the Executive Committee

During SFY 2011, the Executive Committee contributed funding to the *UR Not Alone* campaign through the Nevada Office of Suicide Prevention (OSP). This innovative program enabled students in participating middle and high schools to use text messaging to obtain support and resources when they are emotionally troubled and may demonstrate suicide ideation. This campaign included printing and distribution of school participation packets, informational posters and cards placed at schools, staff engagement and orientation at schools, and development and distribution of ebulletins to lawmakers and stakeholders to promote suicide prevention awareness and funding.

During SFY 2013, the Executive Committee contributed funding to the *Reducing Access to Lethal Means* campaign through the Nevada OSP. The program focused on four key areas: 1) Building community partnerships with relevant agencies including healthcare providers, emergency department personnel, law enforcement agencies, policymakers, school administrators, legislators, heads of state agencies, and people responsible for creating statutes, rules, and regulations ensuring the health and safety of young people in order to consult on key decisions throughout the project and to partner in the development of message delivery. 2) Educating professionals about lethal means restriction and training them how to educate parents on the topic. 3) Directly educating parents on lethal means restriction and other suicide prevention techniques through community-based training sessions. 4) Supplementing project activities through a public information and media campaign focusing on lethal means restriction.

During SFY 2014, the Executive Committee contributed funding to the continuation of the *Reducing Access to Lethal Means* campaign through the Nevada OSP. The continued program focused on five updated areas: 1) Building community partnerships with relevant agencies and businesses including gun shop owners, gun ranges, gun retailers, gun distributors, gun show promoters, and gun owners; along with healthcare providers, law enforcement agencies, policy makers, school administrators, legislators, heads of state agencies, and those people responsible for creating statutes, rules, and regulations to ensure the health and safety of young people. These individuals and the organizations they represent should consult with one another on key decisions throughout the project and to partner in message delivery. 2) Discussing the movement's lethal means restriction with gun promoters, distributors, retailers, owners, buyers, gun range invitees. 3) Educating those who are in the business of selling guns, distributing guns, facilities offering firearms practice (shooting ranges), gun shows, and gun owners about lethal means restriction and training them how to educate parents on the topic. 4) Directly educating parents on lethal means restriction and other suicide prevention techniques through community-based suicide prevention training sessions. 5) Supplementing these project activities through a public information and media campaign focusing on lethal means restriction.

Review: Sudden Infant Death Syndrome (SIDS)

SIDS deaths are required to be reviewed by regional CDR teams per NRS 432B.405, and so data gathered by the regional CDR teams for this cause of death should be representative of statewide data. There were 2 SIDS death in 2011. To protect confidentiality, only limited details are provided as follows:

Basic Demographics

Age:	Under 1
Gender:	Male
Race:	White
Ethnicity:	Latino
Manner:	Natural

Age:	Under 1
Gender:	Male
Race:	Unknown
Ethnicity:	Unknown
Manner:	Undetermined

Findings:

- Conclusive statements are not appropriate for a small number of cases. However, prior years' data shows that SIDS deaths are more common among males. This is consistent with national data, which shows that males die from SIDS at a higher rate than females.[33]
- Again, conclusive statements are not appropriate for a small number of cases. However, prior years' data shows that SIDS deaths are more common among African-Americans and Latinos.

Contributing Factors

Factor	Total
Child exposed to second-hand smoke	1
Child was overheated	0
Child had a history of seizures	0
Child had a history of apnea	0

SIDS Death Sleeping Locations

Location	Total
Bassinette	0
Crib	1

[33] National Center for Injury Prevention and Control. (2011). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2010* [custom data query]. Retrieved September 27, 2012, from http://www.cdc.gov/injury/wisqars/index.html.

