The seal of the State of Nevada is centered in the background. It features a circular border with the text "THE GREAT SEAL OF THE STATE OF NEVADA" at the top and "NEVADA" at the bottom. Inside the border, there is a central figure of a mountain range with a sun rising behind it, a river, and a building. The text "EUREKA" is written across the top of the central scene, and "ALL FOR OUR COUNTRY" is written across the bottom. There are stars on either side of the central scene.

STATE OF NEVADA
DIVISION OF CHILD AND
FAMILY SERVICES

**2006 STATEWIDE
CHILD DEATH REPORT**

Submitted by:

The Executive Committee to Review the Death of Children

Michelle Lucier and Alane Olson, MD, Co-Chairs

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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 AND FEDERAL LAWS AND REGULATIONS.

Executive Summary

Regional child death review (CDR) teams are organized and operational in Nevada based on Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 409. There are six regional CDR teams in the state: The Clark County and Washoe County Teams review child deaths in the two major urban areas of Las Vegas and Reno, respectively. The Elko, Carson, Fallon, and Pahrump Teams review child deaths in all other counties, which comprise Nevada's rural region.

Two statewide groups provide coordination and oversight for the review of child deaths in Nevada: 1) the Administrative Team and 2) the Executive Committee to Review the Death of Children. The Administrative Team 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 makes decisions about funding initiatives to prevent child death, which may be based on recommendations from the Administrative Team 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.

Based on death certificates issued by the State of Nevada in 2006, there were a total of 480 child and adolescent deaths in the state, ages birth through 17 years.¹ This is an increase from 384 total child deaths in 2005. The greatest number of child deaths in 2006 occurred among infants less than one year of age, which is consistent with national death rates that indicate the highest rate of death for infants ages birth to one year. Infant mortality rates are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population), which is common for most other forms of mortality statistics. In 2006, Nevada's infant mortality rate was 7.0 per 1,000 live births. This is above the national average of 6.6 per 1,000 live births for the same year. This also represents an increase for Nevada from the rate of 5.8 per 1,000 live births in 2005.²

During 2006, a total of 262 child deaths were reviewed by the six regional CDR teams. This is an increase from 176 deaths reviewed in 2005, and 159 deaths reviewed in 2004. This demonstrates a commitment on the part of the regional CDR teams to expand their capacity to review child deaths in Nevada and work toward increasing prevention efforts.

Combined evaluation of 2006 statewide vital records data and regional CDR team data shows the following four leading causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

1. Motor vehicle accidents
2. All other accidents combined
3. Homicide
4. Suicide

¹ Hansen, Alicia. (2008). *Custom Vital Statistics Database on Child Deaths 2006*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

² Eldridge, R.I. and Sutton, P.D. (2007). *Births, marriages, divorces, and deaths: Provisional data for December 2006. National Vital Statistics Reports; Vol. 55 No. 20*. Hyattsville, MD: National Center for Health Statistics.

Motor vehicle accidents (MVA) are the leading cause of death, regardless of which data source is evaluated. Leading causes of all other types of accidents include drowning and asphyxia. Leading causes of homicide include gunshot wounds and abuse/neglect. Leading causes of suicide include asphyxia and gunshot wounds.

Starting in 2005, the regional CDR teams began utilizing the national data collection instrument developed by the National Maternal Child Health (MCH) Center for Child Death Review. During this first year, Nevada participated as one of six states selected to pilot the new electronic CDR Case Reporting System for child death data collection, in conjunction with the National Center. This presented an important opportunity for Nevada to implement a nationally-researched data collection instrument, as well as capitalize on a low-cost option for data collection, storage, processing, and reporting through web-based data entry and analysis.

For the third consecutive year, the Executive Committee has also compiled statewide child death data from the Nevada State Health Division (NSHD) – Center for Health Data and Research. This data was then compared with case review data derived from the work of the six regional CDR teams, and analyzed to produce this report. Comparison of vital records data in conjunction with regional CDR team data yields more complete information on causes of death, and contributes to a more effective evaluation of causes where prevention efforts may contribute to a reduction in child deaths. This ongoing statewide data analysis, combined with regional CDR team data analysis, continues to improve the Executive Committee’s work to effectively evaluate child deaths in Nevada.

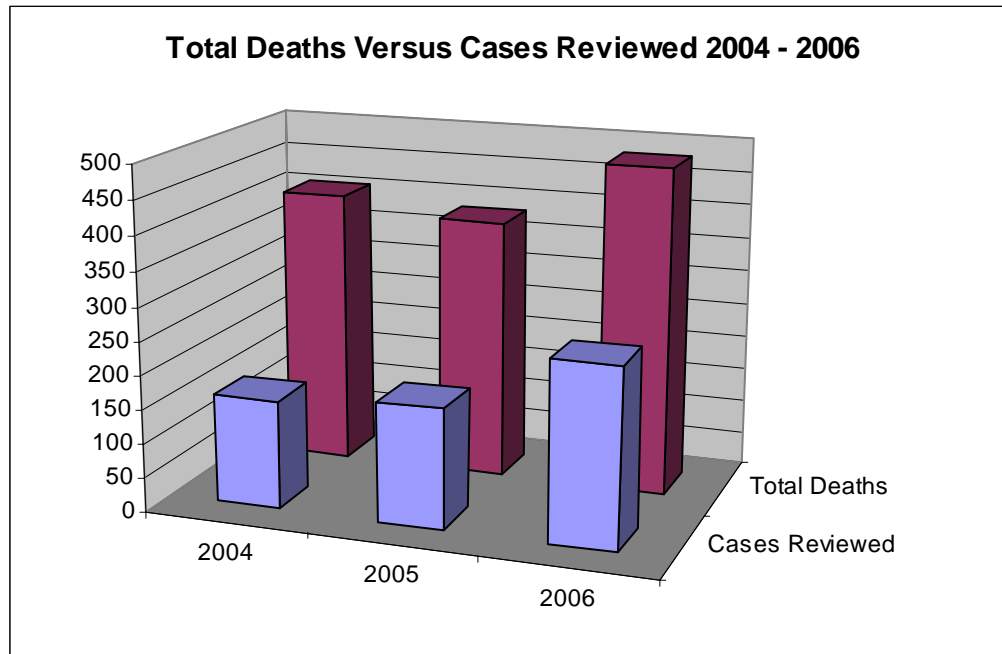
During 2006, the Executive Committee continued its public awareness campaigns for the prevention of child death. Development of a public awareness campaign plan was completed in 2004, and the Executive Committee approved a media campaign contract with the Nevada Broadcasters Association (NBA), which has extensive experience serving government and nonprofit organizations. The initial campaign consisted of public service announcements focused on four topic areas for prevention:

1. Teen suicide
2. Parents co-sleeping with children
3. Shaken baby syndrome
4. Car safety

These topic areas were based on the leading causes of child death outlined in the 2002 –2004 Statewide Child Death Reports. The NBA broadcast a series of targeted radio and television announcements for a nine-month period across calendar years 2005 and 2006. The initial campaign will be evaluated and additional media buying will be reviewed by the Executive Committee for future public awareness campaigns.

2006 Key Findings

Total Statewide Deaths and Child Deaths Reviewed



- Total 2006 statewide child and adolescent deaths: 480
- Total 2006 child and adolescent deaths reviewed: 262

The number of child death cases reviewed by the regional CDR teams has grown for the past three years. This demonstrates a commitment on the part of the regional CDR teams to expand their capacity to review child deaths in Nevada and work toward increasing prevention efforts. Each of the six regional CDR teams reviews all coroner-referred child deaths within their region except the Clark Team, which 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. Currently, most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. In Clark County, the team meets monthly because of its high caseload. In the rural region, the regional teams may meet less frequently if no child fatalities are reported in a given quarter.

Leading Causes of Death: Key Data Findings

The following are the four leading causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

1. Motor vehicle accidents
2. All other accidents combined
3. Homicide
4. Suicide

1. Motor Vehicle Accidents

- Motor vehicle accidents (MVA) are the leading cause of accidental death for children and adolescents in Nevada.
- Motor vehicle deaths among children and adolescents have decreased notably over the past two years, especially in light of Nevada's continued population growth, down from 60 in 2004 to 48 in 2006.
- Over 45% of child deaths by MVA reviewed in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1% and suggests that this population may benefit from greater public awareness efforts related to safe driving.

2. Non-Motor Vehicle Accidents

- Asphyxia deaths were the most common type of accidental death in 2006, following MVA deaths. Of these, two-thirds were caused by unsafe sleeping environments due to excessive bedding, wedging, or adults/children co-sleeping with children, which can result in rolling over or onto the child and causing suffocation (overlay).
- Almost half of asphyxia deaths reviewed in 2006 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%, and indicates that prevention efforts may need to be increased for this population.
- Drownings decreased from 12 in 2005 to nine in 2006.
- Almost half of all drownings reviewed in 2006 occurred among children one to four years of age. This underscores the importance of public awareness efforts regarding pool and water safety for parents and other caregivers with young children.
- Two-thirds of all drownings reviewed in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the Clark County population distribution for Hispanics and Latinos at 37.8%,³ and indicates that public awareness efforts regarding pool and water safety may need to be increased for this population.

³ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2006 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

3. Homicide

- Total homicides increased slightly with a total of 24 in 2006, compared with 22 in 2005.
- Gunshot wounds (GSW) are the leading cause of homicide deaths in Nevada.
- Homicides by abuse and neglect are the second leading cause of homicide deaths in Nevada.
- Almost half of homicide deaths reviewed in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1%.
- 60% of abuse and neglect homicide deaths reviewed in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1%.

4. Suicide

- Total suicides remained relatively stable with a total of 16 in 2006, compared with 17 in 2005.
- Males in Nevada died by suicide at approximately twice the rate of females in 2006. This is inconsistent with national data, which shows the rate of death for male suicides at almost four times that of females.⁴ This trend can be seen across the last three years of Nevada suicide data, but has lessened across time, where in 2004 female adolescents in Nevada died by suicide at almost twice the rate of male adolescents. However, the closer ratio of female to male suicides over time shows that females in Nevada die by suicide more often than the national average and may benefit from increased prevention efforts.
- National data shows that the highest suicide rates for both males and females are among American Indians.⁵ Given Nevada's indigenous American Indian population, the fact that there were no reported suicides among American Indians in 2006 may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported. Because of the ongoing lack of child death data for American Indians, the Executive Committee has recently undertaken an effort to establish formal communication with Nevada's tribes regarding American Indian child deaths. This should result in better data for this report in future years.

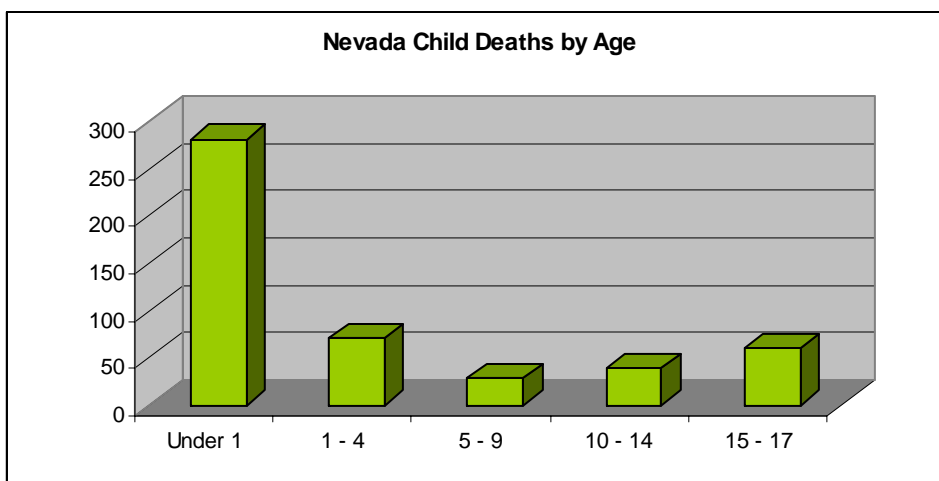
⁴ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

⁵ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Section 1: 2006 Child Deaths in Nevada

All data in Section 1 of this report is derived from the Nevada State Health Division – Center for Health Data and Research. Based on death certificates issued by the State of Nevada in calendar year 2006, there were a total of 480 child and adolescent deaths in the state.⁶ These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data.

Basic Demographics: Age, Gender, and Race



Age Group	Total	%
Under 1	281	58.5%
1 - 4	70	14.6%
5 - 9	29	6.0%
10 - 14	40	8.3%
15 - 17	60	12.5%
TOTAL:	480	100.0%

Findings:

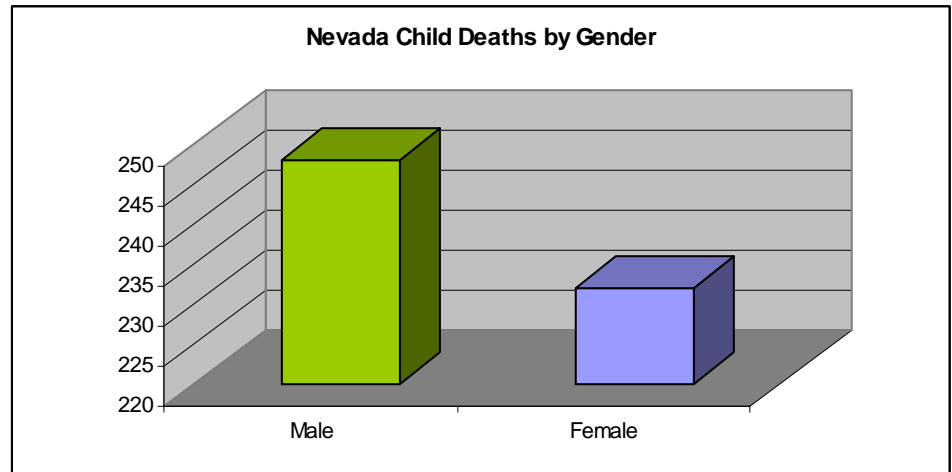
- The greatest number of child deaths in 2006 occurred among infants less than one year of age. This is consistent with national death rates for children and adolescents, which indicate the highest rate of deaths for infants ages birth to one year, at approximately 693 per 100,000 of the population.
- 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.⁷
- Infant mortality rates are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population), which is common for most other forms of mortality statistics. In 2006, Nevada’s infant mortality rate was 7.0 per 1,000 live births. This is above the national average of 6.6

⁶ Hansen, Alicia. (2008). *Custom Vital Statistics Database on Child Deaths 2006*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

⁷ Kung H.C. et. al. (2008). *Deaths: Final data for 2005. National Vital Statistics Reports; Vol. 56 No. 10*. Hyattsville, MD: National Center for Health Statistics.

per 1,000 live births for the same year. This also represents an increase for Nevada from the rate of 5.8 per 1,000 live births in 2005.⁸

Gender	Total	%
Male	248	51.7%
Female	232	48.3%
TOTAL:	480	100.0%

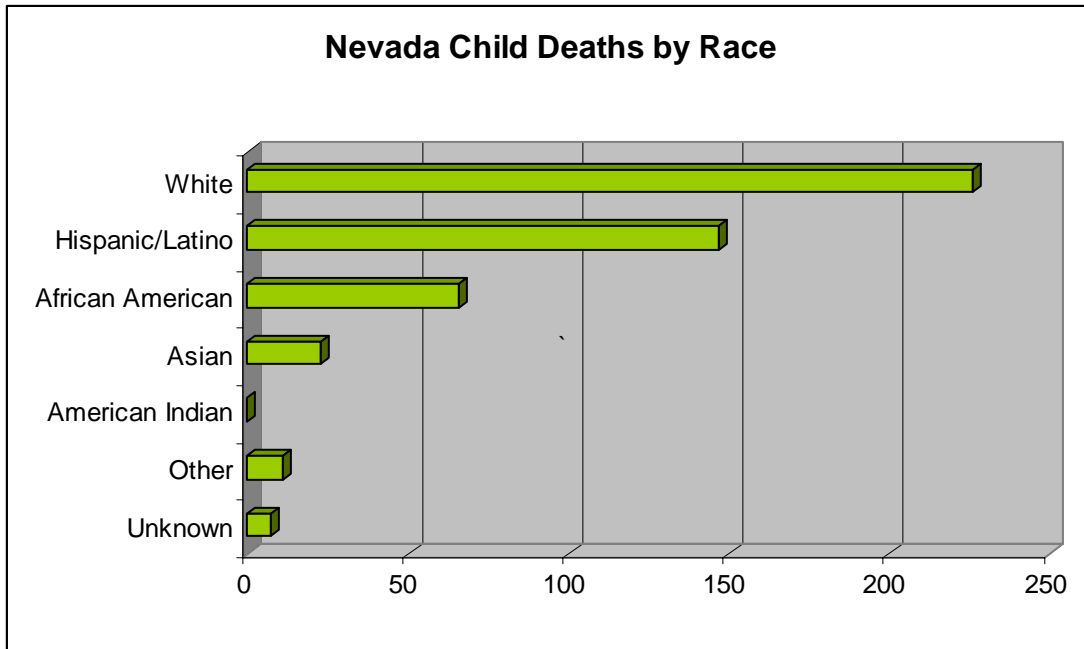


Findings:

- Nevada child deaths in 2006 include more males than females. This is again consistent with national data, which indicates that males die at a higher rate than females.⁹

⁸ Eldrige, R.I. and Sutton, P.D. (2007). *Births, marriages, divorces, and deaths: Provisional data for December 2006. National Vital Statistics Reports; Vol. 55 No. 20.* Hyattsville, MD: National Center for Health Statistics.

⁹ Kung H.C. et. al. (2008). *Deaths: Final data for 2005. National Vital Statistics Reports; Vol. 56 No. 10.* Hyattsville, MD: National Center for Health Statistics.



Race Group	Total	%	Race Group	Total	%
White	226	47.1%	American Indian	0	0.0%
Hispanic/Latino	147	30.6%	Other	11	2.3%
African American	66	13.8%	Unknown	7	1.5%
Asian	23	4.8%			

Review: Child Deaths Compared with Statewide Population Distribution

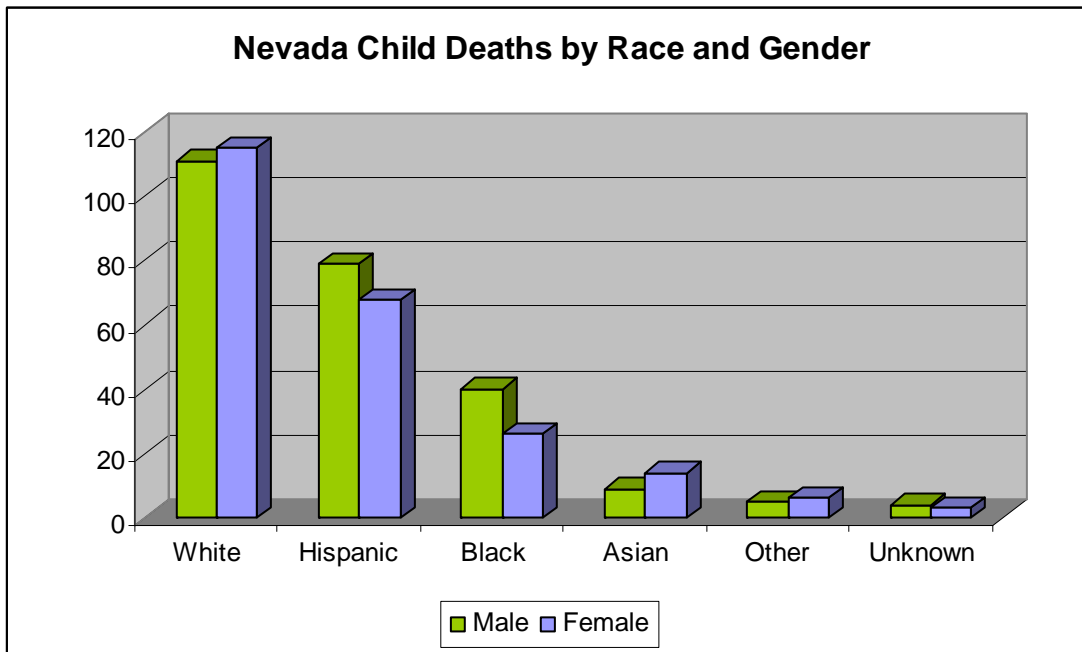
TOTAL CHILD DEATHS			STATEWIDE POPULATION ¹⁰		
Race Group	Total	%	Race Group	Total	%
White	226	47.1%	White	321,268	48.7%
Hispanic/Latino	147	30.6%	Hispanic/Latino	231,182	35.1%
African American	66	13.8%	African American	55,344	8.4%
Asian	23	4.8%	Asian	42,173	6.4%
American Indian	0	0.0%	American Indian	9,077	1.4%
Other	11	2.3%	Other	-	-
Unknown	7	1.5%	Unknown		
TOTAL:	480	100.0%	TOTAL:	659,043	100.0%

Findings:

- For whites, Hispanics/Latinos, and Asians, 2006 child deaths are below the statewide population distribution, indicating that child deaths among these groups are less frequent overall. For Hispanics/Latinos the percentage of total deaths is almost 5% below the statewide population distribution. However, as noted in the Key Findings above and detailed in Section 2 below, Hispanic and Latino child deaths are disproportionately higher within certain leading causes of death.
- For African Americans, 2006 child deaths are more than 5% greater than the statewide population distribution at 13.8% versus 8.4%. This indicates that child deaths among African Americans are more frequent and may benefit from increased prevention efforts.
- Given Nevada's indigenous American Indian population, the lack of child deaths shown among American Indians may suggest that these children are either incorrectly classified by race, or their deaths are under-reported because of the separate governance in tribal lands. Because of the ongoing lack of child death data for American Indians, the Executive Committee has recently undertaken an effort to establish formal communication with Nevada's tribes regarding American Indian child deaths. This should result in better data under Section 2 of this report in future years.

¹⁰ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2006 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

Comparison: Race and Gender



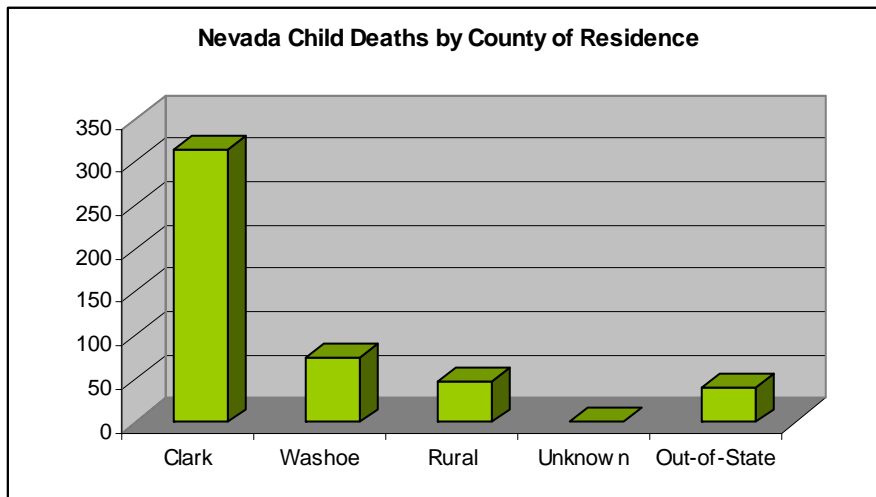
Race Group	Male	Female	Male %	Female %
White	111	115	49.1%	50.9%
Hispanic	79	68	53.7%	46.3%
African American	40	26	60.6%	17.7%
Asian	9	14	39.1%	60.9%
American Indian	0	0	0.0%	0.0%
Other	5	6	45.5%	54.5%
Unknown	4	3	57.1%	42.9%
TOTAL:	248	232	51.7%	48.3%

Findings:

- Comparison by race and gender again demonstrates that in general, males die more frequently than females.
- African American males have the highest percentage of deaths compared with all other males in all other race categories.

