STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

2020 STATEWIDE CHILD DEATH REPORT

Submitted by:

The Executive Committee to Review the Death of Children

Special thanks go to the following who contributed to complete the 2020 Statewide Child Death Report:

2020 Executive Committee to Review Death of Children

2022 Executive Committee to Review Death of Children

Division of Child and Family Services (DCFS)

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EXECUTIVE SUMMARY

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

WHY IS CHILD DEATH PREVENTION IMPORTANT?

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

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

WHERE DOES NEVADA'S CHILD DEATH DATA COME FROM?

The 2020 child deaths were reviewed by Nevada's regional child death review (CDR) teams, which are organized and operational pursuant to Nevada Revised Statutes (NRS) 432B.403 through 432B.4095. (See Appendix D.) In 2020, there were eight regional CDR teams in the state that conducted child death reviews.

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

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

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

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

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

WHAT ARE THE LEADING CAUSES OF CHILD DEATH IN NEVADA?

Excluding natural and undetermined deaths, in 2020, the four leading causes of death were:

1. Homicides caused by bodily force or a weapon
2. Motor vehicle accidents
3. Accidents caused by poisoning, overdose, or acute intoxication
4. Accidents caused by asphyxia

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

	Nevada	United States
Number of child deaths in 2020	244	34,088[1]
Number of child deaths in 2019	268	34,602[1]
Change in number of child deaths from 2019 to 2020	Decrease of 24 (9.0%)	Decrease of 852 (1.5%)
Infant mortality rate per 1,000 live births in 2020[2]	4.34	5.4
Age group experiencing largest number of child deaths in 2020[1]	Under 1 year	Under 1 year
Leading manner of child death in 2020	Natural	Natural

[1] National Center for Injury Prevention and Control (2020). *Web-based Injury Statistics Query and Reporting System: Leading Causes of Death Reports* [custom data query]. Retrieved September 27, 2022 from https://wisqars.cdc.gov/fatal-leading

[2] Centers for Disease Control (2021). *Infant Mortality 2019*. Retrieved September 19, 2022 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

DATA OVERVIEW

DATA SOURCES

All Nevada data in this report are derived from the regional CDR teams, which collect and enter data into an electronic case reporting system maintained by the National Center for Fatality Review and Prevention (CFRP). Based on the multidisciplinary reviews conducted for child deaths that occurred in calendar year 2020, there were a total of 244 child deaths that were reviewed in the state. These fatalities include children and adolescents from birth through 17 years of age.

DATA CONFIDENTIALITY

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

DATA LIMITATIONS

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

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

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

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

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

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

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

REVIEW REQUIREMENTS

The purpose, organization, and functions of the regional CDR teams are mandated by NRS 432B.403-432B.4095. State-mandated child death reviews include the following:

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

DEATHS REVIEWED VS. DEATHS NOT REVIEWED

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

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

Overview of Deaths

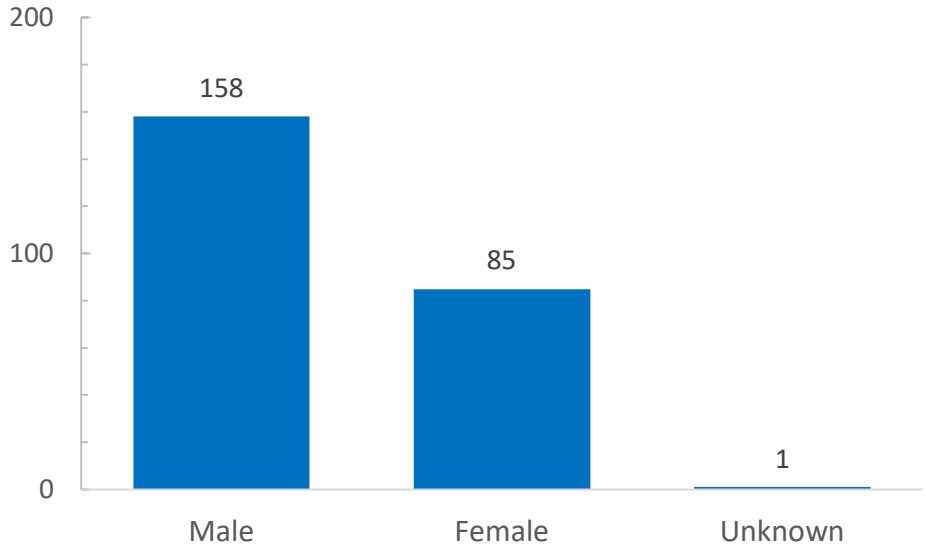
In 2020, the Nevada regional CDR teams reviewed the deaths of 244 children under 18 years of age. In the sections that follow, the overall demographics and manner of these deaths are reviewed.

Demographics

The data used for this report come from the National Fatality Review Case Reporting System, which is the case reporting system used by the regional CDR teams. The response options in the system to report on a child's "sex" include, "Male," "Female," and "Unknown." Based on the available data, the terms sex, male, female, and unknown will be used in the current report.

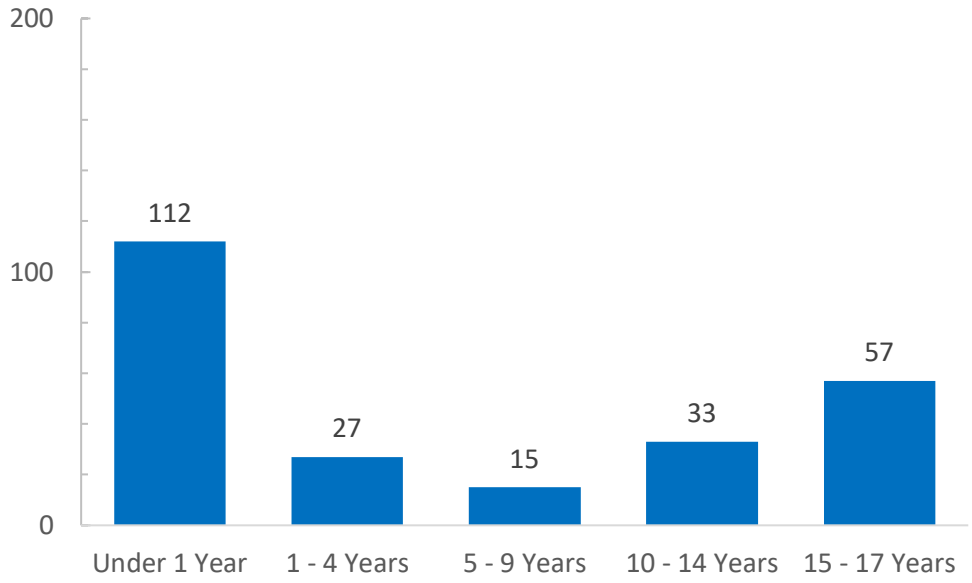
As seen in Figure 1, there were more child deaths in Nevada in 2020 among males as compared to females.