Mattress/Adult Bed	0
Chair	0
Couch	0
Baby swing	0
Floor	0
Unknown	0
Not entered	1

SIDS Death Sleeping Positions

Factor	Total
Child put to sleep on stomach	1
Child put to sleep on side	0
Child put to sleep on back	0
Sleep position unknown	0
Sleep position not entered	1

SIDS Death Unsafe Sleeping Risks

Factor	Total
Child found bed sharing with another adult	0
Child found bed sharing with another child	0
Child found sleeping on mattress/adult bed	0
Child found sleeping on couch	0
Child found with blanket	0
Child found with pillow	0
Child found with comforter	0
Child found with toy(s)	0
Child found with baby bottle, pacifier, and/or other items	0

Related Public Awareness Efforts by the Executive Committee

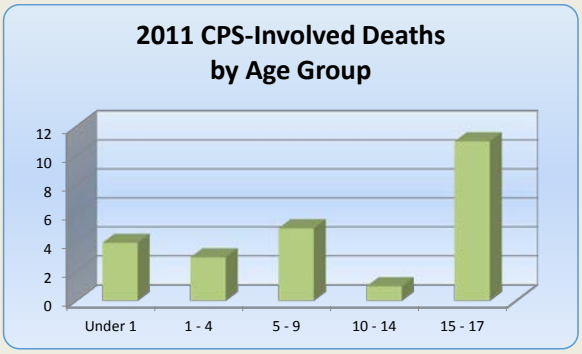
During SFY 2010, the Executive Committee contributed funding to two trainings provided by First Candle, a national organization focused on safe pregnancies and infant safety. The trainings centered on SIDS prevention and safe sleeping, with two each held in Las Vegas and Reno. The Las Vegas trainings were held at the University of Nevada, Las Vegas (UNLV) School of Social Work, and the Clark County Government Center. The Reno trainings were held at the Washoe County Department of Social Services (WCDSS) and the Washoe County Commission Chambers. Both trainings included specific outreach to pharmacists, because research shows that pharmacists are highly trusted advice-givers to consumers. Training was free to attendees and included the option for continuing education credits.

Review: Children Involved in the Child Protective Services (CPS) System

During 2011, 24 out of 337 cases reviewed included children with a current or prior child protective services (CPS) history. Of these 24 cases, 7 had an open CPS case at the time of death, and 7 were living in a foster care setting.

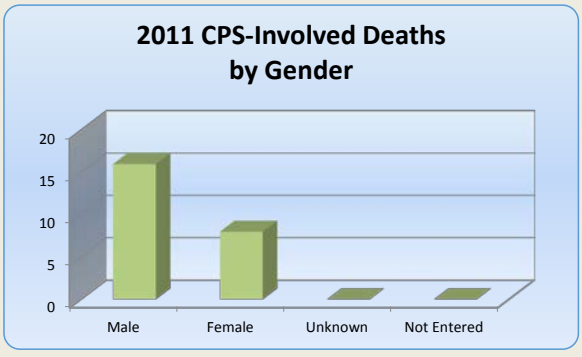
Reviewed by Team	Total	County of Residence	Total
Carson	0	**Clark**	21
Clark	21	**Elko**	1
Elko	1	**Nye**	2
Fallon	0	**Out-of-state**	0
Pahrump	2	**Not entered**	0
Washoe	0		
TOTAL:	24	**TOTAL:**	24

Basic Demographics



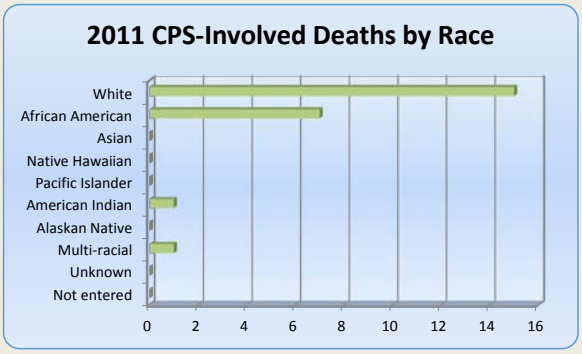
Age Group	Total
Under 1	4
1 - 4	3
5 - 9	5
10 - 14	1
15 - 17	11

