STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

CHILD DEATH REPORT 2002 – 2003

Submitted by:

The Executive Committee to Review the Death of Children

Michelle Lucier and Cyndi Sauchak, Co-Chairs

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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 five 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 Carson City, Elko, and Fallon Teams review child deaths in all other counties, which comprise Nevada's rural region. In order to provide statewide coordination and review of child death, a Statewide Child Death Review Subcommittee functioned as part of the Children's Justice Act (CJA) Task Force from 1994 through 2003, with the primary goal 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.

Assembly Bill (AB) 381, passed by the 2003 Nevada State Legislature, allowed for the implementation of significant changes in the child death review process. This included the establishment of two new 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 recommendations for improvements to laws, policies, and practices. The Executive Committee makes decisions about funding initiatives to prevent child maltreatment and death, which may be based on recommendations from the Administrative Team. 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 a statewide annual report. Together, the Administrative Team and the Executive Committee have taken over the functions of the original Statewide CDR Subcommittee, and now work jointly to prevent future child deaths in Nevada.

During 2002 and 2003, the five regional CDR teams reviewed 304 child death cases out of 645 total cases referred. 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 71% 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; and children who die from Sudden Infant Death Syndrome (SIDS).

The greatest number of deaths during the two-year period occurred in infants less than one year of age, for a total of 142 of the 304 deaths reviewed. This is consistent with national mortality rates, which indicate the highest rate of deaths for infants ages zero to one, at approximately 691 per 100,000 live births. National mortality rates in other age cohorts are significantly lower and range from approximately 16 per 100,000 for children ages five to nine, to approximately 68 per

100,000 for adolescents ages 15 to 19 years. The total national child mortality rate in 2000 was 87.1 per 100,000 for ages zero to 19 years. By comparison, Nevada's child mortality rate was below the national average at 67.1 per 100,000 during the same period. [1]

Natural deaths account for the greatest number of child fatalities during 2002 and 2003, with a total of 410 out of 645 total cases referred. This is again consistent with national data, where the top five of the 10 leading causes of infant death are due to natural causes. [2] While natural deaths comprise the highest number of child fatalities each year, accidental deaths account for the highest number of child fatalities where prevention efforts may result in the reduction of child deaths. Therefore, this manner of death represents the greatest number of cases reviewed by the regional CDR teams, for a total of 145 out of 304 cases reviewed during 2002 and 2003.

The top three leading causes of accidental death in Nevada for child fatalities reviewed during 2002 and 2003 are ranked as follows: 1) motor vehicle accidents, 2) asphyxia, and 3) drowning. While motor vehicle accidents decreased between cases reviewed in 2002 and 2003, deaths from asphyxia and drowning increased within the same two-year period. These causes of death are consistent with national data, which ranks the leading causes of death for infants less than one year of age as follows: 1) suffocation (asphyxia), 2) motor vehicle accidents, and 3) drowning. For children and adolescents ages one to 19 years, national data ranks motor vehicle accidents as the leading cause of death. Drowning is ranked second and suffocation (asphyxia) is ranked fifth nationally in the same age group. [3]

Suicide deaths account for 20 of the 304 child deaths reviewed during 2002 and 2003. Nevada has been ranked number one in suicides nationally from 1996 through 1999, dropped one rank each year from 2000 through 2002, and currently ranks the fourth highest in the nation. [4] According to the National Center for Injury Prevention and Control, suicide is the third leading cause of death in adolescents and young adults ages 15 to 24, and in 2001 approximately 86% of total suicides nationally were males. Suicide rates are highest among Caucasians and American Indian males. [5] Of the 20 cases reviewed in Nevada, 65% (13 of 20) were male. Of these males, more than half were Caucasian (7 of 13).

Based on information gathered from child death reviews conducted during 2002 and 2003, the four primary types of preventable death in Nevada include motor vehicle accidents, asphyxia, drowning, and suicide.

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[1] National MCH Center for Child Death Review. (2004). *United States Child Mortality Data, 2000*. Retrieved November 29, 2004 from http://www.childdeathreview.org/nationalchildmortalitydata.htm.

[2] National Center for Injury Prevention and Control. (2004). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2002* [custom data query]. Retrieved November 29, 2004, from http://www.cdc.gov/ncipc/wisqars/.

[3] National Center for Injury Prevention and Control. (2004). *Web-based Injury Statistics Query and Reporting System: 2002 United States Unintentional Injuries* [custom data query]. Retrieved November 29, 2004, from http://www.cdc.gov/ncipc/wisqars/.