Figure 1. Number of child deaths in Nevada in 2020 by sex of decedent.



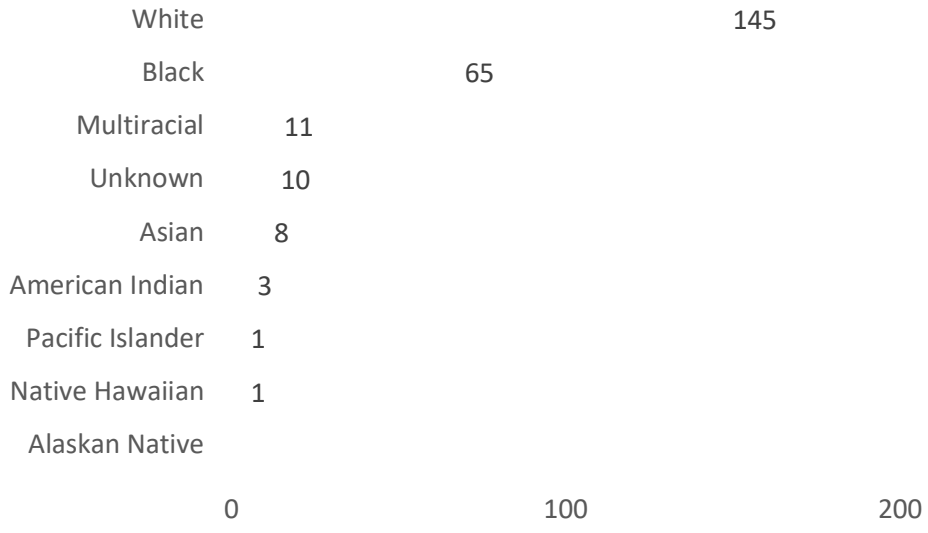
As seen in Figure 2, the largest percentage of child deaths in Nevada in 2020 occurred among those less than one year of age (45.9%).

Figure 2. Number of child deaths in Nevada in 2020 by age category of decedent.



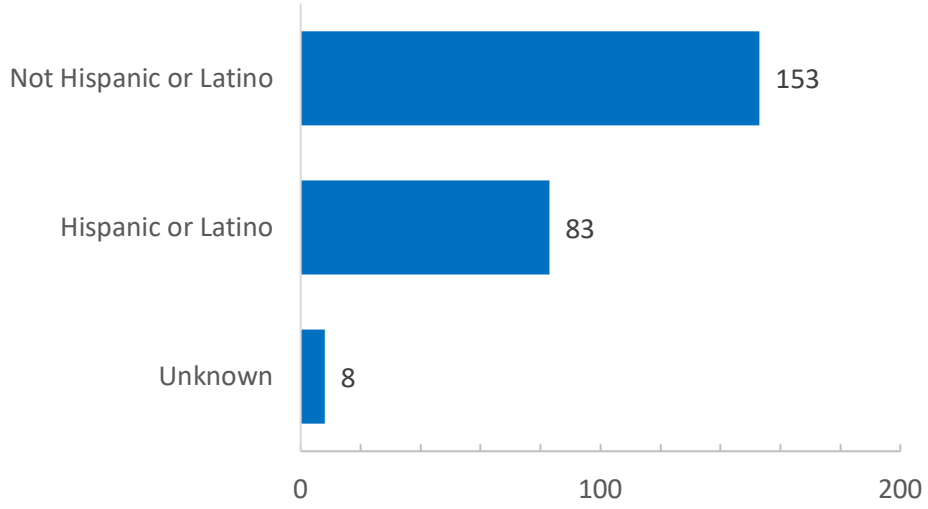
With regard to race, as seen in Figure 3, the largest percentage of child deaths in Nevada in 2020 occurred among White (59.4%) and Black children (26.6%).

Figure 3. Number of child deaths in Nevada in 2020 by race of decedent.



With regard to ethnicity, the largest percentage of child deaths in Nevada in 2020 were among children not of Hispanic or Latino ethnicity (62.7%). See Figure 4.

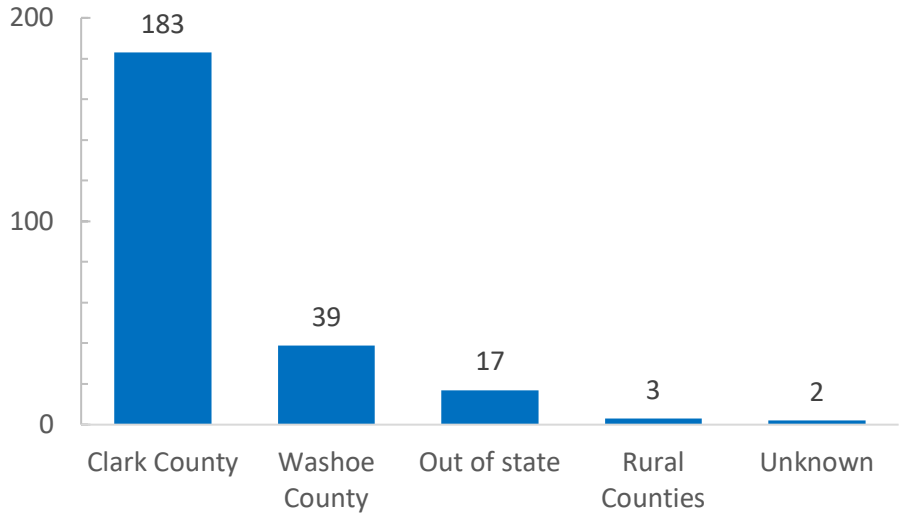
Figure 4. Number of child deaths in Nevada in 2020 by Hispanic or Latino ethnicity of decedent.



Due to the small number of child deaths that occur among children who are residents of the counties of Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine, and to maintain confidentiality, the number of child deaths that occurred in these counties in 2020 have been combined for this report and the county of residence is referred to as the Rural Counties.

As seen in Figure 5, the largest percentage of child deaths in Nevada in 2020 occurred among those who were residents of Clark County (75.0%).

Figure 5. Number of child deaths in Nevada in 2020 by county of residence of the decedent.



MANNER OF DEATH

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

1. **Natural**: Deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases.
2. **Accident**: Deaths not caused by an intent to harm.
3. **Homicide**: The killing of one human by another.
4. **Suicide**: Taking of one's own life voluntarily and intentionally.
5. **Undetermined**: Deaths where sufficient evidence or information cannot be deduced during the initial investigation, usually about intent, to assign a manner of death.