County of Residence

County	Total	%
Clark	315	65.6%
Washoe	75	15.6%
Carson City	8	1.7%
Churchill	3	0.6%
Douglas	2	0.4%
Elko	12	2.5%
Esmeralda	1	0.2%
Eureka	0	0.0%
Humboldt	2	0.4%
Lander	0	0.0%
Lincoln	0	0.0%
Lyon	6	1.3%
Mineral	2	0.4%
Nye	8	1.7%
Pershing	0	0.0%
Storey	2	0.4%
White Pine	1	0.2%
Out-of-state	41	8.5%
Unknown	2	0.4%
TOTAL:	480	100.0%



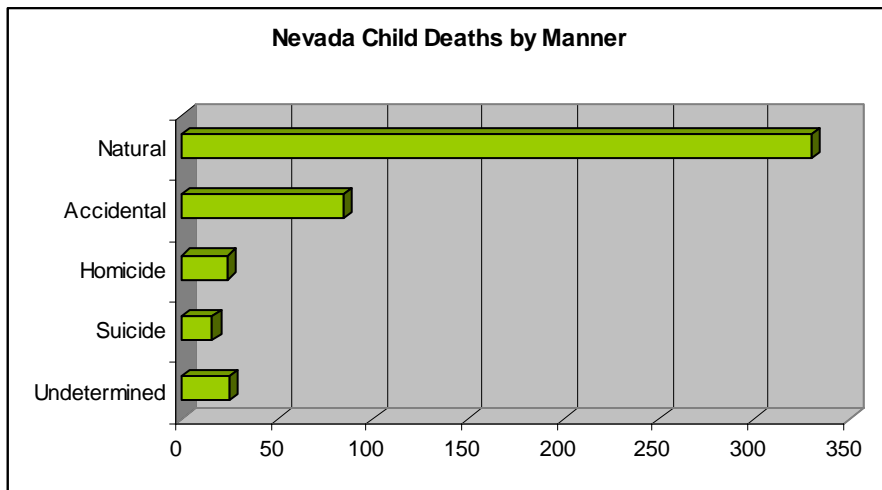
Findings:

- 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 73.2% of the statewide child and adolescent population. With child deaths at 65.6% of total deaths in 2006, 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 15.5% of the statewide child and adolescent population. With child deaths at 15.6% of total deaths in 2006, this means the proportion of child deaths in Washoe County is at the average based on the total child and adolescent population.
- When compared with County of Residence information in Section 2, there are discrepancies in the rural counties, and a higher total of deaths shown for Washoe County. This suggests that county of residence information is gathered incorrectly either through vital records, the CDR database, or both.
- Out-of-state deaths include children who are not Nevada residents that die while they are visiting the state.

Manner of Death

The coroner 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 investigation, usually about intent, to assign a manner of death.



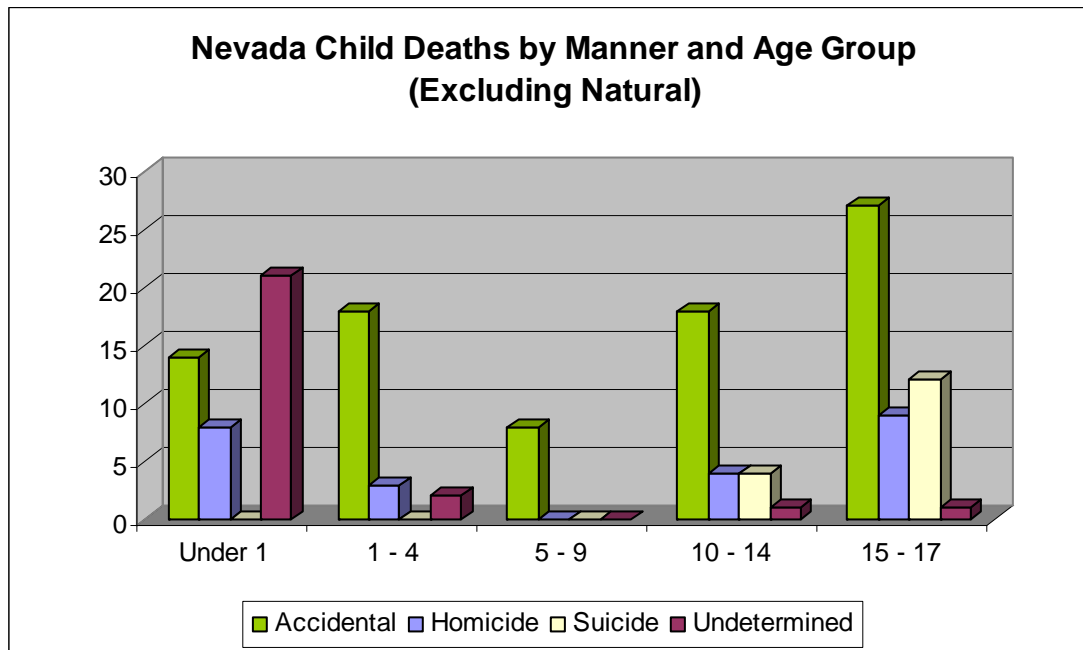
Manner	Total	%
Natural	330	68.8%
Accidental	85	17.7%
Homicide	24	5.0%
Suicide	16	3.3%
Undetermined	25	5.2%
Unknown	0	0.0%
Not entered	0	0.0%
TOTAL:	480	100.0%

Findings:

- The greatest number of child deaths in 2006 were natural, largely due to the high incidence of natural deaths among infants less than one year of age, as discussed above.
- The second most common manner of death is accidental, accounting for almost 18% of child deaths in Nevada. When children under age five are separated out, accidents become the most common manner of death for children and adolescents ages 5 through 17. This is consistent with national data, which shows that accidents are the leading cause of death for all age groups except infants less than one year of age.¹¹
- 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 and in Section 2.

¹¹ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

Comparison: Manner of Death and Age



Manner	Less than 1	1 - 4	5 - 9	10 - 14	15 - 17
Natural	238	47	21	13	11
Accidental	14	18	8	18	27
Homicide	8	3	0	4	9
Suicide	0	0	0	4	12
Undetermined	21	2	0	1	1
TOTAL:	281	70	29	40	60

Findings:

- As noted above, the greatest number of child deaths in 2006 was natural deaths of infants less than one year of age. This is consistent with national data, which indicates that the top five causes of infant death are natural, and that natural deaths represent approximately 64% of infant deaths nationwide.¹²
- Accidental deaths are highest in the age groups of 1 - 4, 10 - 14, and 15 - 17, and they tend to increase with age. This is consistent with national data, which shows that the leading cause of death is accidental for all age groups over one-year, and that the highest number of accidental deaths is in the age groups of 1 - 4 and 15 - 17. National data also shows a continuing increase in accidental deaths across the age groups of 5 - 9, 10 - 14, and 15 - 17, which is reflected in the Nevada data as well.¹³
- Homicides in 2006 occurred in all age groups except 5 - 9. They are highest in the age groups of under 1 and 15 - 17, with decreasing homicide deaths through the 5 - 9 age group, and then increasing homicide

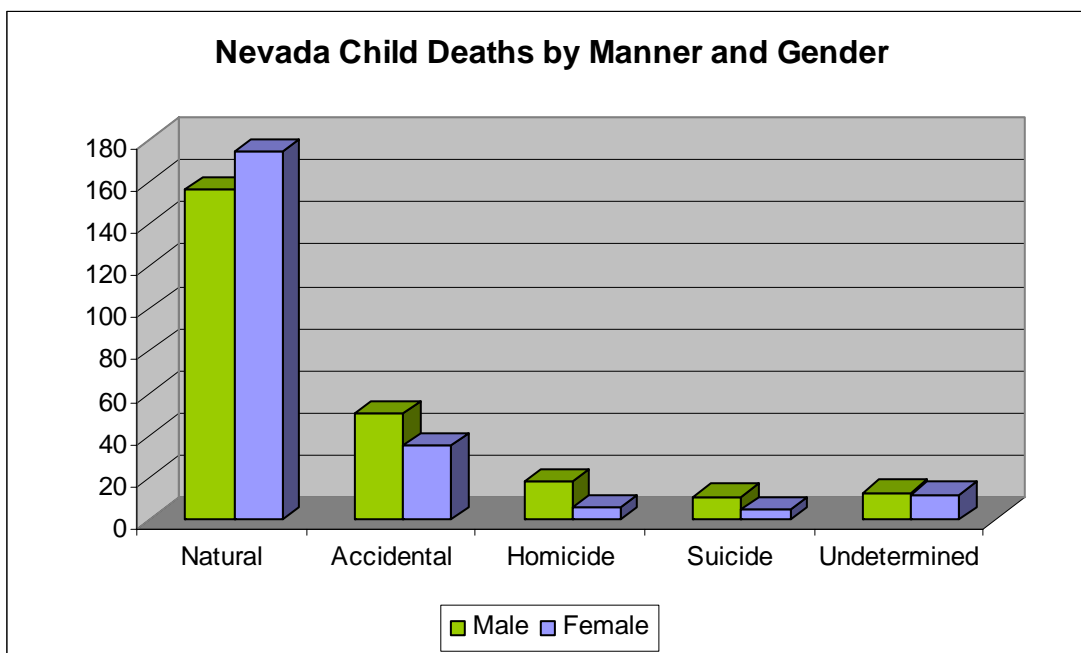
¹² National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

¹³ Ibid.

deaths as adolescents move through their pre-teen and teen years. This u-shaped data pattern is roughly consistent with national death rates for the same age groups, with the exception of infants under 1. National data does not show homicide in the top 10 causes of death for infants less than one year old.¹⁴ This indicates that the number of homicides within this age group is unusually high in Nevada. In Section 2, regional CDR team data shows that homicides by abuse and neglect are the leading type of homicide after gunshot wounds. This indicates a continued need for prevention efforts surrounding child abuse and neglect in Nevada.

- Suicides occur only within the age groups of 10 – 14 and 15 – 17, and demonstrate a sharp increase with age. This is also consistent with national data, which shows suicide as the third leading cause of death for the same age groups, and a substantial increase in suicides with age.¹⁵

Comparison: Manner of Death and Gender



Manner of Death:	Male:	Female:	Male %	Female %
Natural	156	174	47.3%	52.7%
Accidental	50	35	58.8%	41.2%
Homicide	18	6	75.0%	25.0%
Suicide	11	5	68.8%	31.3%
Undetermined	13	12	52.0%	48.0%
TOTAL:	248	232	51.7%	48.3%

¹⁴ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

¹⁵ Ibid.

Findings:

- Comparing manner of death by gender again demonstrates that overall, males die more frequently than females, as discussed above.
- Males in Nevada were victims of homicide at three times the rate of females in 2006. This is roughly consistent with national data, which shows the overall rate of death for male homicides at almost four times that of females across the lifespan (9.2 per 100,000 population for male homicides compared with 2.5 per 100,000 for female homicides).¹⁶
- Males in Nevada died by suicide at approximately twice the rate of females in 2006. This is inconsistent with national data, which shows the rate of death for male suicides in the 15 – 19 age group at almost four times that of females (12.6 per 100,000 population for male suicides compared with 3.5 per 100,000 for female suicides).¹⁷ Other national research shows that adolescent males are much more likely to complete suicide, while adolescent females are much more likely to attempt suicide.¹⁸ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

This trend has lessened across the past three years, where in 2004 female adolescents in Nevada died by suicide at almost twice the rate of male adolescents:



However, the closer ratio of female to male suicides shows that females in Nevada died by suicide more often than the national average and may benefit from increased prevention efforts.

¹⁶ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

¹⁷ Ibid.

¹⁸ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Leading Causes of Death

Target Causes for Prevention Efforts

The four leading causes of child death statewide, excluding natural deaths, are as follows:

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
1. Motor vehicle accidents	48	10.0%
2. Non-motor vehicle accidents	37	7.7%
3. Homicide	24	5.0%
4. Suicide	16	3.3%
TOTAL deaths by leading causes:	125	26.0%

These causes exclude undetermined deaths, which cannot be targeted for prevention efforts due to lack of information. These causes also exclude natural deaths, which are discussed separately below under *Natural Deaths*.

DETAIL: Target Causes for Prevention Efforts

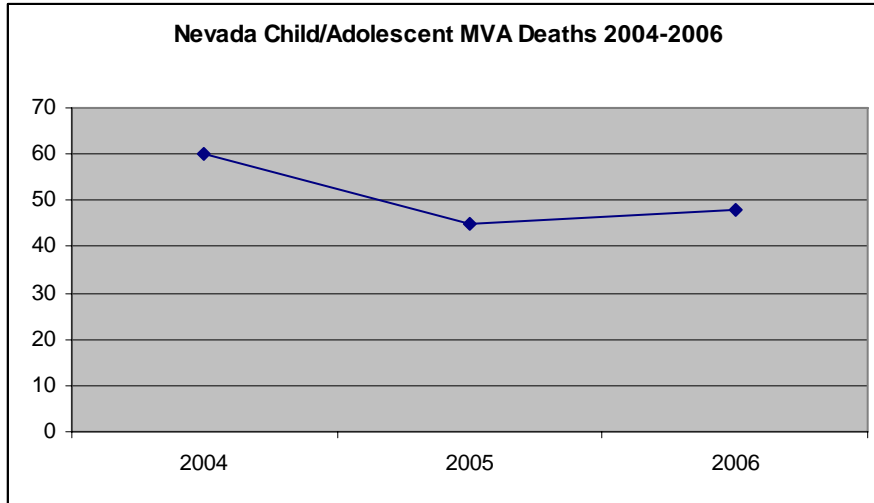
Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
1. Motor vehicle accidents	48	10.0%
• Driver	4	0.8%
• Passenger	8	1.7%
• Pedestrian	7	1.5%
• Motorcycle Driver	2	0.4%
• Motorcycle Passenger	2	0.4%
• Bicycle	3	0.6%
• ATV	1	0.2%
• Watercraft	1	0.2%
• Other	20	4.2%

DATA NOTES: ATV = All-Terrain Vehicle

Findings:

- Motor vehicle accidents (MVA) are the leading cause of accidental death for children and adolescents in Nevada. This is consistent with national data, which shows motor vehicle accidents as the leading cause of death for all Americans, ages one through 34.¹⁹ Motor vehicle deaths among children and adolescents have decreased notably over the past two years, especially in light of Nevada's continued population growth:

¹⁹ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.



- Almost 42% of statewide MVA deaths in 2006 were classified in the “other” category, demonstrating a lack of vehicle type and driver position data coding from death certificates. This may be a practice issue where coroners and medical examiners do not enter detailed information about MVA deaths, or there is a lack of specific information surrounding the circumstances of the death. Greater detail is available through regional CDR team data and MVA deaths are analyzed in detail below in *Section 2*.

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
2. Non-motor vehicle accidents	37	7.7%
• Asphyxia	10	2.1%
• Drowning	9	1.9%
• Overdose	6	1.3%
• Fall	4	0.8%
• Heat	2	0.4%
• GSW	1	0.2%
• Poisoning	1	0.2%
• Other	4	0.8%

DATA NOTES: GSW = gunshot wounds

Findings:

- Asphyxia deaths were the most common type of accidental death in 2006, following MVA deaths. Of these, eight were related to unsafe sleep environments including adults co-sleeping with children.
- Drownings decreased from 12 in 2005 to nine in 2006.
- For both asphyxia deaths and drownings, greater detail is available through regional CDR team data and these deaths are analyzed in detail below in *Section 2*.

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
3. Homicide	24	5.0%
• GSW	11	2.3%
• Abuse	4	0.8%
• Asphyxia	1	0.2%
• Other	8	1.7%

DATA NOTES: GSW = gunshot wounds

Findings:

- Total homicides increased slightly with a total of 24 in 2006, compared with 22 in 2005. Homicides from gunshot wounds remained stable with a total of 11 in 2006, compared with 11 in 2005.
- Gunshot wounds are the leading cause of homicide deaths in Nevada. This is consistent with national data, which shows gunshot wounds as the leading cause of homicide deaths for children and adolescents ages five through 17.²⁰
- As noted above, a key variance when comparing leading causes of death between statewide Health Division data and regional CDR team data is demonstrated when looking at homicides by abuse and neglect. Looking at statewide Health Division data alone, the total number of deaths by abuse or neglect appears to be four. However, the additional amount of detail available through regional CDR team data shows that total deaths caused by abuse or neglect is actually 10. Abuse and neglect deaths are analyzed in detail below in Section 2.

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
4. Suicide	16	3.3%
• Asphyxia	9	1.9%
• GSW	6	1.3%
• All others	1	0.2%

DATA NOTES: GSW = gunshot wounds

Findings:

- Total suicides remained relatively stable with a total of 16 in 2006, compared with 17 in 2005. Suicides from gunshot wounds also remained stable with a total of six in 2006, compared with six in 2005.
- As with other leading causes of death, greater detail is available through regional CDR team data and these deaths are analyzed in detail below in Section 2.

²⁰ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

Natural Deaths

As discussed throughout this section, natural deaths are the leading cause of child death in the state, accounting for 69% of all deaths and occurring primarily in infants less than one year of age. Natural deaths are targeted for review by regional CDR teams when several types of natural causes are indicated 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 medical neglect or over-medication.
- Toxicology reports suggesting maternal drug use: 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 maternal drug use 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 under Section 2.

Section 2: 2006 Child Deaths Reviewed

All data in Section 2 of this report is derived from the regional CDR teams, which collect and enter data into an electronic reporting system maintained by the National Maternal Child Health (MCH) Center for Child Death Review.

Child Death Review Process in Nevada

Six regional CDR teams are required to review local child deaths throughout the State of Nevada as follows:

1. **Clark Team:** covers Clark County
2. **Washoe Team:** covers Washoe County
3. **Elko Team (District 1 – North):** covers Elko, Eureka, Humboldt, Lander, Lincoln, and White Pine
4. **Carson Team (District 2 – West):** covers Carson City, Douglas, and Storey
5. **Fallon Team (District 3 – East):** covers Churchill, Lyon, Mineral, and Pershing
6. **Pahrump Team (District 4 – South):** covers Esmeralda and Nye

All regional CDR teams may also review the deaths of children who are out-of-state residents and die within the teams' counties of jurisdiction.

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 409. 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 died from Sudden Infant Death Syndrome (SIDS).

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

Deaths Reviewed Versus Deaths Not Reviewed

Each of the six regional CDR teams reviews all coroner-referred child deaths within their region except the Clark Team, which 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. Currently, most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their

respective regions. In Clark County, the team meets monthly because of its high caseload. In the rural region, the regional teams may meet less frequently if no child fatalities are reported in a given quarter.

Data Limitations

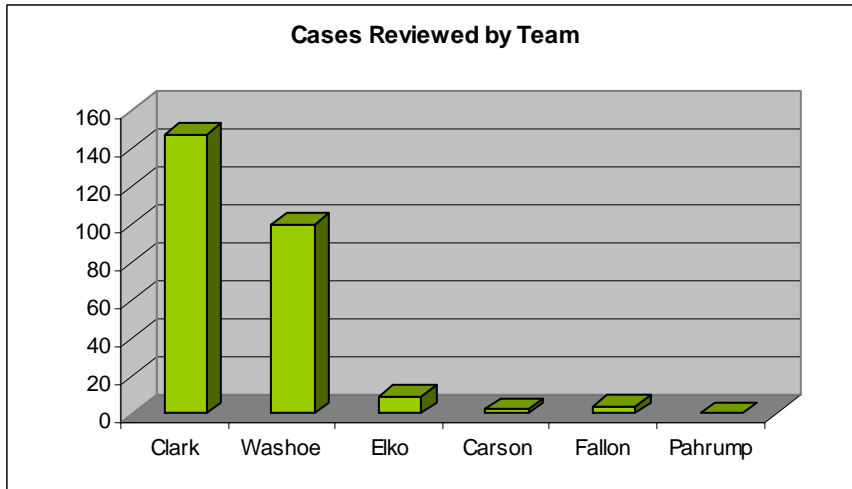
There are certain limitations for the data included in this report:

- 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.
- In 2006, there was no protocol in place for the handling of out-of-state resident deaths. In some cases, these deaths may have been reviewed by the regional CDR teams. In other cases, they may have been referred back to a CDR team in the child's state of residence.
- 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.
- Comparisons with statewide Health Division data, reviewed below, may result in 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 the 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.
- Comparisons with statewide Health Division data, reviewed below, may also result in errors because of coding for the cause of death. For statewide 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.²¹ For regional CDR team data, cause of death is determined by the team and entered based on findings from the review process.
- Although the 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 multi-disciplinary partners.

²¹ National Center for Health Statistics. (2008). *The International Classification of Diseases, Tenth Revision, (ICD-10)*. Retrieved July 14, 2008, from <http://www.cdc.gov/nchs/about/major/dvs/icd10des.htm>.

2006 Child Deaths Reviewed

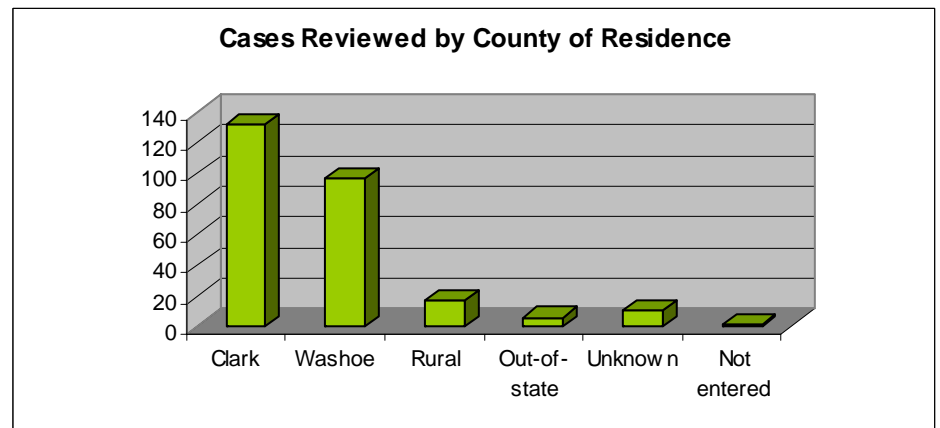
From 2006 child deaths statewide, a total of 262 child deaths were reviewed by the six regional CDR teams. This is an increase from the 176 deaths reviewed in 2005. Fatalities reviewed include ages birth through 17 years. Adults ages 18 and over are not included in this data.



Team	Cases	%
Clark	147	56.1%
Washoe	100	38.0%
Elko	9	3.4%
Carson	2	0.8%
Fallon	4	1.5%
Pahrump	0	0.0%
TOTAL:	262	100.0%

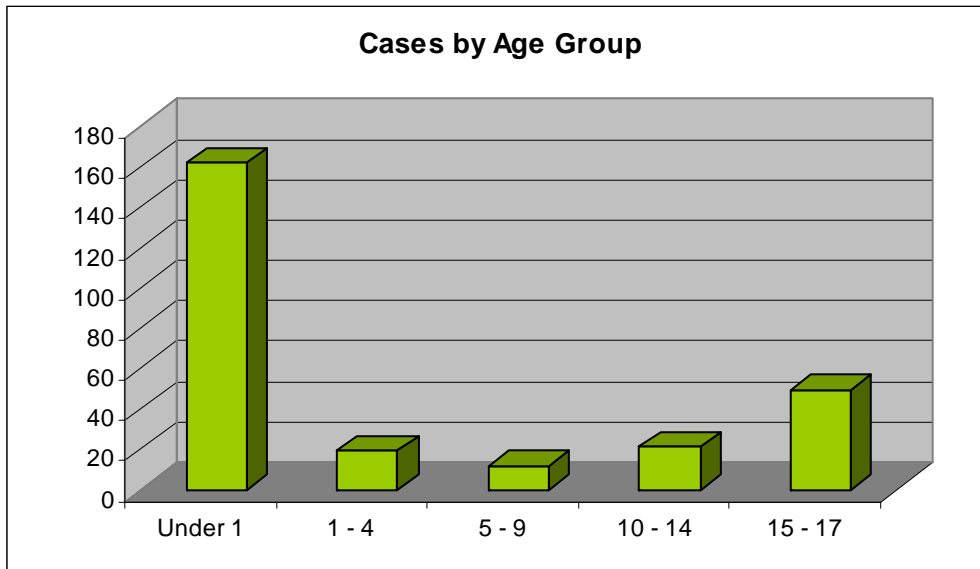
County of Residence

County	Total	%
Clark	131	50.0%
Washoe	97	36.9%
Carson City	3	1.1%
Churchill	1	0.4%
Elko	8	3.0%
Fallon	1	0.4%
Humboldt	1	0.4%
Lyon	1	0.4%
Nye	1	0.4%
Pershing	1	0.4%
Out-of-state	6	2.3%
Unknown	10	3.8%
Not entered	1	0.4%
TOTAL:	262	100.0%



DATA NOTES: There are discrepancies between in the number of child deaths reviewed by team versus by county because children who reside in a certain county may be reviewed by a different team in some cases. Additionally, teams may review cases involving out-of-state residents, or cases involving an unknown county of residence, all of which can affect the total by team compared with the total by county.