[4] McIntosh, J. (1998 – 2004). *Rate, Number, and Ranking of Suicide for Each USA State (1996 – 2002)*. Washington, DC: American Association of Suicidology.

[5] National Center for Injury Prevention and Control. (2004). *Suicide: Fact Sheet*. Retrieved November 29, 2004 from http://www.cdc.gov/ncipc/factsheets/suifacts.htm.

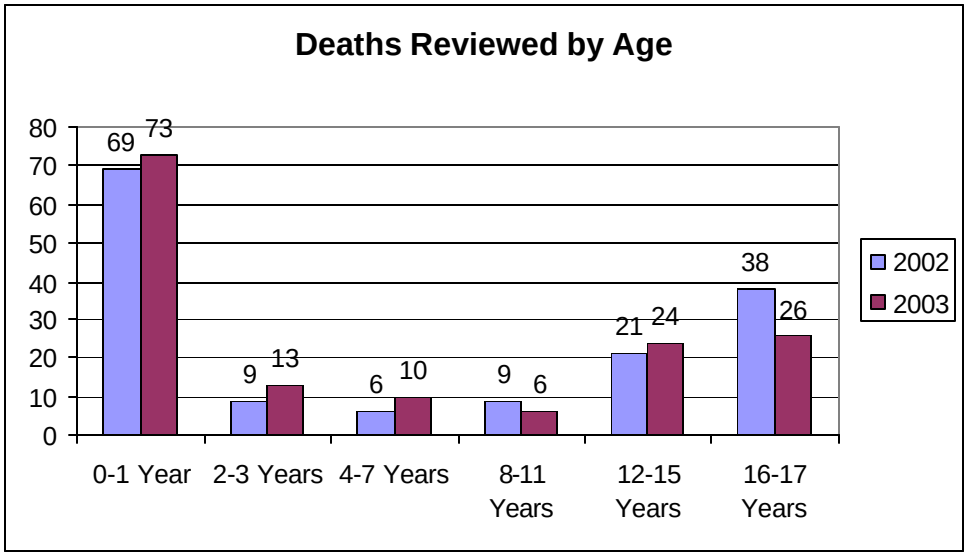
Child Deaths Reviewed: 2002 – 2003

During 2002 and 2003, the five regional CDR teams reviewed a total of 304 child death cases as follows:

Year	*Cases Referred*	*Cases Reviewed*
2002	327	152
2003	318	152
TOTAL:	645	304

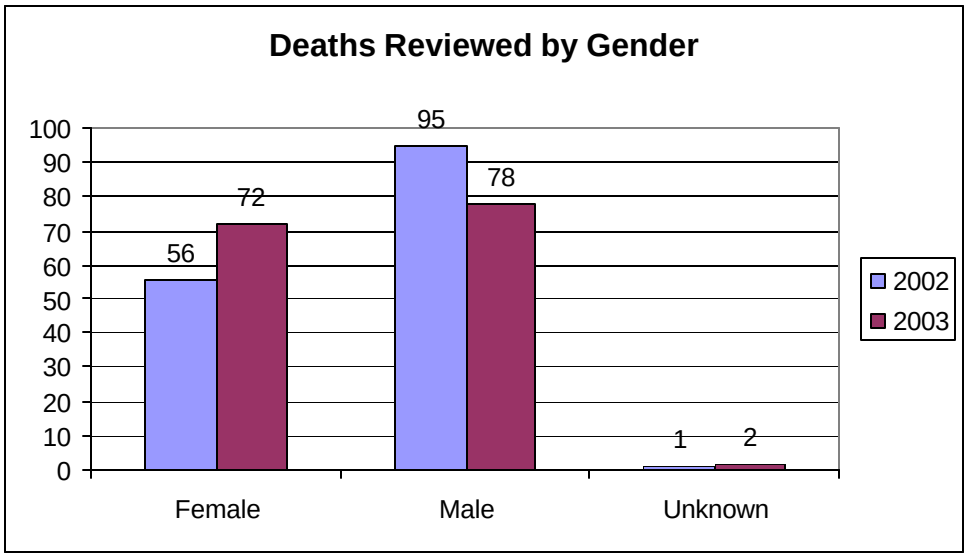
Demographics

The following charts summarize major demographics for cases reviewed by regional CDR teams in 2002 and 2003, including age, gender, and race/ethnicity:

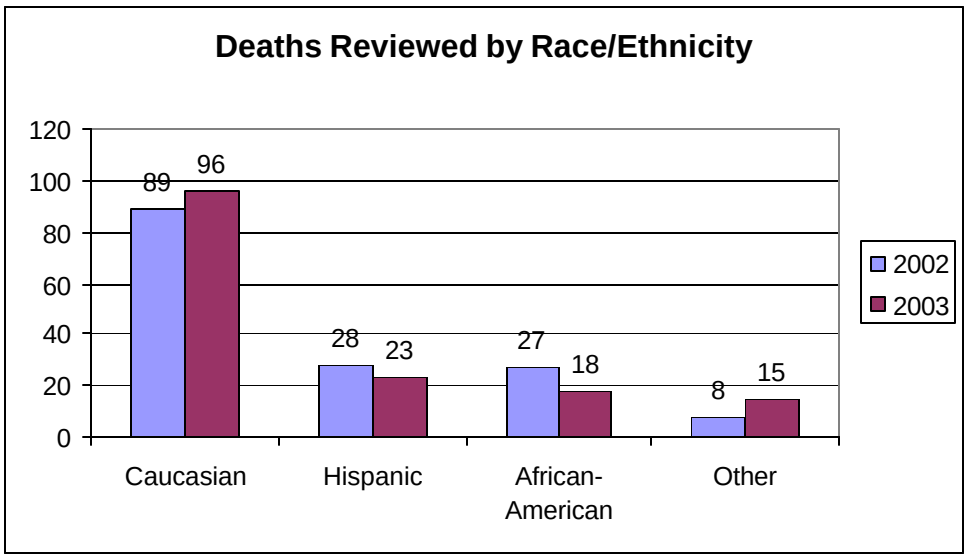


The greatest number of deaths occurred in infants less than one year of age, for a total of 142 of the 304 deaths reviewed. This is consistent with national mortality rates, which indicate the highest rate of deaths for infants ages zero to one, at approximately 691 per 100,000 live births. In the remaining age groups for Nevada, the fewest deaths occurred in children between four and seven years of age, and eight to 11 years of age. The greatest number of deaths outside of the infant age group occurred in adolescents 16 to 17 years of age. This is consistent with national mortality rates in similar age cohorts, which are lowest at approximately 16 per 100,000 for children ages five to nine, and highest at approximately 68 per 100,000 for adolescents ages 15 to 19 years. The total national child mortality rate in 2000 was 87.1 per 100,000 for ages zero to

19 years. By comparison, Nevada's child mortality rate was below the national average at 67.1 per 100,000 during the same period. [6]



Historically, males have had a higher mortality rate than females in Nevada. This is consistent with national data, which also indicates that males have a higher mortality rate than females, and demonstrates that this disparity actually increases with age. For adolescents ages 10 to 14, the national death rate is 1.5 times higher for males than females. For adolescents ages 15 to 19 the rate increases to 2.4 times higher, and for young adults ages 20 to 24 the rate increases to 3.0 times higher. [7]



[6] National MCH Center for Child Death Review. (2004). *United States Child Mortality Data, 2000*. Retrieved November 29, 2004 from http://www.childdeathreview.org/nationalchildmortalitydata.htm.
[7] National Adolescent Health Information Center. (2004). *Fact Sheet on Mortality: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Detail: Race/Ethnicity of Child Deaths Reviewed Compared with Statewide Population Distribution

Race	*2002 Child Deaths Reviewed*	*2002 Statewide Population* [8]	*2003 Child Deaths Reviewed*	*2003 Statewide Population* [9]
Caucasian	58.5%	64.6%	63.2%	63.7%
Hispanic	18.4%	21.3%	15.1%	22.0%
African-American	17.8%	6.9%	11.8%	6.9%
Asian/Pacific Islander	-	5.9%	-	6.0%
American Indian	-	1.3%	-	1.4%
Other	5.3%	-	9.9%	-

When comparing the percentage differences of race/ethnicity between child deaths reviewed and the statewide population distribution, the broadest margin within the Caucasian and Hispanic populations is 6.9 percentage points less than the statewide distribution. This variation appears reasonable based on the fact that cases reviewed by the regional CDR teams do not represent a randomized sample because of the review requirements set forth in NRS 432B.405, and also because the selection method for cases reviewed outside of these requirements may not be randomized.