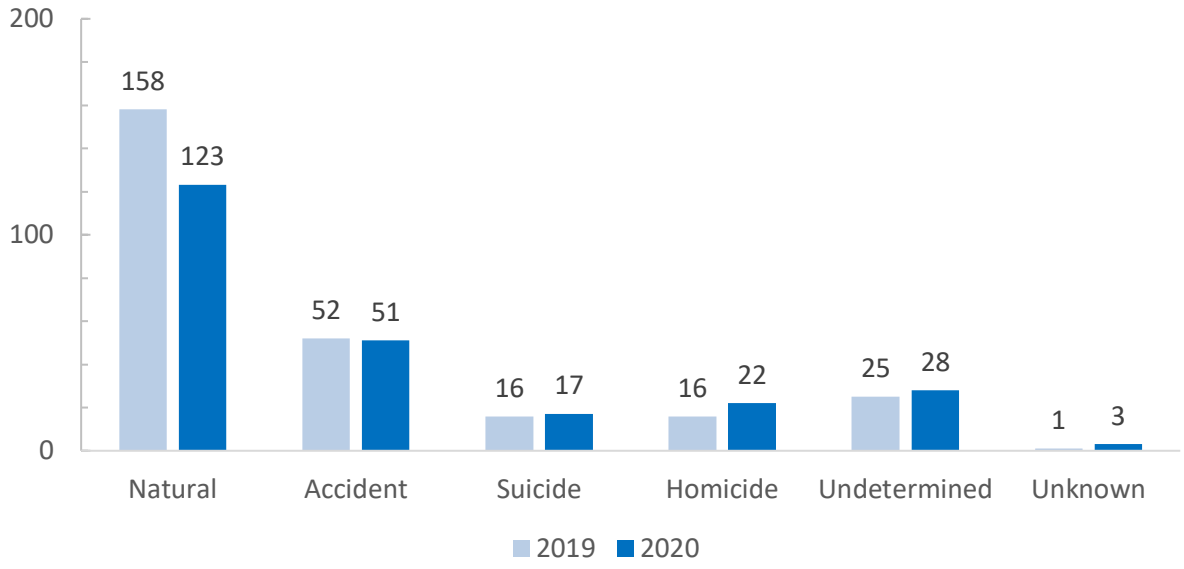
As seen in Table 1, the largest percentage of child deaths by manner in Nevada in 2020 were natural (50.4%), followed by accident (20.9%).

Table 1. Number and percent of child deaths in Nevada in 2020 by manner of death.

	Number	Percent
Natural	123	50.4%
Accident	51	20.9%
Suicide	17	7.0%
Homicide	22	9.0%
Undetermined	28	11.5%
Unknown	3	1.2%
Total	244	100%

As seen in Figure 6, there were fewer natural and accident child deaths in Nevada in 2020 as compared to 2019 but more suicide, homicide and undetermined child deaths.

Figure 6. Number of child deaths in Nevada in 2019 and 2020 by manner of death.



DEATHS BY MANNER

NATURAL

Natural deaths are those deaths that result from natural disease mechanisms and include prematurity, and Sudden Infant Death Syndrome (SIDS) cases. In 2020, the largest percentage of child deaths by manner in Nevada were natural (50.4%). As seen in Table 2 below, the majority of natural deaths occurred among children under one year of age (58.5%). Overall, the most common cause of natural death was due to "other medical condition" (21.1%), followed by prematurity (19.5%), "other perinatal condition" (13.8%), congenital anomaly (12.2%), and cancer (12.2%). "Other perinatal condition" and "other medical condition" are response options in the data collection tool and include natural deaths in which the primary cause of death was due to a medical condition other than those listed in Table 2.

Table 2. Number of natural child deaths in Nevada in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asphyxia	0	1	0	0	0	1
Asthma/Respiratory	2	0	2	3	0	7
Cancer	1	2	5	2	5	15
Cardiovascular	3	1	0	0	2	6
Congenital anomaly	15	0	0	0	0	15
COVID-19	0	0	1	0	1	2
Diabetes	0	0	0	0	2	2
HIV/AIDS	0	0	0	0	0	0
Influenza	0	0	0	0	0	0
Low birth weight	0	0	0	0	0	0
Malnutrition/dehydration	0	0	0	0	0	0
Neurological/seizure	0	1	0	1	1	3
Pneumonia	0	1	0	0	0	1
Prematurity	23	1	0	0	0	24
SIDS	0	1	0	0	0	1
Other infection	1	0	0	1	0	2
Other perinatal condition	17	0	0	0	0	17
Other medical condition	10	5	0	10	1	26
Unknown	0	0	1	0	0	1
Total	72	13	9	17	12	123

ACCIDENT

Accident deaths are deaths not caused by an intent to harm. In 2020, there were 51 accident child deaths reviewed in Nevada. As seen in Table 3 below, the largest percentage of accident deaths (43.1%) occurred among children in the 15 – 17 Years age category. Overall, motor vehicle accidents were the most common cause of accident deaths among children in Nevada in 2020 (35.3%) with most of those deaths occurring among children in the 15 – 17 Years age category. The next most common causes of accident child deaths in Nevada in 2020 were poisoning, overdose, or acute intoxication (23.5%) and asphyxia (21.6%).

Table 3. Number of accident child deaths in Nevada in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	0	0	0	0	0	0
Asphyxia	8	2	1	0	0	11
Motor Vehicle	1	1	1	5	10	18
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	5	0	0	1	6
Bodily Force or Weapon	0	0	0	0	0	0
Fall or Crush	0	0	0	0	1	1
Poisoning, Overdose, or Acute Intoxication	0	0	1	1	10	12
Undetermined	0	0	0	0	0	0
Other Injury	1	1	0	1	0	3
Unknown	0	0	0	0	0	0
Total	10	9	3	7	22	51

HOMICIDE

In 2020, there were 22 homicide child deaths reviewed in Nevada. As seen in Table 4 below, all of the homicides were caused by bodily force or weapon (90.9%) or by falling or crushing (9.1%). Half (50.0%) of the homicide child deaths in Nevada in 2020 were among children in the 15 – 17 Years age category.

Table 4. Number of homicide child deaths in Nevada in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	3	2	1	3	11	20
Fall or Crush	2	0	0	0	0	2
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0
Total	5	2	1	3	11	22

SUICIDE

In 2020, there were 17 suicide child deaths reviewed in Nevada. As seen in Table 5, all of the suicide deaths occurred among children in the 5 – 9 Years, 10 – 14 Years, and 15 – 17 Years age categories. More than half of the suicide child deaths were the result of bodily force or a weapon (52.9%) and more than a third (35.3%) were caused by "other injury". A review of these cases indicates that they were all suicide by hanging.

Table 5. Number of suicide child deaths in Nevada in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	4	5	9
Fall or Crush	0	0	0	0	1	1
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	1	1
Other Injury*	0	0	2	1	3	6
Total	0	0	2	5	10	17
*All suicide deaths caused by other injury were suicide deaths by hanging.						