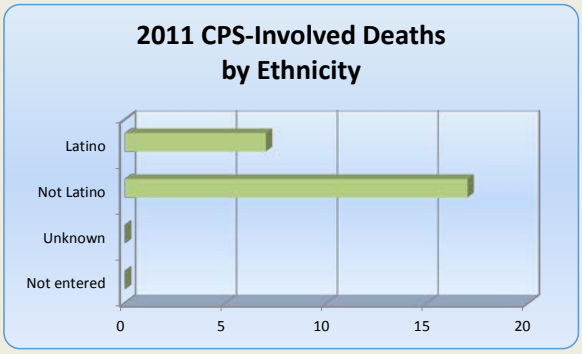
Gender	Total
Male	16
Female	8
Unknown	0
Not Entered	0



Findings:

- For children involved in the CPS system, there is a lower number of deaths among children in the under 1 and 10 -14 age groups compared with prior years' data, which typically demonstrates the u-shaped age group distribution seen in the data overview in *Section 1*.
- Twice as many (16 of 24 compared with 8 of 24) 2011 deaths of children with a current or prior CPS history occurred among males. This is consistent with data throughout this report demonstrating that males die more frequently than females.





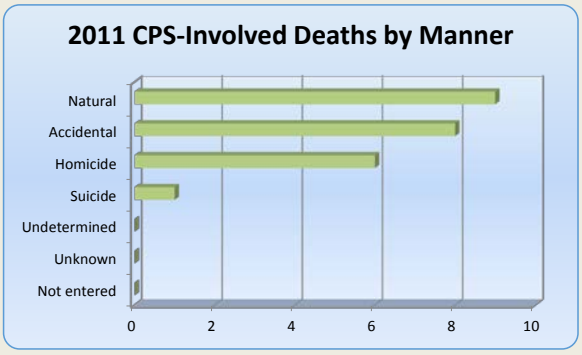
Race Group	Total	Race Group	Total
White	15	**American Indian**	1
African American	7	**Alaskan Native**	0
Asian	0	**Multi-racial**	1
Native Hawaiian	0	**Unknown**	0
Pacific Islander	0	**Not entered**	0

Ethnicity	Total	Ethnicity	Total
Latino	7	**Unknown**	0
Not Latino	17	**Not entered**	0

Findings:

- Approximately 30% (7 of 24) of 2011 deaths of children with a current or prior CPS history occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%.

Manner of Death



Manner	Total
Natural	9
Accidental	8
Homicide	6
Suicide	1
Undetermined	0
Unknown	0
Not entered	0

Findings:

- 25% (6 of 24) of 2011 deaths of children with a current or prior CPS history were homicides. This is disproportionately higher than the statewide percentage of homicides in 2011 at 6.8%. This underscores the risks faced by children with CPS involvement, whose families have become known to CPS through child safety concerns.

Appendix A: Background on Child Death Review in Nevada

The State of Nevada Division of Child and Family Services (DCFS) established the Children's Justice Act (CJA) Task Force in 1994, based on a federal mandate through the Child Abuse Prevention and Treatment Act (CAPTA). The Statewide Child Death Review (CDR) Subcommittee, operating as part of the CJA Task Force, was formed as a partnership of professionals, organizations, and agencies to coordinate the statewide activities of child welfare agencies involved in the review of child deaths. Prior to 2003, the Statewide CDR Subcommittee engaged in several core activities:

- Reviewing cases of child fatalities to gain a better understanding of the causes of child death
- Identifying patterns of abuse, neglect, and other causal factors of child death that may respond to intervention
- Collecting data and completing trends analysis surrounding child death
- Reviewing laws, policies, and practices
- Addressing statewide staff training needs
- Addressing public awareness and education needs

The primary goal of the Statewide CDR Subcommittee was to prevent future child maltreatment and deaths in Nevada by making recommendations for law, policy, and practice changes; staff training; and public education based on data from child death reviews.