Basic Demographics: Age, Gender, and Race

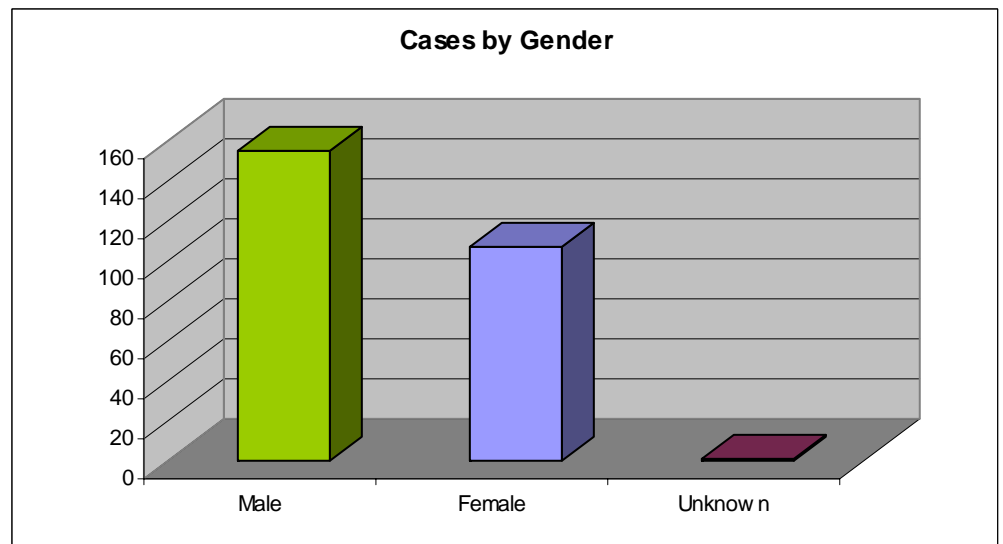


Age Group	Total	%
Under 1	162	61.6%
1 - 4	19	7.2%
5 - 9	12	4.6%
10 - 14	21	8.0%
15 - 17	48	18.3%
TOTAL:	262	100.0%

Findings:

- Consistent with national data, most child deaths occur among infants less than one year of age.²²

Gender	Total	%
Male	154	58.8%
Female	107	40.7%
Unknown	1	0.4%
TOTAL:	262	100.0%

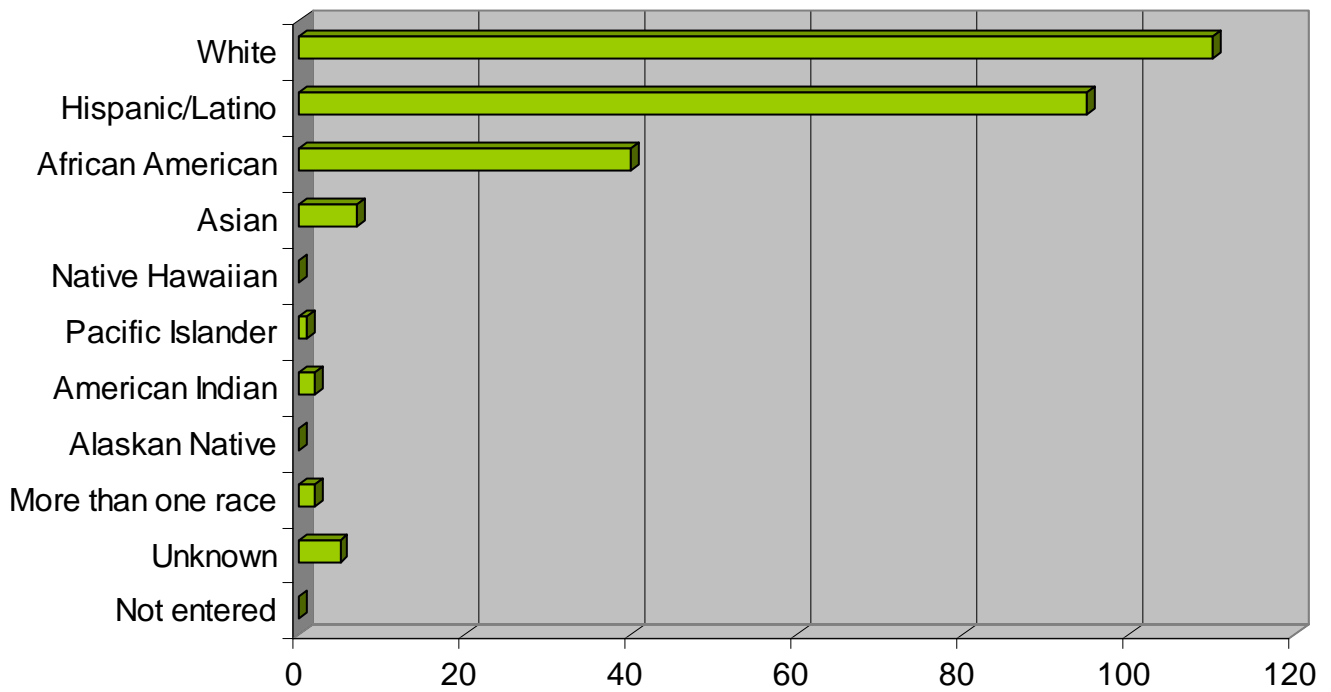


Findings:

- Consistent with national data, males die more frequently than females.²³

²² Eldrige, R.I. and Sutton, P.D. (2007). *Births, marriages, divorces, and deaths: Provisional data for December 2006. National Vital Statistics Reports; Vol. 55 No. 20.* Hyattsville, MD: National Center for Health Statistics.

Cases by Race



Race Group	Total	%	Race Group	Total	%
White	110	41.8%	American Indian	2	0.8%
Hispanic/Latino	95	36.3%	Alaskan Native	0	0.0%
African American	40	15.2%	More than one race	2	0.8%
Asian	7	2.7%	Unknown	5	1.9%
Native Hawaiian	0	0.0%	Not entered	0	0.0%
Pacific Islander	1	0.4%			

²³ Kung H.C. et. al. (2008). *Deaths: Final data for 2005. National Vital Statistics Reports; Vol. 56 No. 10.* Hyattsville, MD: National Center for Health Statistics.

Review: Cases by Race Compared with Statewide Population Distribution

CASES REVIEWED			STATEWIDE POPULATION ²⁴		
Race Group	Total	%	Race Group	Total	%
White	110	41.8%	White	321,268	48.7%
Hispanic/Latino	95	36.3%	Hispanic/Latino	231,182	35.1%
African American	40	15.2%	African American	55,344	8.4%
Asian	7	2.7%	Asian	42,173	6.4%
Native Hawaiian	0	0.0%	Native Hawaiian	-	-
Pacific Islander	1	0.4%	Pacific Islander	-	-
American Indian	2	0.8%	American Indian	9,077	1.4%
Alaskan Native	0	0.0%	Alaskan Native	-	-
More than one race	2	0.8%			
Unknown	5	1.9%			
Not entered	0	0.0%			
TOTAL:	262	100.0%	TOTAL:	659,043	100.0%

DATA NOTES: Although case data allows for Hispanic/Latino data to be gathered separately as an ethnicity, independent of race data, it is combined with race data in order to make more meaningful comparisons. For statewide population data, the Asian race category includes Native Hawaiians and Pacific Islanders, and the American Indian race category includes Alaskan Natives.

Findings:

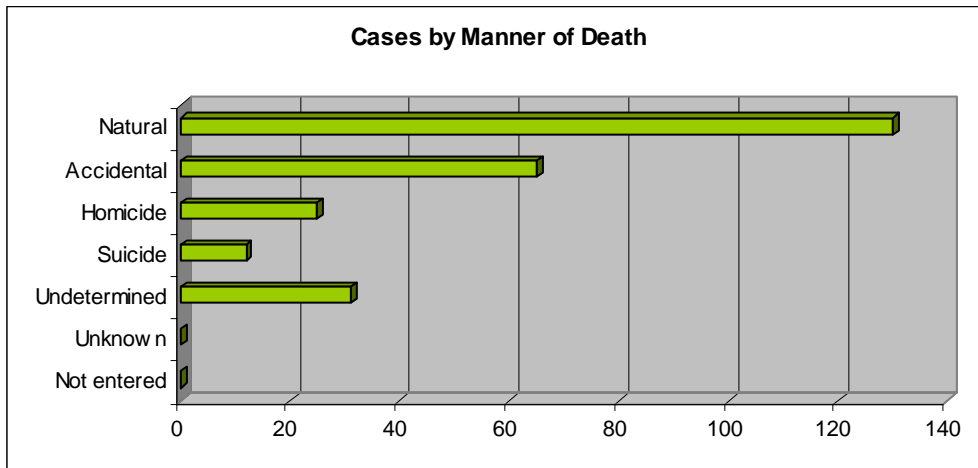
- For whites, 2006 child death cases reviewed are 7% below the statewide population distribution, indicating that child deaths among whites are less frequent.
- For Hispanics and Latinos, 2006 child death cases reviewed are slightly above the statewide population distribution.
- For African Americans, 2006 child death cases reviewed are almost 7% greater than the statewide population distribution at 15.2% versus 8.4%. This indicates that child deaths among African Americans are disproportionately higher and may benefit from increased prevention efforts.
- For Asians, 2006 child death cases reviewed are less than half the statewide population distribution. However, this comparison may be skewed because of the small number of cases reviewed (fewer than 10).

²⁴ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2006 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

Manner of Death

Prior to the regional CDR teams' review and analysis of a child fatality, a coroner, medical examiner, or private attending physician identifies the manner of death. The coroner then forwards the information to the regional CDR team coordinator. The coroner 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 investigation, usually about intent, to assign a manner of death.



Manner	Total	%
Natural	130	49.4%
Accidental	65	24.7%
Homicide	24	9.2%
Suicide	12	4.6%
Undetermined	31	11.8%
TOTAL:	262	100.0%

Manner of Death by Team

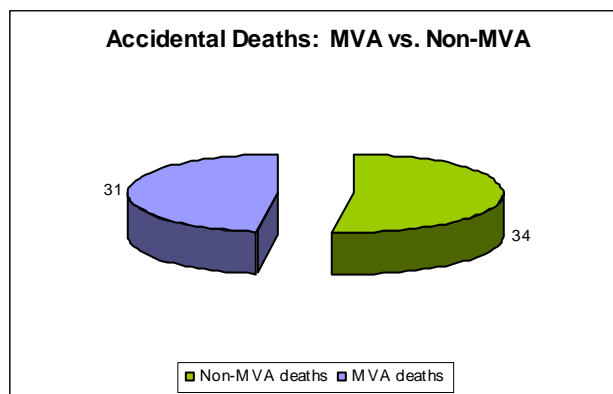
Team	Natural	Accidental	Homicide	Suicide	Undetermined	TOTAL
Clark	48	52	20	9	18	147
Washoe	77	8	2	2	11	100
Elko	2	3	1	1	2	9
Carson	1	0	1	0	0	2
Fallon	2	2	0	0	0	4
Pahrump	0	0	0	0	0	0
TOTAL:	130	65	24	12	31	262

Target Causes of Death for Data Comparison

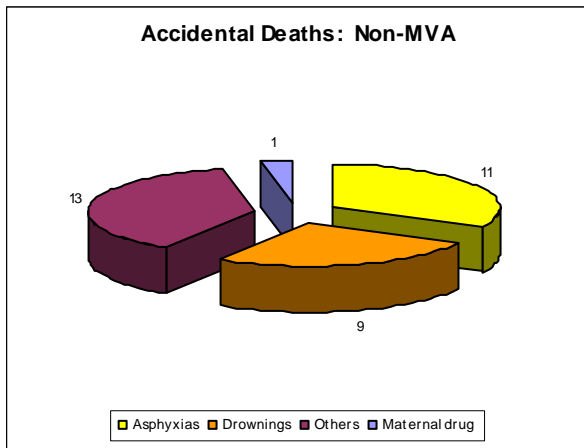
For regional CDR team data, groupings for target causes of death are made based on the five manners of death, deaths required for review by NRS 432B.405, deaths commonly related to abuse and neglect, and causes of death where prevention efforts could contribute to a reduction in fatalities such as suicides and accidental drownings.

ACCIDENTAL DEATHS

Target Cause	Total	%
● <u>MVA Deaths</u>	31	11.8%
MVA – driver	3	1.1%
MVA – passenger	13	4.9%
MVA – pedestrian	7	2.7%
MVA – motorcycle driver	2	0.8%
MVA – motorcycle passenger	1	0.4%
MVA – moped	0	0.0%
MVA – bicycle	3	1.1%
MVA – ATV	0	0.0%
MVA – watercraft	1	0.4%
MVA – unknown	1	0.4%



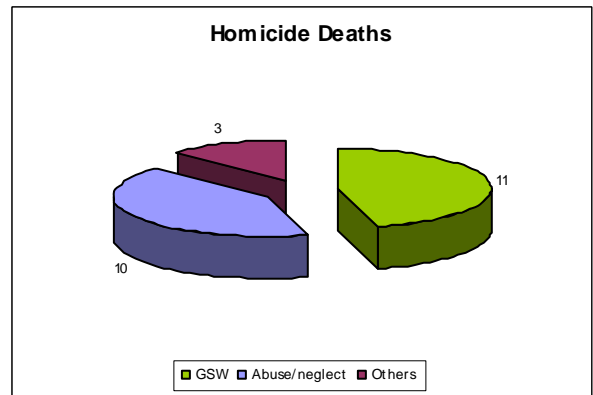
DATA NOTES: There are a total of six driver deaths for 2006: Three in cars or trucks (MVA – driver), two on motorcycles (MVA – motorcycle driver), and one on a jet ski (MVA – watercraft). There are a total of 14 passenger deaths for 2006: 13 in cars or trucks (MVA – passenger) and one on a motorcycle (MVA – motorcycle passenger).



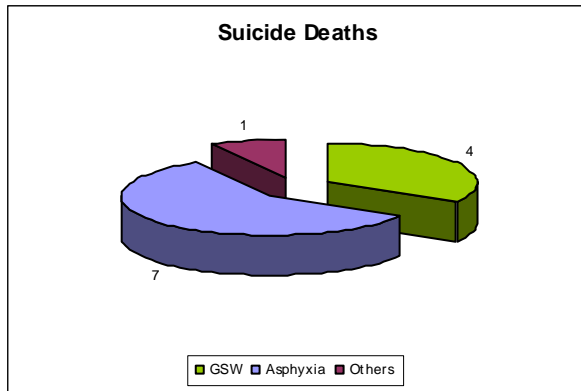
Target Cause	Total	%
Non-MVA Deaths	34	12.9%
Asphyxias	11	4.2%
Asphyxia – bedding	7	2.7%
Asphyxia – food	0	0.0%
Asphyxia – other	4	1.5%
Asphyxia – undetermined	0	0.0%
Drownings	9	3.4%
Drowning – pool	7	2.7%
Drowning – natural water	2	0.8%
Drowning – other	0	0.0%
Other Accidents	14	5.3%
Accident – GSW	1	0.4%
Accident – overdose	4	1.5%
Accident – fall	4	1.9%
Accident – fire	2	0.8%
Accident – heat	0	0.0%
Accident – poisoning	1	0.4%
Accident – other weapon	0	0.0%
Accident – other	1	0.4%
Accident – Maternal drug use	1	0.4%

HOMICIDE DEATHS

Target Cause	Total	%
Homicide Deaths	24	9.2%
Homicide – GSW	11	4.2%
Homicide – abuse	9	3.4%
Homicide – neglect	1	0.4%
Homicide – asphyxia	1	0.4%
Homicide – other weapon	1	0.4%
Homicide – other	1	0.4%



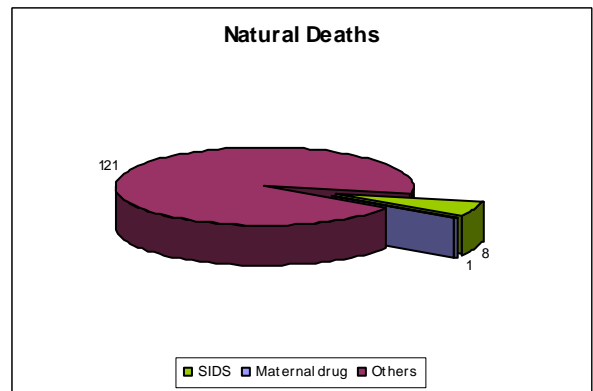
SUICIDE DEATHS



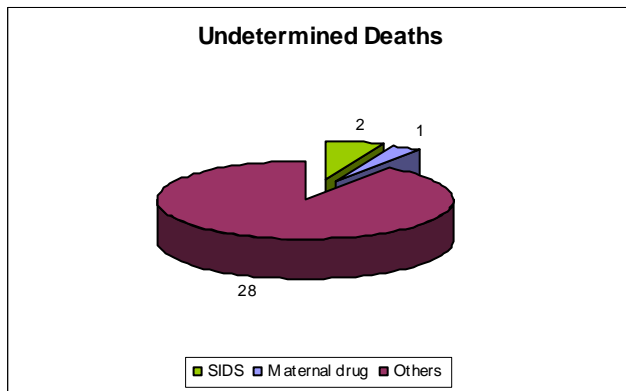
Target Cause	Total	%
Suicide Deaths	12	4.6%
● Suicide – GSW	4	1.5%
● Suicide – asphyxia	7	2.7%
● Suicide – overdose	0	0.0%
● Suicide – other	1	0.4%

NATURAL DEATHS

Target Cause	Total	%
Natural Deaths	130	49.4%
● Natural – SIDS	8	3.0%
● Natural – Prematurity	32	12.2%
● Natural – IUFD	5	1.9%
● Natural – Maternal drug use	1	0.4%
● Natural – other	84	31.9%



UNDETERMINED DEATHS



Target Cause	Total	%
Undetermined Deaths	31	11.8%
● Undet – SIDS	2	0.8%
● Undet – prematurity	2	0.8%
● Undet – maternal drug use	1	0.4%
● Undet – accident – fall	1	0.4%
● Undet – asphyxia – other	1	0.4%
● Undet – natural	1	0.4%
● Undet – all others	23	8.7%

Although the 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 multi-disciplinary partners. This is true for the eight undetermined cases detailed above: Two SIDS deaths, two prematurity deaths, one maternal drug use death, one accident by fall, one accident by asphyxia, and one natural death.

DATA NOTES:

- MVA = motor vehicle accident
- ATV = all terrain vehicle
- GSW = gunshot wound
- SIDS = Sudden Infant Death Syndrome
- IUFD = intra-uterine fetal demise

Percentages shown above are for each cause out of all 262 deaths reviewed.

Leading Causes of Death

Target Causes for Prevention Efforts

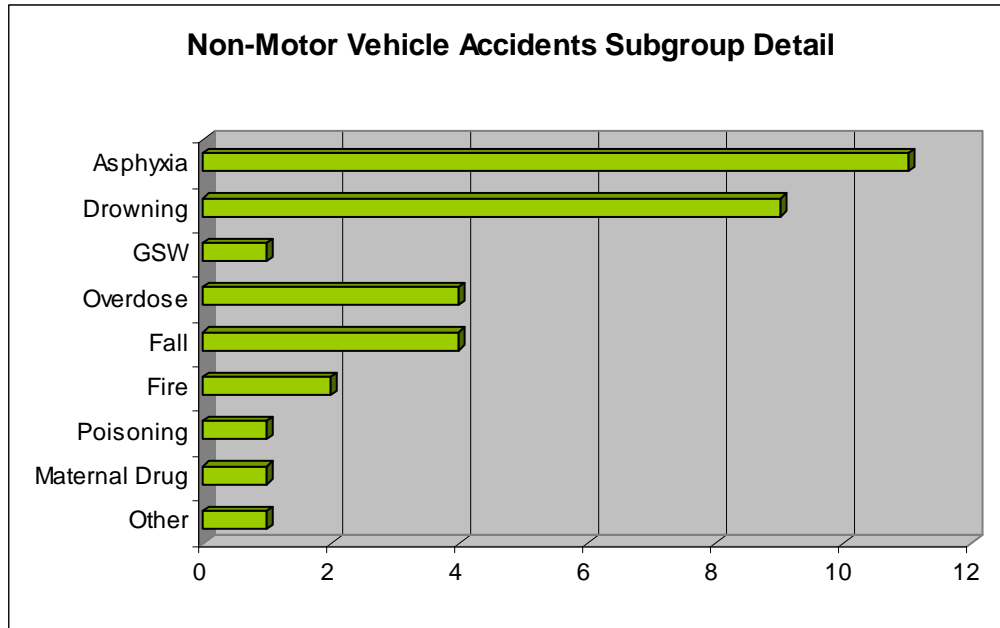
Based on analysis of data derived from the 262 cases reviewed by the six regional CDR teams, the four leading causes of child death where prevention efforts may contribute to a reduction in fatalities are as follows:

Leading Cause	Total Deaths by Cause	Percentage of Total Deaths Reviewed
1. Non-motor vehicle accidents	34	13.0%
2. Motor vehicle accidents	31	11.8%
3. Homicide	24	9.2%
4. Suicide	12	4.6%
TOTAL targeted deaths:	101	38.5%

These causes exclude undetermined deaths, which cannot be targeted for prevention due to lack of information. These causes also exclude deaths by natural causes, which are discussed separately above in Section 1 under *Natural Deaths*.