UNDETERMINED

In 2020, there were 28 child deaths reviewed in Nevada in which the manner of death was undetermined. Undetermined deaths are deaths in which there is lack of sufficient evidence or information during the initial investigation, usually about intent, to assign a different manner of death. As seen in Table 6 below, the majority of the undetermined child deaths were among children under one year of age (82.1%). Further, in the majority of the undetermined child deaths (89.3%), it was undetermined if they were caused by an injury or due to a medical reason.

Table 6. Number of undetermined child deaths in Nevada in 2020 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	1	0	1
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	1	0	0	0	0	1
Undetermined	0	0	0	0	0	0
Unknown Injury	1	0	0	0	0	1
Undetermined if Injury or Medical Cause	21	3	1	0	0	25
Total	23	3	1	1	0	28

For details regarding the age, gender, race, Hispanic or Latino ethnicity, and county of residence for all of the 2020 Nevada child decedents by manner, see Appendix A.

LEADING MANNERS AND CAUSES OF CHILD DEATH

Excluding natural and undetermined manners of death, in Nevada in 2020, the four leading manners and causes of death included homicide caused by bodily force or weapon (22.2%), motor vehicle accidents (20.0%), accidents caused by poisoning, overdose, or acute intoxication (13.3%), and accidents caused by asphyxia (12.2%). See Table 7 for the number and percent of manner and causes of child deaths in Nevada in 2020, excluding natural and undetermined manners of death.

Table 7. Number and percent of manner and causes of child deaths in Nevada in 2020 excluding natural and undetermined manners of death.

Manner	Cause	Number	Percent
Homicide	Bodily Force or Weapon	20	22.2%
Accident	Motor Vehicle	18	20.0%
Accident	Poisoning, Overdose, or Acute Intoxication	12	13.3%
Accident	Asphyxia	11	12.2%
Suicide	Bodily Force or Weapon	9	10.0%
Accident	Drowning	6	6.7%
Suicide	Other Injury*	6	6.7%
Accident	Other Injury	3	3.3%
Homicide	Fall or Crush	2	2.2%
Suicide	Poisoning, Overdose, or Acute Intoxication	1	1.1%
Accident	Fall or Crush	1	1.1%
Suicide	Fall or Crush	1	1.1%
	Total	90	100%
*All suicide deaths caused by other injury were suicide deaths by hanging.			

HOMICIDES CAUSED BY BODILY FORCE OR WEAPON (N = 20)

As seen in Table 8, there were more male children (75.0%) that died of homicide caused by bodily force or a weapon in Nevada in 2020 as compared to female children (25.0%).

Table 8. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2020 by sex of the decedent.

	Number	Percent
Male	15	75.0%
Female	5	25.0%
Unknown	0	0.0%
Total	20	100%

More than half (55.0%) of child homicides caused by bodily force or a weapon were among children in the 15 – 17 Years age category. See Table 9.

Table 9. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2020 by age category of the decedent.

	Number	Percent
<1 Year	3	15.0%
1 - 4 Years	2	10.0%
5 - 9 Years	1	5.0%
10 - 14 Years	3	15.0%
15 - 17 Years	11	55.0%
Total	20	100%

All of the child homicides caused by bodily harm or a weapon in Nevada in 2020 were among children that were White (55.0%) or Black (45.0%). As seen in Table 10, the majority of child homicides caused by bodily harm or a weapon in Nevada in 2020 were among children not of Hispanic or Latino ethnicity (80.0%).

Table 10. Number and percent of child homicides caused by bodily harm or a weapon in Nevada in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	4	20.0%
Not Hispanic or Latino	16	80.0%
Unknown	0	0.0%
Total	20	100%

As seen in Table 11, the majority of child homicides caused by bodily harm or a weapon in Nevada in 2020 were the result of a firearm (70.0%).

Table 11. Number and percent of child homicides caused by bodily harm or a weapon in Nevada in 2020 by type of weapon used.

	Number	Percent
Firearm	14	70.0%
Knife/Sharp instrument	1	5.0%
Bodily Force	4	20.0%
Rope	0	0.0%
Other	0	0.0%
Unknown	1	5.0%
Total	20	100%

As seen in Table 12, in six of the child homicides caused by a firearm, the owner of the firearm was a caregiver and in three of the child homicides caused by a firearm, the firearm was stored loaded.

Table 12. Circumstances related to child homicides caused by a firearm in Nevada in 2020.

Storage	Firearm loaded	3
	Firearm kept locked	1
Owner of firearm	Caregiver	6
	Other family member	2
	Stranger	2
	Other	1
	Unknown	3
Note: More than one circumstance can apply to a case		

Table 13 identifies how the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Nevada in 2020.

Table 13. How the fatal weapon was being used at the time of the child homicides caused by bodily harm or a weapon in Nevada in 2020.

	Number of Cases
Self-injury	2
Commission of a crime	7
Drug dealing/trading	0
Drive-by shooting	0
Random violence	3
Child was a bystander	1
Argument	4
Jealousy	0
Intimate partner violence	0
Hate crime	0
Bullying	0
Hunting	0
Target shooting	0
Playing with the weapon	2
Weapon mistaken for a toy	1
Showing the gun to others	3
Russian Roulette	0
Gang-related activity	0
Self-defense	2
Cleaning the weapon	0
Murder-suicide	3
Other	2
Unknown	0
Note: More than one use can apply to a case	

MOTOR VEHICLE ACCIDENTS (N = 18)

As seen in Table 14, there were more male children (66.7%) that died of motor vehicle accidents in Nevada in 2020 as compared to female children (33.3%).

Table 14. Number and percent of motor vehicle accident child deaths in Nevada in 2020 by sex of the decedent.

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

More than half (55.6%) of the motor vehicle accident child deaths were among children in the 15 – 17 Years age category. See Table 15.

Table 15. Number and percent of motor vehicle accident child deaths in Nevada in 2020 by age category of the decedent.

	Number	Percent
<1 Year	1	5.6%
1 - 4 Years	1	5.6%
5 - 9 Years	1	5.6%
10 - 14 Years	5	27.8%
15 - 17 Years	10	55.6%
Total	18	100%

As seen in Table 16, the majority of motor vehicle accident child deaths were among White children (77.8%).

Table 16. Number and percent of motor vehicle accident child deaths in Nevada in 2020 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	1	5.6%
Asian	0	0.0%
Black	1	5.6%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	14	77.8%
Multiracial	1	5.6%
Unknown	1	5.6%
Total	18	100%

As seen in Table 17, more than half (55.6%) of the motor vehicle accident child deaths in Nevada in 2020 were among children not of Hispanic or Latino ethnicity.

Table 17. Number and percent of motor vehicle accident child deaths in Nevada in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	7	38.9%
Not Hispanic or Latino	10	55.6%
Unknown	1	5.6%
Total	18	100%

Half (50.0%) of the motor vehicle accident child deaths in Nevada in 2020 occurred among those who were a passenger in the motor vehicle. The next largest percentage of deaths occurred among those who were pedestrians (33.3%), followed by those who were drivers of the motor vehicle (16.7%). See Table 18.