However, the percentage difference among African-American child deaths reviewed is greater for both years compared with the statewide population, for a total of 10.9 percentage points higher in 2002, and 4.9 percentage points higher in 2003. Given the small population percentage for this racial group compared with Caucasians and Hispanics statewide, this variation suggests that deaths among African-American children may be disproportionately high in Nevada when compared with other racial groups. This is consistent with national data published by the National Adolescent Health Information Center, which indicates that African-American and American Indian adolescent males have the highest mortality rate, within an age group of 10 to 24 years. [10] The lack of data on American Indian child death in Nevada suggests the need for a formal interface with tribal governments in the state.

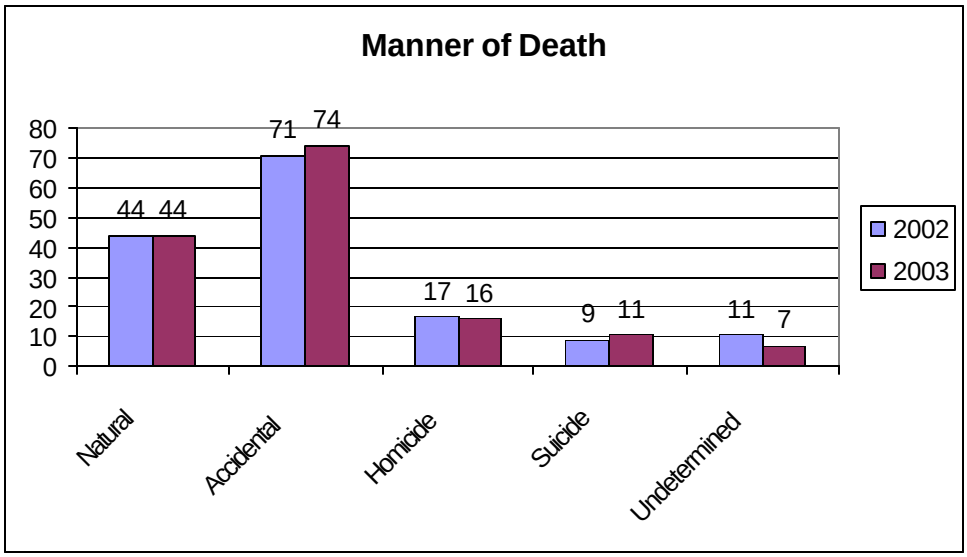
[8] Hardcastle, J. (2004). *ASRHO Estimates from 1990 to 2003 and Projections from 2004 to 2024 for Nevada and its Counties*. Retrieved November 29, 2004, from http://www.nsbdc.org/demographer/pubs.
[9] Ibid.
[10] National Adolescent Health Information Center. (2004). *Fact Sheet on Mortality: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Manner of Death

Prior to the regional CDR teams' analysis or involvement in a child fatality, a coroner 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 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 that do not have a clear indicator of what caused the death.

The following chart summarizes the manner of death for cases reviewed by regional CDR teams in 2002 and 2003, totaling 304 cases:



Natural Deaths

As discussed above, natural death is the most common manner of death for children. Natural deaths include cases not reviewed by a coroner, in which children have a diagnosed illness and are under a physician's care at the time of their death. For these cases, the practicing physician determines the cause of death and signs the death certificate.

A large number of the natural deaths in Nevada are due to severe pre-maturity in infants under the age of one year. These cases are reviewed if there is reported maternal drug use, domestic violence, or unclear circumstances surrounding the premature birth.

During 2002, out of the 327 cases referred to the regional CDR teams, 212 were due to natural causes, and 44 of these natural deaths were reviewed by the regional CDR teams as follows:

Natural Cause	***Number of Deaths in 2002***
SIDS	20
Bronchopneumonia/Pneumonia	6
Intrauterine Fetal Demise	3
Status Asthmaticus	2
Congential Heart Disease	1
Embolic Cerebral Vascular Episode	1
Frederichsen Syndrome	1
Hepatitis	1
Hypoxia	1
Meningitis	1
Multiple Congenital Anomalies	1
Myocardial Ischemia	1
Peritonitis	1
Sepsis, Short Bowel Syndrome	1
Severe Prematurity	1
Seizure Disorder	1
Toxic Shock, Pericarditis	1

During 2003, out of the 318 cases referred to the regional CDR teams, 198 were due to natural causes, and 44 of these natural deaths were reviewed by the regional CDR teams as follows:

Natural Cause	***Number of Deaths in 2003***
SIDS	12
Bronchopneumonia/Pneumonia	5
Extreme Prematurity	4
Encephalopathy, Etiology Unknown	3
Fetal Demise	2
Stillbirth	2
Abrupted Placenta	1
Birth Defect	1
Brain Tumor	1
Cardiac Anomalies/Downs Syndrome	1
Cardiopulmonary Arrest/Cerebral Palsy	1
Cerebral Anoxia/Etiology Unknown	1
Cerebral Atrophy with Ventriculomegaly	1
Congenital Heart Disease	1
Hypoxia	1
Maternal Chorioamnionitis	1

Natural Cause	*Number of Deaths in 2003*
Maternal Uterine Rupture	1
Microabscesses of Liver and Lungs	1
Myocarditis/Infectious Disease	1
Perinatal Asphyxia	1
Sepsis	1
Severe Congenital Malformations	1

Detail: Sudden Infant Death Syndrome (SIDS)

Deaths from SIDS accounted for the largest number of natural deaths for both years in cases reviewed, with 20 in 2002 and 12 in 2003. Following is a breakdown of SIDS deaths by age, gender, and race/ethnicity:

2002

Age		*Gender*		*Race/Ethnicity*	
< 1 month:	3	Males:	13	Caucasian:	7
1 month:	4	Females:	7	African-American:	9
2 months:	2			Hispanic:	4
3 months:	6				
4 months:	4				
6 months:	1				
TOTAL:	20				

2003

Age		*Gender*		*Race/Ethnicity*	
< 1 month:	2	Males:	4	Caucasian:	8
1 month:	3	Females:	7	African-American:	3
2 months:	4	Unknown:	1	Hispanic:	1
3 months:	1				
4 months:	1				
6 months:	1				
TOTAL:	12				

SIDS Deaths by County

County	*2002*	*2003*
Clark	15	9
Washoe	2	1
Elko	2	0
Humboldt	0	1
Lyon	1	1
TOTAL:	20	12

Detail: Comparison of State and National Leading Causes of Natural Death

SIDS deaths rank number one in Nevada for natural deaths in cases reviewed for children under one year of age because of the requirement to investigate such cases in NRS 432B.405. SIDS deaths rank third nationally based on the leading causes of deaths for children in the same age group. The following compares the top three state and national leading causes of natural death in children and adolescents:

Nevada Cases Reviewed 2002	*Nevada Cases Reviewed 2003*	*National <1 Year 2002* [11]	*National 1 to 18 Years 2002* [12]
1. SIDS	1. SIDS	1. Congenital Anomalies	1. Malignant Neoplasms
2. Bronchopneumonia/ Pneumonia	2. Bronchopneumonia/ Pneumonia	2. Short Gestation	2. Congenital Anomalies
3. Intrauterine Fetal Demise	3. Extreme Prematurity	3. SIDS	3. Heart Disease

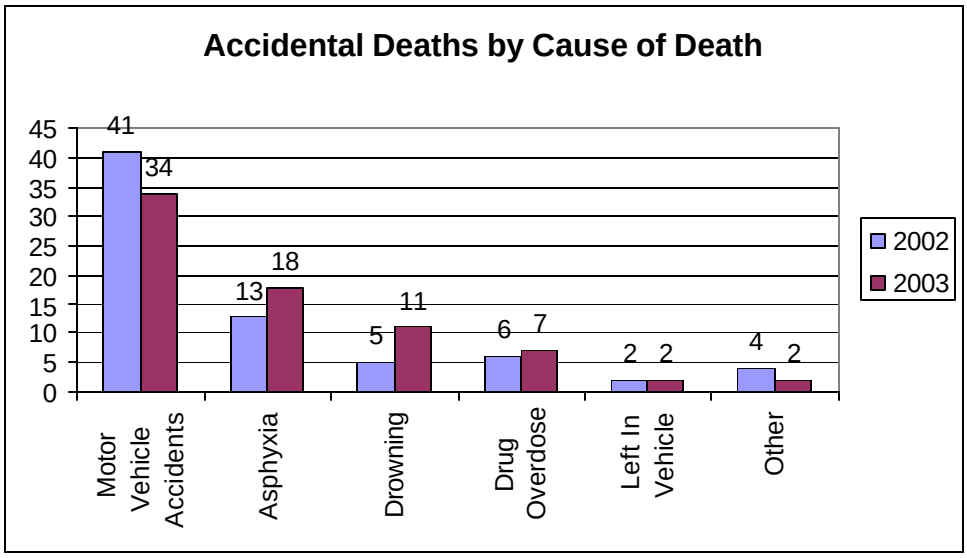
Accidental Deaths

While natural deaths comprise the highest number of child fatalities each year, accidental deaths account for the highest number of child fatalities where prevention efforts may result in the reduction of child deaths. This manner of death includes motor vehicle accidents, asphyxia, incidents of drowning, and house fires. Some of these deaths could have been prevented if the children involved were being properly supervised at the time of the incident, or if parents and caretakers were educated about some of the causal factors surrounding child death. Although new parents receive safety information when being discharged from the hospital after giving birth, there are a number of areas where additional parent education is needed. These include