DETAIL: Target Causes for Prevention Efforts

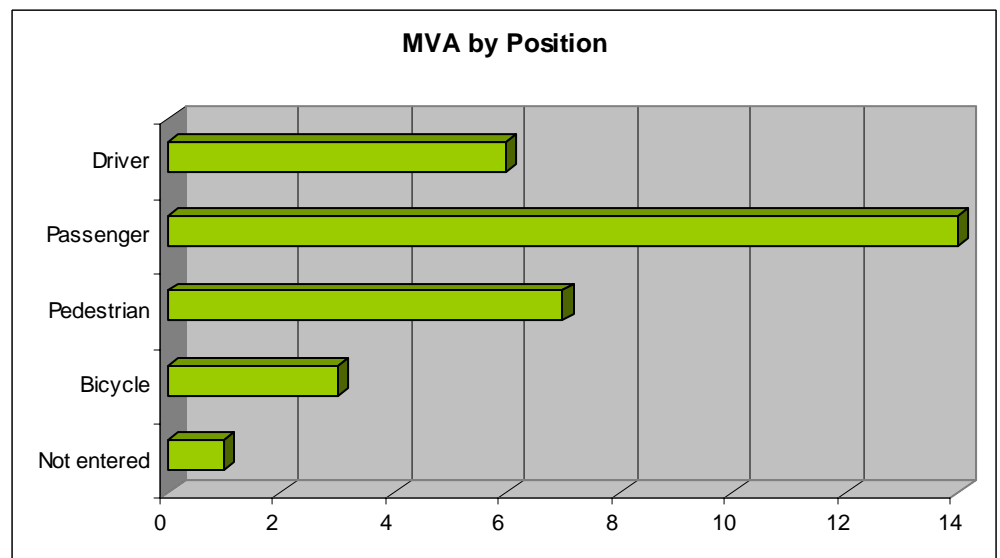
— Non-Motor Vehicle Accidents: 34 total deaths —



Subgroup	Total
Asphyxia	11
Drowning	9
GSW	1
Overdose	4
Fall	4
Fire	2
Poisoning	1
Mat Drug	1
Other	1

— Motor Vehicle Accidents: 31 total deaths —

Position	Total
Driver	6
Passenger	14
Pedestrian	7
Bicycle	3
Not entered	1

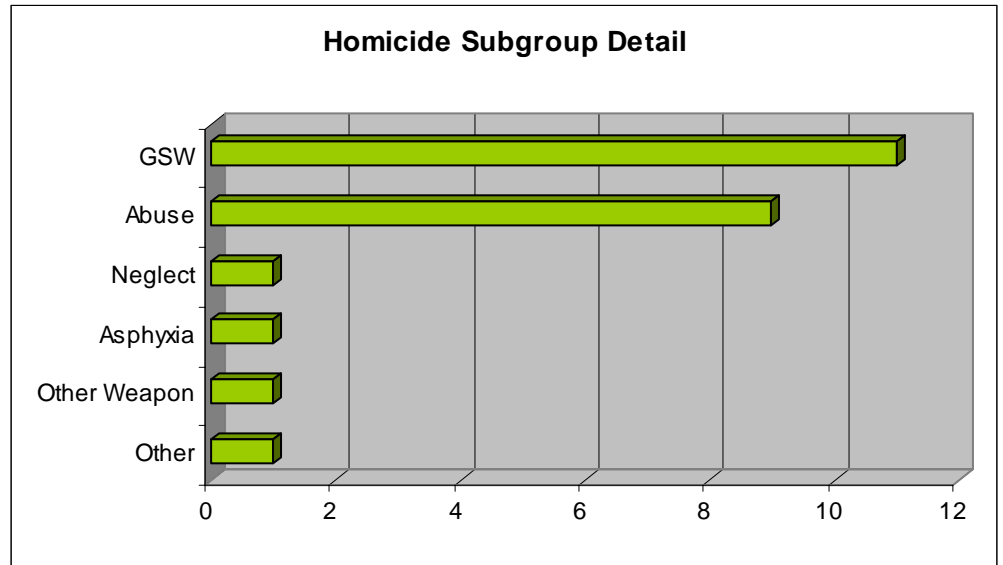


DATA NOTES: This chart shows MVA deaths by child position, which is contrasted with the detail provided in the chart on page 31 that shows MVA deaths by vehicle type and position. There are a total of six driver deaths for 2006: Three in cars

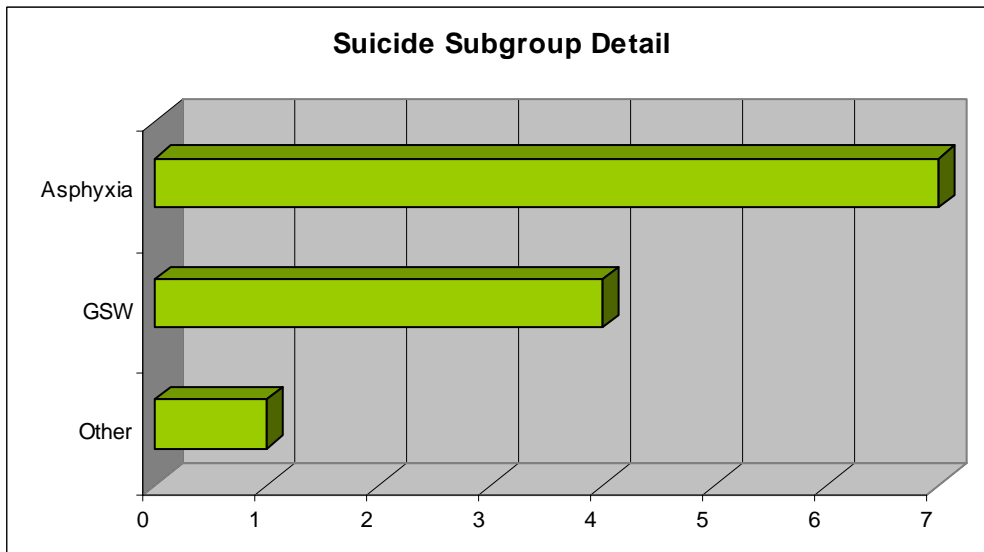
or trucks (MVA – driver), two on motorcycles (MVA – motorcycle driver), and one on a jet ski (MVA – watercraft). There are a total of 14 passenger deaths for 2006: 13 in cars or trucks (MVA – passenger) and one on a motorcycle (MVA – motorcycle passenger).

— Homicides: 24 total deaths —

Subgroup	Total
GSW	11
Abuse	9
Neglect	1
Asphyxia	1
Other Weapon	1
Other	1



— Suicides: 12 total deaths —



Subgroup	Total
Asphyxia	7
GSW	4
Other	1

DATA NOTES: GSW = gunshot wound

Statewide Health Division Data Versus Regional CDR Team Data

Leading Cause:	STATEWIDE HEALTH DIVISION DATA		REGIONAL CDR TEAM DATA	
	Total Deaths by Cause:	Percentage of Total Deaths:	Total Deaths by Cause:	Percentage of Total Deaths:
1. Motor vehicle accidents	48	10.0%	31	11.8%
2. Non-motor vehicle accidents	37	7.7%	34	13.0%
• Asphyxia	10	2.1%	11	4.2%
• Drowning	9	1.9%	9	3.4%
• All others	18	3.8%	14	5.3%
3. Homicide	24	5.0%	24	9.2%
• GSW	11	2.3%	11	4.2%
• Abuse /neglect	4	0.8%	10	3.8%
• All others	9	1.9%	3	1.1%
4. Suicide	16	3.3%	12	4.6%
• Asphyxia	9	1.9%	7	2.7%
• GSW	6	1.3%	4	1.5%
• All others	1	0.2%	2	0.4%
TOTAL targeted deaths:	125	26.0%	101	38.5%

DATA NOTES: GSW = gunshot wound

There are three key variances when comparing leading causes of death between statewide Health Division data and the regional CDR team data:

1. Based on regional CDR team data alone, it appears that non-motor vehicle accidents are the leading cause of death, excluding natural deaths. However, when statewide Health Division data is evaluated, motor vehicle accidents (MVA) are seen to be the leading cause of accidental death. Because statewide Health Division data is the most complete, MVA is actually the leading cause of accidental death.
2. Based on statewide Health Division data alone, it appears that the total number of deaths by abuse or neglect is four. However, the additional amount of detail available through regional CDR team data shows that total deaths caused by abuse or neglect is actually 10.
3. Total deaths by leading cause differ between statewide Health Division data (125) and regional CDR team data (101) because all deaths are not reviewed by the regional CDR teams, as discussed above under *Deaths Reviewed Versus Deaths Not Reviewed* and *Data Limitations*.

Regardless of which data source is evaluated, the following are the four leading causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

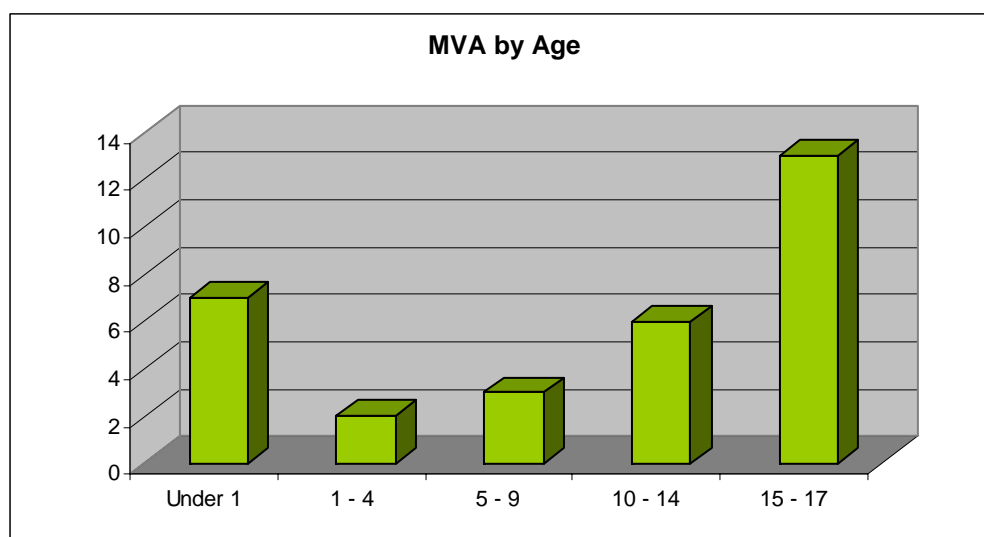
1. Motor vehicle accidents
2. All other accidents combined
3. Homicide
4. Suicide

Review: Motor Vehicle Accidents (MVA)

Reviewed by Team		County of Residence	
Clark	22	Carson	1
Elko	2	Churchill	1
Fallon	1	Clark	15
Washoe	6	Elko	2
		Washoe	5
		Out-of-state	3
		Unknown	3
		Not entered	1
TOTAL:	31	TOTAL:	31

MVA – Basic Demographics: Age, Gender, and Race

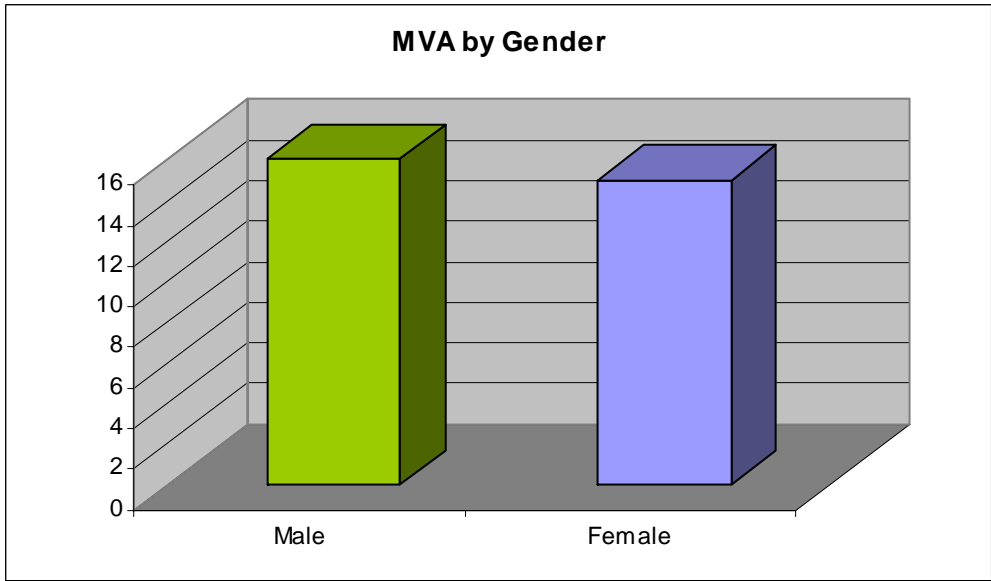
Age Group	Total
Under 1	7
1 - 4	2
5 - 9	3
10 - 14	6
15 - 17	13



Findings:

- Consistent with the statewide data analysis, the risk of death from MVA generally increases with age for children in Nevada.²⁵

²⁵ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

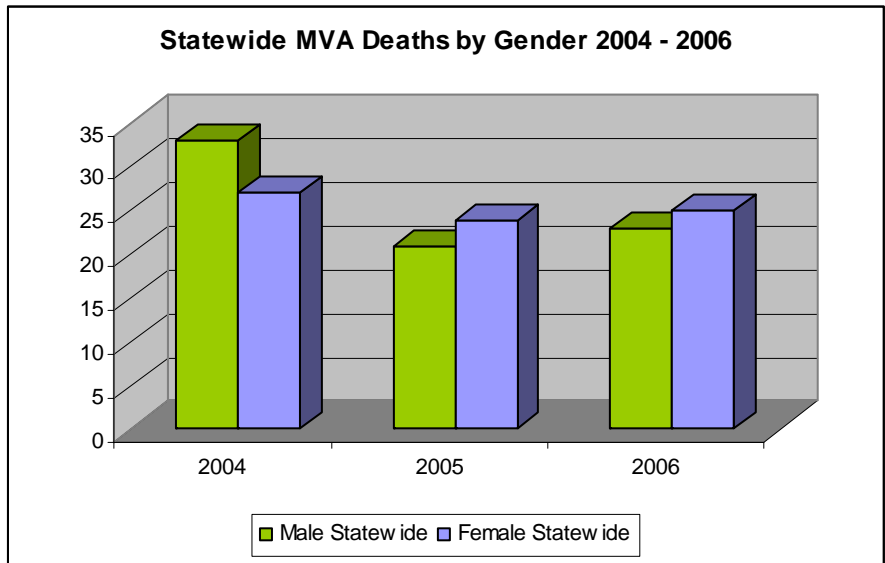


Gender	Total
Male	16
Female	15

Findings:

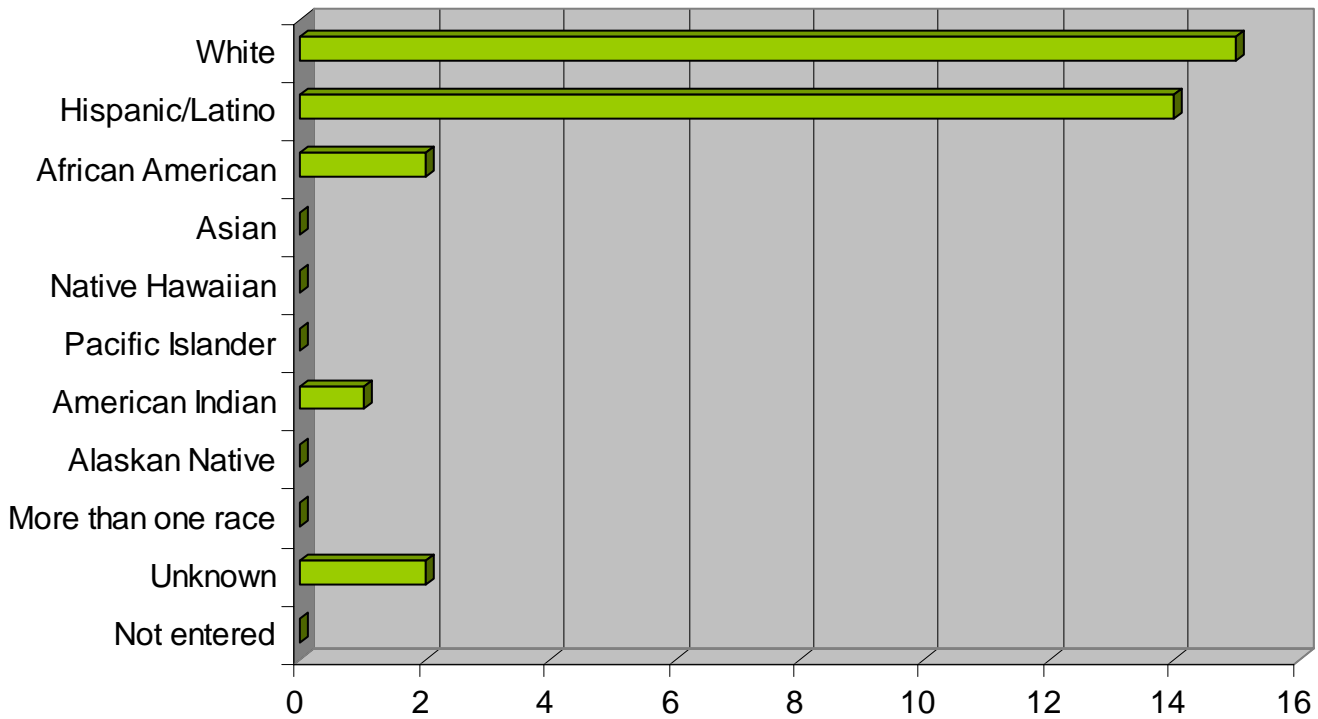
- In 2006 cases reviewed, female deaths from motor vehicle accidents are nearly equal with those of males. This is inconsistent with national data which shows that males typically die at twice the rate of females in motor vehicle accidents across the lifespan (21.4 per 100,000 versus 9.3 per 100,000).²⁶

This trend has been consistent over the past three years for both statewide deaths and cases reviewed. In both 2005 and 2006, female MVA deaths statewide have exceeded male MVA deaths statewide:



²⁶ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

MVA by Race



Race Group	Total	Race Group	Total
White	12	American Indian	1
Hispanic/Latino	14	Alaskan Native	0
African American	2	More than one race	0
Asian	0	Unknown	2
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

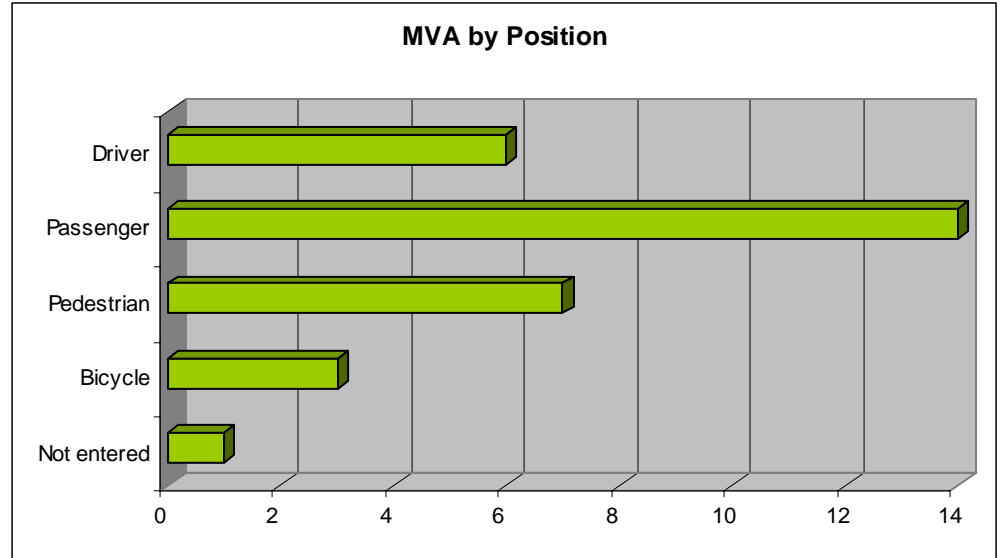
Findings:

- Over 45% (14 of 31) of child deaths by MVA in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1%.

MVA – Contributing Factors

Position of Child in Accident

Position	Total
Driver	6
Passenger	14
Pedestrian	7
Bicycle	3
Not entered	1



Findings:

- Over 45% (14 of 31) of children who died in motor vehicle accidents were passengers in vehicles.
- Of the 14 passengers, 12 were in cars or trucks, one was riding on a motorcycle, and in one case the vehicle type was unknown.
- Of the six drivers, three were driving cars, two were driving motorcycles, and one was operating a jet ski.

Position of Child by Age Group

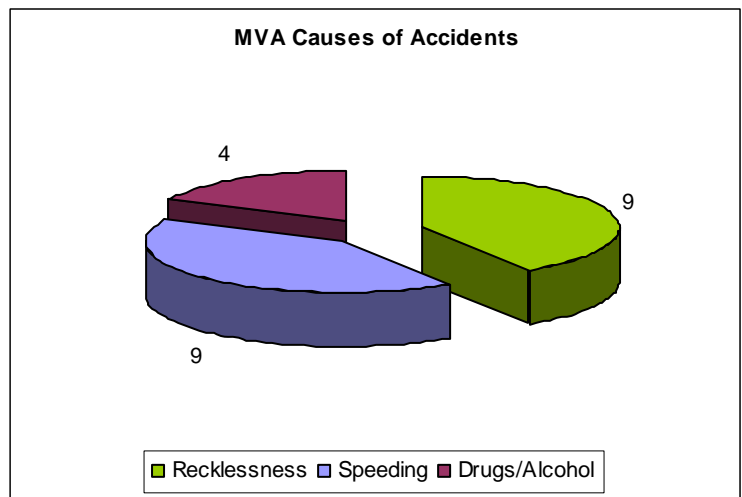
Age Group	Driver	Passenger	On Bicycle	Pedestrian	Unknown	Not Entered	Total
Less than 1	0	4	0	2	0	1	7
1 – 4	0	0	0	2	0	0	2
5 – 9	0	3	0	0	0	0	3
10 – 14	0	2	3	1	0	0	6
15 – 17	6	5	0	2	0	0	13
TOTAL:	6	14	3	7	0	1	31

Findings:

- All driver deaths in 2006 occurred in the 15 – 17 age group. This is not to be expected per se based on driver’s license eligibility, because operators of other vehicle types may be younger, such as ATVs, watercraft, and dirt bikes.
- All bicycle deaths in 2006 occurred in the 10 – 14 age group.
- Almost half of pedestrian deaths in 2006 occurred among children four years of age or younger.

Causes of Accidents for All Cases

Cause	Total
● Speeding over limit	5
● Unsafe speed for conditions	4
● Recklessness	9
● Ran stop sign/red light	1
● Driver distraction	2
● Mechanical failure	1
● Poor tires	0
● Poor weather	0
● Poor visibility	2
● Drug or alcohol use	4
● Fatigue/sleeping	1
● Medical event	0
● Back over	2
● Poor sight line	4
● Car changing lanes	1
● Road hazard	0
● Animal in road	0
● Cell phone use while driving	0
● Racing	1
● Other driver error	3
● Other cause	2
● Unknown	6



DATA NOTES: More than one cause may apply to more than one case, therefore total causes exceed the total of 34 accidents.

Findings:

- Approximately 29% of cases (9 of 31) involved speeding or unsafe speed for conditions.
- Approximately 29% of cases (9 of 31) involved recklessness or driver inexperience.
- Approximately 13% of cases (4 of 31) involved drug or alcohol use.

Causes of Accidents When Child Was Responsible for Accident

Cause	Total
Child responsible for causing accident	4
Child was alcohol or drug impaired	1
Child had no license	0
Child had a valid license	1
Child had full license, not graduated	0
Child had suspended license	0
Child had graduated license	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	10
Child's driver was alcohol or drug impaired	2
Child's driver had no license	0
Child's driver had a valid license	2
Child's driver had full license, not graduated	0
Child's driver had suspended license	0
Child's driver had graduated license	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	7
Another driver was alcohol or drug impaired	0
Another driver had no license	0
Another driver had a valid license	1
Another driver had full license, not graduated	0
Another driver had suspended license	0
Another driver had graduated license	0
Another driver was violating graduated license rules	0

DATA NOTES: Detail for causes of accidents is limited in many cases, which may represent lack of information collection or determination during investigations, difficulty in obtaining investigation information, and/or increase need for data entry on the part of the regional CDR teams.