Table 18. Number and percent of motor vehicle accident child deaths in Nevada in 2020 by position of child during the accident.

	Number	Percent
Driver	3	16.7%
Passenger	9	50.0%
On bicycle	0	0.0%
Pedestrian	6	33.3%
Unknown	0	0.0%
Total	18	100%

Details regarding the causes of the motor vehicle accident child deaths in Nevada in 2020 can be seen in Table 19.

Table 19. Causes of motor vehicle accident child deaths in Nevada in 2020.

	Number of cases
Speeding over limit	10
Unsafe speed for conditions	1
Recklessness	10
Ran stop sign/red light	0
Driver distraction	0
Inexperienced driver	2
Poor weather	1
Poor visibility	2
Drug/alcohol use	6
Vehicle ran over child	0
Vehicle flipped over	1
Poor sightline	1
Car changing lanes	0
Road hazard	0
Electronic use	1
Racing	1
Other driver error	0
Other cause	2
Unknown	4
Note: More than one cause may apply to a case	

Among the motor vehicle accident child deaths that occurred in Nevada in 2020, the child was responsible in three cases, the child's driver was responsible in seven cases, and the other driver was responsible in five cases. There were three cases in which the driver responsible for the incident was unknown. Table 20 identifies some of the factors contributing to the motor vehicle accident child deaths based on who was responsible.

Table 20. Number of cases in which the following were contributing factors in motor vehicle accident child deaths in Nevada in 2020 by person responsible for the accident.

	Child Responsible	Child's Driver Responsible	Other Driver Responsible
No license	1	0	0
Learners permit	0	0	0
Graduated license	0	0	0
Full license, not graduated	1	2	1
Full license, restricted	0	0	0
Suspended license	0	0	0
In violation of graduated license rules	0	0	0
Note: More than one contributing factor may apply to a case			

ACCIDENTS CAUSED BY POISONING, OVERDOSE, OR ACUTE INTOXICATION (N = 12)

As seen in Table 21, there were more male children (83.3%) that died of accidents caused by poisoning, overdose, or acute intoxication in Nevada in 2020 as compared to female children (16.7%).

Table 21. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020 by sex of the decedent.

	Number	Percent
Male	10	83.3%
Female	2	16.7%
Unknown	0	0.0%
Total	12	100%

The majority (83.3%) of the accident child deaths caused by poisoning, overdose, or acute intoxication were among children in the 15 – 17 Years age category. See Table 22.

Table 22. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	0	0.0%
5 - 9 Years	1	8.3%
10 - 14 Years	1	8.3%
15 - 17 Years	10	83.3%
Total	12	100%

All of the accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020 were among White (83.3%) and Black (16.7%) children. As seen in Table 23, more than half (58.3%) of the accident child deaths caused by poisoning, overdose, or acute intoxication were among children not of Hispanic or Latino ethnicity.

Table 23. Number and percent of accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	41.7%
Not Hispanic or Latino	7	58.3%
Unknown	0	0.0%
Total	12	100%

As seen in Table 24 below, most of the substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020 were obtained from unknown sources.

Table 24. Type and source of substances associated with accident child deaths caused by poisoning, overdose, or acute intoxication in Nevada in 2020.

	Source of Substance				
	Bought from Dealer or Stranger	Took from Friend or Relative	From Friend or Relative for Free	Unknown Source	Total
Benzodiazepines	1	0	0	5	6
Prescription opioid pain medication	2	0	0	4	6
Over the counter cold medicine	0	1	0	0	1
Cocaine	0	0	0	2	2
Fentanyl/Fentanyl analogs	0	0	0	7	7
Marijuana/THC	0	0	1	0	1
Alcohol	0	0	1	0	1
Other	0	0	1	0	1
Total	3	1	3	18	25
Note: More than one substance can apply to a case					

ACCIDENTS CAUSED BY ASPHYXIA (N = 11)

All but one of the accident child deaths caused by asphyxia in Nevada in 2020 were sleep-related. As seen in Table 25, there were more male children that died of asphyxia accidents in Nevada in 2020 as compared to female children.

Table 25. Number and percent of accident child deaths caused asphyxia in Nevada in 2020 by sex of the decedent.

	Number	Percent
Male	7	63.6%
Female	4	36.4%
Unknown	0	0.0%
Total	11	100%

As seen in Table 26, the majority of accident child deaths caused by asphyxia were among children under one year of age (72.7%).

Table 26. Number and percent of accident child deaths caused by asphyxia in Nevada in 2020 by age category of the decedent.

	Number	Percent
<1 Year	8	72.7%
1 - 4 Years	2	18.2%
5 - 9 Years	1	9.1%
10 - 14 Years	0	0.0%
15 - 17 Years	0	0.0%
Total	11	100%

All of the accident child deaths caused by asphyxia in Nevada in 2020 were among children that were White (54.5%) or Black (45.5%). As seen in Table 27, the majority of accident child deaths caused by asphyxia in Nevada in 2020 were among children not of Hispanic or Latino ethnicity (81.8%).

Table 27. Number and percent of accident child deaths caused by asphyxia in Nevada in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	2	18.2%
Not Hispanic or Latino	9	81.8%
Unknown	0	0.0%
Total	11	100%

Some of the circumstances of the accident child deaths caused by asphyxia in Nevada in 2020, including the objects found in the sleeping area, how the child was placed to sleep, and if the caregiver fell asleep feeding the child, are identified in Table 28.

Table 28. Circumstances of accident child deaths caused by asphyxia in Nevada in 2020.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	6
	Child(ren)	2
	Animal(s)	0
	Comforter, quilt, or other	1
	Thin blanket/flat sheet	2
	Pillow	3
	Cushion	0
	Nursing or U-shaped pillow	0
	Sleep positioner	0
	Bumper pads	0
	Clothing	0
	Crib railing/side	0
	Wall	1
	Toys	0
	Other	1
Child placed to sleep	With a pacifier	0
	On stomach	3
	On side	1
	In adult bed	8
	On couch	0
	Wrapped or swaddled in blanket	1
	On floor	0
	In car seat	1
	Bottle feeding child	0
	Breastfeeding child	0
Note: More than one circumstance can apply to a case		

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

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

In Nevada in 2020, there were 65 deaths in which abuse (n = 11), neglect (n = 16), poor/absent supervision (n = 5), or exposure to hazards (n = 33) caused or contributed to the death. Abuse is any injury inflicted on a child by a parent or caregiver. The parent or caretaker may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment. Neglect is failure on the part of a parent, caregiver, or supervisor to provide for the shelter, safety, supervision and nutritional needs of the child that results in harm to the child. Poor/absent supervision is failure on the part of the parent, caregiver, or supervisor to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death. Exposure to hazards refers to behavior by a parent, caregiver, or supervisor that exposes a child to a hazard that poses a threat of harm to the child, but does not meet the criteria to be classified as child neglect.