During 2002, the Statewide CDR Subcommittee developed recommendations for new laws relating to child death review. A primary goal was to give the regional CDR teams a mechanism to channel recommendations to appropriate agencies and maximize community resources so that future child deaths can be prevented.

These efforts resulted in Assembly Bill (AB) 381, enacted by the 2003 Nevada State Legislature. This legislation allowed for the implementation of significant changes in the child death review process. It created a clear purpose for the regional CDR teams to review child death and make recommendations for the improvement of laws, policies, and practices; support the safety of children; and prevent future deaths. Other provisions of the legislation established the confidentiality of information obtained and reviewed by the regional teams, including protection from disclosure, subpoena, discovery, and introduction into evidence for civil or criminal proceedings.

Additionally, this bill established two statewide oversight committees: 1) the Administrative Team and 2) the Executive Committee to review the death of children. The Administrative Team reviewed reports and recommendations from the regional CDR teams and makes decisions regarding the recommendations for improvements to laws, policies, and practices. The Administrative Team also made recommendations about funding for improvements, initiatives, and public education requiring expenditures.

The Executive Committee, in turn, made decisions about funding initiatives to prevent child maltreatment and death, which were based on recommendations from the Administrative Team. Additionally, per NRS, the Executive Committee adopted statewide protocols for the review of the death of children; designated the members of the Administrative Team; oversaw training and development for the regional CDR teams; and compiled and distributes a statewide annual report. Funding for the work of the Committee was also established as a result of AB 381, and is derived from a $1 fee collected from death certificates issued by the State. The funds are intended to be used for prevention efforts and training of the regional CDR teams.

Subsequently, the 2013 Nevada State Legislature enacted AB 154, which combined the functions of the two statewide oversight committees established in 2003, leaving the Executive Committee as the active statewide oversight group. Additionally, this legislation allows for the use of de-identified, aggregate child death data for research and child death prevention purposes. In essence, the Executive Committee has taken over the functions of the original Statewide CDR

Team and the Administrative Team, and now works directly with the regional CDR teams to prevent future child deaths in Nevada.

Currently, seven regional CDR teams review local child deaths throughout the State of Nevada as follows:

1. **Clark Team**: Reviews deaths in Clark County.
2. **Southern Nevada Child Fatality Task Force**: Works in Clark County to improve the investigation of child deaths by stakeholders in the CDR process.
3. **Washoe Team**: Reviews deaths in Washoe County.
4. **Elko Team (District 1 – North)**: Reviews deaths in Elko, Eureka, Humboldt, Lander, Lincoln, and White Pine Counties.
5. **Carson Team (District 2 – West)**: Reviews deaths in Carson City, Douglas, and Storey Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Carson Team covers Stagecoach and Dayton.
6. **Fallon Team (District 3 – East)**: Reviews deaths in Churchill, Mineral, and Pershing Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Fallon Team covers Fernley, Silver Springs, and Yerington.
7. **Pahrump Team (District 4 – South)**: Reviews deaths in Esmeralda and Nye Counties.

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 4095. Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region with two exceptions: 1) The Clark Team reviews all coroner-referred child deaths with the exception of some natural death cases. Clark County accounts for approximately 72% of the state's population, and it is not feasible for the Clark Team to review all child deaths in the region because of the high caseload. 2) The Southern Nevada Child Fatality Task Force reviews only select cases in its work to improve the investigation of child deaths by stakeholders in the CDR process.

State-mandated reviews include the following:

- Reviews requested from 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 die from Sudden Infant Death Syndrome (SIDS).

In Clark County, the team meets monthly because of its high caseload. The Southern Nevada Child Fatality Task Force meets every other month. 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 may meet less frequently if no child fatalities are reported in a given quarter.