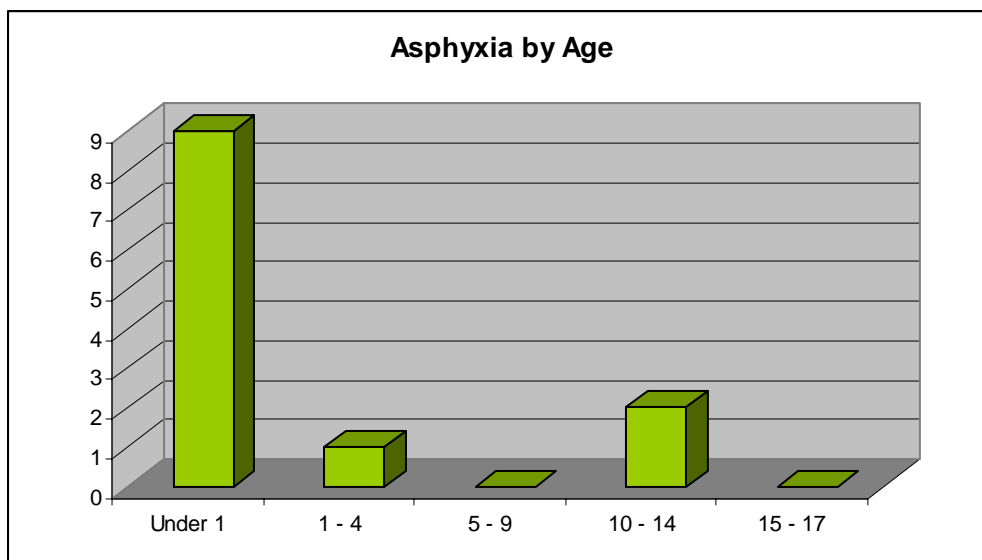
Review: Accidents Involving Asphyxia

In addition to the 11 asphyxia deaths determined to be accidental based on manner of death, this review includes the additional asphyxia death with an undetermined manner.

Reviewed by Team		County of Residence	
Clark	10	Clark	10
Elko	2	Elko	2
TOTAL:	12	TOTAL:	12

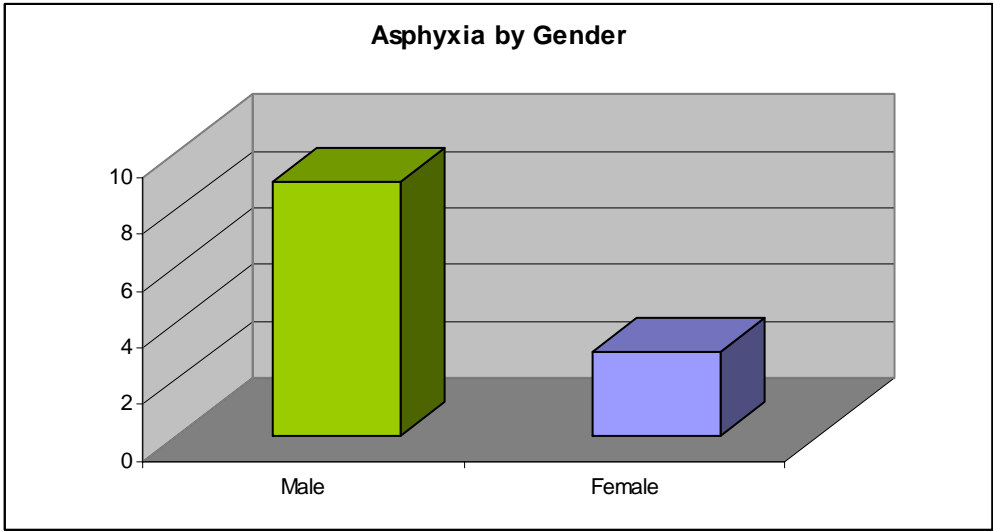
Asphyxia – Basic Demographics: Age, Gender, and Race

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



Findings:

- 75% (9 of 12) of asphyxia deaths in 2006 occurred among infants less than one year of age.

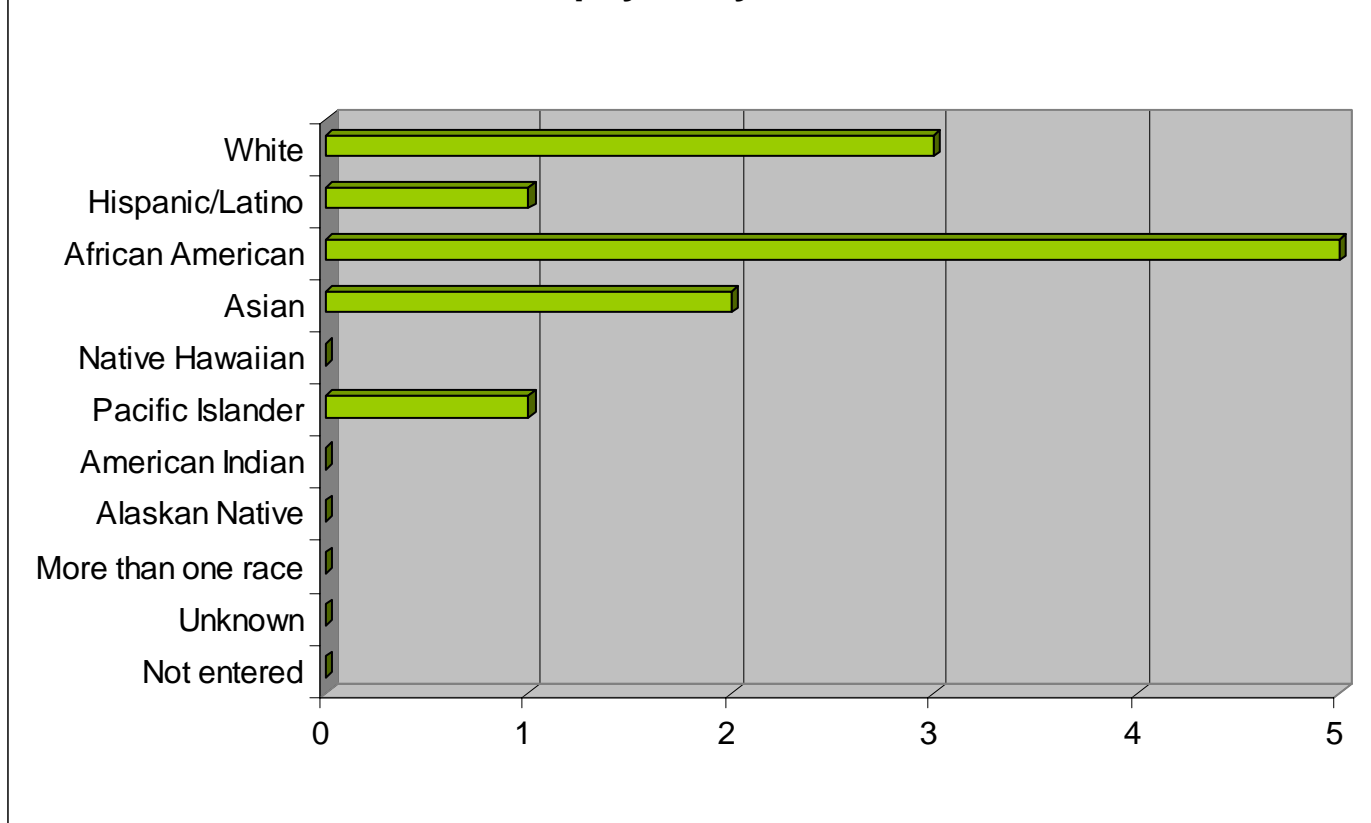


Gender	Total
Male	9
Female	3

Findings:

- 75% (9 of 12) of asphyxia deaths in 2006 occurred among males.

Asphyxia by Race



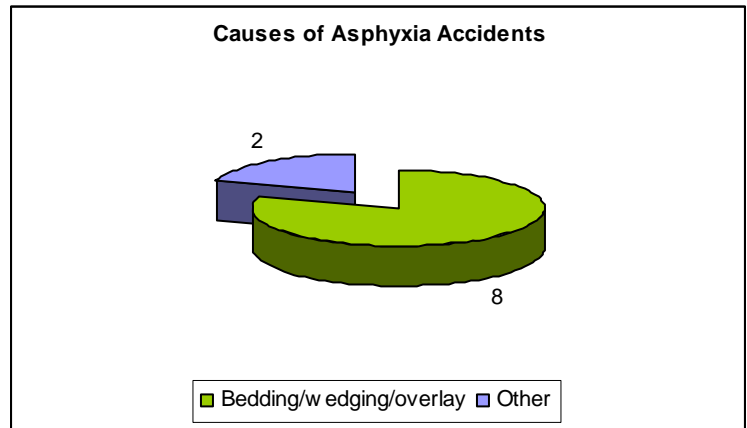
Race Group	Total	Race Group	Total
White	3	American Indian	0
Hispanic/Latino	1	Alaskan Native	0
African American	5	More than one race	0
Asian	2	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	1		

Findings:

- Almost half (5 of 12) of asphyxia deaths in 2006 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%, and indicates that prevention efforts may need to be increased for this population.

Asphyxia – Contributing Factors

Cause	Total
● Bedding/wedging/overlay	8
● Covered/fell	1
● Strangled	1
Not entered	2



DATA NOTES: Wedging means the child was wedged between surfaces that caused suffocation, such as falling between a mattress and a wall. Covered or fell means the child was covered by something or fell into something that caused suffocation.

Findings:

- Two-thirds (8 of 12) of asphyxia deaths in 2006 were caused by unsafe sleeping environments due to excessive bedding, wedging, or adults/children co-sleeping with children, which can result in rolling over or onto the child and causing suffocation (overlay).

Unsafe Sleeping Death Detail

Detail	Total
Child was in an unsafe sleeping environment	6
Adult was co-sleeping with child resulting in overlay	2

Location Child Found

Location	Total
Bassinette	1
Crib	1
Mattress	4
Chair	1
Couch	1

Unsafe Sleeping Death Risk Factors

Factor	Total
Child put to sleep on stomach	2
Child found with blanket	3
Child found with pillow	4
Child found with comforter	1
Child found with toy(s)	0
Child co-sleeping with another adult	2

Other Asphyxia Death Detail

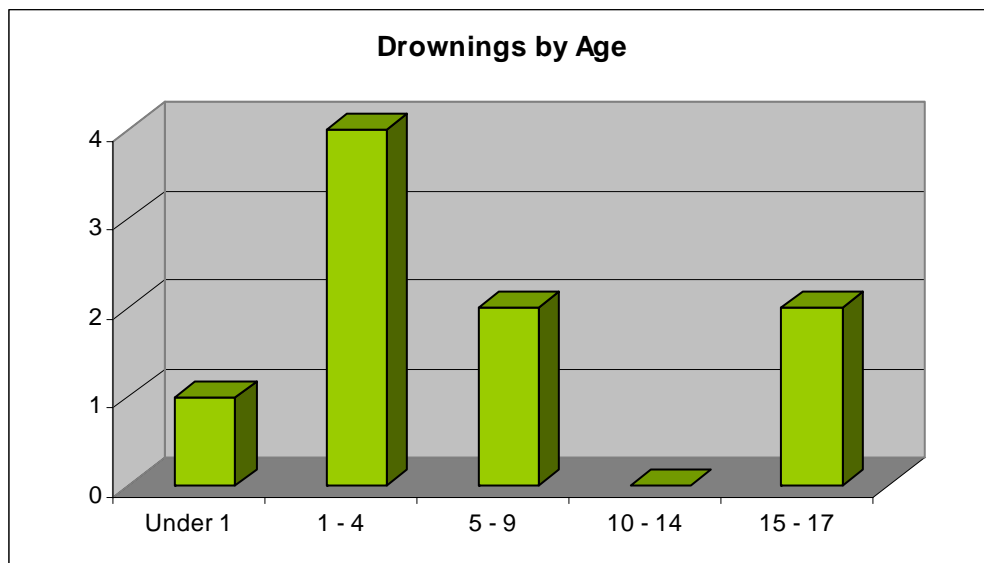
Detail	Total
Covered/fell: Child was covered by a plastic container	1
Strangled: Child was strangled by a rope, cord, or string	1

Review: Accidents Involving Drowning

Reviewed by Team		County of Residence	
Clark	9	Clark	9
TOTAL:	9	TOTAL:	9

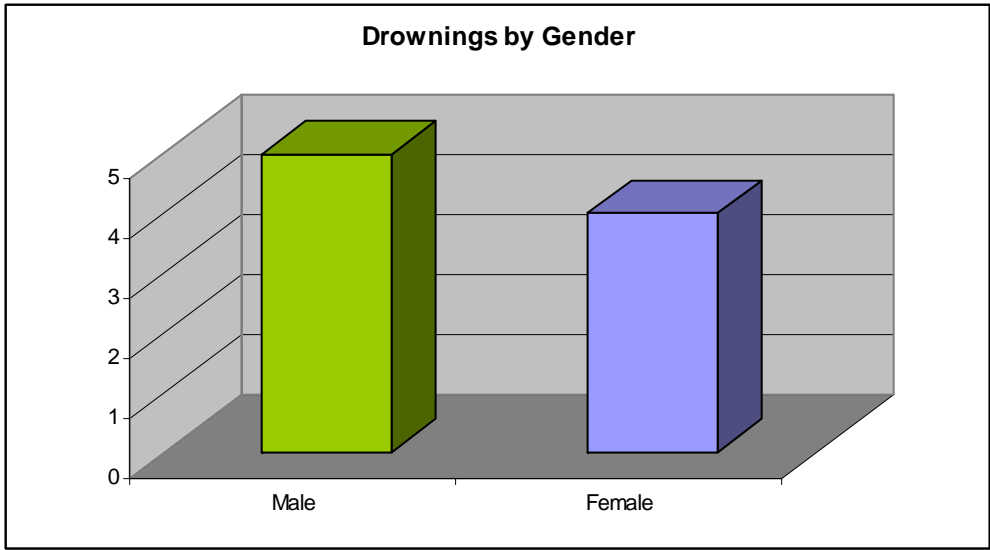
Drowning – Basic Demographics: Age, Gender, and Race

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



Findings:

- Almost half (4 of 9) of all drownings in 2006 occurred among children one to four years of age.

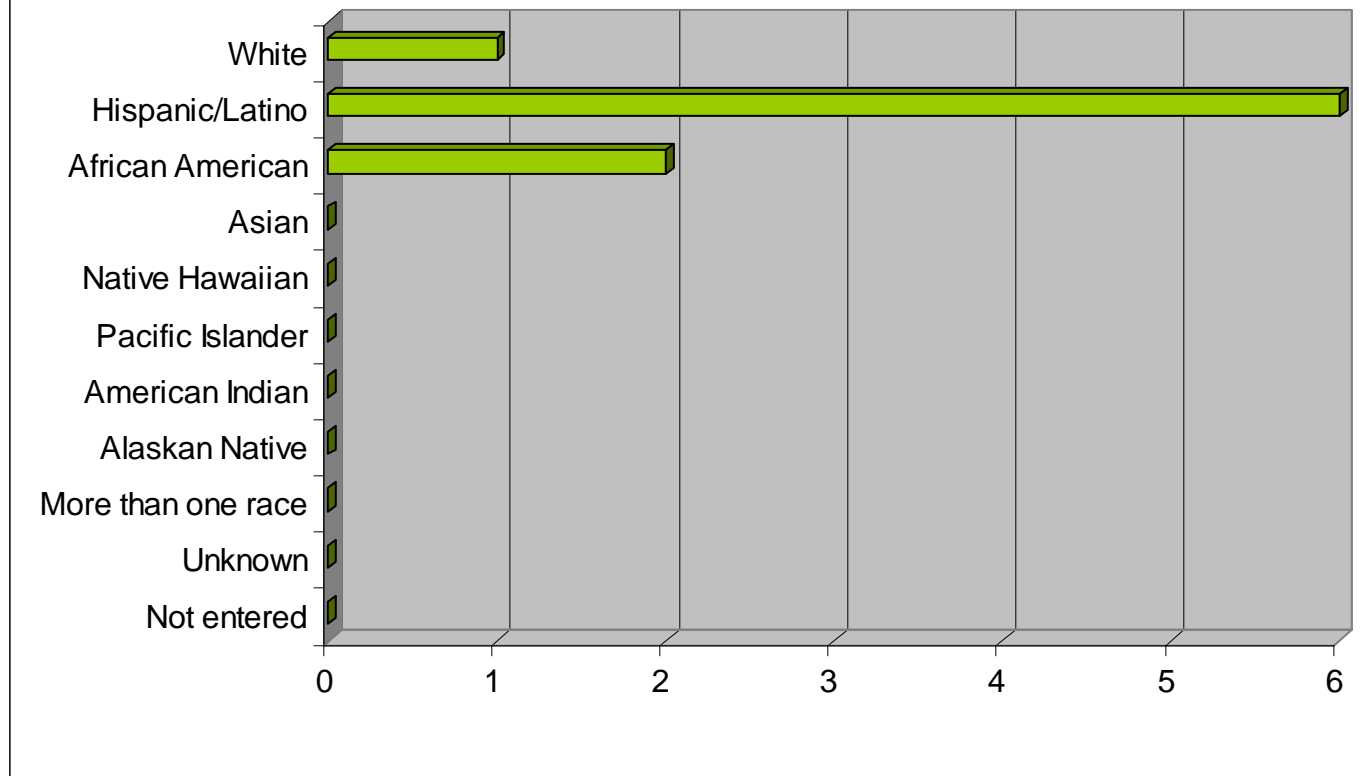


Gender	Total
Male	5
Female	4

Findings:

- Drownings in 2006 were nearly equivalent between males and females.

Drownings by Race



Race Group	Total	Race Group	Total
White	1	American Indian	0
Hispanic/Latino	6	Alaskan Native	0
African American	2	More than one race	0
Asian	0	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

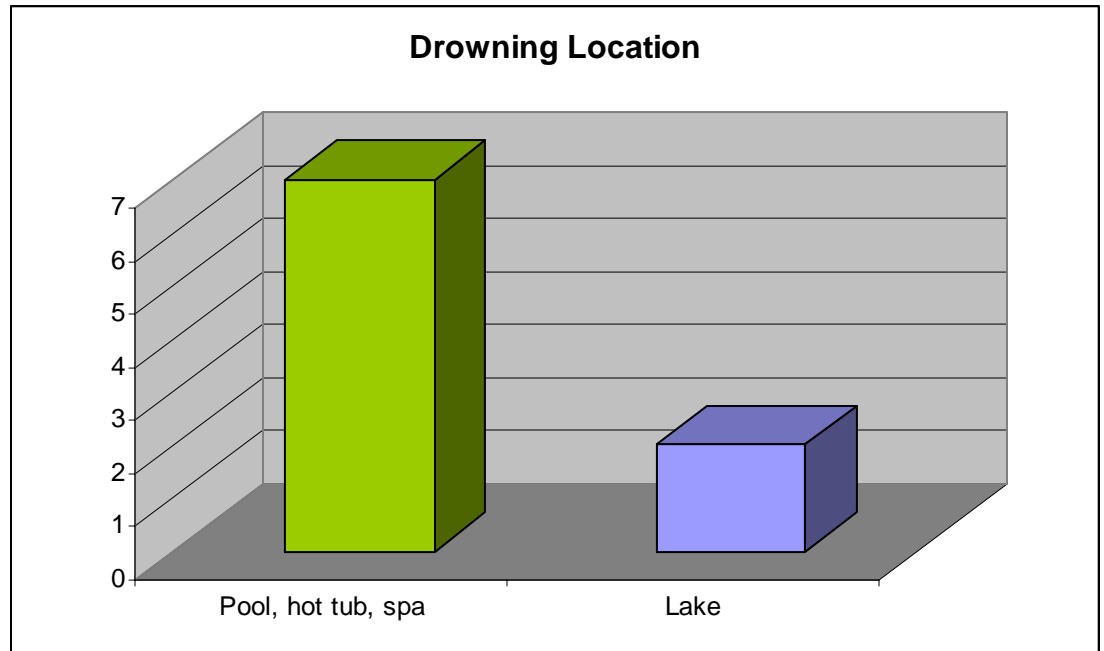
- Two-thirds (6 of 9) of all drownings in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the Clark County population distribution for Hispanics and Latinos at 37.8%,²⁷ and indicates that public awareness efforts regarding pool and water safety may need to be increased for this population.

²⁷ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2006 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

Drowning – Contributing Factors

Location of Accident

Position	Total
Pool, hot tub, or spa	7
Lake	2



Findings:

- Most drownings occur in man-made swimming locations such as a pool, hot tub, or spa.

Emergency Response

Response	Total
911 was called to the scene	8
CPR was performed on the child	7
Emergency medical services arrived at the scene	8

Safety Factors

Factor	Total
Child <u>was</u> able to swim	2
Child <u>was not</u> able to swim	4
Child's swimming ability <u>unknown</u>	3
Child had a personal flotation device	0
No barriers to swimming area	4
Fence around swimming area	5
Gate to swimming area	3

Factor	Total
Door to swimming area	2
Alarm for swimming area	0
Cover for swimming pool, hot tub, or spa	0

Safety Breaches

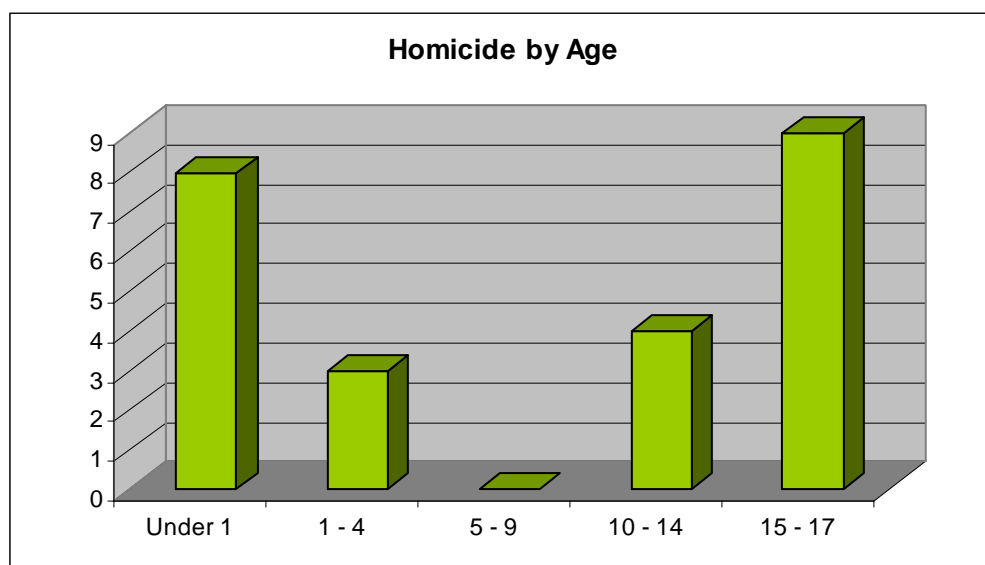
Breach	Total
No barrier breached	5
Gate left open	1
Gate unlocked	1
Gate latch failed	1
Gap in gate	0
Child climbed fence to access swimming area	0
Gap in fence	0
Damaged fence	0
Fence too short	0
Door left open	0
Door unlocked	1
Door broken	0
Door screen torn	0
Door closer failed	0
Window left open	0
Alarm not working	0
Alarm not answered	0
Cover left off	0
Cover not locked	0
Other cause: Child unlocked door on his/her own	1

Review: Homicides

Reviewed by Team		County of Residence	
Carson	1	Carson	1
Clark	20	Clark	17
Elko	1	Humboldt	1
Washoe	2	Nye	1
		Washoe	2
		Out-of-state	1
		Not entered	1
TOTAL:	24	TOTAL:	24

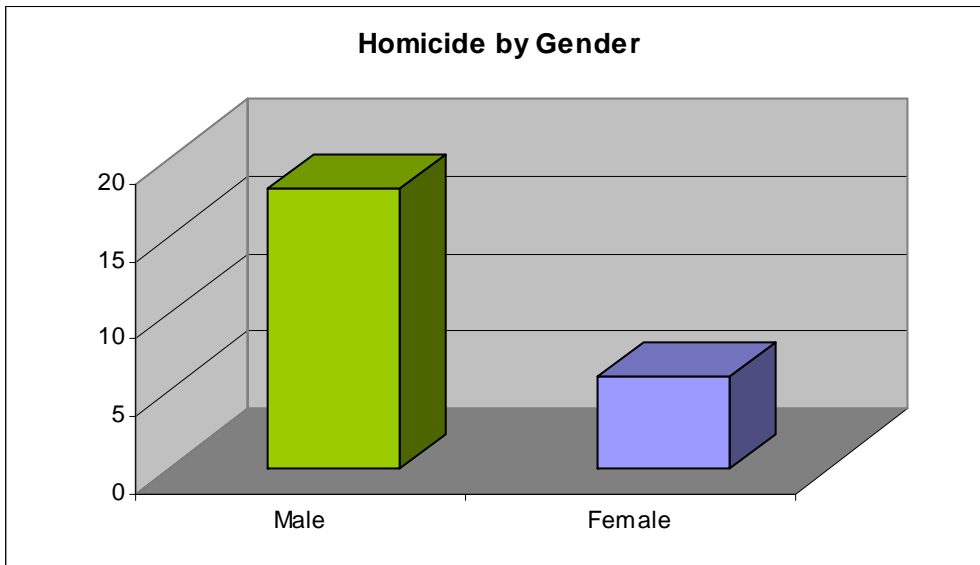
Homicide – Basic Demographics: Age, Gender, and Race

Age Group	Total
Under 1	8
1 - 4	3
5 - 9	0
10 - 14	4
15 - 17	9



Findings:

- 42% (10 of 24) of homicide deaths in 2006 occurred among adolescents ages 15 to 17.
- 33% (8 of 24) of homicide deaths in 2006 occurred among infants less than one year of age.