As seen in Table 29, for child deaths in which abuse, neglect, poor/absent supervision, or exposure to hazards caused or contributed to the death, the largest percentage of deaths were accidents (35.4%) followed by undetermined deaths (23.1%).

Table 29. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 by manner of death.

	Number	Percent
Natural	3	4.6%
Accident	23	35.4%
Suicide	11	16.9%
Homicide	13	20.0%
Undetermined	15	23.1%
Unknown	0	0.0%
Total	65	100%

As seen in Table 30, there were more deaths of male children (69.2%) than of female children (30.8%) in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death.

Table 30. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 by sex of the decedent.

	Number	Percent
Male	45	69.2%
Female	20	30.8%
Unknown	0	0.0%
Total	65	100%

In Nevada in 2020, the majority of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among children under one year of age (44.6%). See Table 31.

Table 31. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 by age category of the decedent.

	Number	Percent
<1 Year	29	44.6%
1 - 4 Years	12	18.5%
5 - 9 Years	3	4.6%
10 - 14 Years	8	12.3%
15 - 17 Years	13	20.0%
Total	65	100%

As seen in Table 32 below, the largest percentage of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among White children (61.5%) followed by Black children (32.3%).

Table 32. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	2	3.1%
Black	21	32.3%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	40	61.5%
Multiracial	1	1.5%
Unknown	1	1.5%
Total	65	100%

The majority of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 were among children not of Hispanic or Latino ethnicity (67.7%). See Table 33.

Table 33. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	20	30.8%
Not Hispanic or Latino	44	67.7%
Unknown	1	1.5%
Total	65	100%

The types of abuse and neglect indicated in the child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2020 are shown in Table 34. Neglect by exposure to hazards was indicated in 11 deaths. These hazards included sleep environment hazards, motor vehicle hazards, unsecured medication/poison, and water hazards. Other abuse was indicated in five deaths and abusive head trauma was indicated in four deaths. "Other abuse" is a response option in the data collection tool and includes types of abuse not listed in Table 34. In Nevada in 2020, these types of abuse specifically included assault and asphyxia.

Table 34. Types of abuse and neglect in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020.

		Number of Cases
Type of Abuse	Abusive head trauma	4
	Chronic Battered Child Syndrome	0
	Beating/kicking	1
	Scalding/burning	0
	Munchausen Syndrome by Proxy	0
	Sexual assault	0
	Other abuse*	5
	Unknown abuse	1
Type of Neglect	Failure to provide necessities – Food	0
	Failure to provide necessities – Shelter	0
	Failure to provide necessities – Other	0
	Failure to seek/follow treatment	3
	Failure to provide supervision	0
	Emotional	2
	Abandonment	1
	Exposure to hazards**	11
Note: More than one type of abuse or neglect can occur in a case *Cases included assault (2) and asphyxia (3) **Cases included sleep environment hazards (5), motor vehicle hazards (3), unsecured medication/poison (2), and water hazards (1)		

Details regarding the reported events that triggered the physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020 can be seen in Table 35. In two cases, the physical abuse was reported to be triggered by a domestic argument and in two cases, it was triggered by alcohol use.

Table 35. Events reported as triggering physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020.

	Number of Cases
Crying	0
Toilet training mishap	0
Disobedience	0
Feeding problems	0
Domestic argument	2
Alcohol use	2
None	0
Other	0
Unknown	7
Note: More than one event can be reported for a case.	

The historical type of abuse or neglect experienced by the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020 can be seen in Table 36.

Table 36. History of abuse and neglect of the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020.

	Number of Cases
History of physical maltreatment	6
History of neglect	5
History of sexual maltreatment	0
History of emotional maltreatment	0
Note: More than one type of abuse or neglect can occur for a case.	

Table 37 details the CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020.

Table 37. CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2020.

	Number of Cases
Evidence of prior abuse	14
CPS action taken as a result of the death	7
Open CPS case with child at time of death	1
Child ever placed in foster care	5
Note: More than one type of involvement can apply to a case	

In four of the child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2020, there was child abuse in the form of abusive head trauma. The impact of this abusive trauma is noted in Table 39.

Table 38. Abusive head trauma in cases of homicide child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2020.

	Number of Cases with a yes response
For abusive head trauma, were there retinal hemorrhages?	3
For abusive head trauma, was the child shaken?	2
If the child was shaken, was there impact?	0
Note: More than one condition can apply to a case	

INFANT DEATHS IN WHICH THE CHILDBEARING PARENT USED SUBSTANCES DURING PREGNANCY

There were 20 deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy. The manner of these deaths included natural (60.0%), undetermined (20.0%), homicide (10.0%), accident (5.0%), and unknown (5.0%).

More than half (55.0%) of the deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy were among males. See Table 39.

Table 39. Number and percent of deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy by gender of decedent.

	Number	Percent
Male	11	55.0%
Female	9	45.0%
Unknown	0	0.0%
Missing	0	0.0%
Total	20	100%

As seen in Table 40, the largest percentage of deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy were among White children (40.0%) and Black children (30.0%).

Table 40. Number and percent of deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	1	5.0%
Black	6	30.0%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	8	40.0%
Multiracial	2	10.0%
Unknown	3	15.0%
Missing	0	0.0%
Total	20	100%

As seen in Table 41, the majority of deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy were among children that were not Hispanic or Latino (80.0%).

Table 41. Number and percent of deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	2	10.0%
Not Hispanic or Latino	16	80.0%
Unknown	2	10.0%
Missing	0	0.0%
Total	20	100%

Risk factors associated with deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy can be seen in Table 42. The types of risk factors shown include those that occurred prior to pregnancy, during pregnancy, and indicate exposure to the child.

Table 42. Risk factors associated with deaths of children under 1 year of age in Nevada in 2020 in which the childbearing parent used substances during pregnancy.

		Number of Cases
Prior to Pregnancy	Childbearing parent was a prior victim of child maltreatment	6
	Childbearing parent was a prior perpetrator of child maltreatment	9
	Childbearing parent's history included a prior child death	0
During Pregnancy	Childbearing parent smoked	3
	Childbearing parent used alcohol	2
	Childbearing parent used cocaine	0
	Childbearing parent used heroin	2
	Childbearing parent used marijuana	5
	Childbearing parent used methamphetamines	10
	Childbearing parent used opiates	1
Child Exposure	Toxicology screen completed on child	14
	Toxicology screen was negative	5
	Child tested positive for alcohol	0
	Child tested positive for cocaine	0
	Child tested positive for marijuana	3
	Child tested positive for methamphetamines	4
	Child tested positive for opiates	2
	Child tested positive for prescription drugs	0
	Child tested positive for other drugs	2
	Child test results unknown	2
Note: More than one risk factor can apply to a case.		

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

Of the 244 child deaths in Nevada in 2020, there were 22 in which the child had been involved with the Child Protective Services (CPS) System. In 19 of these deaths, there was a past history of child maltreatment of the decedent as identified through CPS. See Table 43 for information regarding the status of the involvement of CPS with the decedent.

Table 43. Status of the involvement of Child Protective Services (CPS) System in which there was CPS involvement in Nevada in 2020.

	Number	Percent
Past history of child maltreatment as identified through CPS	19	86.4%
Past history of child maltreatment as identified through CPS and open CPS case at time of death	2	9.1%
Open CPS case at time of death	1	4.5%
Total	22	100%

As seen in Table 44, less than one-third of child deaths in Nevada with CPS involvement in 2020 were natural (27.3%) and accidents (27.3%). The next largest percentage of child deaths with CPS involvement were homicides (18.2%).

Table 44. Number and percent of child deaths in Nevada with CPS involvement in 2020 by manner of death.

	Number	Percent
Natural	6	27.3%
Accident	6	27.3%
Suicide	2	9.1%
Homicide	4	18.2%
Undetermined	2	9.1%
Missing	2	9.1%
Total	22	100%

In the deaths of children in which there was CPS involvement in Nevada in 2020, more than three-fourths were male (77.3%) and less than one-fourth were female (22.7%).

In Nevada in 2020, the largest percentage of child deaths with CPS involvement occurred among those less than one year of age (31.8%). See Table 45.

Table 45. Number and percent of child deaths with CPS involvement in Nevada in 2020 by age category of decedent.

	Number	Percent
<1 Year	7	31.8%
1 - 4 Years	3	13.6%
5 - 9 Years	3	13.6%
10 - 14 Years	4	18.2%
15 - 17 Years	5	22.7%
Total	22	100%

The majority of child deaths with CPS involvement in Nevada in 2020 occurred among White children (59.1%) and Black children (31.8%). See Table 46.

Table 46. Number and percent of child deaths with CPS involvement in Nevada in 2020 by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	1	4.5%
Asian	0	0.0%
Black	7	31.8%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	13	59.1%
Multiracial	1	4.5%
Unknown	0	0.0%
Missing	0	0.0%
Total	22	100%

The majority of child deaths with CPS involvement in Nevada in 2020 occurred among those that were not Hispanic or Latino (86.4%). See Table 47.

Table 47. Number and percent of child deaths with CPS involvement in Nevada in 2020 by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	3	13.6%
Not Hispanic or Latino	19	86.4%
Unknown	0	0.0%
Missing	0	0.0%
Total	22	100%

REGIONAL TEAM RECOMMENDATIONS

Each of the regional child death review teams in Nevada are responsible for completing and submitting a quarterly report form to the Executive Committee to Review of the Death of Children (Executive Committee). The form requires the team to report the number of cases reviewed each quarter by manner and leading cause of death and the number of cases requiring a mandatory review as outlined in NRS 432B.405. The form also allows the team to submit recommendations aimed at improving laws, policies, and practices to support the safety of children and prevent future child deaths. In submitting recommendations, teams are instructed to:

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

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

RECOMMENDATIONS RECEIVED

During 2020, only one recommendation was made to the Executive Committee by the regional teams. It was recommended that health insurance policies should not prevent individuals from filling prescriptions for mental or physical health issues.

ACTION TAKEN ON RECOMMENDATIONS

Below are the actions taken to date by the Executive Committee regarding the recommendation that health insurance policies should not prevent individuals from filling prescriptions for mental or physical health issues.

- After discussing the recommendation, the Executive Committee decided to reach out to the Nevada State Board of Pharmacy to request a list of medications that are critical for suicide prevention. It was decided that, after receiving the list, the Executive Committee would send letters to the Nevada Insurance Commissioner and Nevada Medicaid to notify them of the recommendation and include the list of medications received by the Nevada State Board of Pharmacy.
- After receiving a short presentation on the policies that Medicaid has in place to protect vulnerable children from polypharmacy, the Executive Committee discussed revising some of the language in the letters to the Nevada State Board of Pharmacy, the Nevada Insurance Commissioner, and Nevada Medicaid. The Executive Committee also decided to specify asthma as the physical health issue of concern with the request that asthma medication be dispensed prior to patients leaving the hospital. These letters were sent to the respective agencies.
- A representative from the Nevada Insurance Commissioner's office reached out the Executive Committee and indicated that although the mental health of Nevadans is of great concern to their office, they lack the regulatory authority necessary to gain compliance from insurance agencies

to carry the recommendation forward. The Executive Committee was encouraged to reach out to the Interim Health Committee to see if the recommendation fit with their legislative priorities. The Executive Committee sent a letter to the Interim Health Committee, but was told the letter lacked necessary information, including possible barriers and solutions, and therefore would not be passed onto the committee.

- The Executive Committee learned that the Nevada Chapter for the American Academy of Pediatrics would be highlighting this recommendation as a legislative priority, therefore this recommendation was closed.

PUBLIC AWARENESS EFFORTS FUNDED BY THE EXECUTIVE COMMITTEE

NRS 432B.409 establishes the creation of the Review of Death of Children Account in the State General Fund. One dollar of the fee associated with the purchase of a certificate of death through the state registrar funds this account. The Executive Committee to Review the Death of Children (Executive Committee) uses these funds to support efforts to prevent child deaths. Each year, the Executive Committee posts a Notice of Funding Opportunity (NOFO) for competitive applications to prevent the death of children with funding priorities based on the leading causes of death in Nevada. The NOFOs for State Fiscal Years 2020 (7/2019 – 6/2020) and 2021 (7/2020 – 6/2021) prioritized drowning and near drowning prevention, safe-sleep, and suicide prevention efforts. Below are the programs that were awarded funding in State Fiscal Years 2020 and 2021 by the Executive Committee.