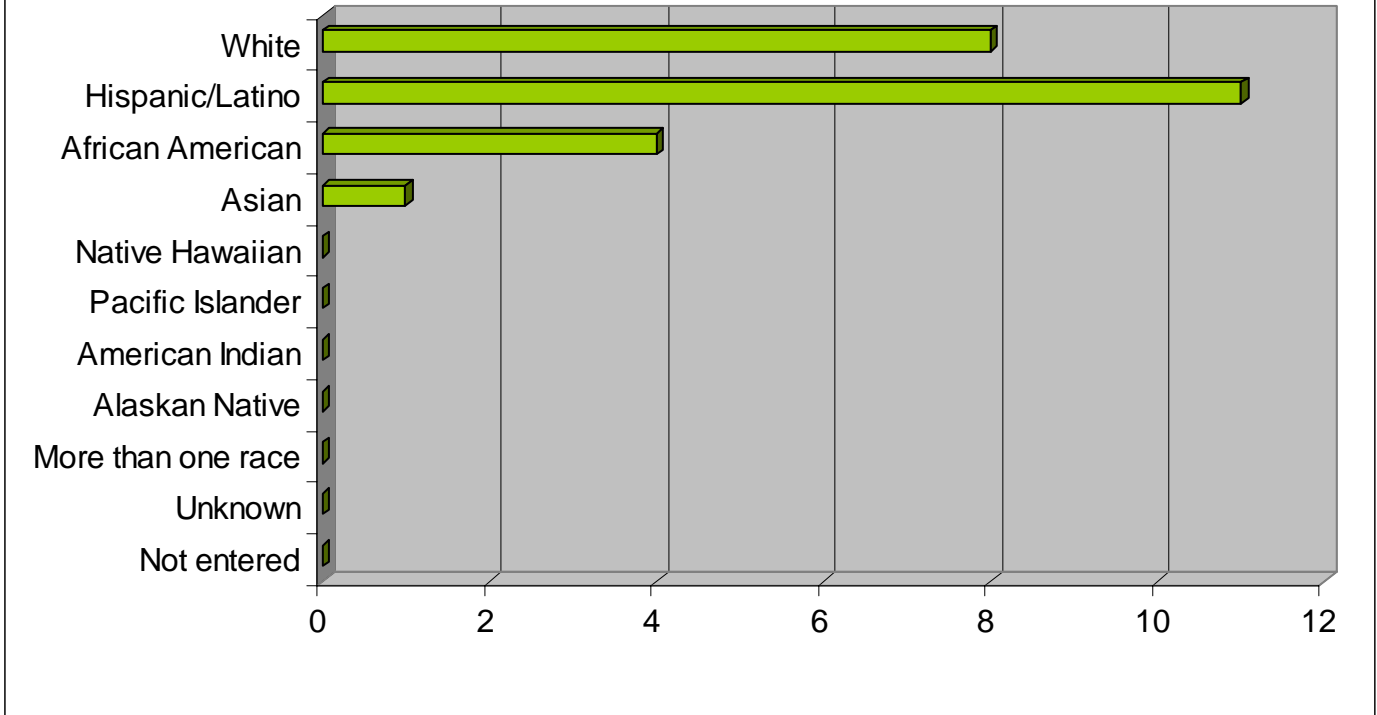
Gender	Total
Male	18
Female	6

Findings:

- 75% (18 of 24) of homicide deaths in 2006 occurred among males.
- This is roughly consistent with national data that shows male homicide death rates are almost four times that of females across the lifespan.²⁸

²⁸ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

Homicide by Race



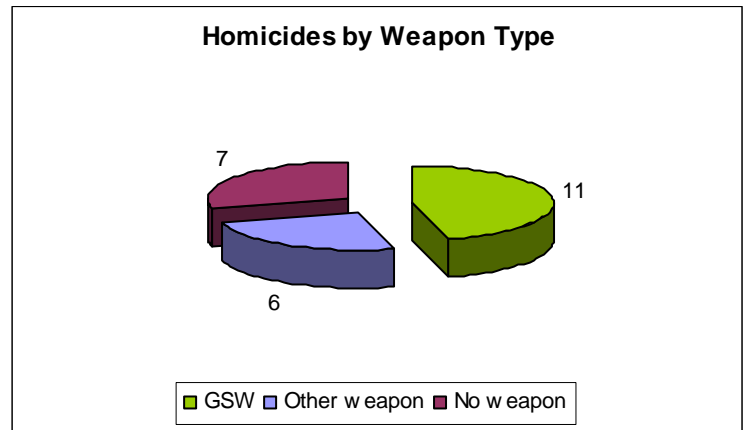
Race Group	Total	Race Group	Total
White	8	American Indian	0
Hispanic/Latino	11	Alaskan Native	0
African American	4	More than one race	0
Asian	1	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

- Almost half (11 of 24) of homicide deaths in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1%.
- 17% (4 of 24) of homicide deaths in 2006 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%.

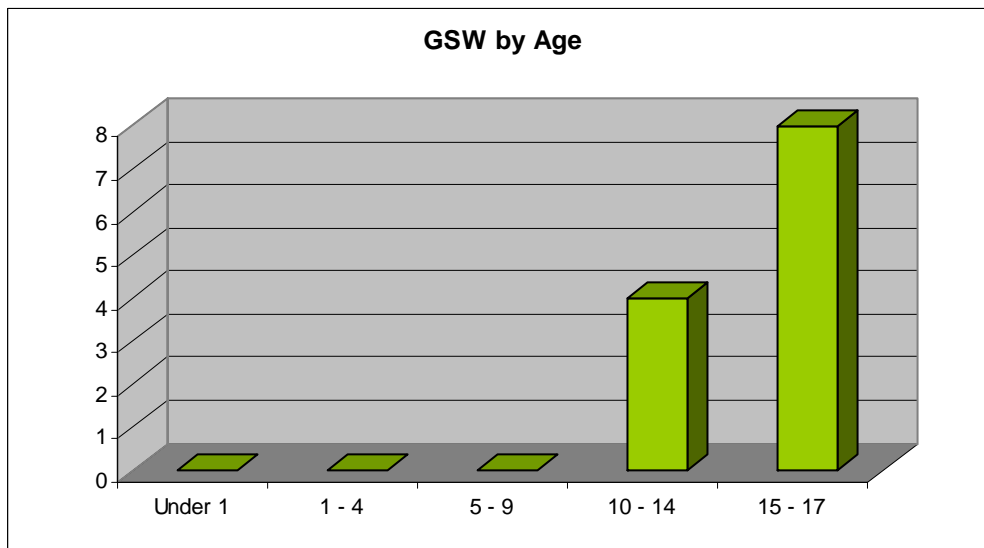
Homicide – Contributing Factors

Cause	Total
● Gunshot wounds (GSW)	11
● Other weapons	6
● No weapon involved	7



Findings:

- Almost half (11 of 24) of homicide deaths in 2006 were caused by gunshot wounds (GSW).



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

Findings:

- All homicide deaths by gunshot wound (GSW) in 2006 occurred among the 10 – 14 and 15 – 17 age groups.
- This is consistent with national data, which shows that deaths from firearm-related injuries increase considerably in the 15 – 19 age group.²⁹ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

²⁹ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

GSW Deaths: Incident Detail

Detail	Total
Person handling fatal weapon was a friend	1
Person handling fatal weapon was an acquaintance	2
Person handling fatal weapon was a rival gang member	2
Person handling fatal weapon was a law enforcement officer	1
Person handling fatal weapon was unknown	1

GSW Deaths: Criminal Activity Detail

Detail	Total
Use of fatal weapon involved commission of a crime	2
Use of fatal weapon involved a drive-by shooting	1
Use of fatal weapon involved an argument	1
Use of fatal weapon involved gang-related activity	3
Use of fatal weapon involved unknown activity	4

Other Weapon Deaths (not GSW): Incident Detail

Detail	Total
Homicide involved child abuse and neglect	5
Homicide involved a knife	1

Non-Weapon Deaths (not GSW or other weapons): Incident Detail

Detail	Total
Homicide involved child abuse and neglect	5
Homicide involved asphyxia	1
Homicide involved an unknown injury	1

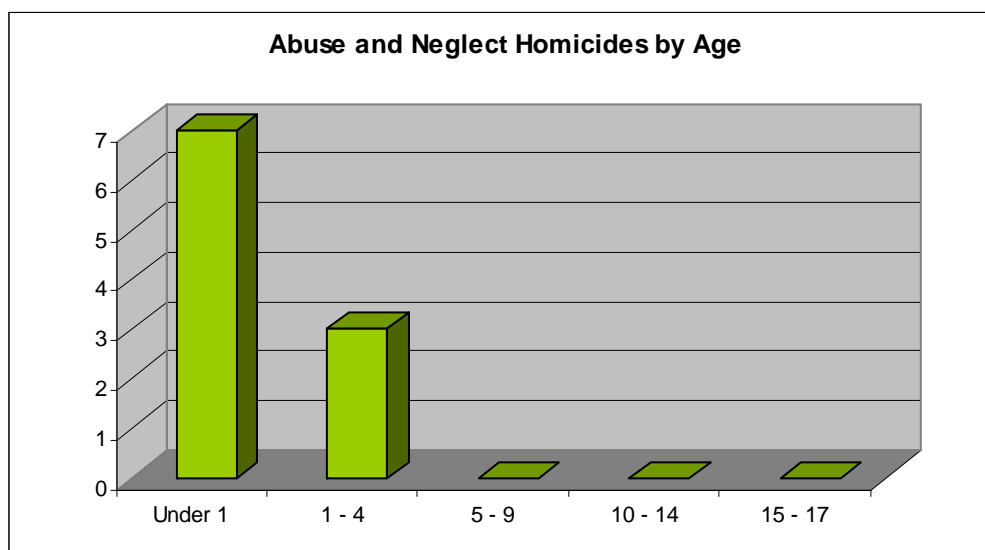
DATA NOTES: The 10 homicides involving child abuse and neglect (five weapon deaths, five non-weapon deaths) are included in the detailed analysis below.

Review: Abuse and Neglect Homicides

Reviewed by Team		County of Residence		Cause	
Carson	1	Carson	1	Abuse	9
Clark	7	Clark	5	Neglect	1
Elko	1	Humboldt	1	Both	0
Washoe	1	Washoe	1		
		Out-of-state	1		
		Not entered	1		
TOTAL:	10	TOTAL:	10	TOTAL:	10

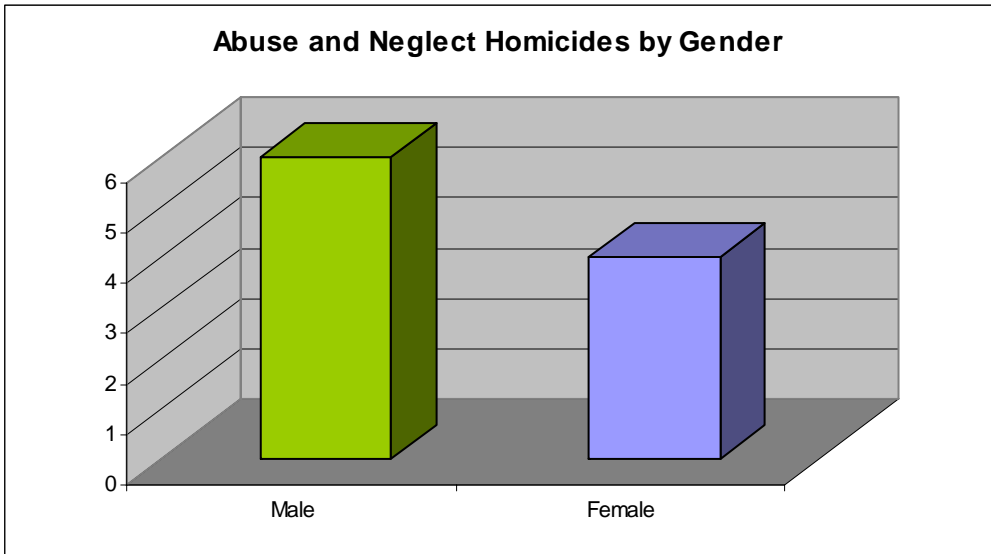
Abuse and Neglect Homicides – Basic Demographics: Age, Gender, and Race

Age Group	Total
Under 1	7
1 - 4	3
5 - 9	0
10 - 14	0
15 - 17	0



Findings:

- All abuse and neglect homicide deaths in 2006 occurred among children less than five years of age.
- 70% (7 of 10) of abuse and neglect homicide deaths in 2006 occurred among infants less than one year of age.



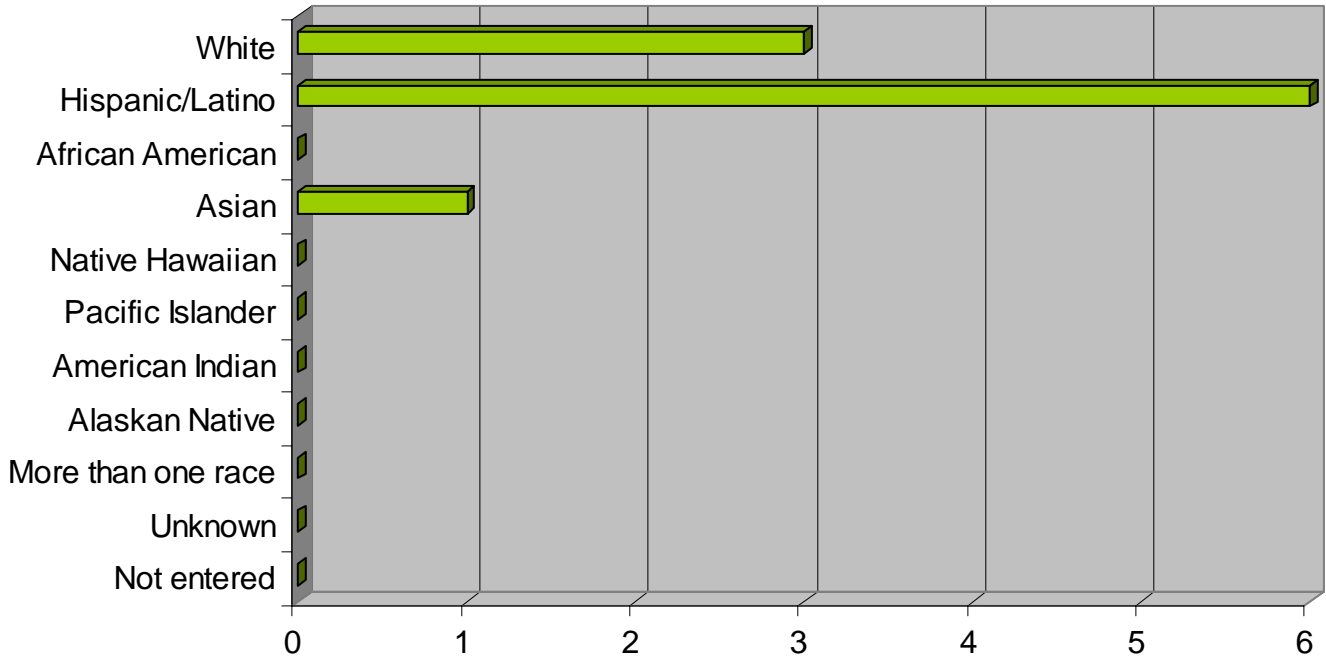
Gender	Total
Male	6
Female	4

Findings:

- 60% (6 of 10) of abuse and neglect homicide deaths in 2006 occurred among males.
- This is consistent with national data that shows male homicide death rates are much higher than that of females.³⁰

³⁰ National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

Abuse and Neglect Homicides by Race



Race Group	Total	Race Group	Total
White	3	American Indian	0
Hispanic/Latino	6	Alaskan Native	0
African American	0	More than one race	0
Asian	1	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

- 60% (6 of 10) of abuse and neglect homicide deaths in 2006 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanics and Latinos at 35.1%.

Abuse and Neglect Homicides – Contributing Factors

For many contributing factors, responses may exceed the total because they apply to more than one case.

Type of Abuse or Neglect

Type of Abuse	Abuse Cases Total	Type of Neglect	Neglect Case Total
Abusive head trauma	7	Failure to protect from hazards	0
Chronic battered child syndrome	2	Failure to provide necessities	0
Beating/kicking	4	Failure to provide food	0
Scalding/burning	0	Failure to provide shelter	0
Munchausen syndrome by proxy	0	Failure to seek/follow treatment	1
		Emotional neglect	0
		Abandonment	0

Persons Responsible for Abuse

Abuse Perpetrator	Total	Male	Female	Gender Unknown	Gender Not entered
Biological parent	4	3	0	1	0
Mother's partner	2	2	0	0	0
Other relative	1	0	1	0	0
Foster parent	0	0	0	0	0
Not Entered	1	-	-	-	-
Unknown	1	-	-	-	-

Persons Responsible for Neglect

Neglect Perpetrator	Total	Male	Female	Gender Unknown	Gender Not entered
Biological parent	0	0	0	0	0
Mother's partner	0	0	0	0	0
Other relative	0	0	0	0	0
Foster parent	1	0	1	0	0
Not Entered	0	-	-	-	-
Unknown	0	-	-	-	-

Triggering Events

Trigger	Abuse Cases Total	Neglect Case Total
Crying	3	0
Toilet training problem	1	0
Disobedience	0	0

Trigger	Abuse Cases Total	Neglect Case Total
Feeding problems	1	0
Domestic argument	0	0
None	0	0
Other	0	0
Unknown event	4	0
Not entered	1	0

Term of Abuse or Neglect

Term	Abuse Cases Total	Neglect Case Total
Chronic with child	3	0
Pattern in family or with perpetrator	0	0
Isolated incident	2	0
Unknown	3	0
Not entered	1	1

Prior Abuse or Neglect

Factor	Abuse Cases Total	Neglect Case Total
Child had a history of physical maltreatment	1	0
Child had a history of neglect	2	1
Child had a history of sexual maltreatment	0	0
Child had a history of emotional maltreatment	0	0
Unknown	0	0
Not entered	0	0

Drug or Alcohol Exposure

Factor	Abuse Cases Total	Neglect Case Total
Toxicology screen completed	1	0
Toxicology screen outcome: negative	1	0

CPS Involvement

Factor	Abuse Cases Total	Neglect Case Total
CPS record check conducted	9	1
Evidence of prior abuse	4	0
CPS action taken as a result of the death	6	1
Open CPS case on child at time of death	0	1
Was the child ever placed in foster care?	0	1

Review: Abusive Head Trauma

In 2006, seven children died of abusive head injuries, some of which were reported to include a component of shaking. These deaths highlight the importance of public awareness campaigns and other prevention activities related to shaken baby syndrome.

Ref	Cause	Age Group	Gender	Race	County
1	Homicide – abuse	Under 1	Male	Hispanic/Latino	-
2	Homicide – abuse	Under 1	Male	Hispanic/Latino	-
3	Homicide – abuse	Under 1	Female	White	-
4	Homicide – abuse	Under 1	Male	Hispanic/Latino	-
5	Homicide – abuse	Under 1	Female	Hispanic/Latino	-
6	Homicide – abuse	Under 1	Male	Hispanic/Latino	-
7	Homicide – abuse	1 – 4	Female	White	-

DATA NOTES: County of residence is redacted in this section to protect the confidentiality of the decedents.

Abusive Head Trauma – Contributing Factors

Factor	Detail
Type of physical abuse:	Ref 1: Abusive head trauma; beating and kicking Ref 2: Abusive head trauma Ref 3: Abusive head trauma; beating and kicking Ref 4: Abusive head trauma Ref 5: Abusive head trauma Ref 6: Abusive head trauma Ref 7: Abusive head trauma; chronic battered child syndrome; beating and kicking
For abusive head trauma, were there retinal hemorrhages?	Ref 1: Yes Ref 2: Yes Ref 3: Unknown Ref 4: Yes Ref 5: Unknown Ref 6: Unknown Ref 7: Yes
For abusive head trauma, was the child shaken?	Ref 1: Yes Ref 2: Yes Ref 3: Yes Ref 4: Unknown Ref 5: Unknown Ref 6: Unknown Ref 7: Unknown

Factor	Detail
If the child was shaken, was there impact?	Ref 1: Yes Ref 2: Unknown Ref 3: Yes Ref 4: n/a Ref 5: n/a Ref 6: n/a Ref 7: n/a
Events triggering physical abuse:	Ref 1: Crying Ref 2: Crying Ref 3: Crying; feeding problems Ref 4: Unknown Ref 5: Unknown Ref 6: Unknown Ref 7: Unknown

Review: Abuse and Neglect Related Deaths

In addition to homicide deaths where abuse and neglect were the primary cause, there are other deaths where abuse and neglect were contributing factors. It is useful to examine these related deaths to understand the impact that abuse and neglect has on child fatalities.

Related Deaths – Child Neglect

Ref	Cause	Age Group	Gender	Race	County
1	Natural	Under 1	Female	White	-
2	Accident – asphyxia	Under 1	Male	Asian	-
3	Natural	Under 1	Female	Asian	-
4	Homicide – fire/burn	1 – 4	Male	Asian	-
5	Accident – drowning	1 – 4	Male	Hispanic/Latino	-

DATA NOTES: County of residence is redacted in this section to protect the confidentiality of the decedents.

Ref	Case Details
1	Mother did not seek prenatal care
2	Unsafe sleeping: child was put to sleep in king size bed and found wedged into bedding
3	Maternal drug use; mother did not seek prenatal care
4	Father's partner placed child in scalding bath
5	Failure to protect from hazards; no locks on pool gates

Related Deaths – Other Negligence

Ref	Cause	Age Group	Gender	Race	County
1	Natural – IUFD	Under 1	Male	Black	-
2	Accidental – IUFD	Under 1	Male	White	-
3	MVA	5 – 9	Male	American Indian	-
4	MVA	10 – 14	Male	White	-
5	MVA	15 – 17	Female	Hispanic/Latino	-
6	MVA	15 – 17	Female	Hispanic/Latino	-
7	MVA	15 – 17	Male	Black	-

DATA NOTES: IUFD = Intra-uterine fetal demise; MVA = Motor Vehicle Accident. County of residence is redacted in this section to protect the confidentiality of the decedents.

Ref	Case Details
1	Maternal drug use
2	Maternal drug use
3	Driver of vehicle in which child died was drug and alcohol impaired
4	Child was riding bicycle; driver of vehicle that struck him was negligent
5	Child's friend was driving vehicle in which child died; child did not have seatbelt on
6	Child's friend was driving vehicle in which child died and racing with another driver
7	Child was crossing the street, not in a crosswalk, and was struck by a car

Related Deaths – Poor or Absent Supervision

This section includes the additional asphyxia death with an undetermined manner.