SFY 2020 (7/2019 – 6/2020)

- Baby's Bounty ($10,500.00) – Continued funding for their Safe Sleep program
- DHHS-Office of Suicide Prevention ($13,140.00) – Training on safeTALK and leadership and purchase of AR-15 gun locks
- Southern Nevada Health District (SNHD) ($3,253.00) – Train-the-trainer training on safeTALK so that SNHD staff can be trained internally to help prevent suicide
- Washoe County HSA Child Suicide Awareness Prevention ($8,950.00) – PSA media campaign for children and teens in Washoe County
- Renown Health & The Child Health Institute ($15,000.00) – Increase suicide prevention outreach to Hispanic and Latino and Native American populations
- Desert Rose Counseling ($15,000.00) – Production of an episode of the Soul Survivor Nevada Docuseries to fill the gap of available suicide prevention content
- Crisis Support Services of Nevada ($10,716.50)– Continued funding for the suicide prevention call center with a focus on child suicide prevention
- Henderson Fire Department ($10,000.00)– Creation of a suicide prevention awareness program for children and adults
- Immunize Nevada, Healthy Young Nevada ($5,000.00) – Increase the number of community events for adolescents aimed at reducing the instances of diseases and disorders and increase membership in Healthy Young Nevada Youth Advisory Council
- Prevent Child Abuse Nevada ($8,800.00) – Continue efforts to provide child maltreatment prevention training to parents and professionals who work with parents

SFY 2021 (7/2020 – 6/2021)

- NyE Community ($19,584.00) – Work with community partners to provide water safety education and focus on safe sleep initiatives and suicide prevention

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

APPENDIX A: DEMOGRAPHICS OF DECEDENTS BY MANNER OF DEATH

Age Category	Natural	Accident	Suicide	Homicide	Undetermined	Unknown	Total
Under 1 Year	72	10	0	5	23	2	112
1 - 4 Years	13	9	0	2	3	0	27
5 - 9 Years	9	3	2	1	0	0	15
10 - 14 Years	17	7	5	3	1	0	33
15 - 17 Years	12	22	10	11	1	1	57
Total	123	51	17	22	28	3	244
Gender	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Male	73	36	15	17	17	0	158
Female	49	15	2	5	11	3	85
Unknown	1	0	0	0	0	0	1
Total	123	51	17	22	28	3	244
Race	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Alaska Native	0	0	0	0	0	0	0
American Indian	2	1	0	0	0	0	3
Asian	5	2	1	0	0	0	8
Black	35	10	2	10	8	0	65
Native Hawaiian	1	0	0	0	0	0	1
Pacific Islander	1	0	0	0	0	0	1
White	64	36	12	12	18	3	145
Multiracial	7	1	2	0	1	0	11
Unknown	8	1	0	0	1	0	10
Total	123	51	17	22	28	3	244
Hispanic or Latino Ethnicity	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Hispanic or Latino	46	16	8	4	9	0	83
Not Hispanic or Latino	70	34	9	18	19	3	153
Unknown	7	1	0	0	0	0	8
Total	123	51	17	22	28	3	244
County of Residence	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Clark	99	34	15	16	19	0	183
Washoe	18	7	1	6	5	2	39
Rural	0	1	0	0	1	1	3
Out of state	6	8	1	0	2	0	17
Unknown	0	1	0	0	1	0	2
Total	123	51	17	22	28	3	244

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

Natural Deaths

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

Accident Deaths

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

Suicide Deaths

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

Homicide Deaths

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

Undetermined Deaths

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

APPENDIX C: NUMBER AND PERCENT OF CHILD DEATHS IN NEVADA IN 2020 BY DECEDENT'S COUNTY OF RESIDENCE FOR CATEGORIES OF DEATHS REVIEWED IN THIS REPORT

	Clark County	Washoe County	Rural Counties	Out of State	Unknown	Total
Homicides caused by bodily force or weapon	14 (70.0%)	6 (30.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	20 (100%)
Motor vehicle accidents	11 (61.1%)	3 (16.7%)	1 (5.5%)	2 (11.1%)	1 (5.5%)	18 (100%)
Accidents caused by poisoning, overdose, or acute intoxication	9 (75.0%)	2 (16.7%)	0 (0.0%)	1 (8.3%)	0 (0.0%)	12 (100%)
Accidents caused by asphyxia	9 (81.8%)	0 (0.0%)	0 (0.0%)	2 (18.2%)	0 (0.0%)	11 (100%)
Deaths in which abuse or neglect caused or contributed to the death	52 (80.0%)	3 (4.6%)	0 (0.0%)	8 (12.3%)	2 (3.1%)	65 (100%)
Infant deaths in which the childbearing parent used substances during pregnancy	15 (75.0%)	4 (20.0%)	0 (0.0%)	1 (5.0%)	0 (0.0%)	20 (100%)
Deaths in which the child was involved in the Child Protective Services (CPS) System	12 (54.5%)	8 (36.4%)	1 (4.5%)	1 (4.5%)	0 (0.0%)	22 (100%)

APPENDIX D: NEVADA REVISED STATUTES FOR CHILD DEATH REVIEW

NRS 432B.403 Purpose of organizing child death review teams. The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.409, inclusive, is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this state;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children.

(Added to NRS by 2003, 863)

NRS 432B.405 Organization of child death review teams.

1. An agency which provides child welfare services:
    a. May organize one or more multidisciplinary teams to review the death of a child; and
    b. Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:
        1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;
        2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;
        3) If the death is alleged to be from abuse or neglect of the child;
        4) If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending;
        5) If the child was adopted through an agency which provides child welfare services; or
        6) If the child died of Sudden Infant Death Syndrome.
2. A review conducted pursuant to subparagraph (2) of paragraph (b) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

(Added to NRS by 1993, 2051; A 2001 Special Session, 47; 2003, 864)

NRS 432B.406 Composition of child death review teams.

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:
    a. A representative of any law enforcement agency that is involved with the case under review;
    b. Medical personnel;
    c. A representative of the district attorney's office in the county where the case is under review;
    d. A representative of any school that is involved with the case under review;

e. A representative of any agency which provides child welfare services that is involved with the case under review; and
f. A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.

(Added to NRS by 2003, 863)

NRS 432B.407 Information available to child death review teams; sharing of certain information; subpoena to obtain information; confidentiality of information.

1. A multidisciplinary team to review the death of a child is entitled to access to:
   a. All investigative information of law enforcement agencies regarding the death;
   b. Any autopsy and coroner's investigative records relating to the death;
   c. Any medical or mental health records of the child; and
   d. Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.
2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.
3. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.
4. Information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

(Added to NRS by 2003, 863)

NRS 432B.408 Administrative team to review report of child death review team.

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted for review to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409.
2. The Executive Committee shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

(Added to NRS by 2003, 864; A 2013, 438)

NRS 432B.409 Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account.

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of:
   a. Representatives from multidisciplinary teams formed pursuant to paragraph (a) of subsection 1 of NRS 432B.405 and NRS 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.
   b. Administrators of agencies which provide child welfare services, and agencies responsible for mental health and public safety, to the extent that such administrators are not already appointed pursuant to paragraph (a). Members of the Executive Committee who are appointed pursuant to this paragraph shall serve as nonvoting members.
2. The Executive Committee shall:

a. Adopt statewide protocols for the review of the death of a child;
b. Adopt regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;
c. Adopt bylaws to govern the management and operation of the Executive Committee;
d. Appoint one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS 432B.405;
e. Oversee training and development of multidisciplinary teams to review the death of children;
f. Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes; and
g. Carry out the duties specified in NRS 432B.408.

3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive.

(Added to NRS by 2003, 864; A 2007, 1509; 2013, 439)