Ref	Cause	Age Group	Gender	Race	County
1	Natural – SIDS	Under 1	Male	African American	-
2	Accident – asphyxia	Under 1	Female	White	-
3	Accident – drowning	1 – 4	Male	Hispanic/Latino	-
4	Accident – drowning	1 – 4	Female	Hispanic/Latino	-

DATA NOTES: County of residence is redacted in this section to protect the confidentiality of the decedents.

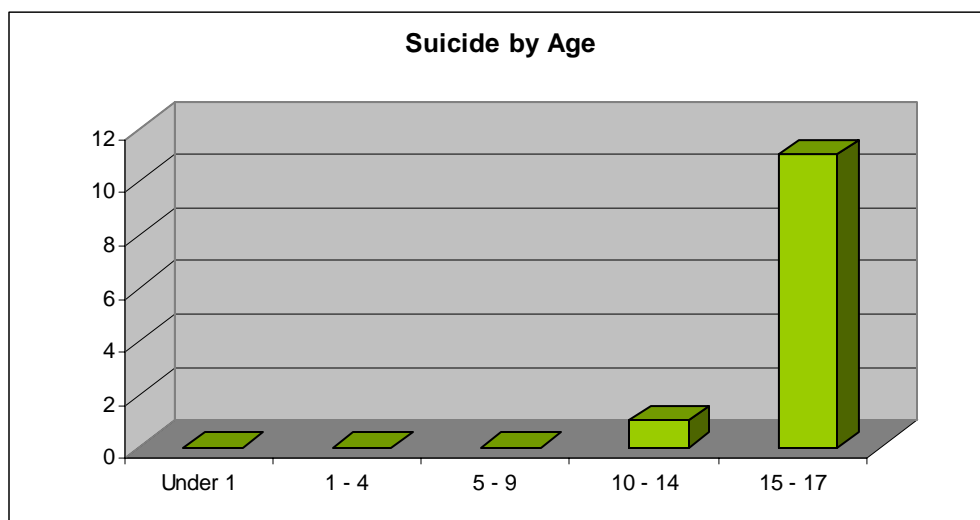
Ref	Case Details
1	Unsafe sleeping: child was co-sleeping on a couch with mother and found pressed into couch (ruled SIDS not asphyxia)
2	Child fell into a plastic bag and suffocated; mother was asleep; father was distracted (ruled undetermined but classified for data report purposes as accident – asphyxia)
3	Child unlocked door leading to patio and pool area; mother was in another room
4	No barriers existed to prevent access to pool; mother was distracted

Review: Suicides by All Causes

Reviewed by Team		County of Residence	
Clark	9	Clark	8
Elko	1	Elko	1
Washoe	2	Washoe	2
		Unknown	1
TOTAL:	12	TOTAL:	12

Suicide – Basic Demographics: Age, Gender, and Race

Age Group	Total
Under 1	0
1 - 4	0
5 - 9	0
10 - 14	1
15 - 17	11



Findings:

- Suicide deaths 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.³¹

³¹ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>



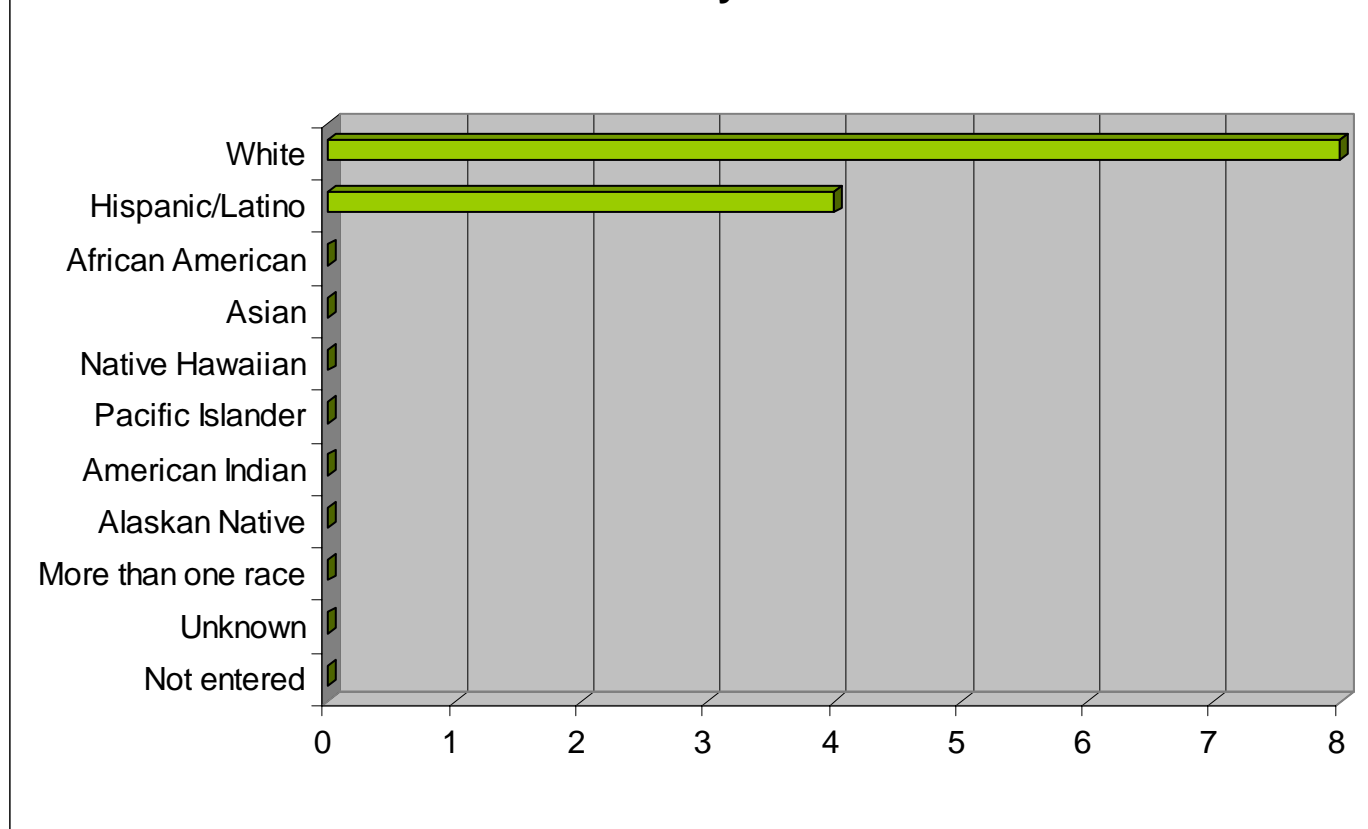
Gender	Total
Male	8
Female	4

Findings:

- In 2006, males in Nevada died by suicide at twice the rate of females. As noted in *Section 1*, this is inconsistent with national data, which shows the rate of death for male suicides in the 15 – 19 age group at almost four times that of females (12.6 per 100,000 population for male suicides compared with 3.5 per 100,000 for female suicides).³² [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.] Also as noted above, while this trend has lessened across the past three years, the closer ratio of female to male suicides shows that females in Nevada died by suicide more often than the national average and may benefit from increased prevention efforts.

³² National Center for Health Statistics. (2006). *Health, United States, 2006, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

Suicide by Race



Race Group	Total	Race Group	Total
White	8	American Indian	0
Hispanic/Latino	4	Alaskan Native	0
African American	0	More than one race	0
Asian	0	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

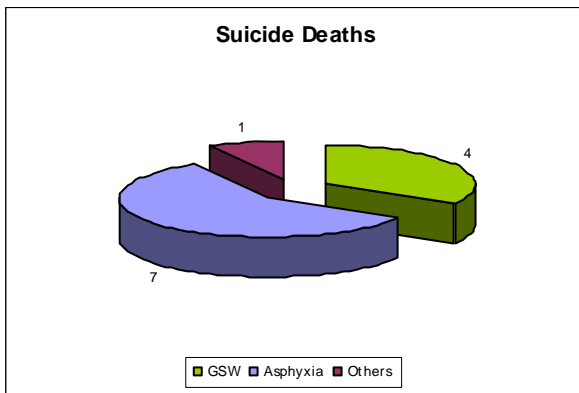
- Suicide occurs most frequently among whites. This is generally consistent with national data, which shows that whites account for the second highest suicide rate within race categories.³³
- One-third (4 of 12) of suicides in 2006 occurred among Hispanics and Latinos. This is generally consistent with the statewide population distribution of Hispanics and Latinos at 35.1%.
- National data shows that the highest suicide rates for both males and females are among American Indians.³⁴ Given Nevada's indigenous American Indian population, the fact that there were no reported suicides among American Indians in 2006 may suggest that some suicides are incorrectly classified by

³³ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

³⁴ Ibid.

either race or cause, or they are under-reported. As noted in *Section 1*, because of the ongoing lack of child death data for American Indians, the Executive Committee has recently undertaken an effort to establish formal communication with Nevada’s tribes regarding American Indian child deaths. This should result in better data under *Section 2* of this report in future years.

Suicide – Methods



Method	Total	Percentage
● Suicide – GSW	4	1.5%
● Suicide – asphyxia	7	2.7%
● Suicide – overdose	0	0.0%
● Suicide – other	1	0.4%

DATA NOTES: GSW = gunshot wound

Findings:

- Asphyxia was the most common method of suicide based on regional CDR team data, accounting for seven of 12 deaths reviewed. Gunshot wounds (GSW) accounted for four suicide deaths, and the remaining death resulted from an intentional motor vehicle accident. This is inconsistent with national trends, which indicate that suicide by GSW is the most common method, accounting for almost half of all completed suicides. However, the same national data indicates that suicides by GSW have decreased across the last decade, with a corresponding increase in suicides by asphyxia.³⁵ Suicides in Nevada mirror this trend toward an increase in suicides by asphyxia.
- National data also shows that females typically attempt suicide by ingesting pills, while males typically complete suicide by GSW.³⁶ This is consistent with Nevada data, which shows three of four suicides by GSW for males, although there were no suicides by overdose for females in 2006.

³⁵ American Association of Suicidology. (2006). *Youth Suicide Fact Sheet*. Washington, DC: American Association of Suicidology.

³⁶ Ibid.

Suicide – Contributing Factors

Child History

Factor	Number
• History of homelessness	0
• History of mental illness	3
• History of substance abuse	4
• Drug or alcohol impaired at time of incident	4
• History of child abuse – physical	0
• History of child abuse – neglect	1
• History of child abuse – sexual	1
• History of child abuse – emotional	0
• History of child abuse – unknown	3
• History of delinquent or criminal behavior	2
• Child spent time in juvenile detention	0
• Child was gay, lesbian, bisexual, or questioning orientation	0

Circumstances Surrounding Event

Factor	Number
• Child left a note	2
• Child talked about suicide	5
• Prior suicide threats were made	3
• Prior suicide attempts were made	3
• Suicide was completely unexpected	3
• Child had received prior mental health services	3
• Child was receiving mental health services at time of death	3
• Child was on medication(s) for mental illness	0
• Issues prevented child from receiving mental health services	0
• Child had a history of running away	1
• Child had a history of self-mutilation	2
• 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

CPS Involvement

Factor	Number
• Open CPS case on child at time of death	2
• Was the child ever placed in foster care?	0

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.

When ranked in conjunction with other leading causes of death, SIDS is the fifth leading cause of child death after suicides. However, there is no known cause for SIDS, although it is associated with several risk factors, discussed below under *Contributing Factors*.

This section includes the two SIDS deaths with an undetermined manner.

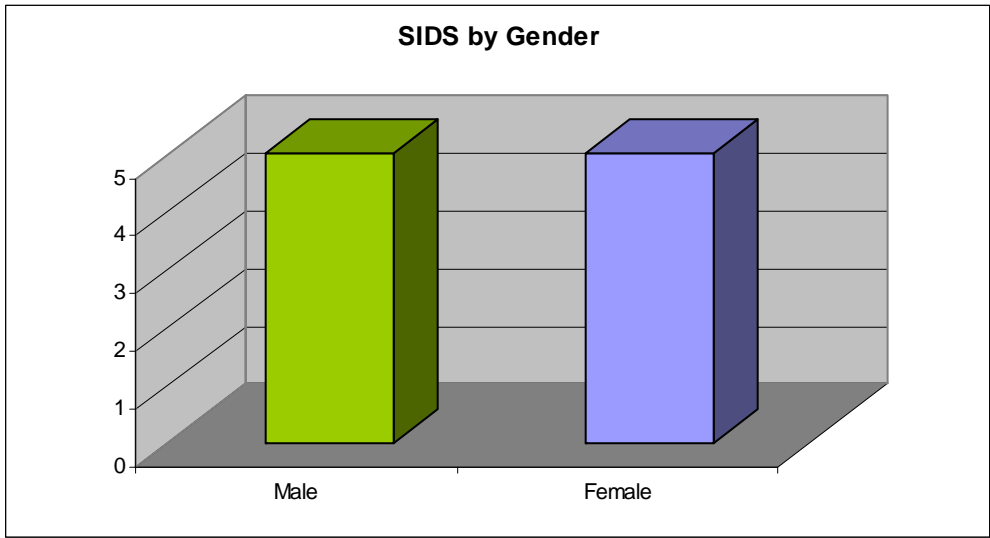
Reviewed by Team		County of Residence	
Clark	7	Clark	6
Washoe	3	Washoe	3
		Unknown	1
TOTAL:	10	TOTAL:	10

SIDS – Basic Demographics: Age, Gender, and Race

Age

By definition, all SIDS deaths occur in infants less than one year of age.³⁷

³⁷ Centers for Disease Control and Prevention. (2008). *Sudden Infant Death Syndrome (SIDS): Home*. Retrieved June 18, 2008, from <http://www.cdc.gov/SIDS/index.htm>.



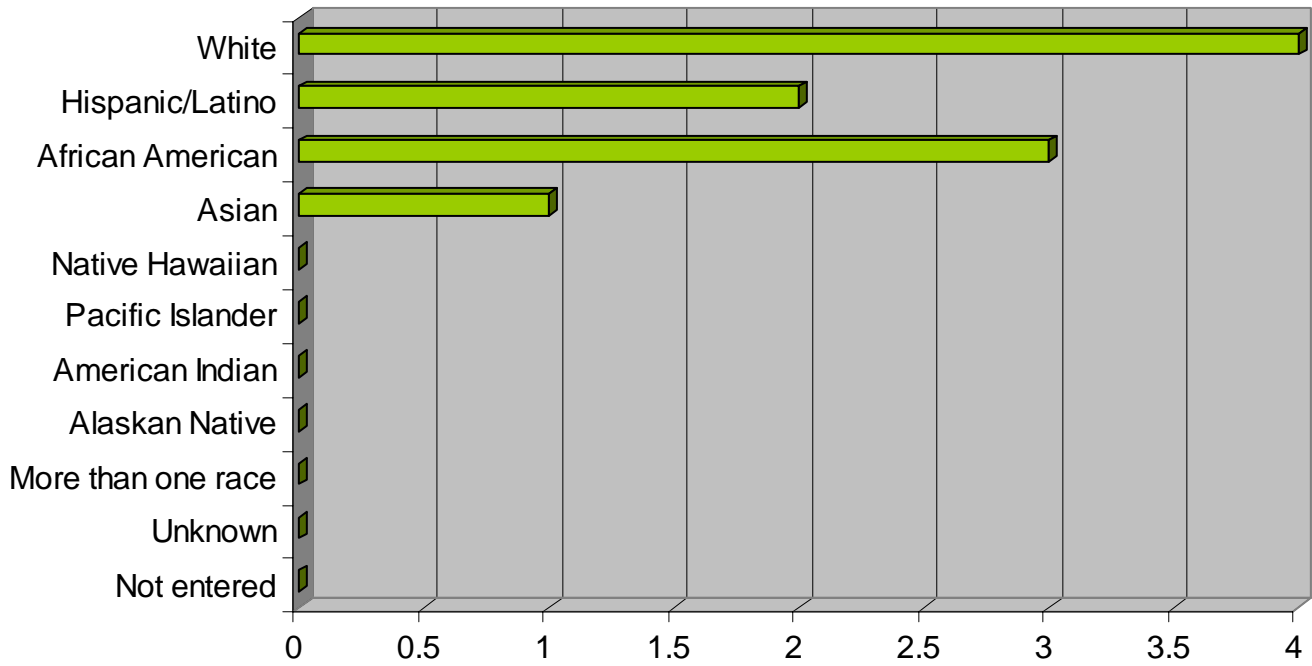
Gender	Total
Male	5
Female	5

Findings:

- In 2006, SIDS deaths were equal between males than females. This is inconsistent with national data, which shows that males die from SIDS at more than twice the rate of females.³⁸

³⁸ National Center for Injury Prevention and Control. (2008). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2005* [custom data query]. Retrieved June 10, 2008, from <http://www.cdc.gov/ncipc/wisqars/>.

SIDS by Race

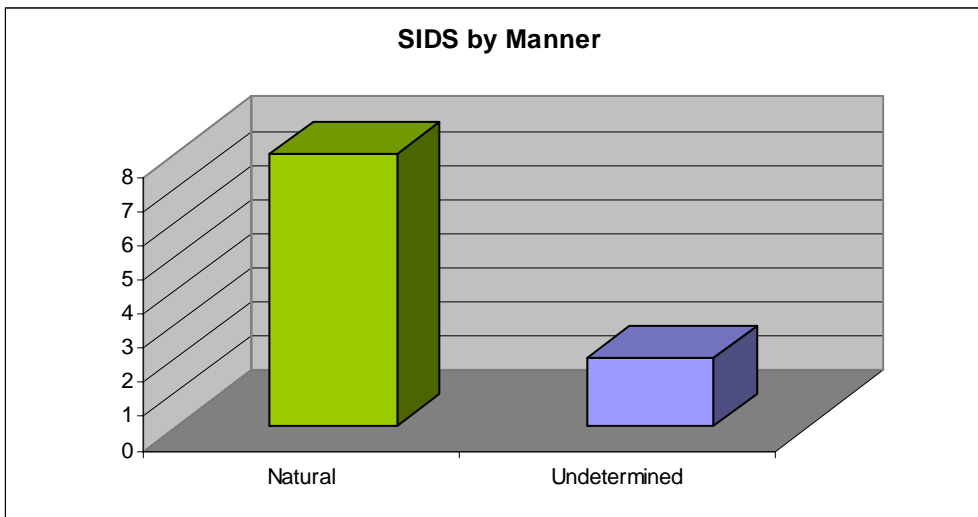


Race Group	Total	Race Group	Total
White	4	American Indian	0
Hispanic/Latino	2	Alaskan Native	0
African American	3	More than one race	0
Asian	1	Unknown	0
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

- Approximately one-third (3 of 10) of SIDS deaths in 2006 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%. It is important to note, however, that African Americans have a higher overall infant mortality rate than whites (13.6 deaths per 1,000 live births for African Americans versus 5.7 deaths per 1,000 live births for whites),³⁹ and the rate of SIDS in African American infants is 2.5 times that of whites.⁴⁰

SIDS – Manner of Death



Manner	Total
Natural	8
Undetermined	2

Findings:

- The two cases with an undetermined manner of death have many characteristics of SIDS, although this was not concluded to be the manner of death by the coroner, but was determined to be the likely cause of death by the regional CDR teams.

³⁹ National Center for Health Statistics. (2007). *Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set, National Vital Statistics Reports, Vol. 55, Number 14*. Hyattsville, MD: National Center for Health Statistics.

⁴⁰ National Center for Health Statistics. (2007). *Infant Mortality Statistics from the 2001 Period Lined Birth/Infant Death Data Set, National Vital Statistics Reports, Vol. 52, Number 2*. Hyattsville, MD: National Center for Health Statistics.

SIDS – Contributing Factors

Factor	Number
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	1
Crib	2
Mattress	2
Chair	0
Couch	1
Car seat or stroller	1
Portable bed	1
Unknown	0
Not entered	2

SIDS Death Sleeping Positions

Factor	Total
Child put to sleep on stomach	0
Child put to sleep on side	4
Child put to sleep on back	3
Sleep position unknown	1
Sleep position not entered	2

SIDS Death Unsafe Sleeping Risks

Factor	Total
Child found with blanket	5
Child found with pillow	1
Child found with comforter	1
Child found with toy(s)	1
Child found with baby bottle, pacifier, and/or other items	2
Child co-sleeping with another adult	1

Review: Maternal Drug Use

Statewide data showed no deaths by maternal drug use in 2006, because drug-related deaths are often difficult to identify or coroners do not have substantial evidence to support this as a cause of death. Regional CDR team data showed a total of three deaths caused by maternal drug use in 2006. However, the number of deaths is likely higher, as discussed below under *Prematurity and Other Perinatal Conditions*.

Individual Case Detail

Ref	Manner	Age Group	Gender	Race	County
1	Natural	Under 1	Female	White	Clark
2	Undetermined	Under 1	Female	Hispanic/Latino	Washoe
3	Accidental	Under 1	Male	White	Clark

Maternal Drug Use – Contributing Factors

For all of the information below, the caregiver is the biological mother of the child.

Factor:	Detail:
During pregnancy did mother smoke tobacco?	Ref 1: No Ref 2: Yes Ref 3: No
During pregnancy did mother use illicit drugs?	Ref 1: Yes Ref 2: Yes Ref 3: Yes
Infant born drug exposed	Ref 1: Unknown Ref 2: Yes Ref 3: Yes
During pregnancy did mother misuse over-the-counter or prescription drugs?	Ref 1: No Ref 2: No Ref 3: No
During pregnancy did mother have heavy alcohol use?	Ref 1: No Ref 2: Yes Ref 3: No
Infant born with fetal alcohol effects or syndrome	Ref 1: No Ref 2: Yes Ref 3: No

Factor:	Detail:
Access or compliance issues related to prenatal care	Ref 1: Unknown Ref 2: Yes Ref 3: Unknown
Caregiver has a history of substance abuse	Ref 1: Yes – methamphetamine Ref 2: Yes – alcohol, other street drugs, prescription drugs Ref 3: Yes – marijuana, methamphetamine, other street drugs
Caregiver has a history of child maltreatment as a victim	Ref 1: Yes – unknown type Ref 2: No Ref 3: No
Caregiver has a history of child maltreatment as a perpetrator	Ref 1: Yes Ref 2: No Ref 3: Yes
Caregiver has prior child deaths	Ref 1: No Ref 2: Unknown Ref 3: Yes – two pregnancies never delivered
Caregiver has a delinquent or criminal history	Ref 1: Unknown Ref 2: Unknown Ref 3: Unknown
Toxicology screen completed on child	Ref 1: Unknown Ref 2: Yes – positive for alcohol Ref 3: Yes – positive for marijuana, methamphetamine, other street drugs
Was a CPS record check conducted?	Ref 1: Yes Ref 2: Yes Ref 3: No
Did investigation find evidence of prior abuse?	Ref 1: No Ref 2: No Ref 3: No
Primary cause of death:	Ref 1: Placental abruption due to maternal substance abuse. Ref 2: Undetermined. Ref 3: Intrauterine fetal demise (IUFD)

Prematurity and Other Perinatal Conditions

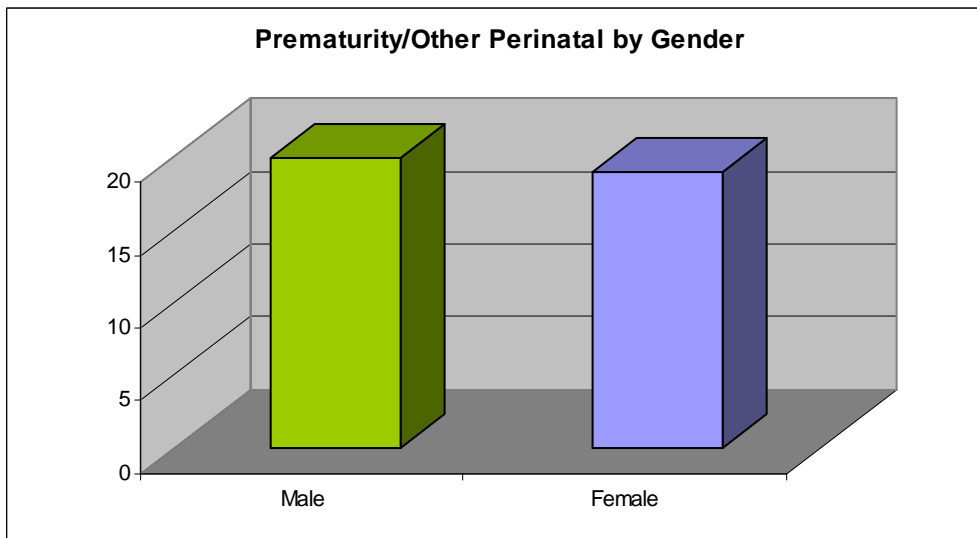
In addition to deaths caused by drug overdose and intoxication, deaths caused by prematurity and other perinatal conditions also may be a result of maternal drug use. When prematurity or other perinatal conditions are determined to be the cause of death by the coroner, maternal drug use becomes less obvious when completing a statistical analysis and review of data. In 2006, a total of 39 child deaths reviewed were caused by prematurity or other perinatal conditions.

This section includes the two prematurity deaths with an undetermined manner.

Prematurity and Other Perinatal Conditions – Basic Demographics: Age, Gender, and Race

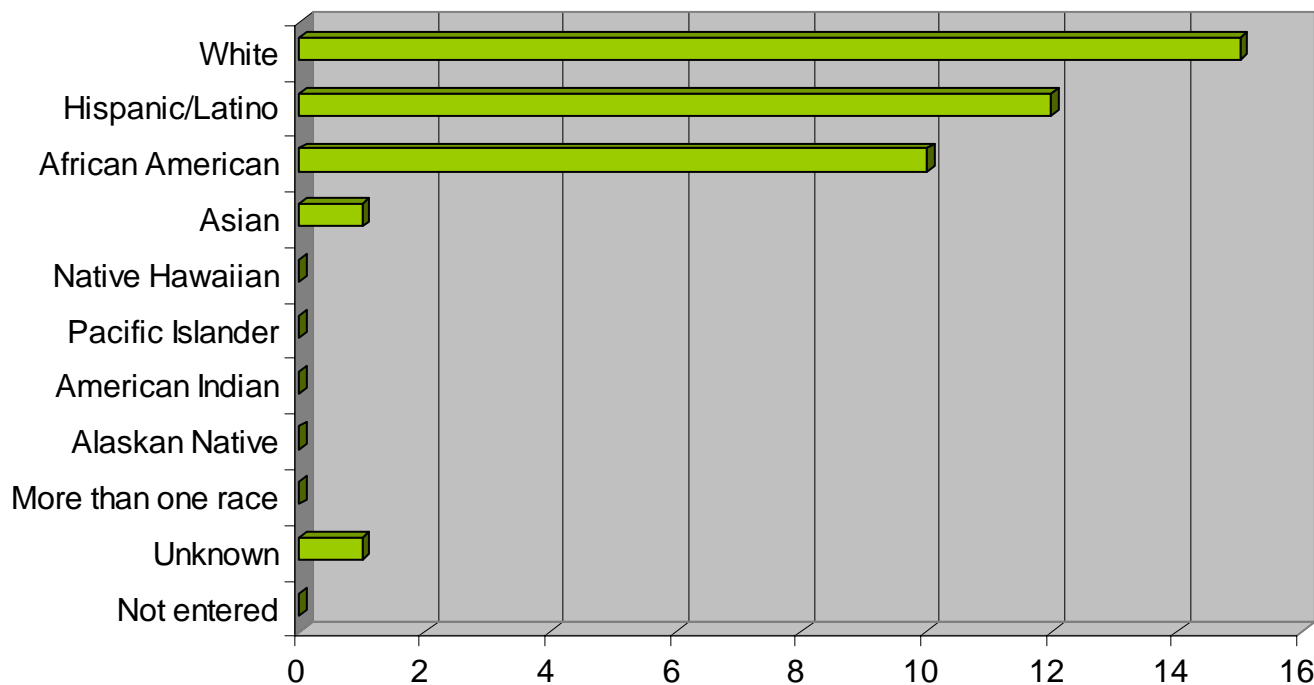
Age

All deaths caused by prematurity and other perinatal conditions in 2006 occurred among infants less than one year of age.



Gender	Total
Male	20
Female	19

Prematurity/Other Perinatal by Race

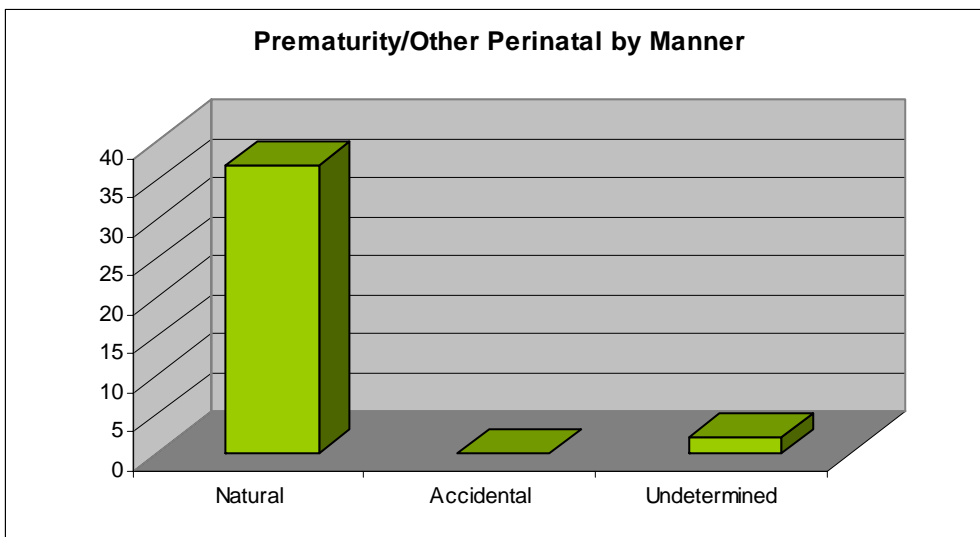


Race Group	Total	Race Group	Total
White	15	American Indian	0
Hispanic/Latino	12	Alaskan Native	0
African American	10	More than one race	0
Asian	1	Unknown	1
Native Hawaiian	0	Not entered	0
Pacific Islander	0		

Findings:

- Over 25% (10 of 39) of 2006 deaths resulting from prematurity and other perinatal conditions occurred among African-Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.4%. However, African Americans have a significantly higher rate of infants born at low birthweight than whites (13.8% of live births for African Americans versus 7.1% of live births for whites), a higher percentage of preterm births than whites (17.8% of live births for African Americans versus 11.6% for whites), and a preterm-related infant mortality rate 3.5 times higher than that of whites.⁴¹

Prematurity and Other Perinatal Conditions – Manner of Death



Manner	Total
Natural	37
Accidental	0
Undetermined	2

⁴¹ National Center for Health Statistics. (2007). *Infant Mortality Statistics from the 2004 Period Linked Birth/Infant Death Data Set, National Vital Statistics Reports, Vol. 55, Number 14*. Hyattsville, MD: National Center for Health Statistics.

Prematurity and Other Perinatal Conditions – Contributing Factors

Unfortunately, comprehensive contributing factors are not available for the 39 cases of prematurity and other perinatal conditions. Prematurity is a complex biological and sociological phenomenon, and frequently no inciting cause is discovered. In only three of these cases was it determined that the biological mother used drugs during pregnancy. For all of the information below, the caregiver is the biological mother of the child.

Factor:	Detail:
During pregnancy did mother smoke tobacco?	Ref 1: No Ref 2: No Ref 3: No
During pregnancy did mother use illicit drugs?	Ref 1: Yes Ref 2: Yes Ref 3: Yes
Infant born drug exposed	Ref 1: Yes Ref 2: Yes Ref 3: No
During pregnancy did mother misuse over-the-counter or prescription drugs?	Ref 1: No Ref 2: No Ref 3: No
During pregnancy did mother have heavy alcohol use?	Ref 1: No Ref 2: No Ref 3: No
Infant born with fetal alcohol effects or syndrome	Ref 1: No Ref 2: No Ref 3: No
Access or compliance issues related to prenatal care	Ref 1: Yes Ref 2: Unknown Ref 3: Unknown
Caregiver has a history of substance abuse	Ref 1: Unknown Ref 2: Yes – marijuana, methamphetamine, other street drugs Ref 3: Yes – unknown type
Caregiver has a history of child maltreatment as a victim	Ref 1: Unknown Ref 2: Unknown Ref 3: Unknown

Factor:	Detail:
Caregiver has a history of child maltreatment as a perpetrator	Ref 1: No Ref 2: Yes – unknown type Ref 3: Yes – physical abuse and neglect
Caregiver has prior child deaths	Ref 1: No Ref 2: Yes – two pregnancies never delivered Ref 3: Yes – sepsis and prematurity
Caregiver has a delinquent or criminal history	Ref 1: Unknown Ref 2: Unknown Ref 3: Unknown
Toxicology screen completed on child	Ref 1: Yes – positive for opiates Ref 2: Yes – marijuana, methamphetamine, other street drugs Ref 3: Unknown
Was a CPS record check conducted?	Ref 1: Unknown Ref 2: No Ref 3: No
Did investigation find evidence of prior abuse?	Ref 1: n/a Ref 2: n/a Ref 3: n/a
Primary cause of death:	Ref 1: Fetal demise Ref 2: Intrauterine demise Ref 3: Prematurity

Findings:

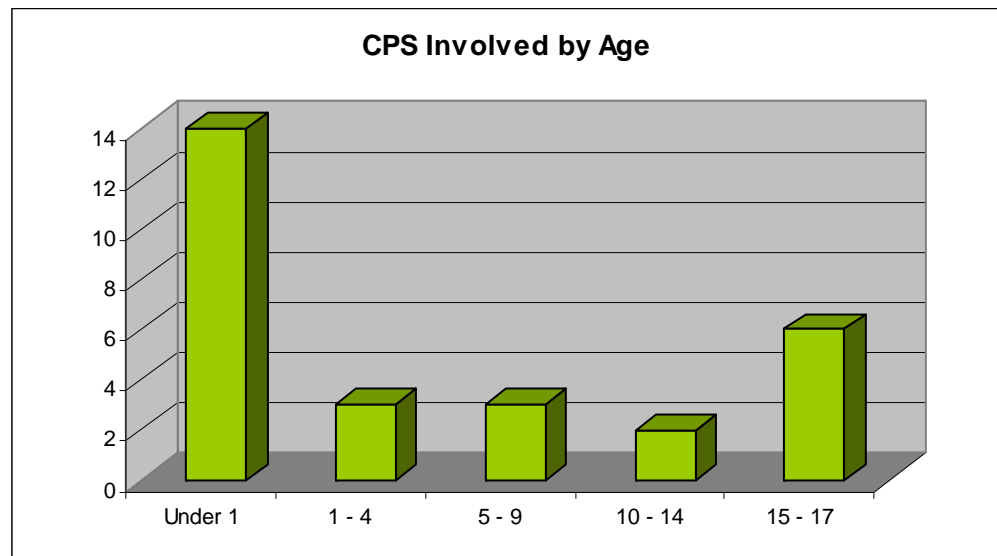
- Prematurity is a complex biological and sociological phenomenon. Even in cases where maternal drug use is indicated either by admission or by laboratory testing of the mother and/or child, the premature birth cannot always be attributed to maternal drug use.
- The regional CDR teams may need to expand their review process in order to obtain better information on contributing factors that may better identify deaths from maternal drug use.
- Collaboration and/or education for medical examiners and coroners may be needed in order to increase toxicology testing in cases of prematurity and other perinatal conditions, which may better identify deaths from maternal drug use.

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

During 2006, 28 out of 262 cases reviewed included children with a current or prior child protective services (CPS) history.

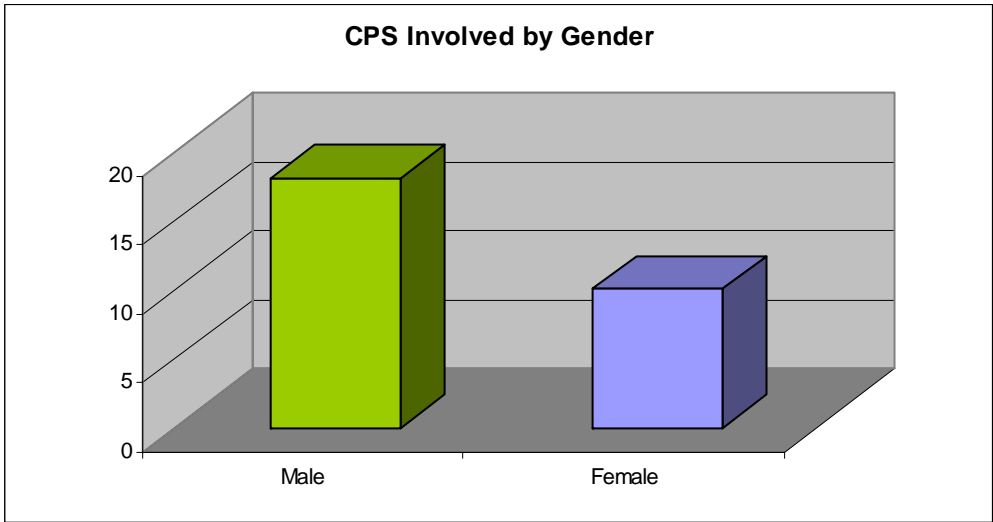
CPS Involved – Basic Demographics: Age, Gender, and Race

Age Group	Total
Under 1	14
1 - 4	3
5 - 9	3
10 - 14	2
15 - 17	6



Findings:

- Half (14 of 28) of 2006 deaths of children with a current or prior CPS history occurred for those less than one year of age.



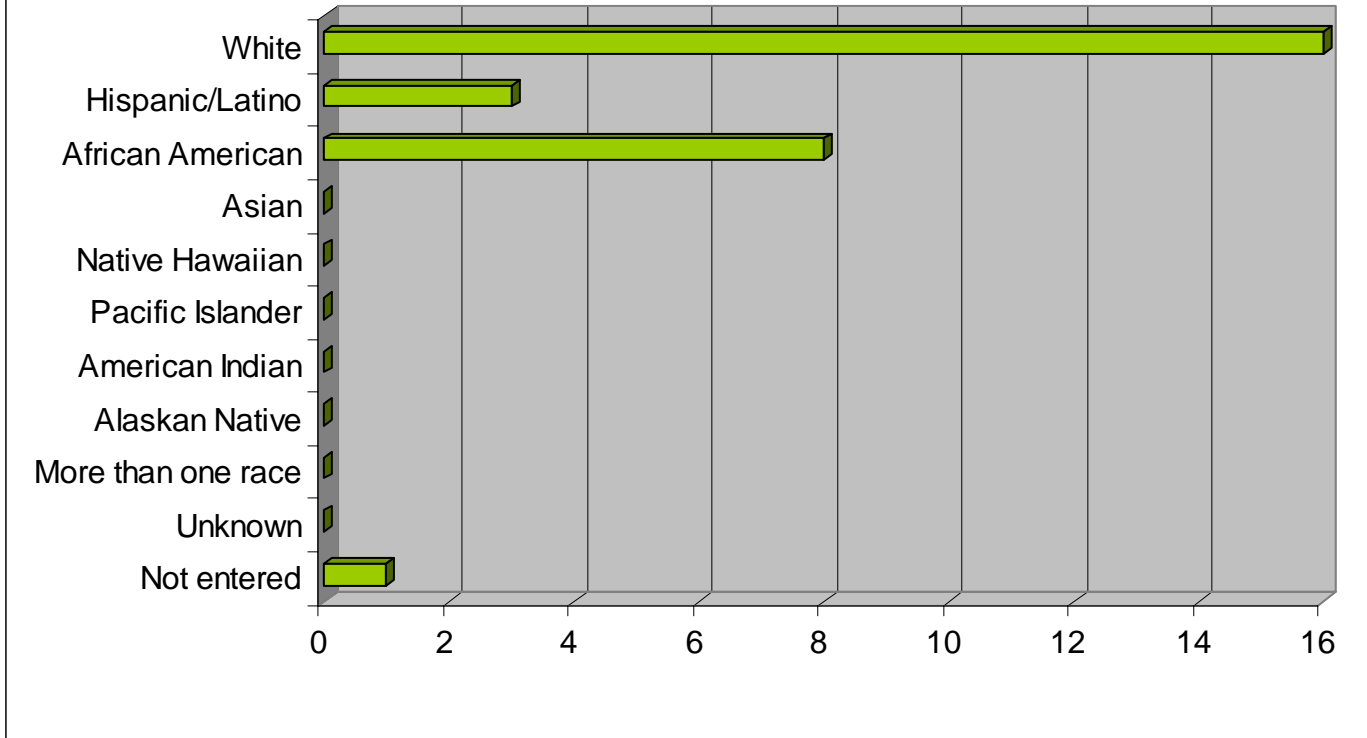
Gender	Total
Male	18
Female	10

Findings:

- Approximately 64% (18 of 28) of 2006 deaths of children with a current or prior CPS history occurred among males. This is again consistent with national and statewide data reviewed throughout this report, which indicates that males die at a higher rate than females in general.⁴²

⁴² Kung H.C. et. al. (2008). *Deaths: Final data for 2005. National Vital Statistics Reports; Vol. 56 No. 10.* Hyattsville, MD: National Center for Health Statistics.

CPS Involved by Race

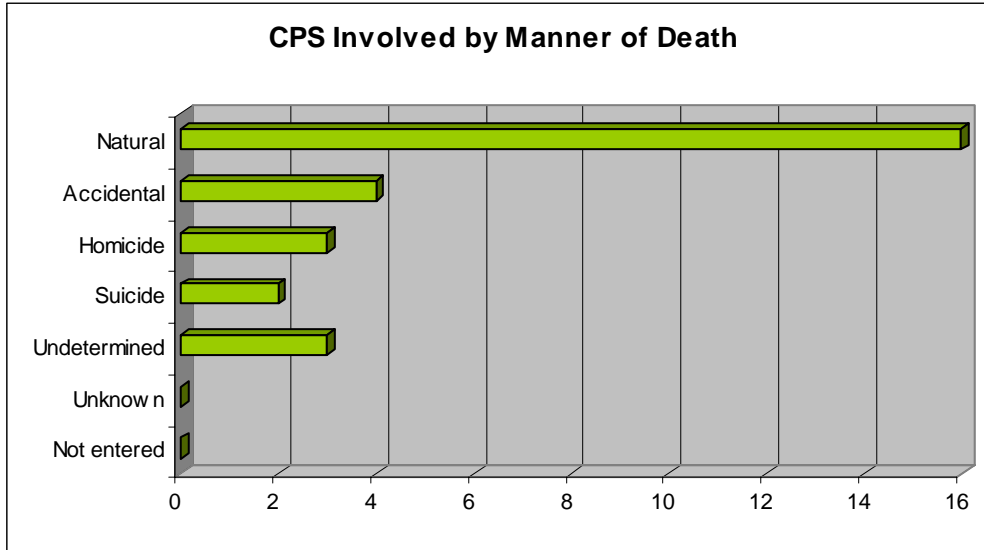


Race Group	Total	Race Group	Total
White	16	American Indian	0
Hispanic/Latino	3	Alaskan Native	0
African American	8	More than one race	0
Asian	0	Unknown	0
Native Hawaiian	0	Not entered	1
Pacific Islander	0		

Findings:

- Nearly 29% (8 of 28) of 2006 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%.

CPS Involved – Manner of Death



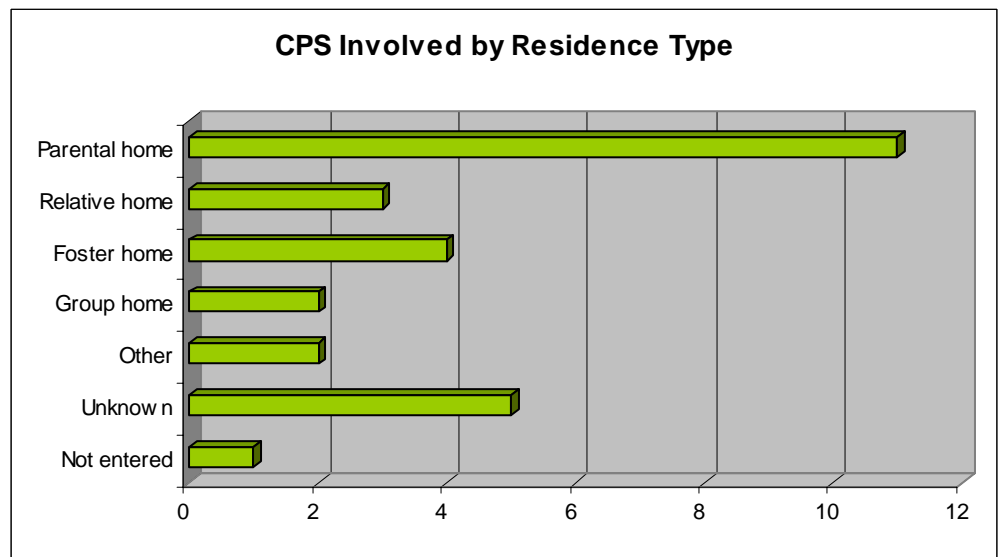
Manner	Total
Natural	16
Accidental	4
Homicide	3
Suicide	2
Undetermined	3
Unknown	0
Not entered	0

Findings:

- Almost 11% (3 of 28) of deaths of children with a current or prior CPS history in 2006 resulted from homicide. This is disproportionately higher than all cases reviewed in 2006, where homicides represent 9.8% of all deaths.

CPS Involved – Residence Type

Residence	Total
Parental home	11
Relative home	3
Foster home	4
Group home	2
Other	2
Unknown	5
Not entered	1



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.

While the Statewide CDR Team reviewed select cases of child death statewide in order to meet its goals, six regional CDR are required to review local child deaths throughout the State of Nevada as follows:

1. **Clark Team:** covers Clark County
2. **Washoe Team:** covers Washoe County
3. **Elko Team (District 1 – North):** covers Elko, Eureka, Humboldt, Lander, Lincoln, and White Pine
4. **Carson Team (District 2 – West):** covers Carson City, Douglas, and Storey
5. **Fallon Team (District 3 – East):** covers Churchill, Lyon, Mineral, and Pershing
6. **Pahrump Team (District 4 – South):** covers Esmeralda and Nye

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 409. Each of the teams reviews all child deaths within their region with the exception of the Clark County Team, which reviews State-mandated cases along with a selection of additional cases because of high caseload. Clark County accounts for approximately 72% of the state's population, and it is not feasible for the Clark County Team to review all child deaths in the area. 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).

Currently, most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. In Clark County, the team meets monthly because of its high caseload. In the rural region, the regional teams may meet less often if coroners' reports are not received within a given quarter.

During 2002, the Statewide CDR Subcommittee developed recommendations for new laws relating to child death review. A primary goal was to give the six regional 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 a bill draft request supported by State Assemblywoman Sheila Leslie, who sponsored Assembly Bill (AB) 381 during the 2003 Nevada State Legislature. This landmark legislation was passed by the Legislature and allows for the implementation of significant changes in the child death review process. This legislation creates a clear purpose for the regional 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 establish 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 reviews 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 makes recommendations about funding for improvements, initiatives, and public education requiring expenditures.

The Executive Committee, in turn, makes decisions about funding initiatives to prevent child maltreatment and death, which may be based on recommendations from the Administrative Team. Additionally, per NRS, the Executive Committee adopts statewide protocols for the review of the death of children; designates the members of the Administrative Team; oversees training and development for the regional CDR teams; and compiles 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.

In essence, the Administrative Team and the Executive Committee have taken over the functions of the original Statewide CDR Team, and now work together to prevent future child deaths in Nevada.