[11] National Center for Injury Prevention and Control. (2004). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2002* [custom data query]. Retrieved November 29, 2004, from http://www.cdc.gov/ncipc/wisqars/.
[12] Ibid.

proper supervision around a swimming pool, appropriate bedding in a crib, and the risks of co-sleeping with infants.

A total of 145 accidental deaths were reviewed by the regional CDR teams during the two-year period, with 71 in 2002 and 74 in 2003. They are arrayed by cause of death as follows:



Motor Vehicle Accidents

Motor vehicle accidents are the leading cause of accidental deaths in cases reviewed by the regional CDR teams. In contrast to the types of death that occur in early childhood, many of these deaths involve teenage drivers and passengers, very few of whom use safety restraints. The following summarizes victim status (driver, passenger, or pedestrian) and safety restraint use in the cases reviewed:

Status	***2002***	***2003***
Victim was a driver	6	8
Victim was a passenger	16	11
Victim was a pedestrian	3	9
Unknown	16	6
TOTAL:	41	34
Driver victims used seatbelts?	1 – yes	1 – yes
	3 – no	4 – no
	2 – unknown	3 – unknown
Passenger victims used seatbelts?	2 – yes	4 – yes
	14 – no	7 – no

Asphyxia

Asphyxia deaths follow motor vehicle accidents as the second leading cause of accidental deaths in cases reviewed by the regional CDR teams, with a rise from 13 in 2002 to 18 in 2003. Causes include parents placing children on inappropriate beds or putting a large number of pillows and blankets in a crib or bassinet. This results in children dying from asphyxiation because they get tangled in bedding or lay face down in large, fluffy pillows. Parents co-sleeping with infants has also been associated with an alarmingly higher rate of child deaths in recent years.

Drowning Deaths

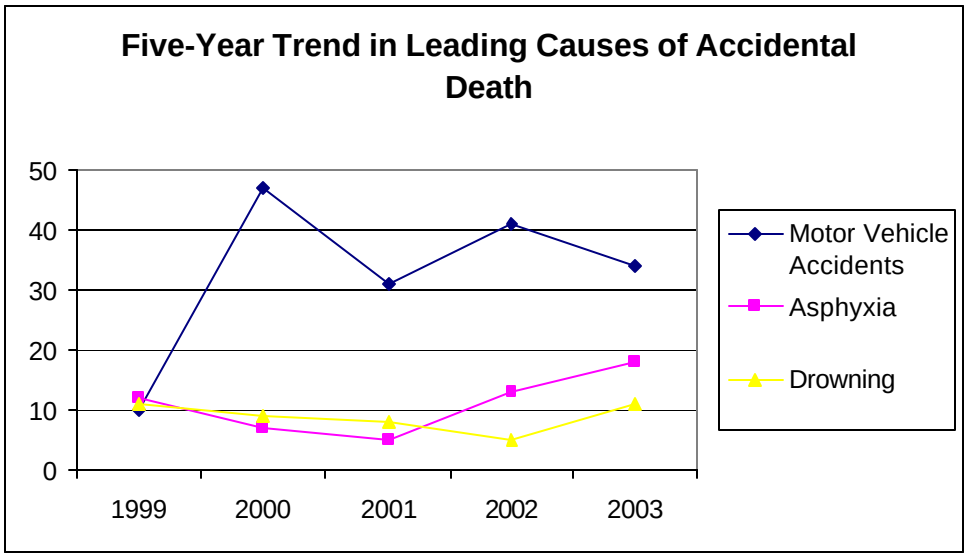
Drowning deaths are the third leading cause of accidental deaths in cases reviewed by the regional CDR teams. Although drowning deaths have reduced historically, decreasing steadily between 1999 and 2003, they demonstrated a sharp increase from five in 2002 to 11 in 2003. Drowning deaths often result from a lack of pool safety and proper supervision of children in and around swimming pools. Several drowning deaths each year are also attributed to parents leaving their children unsupervised in bathtubs.

Detail: Accidental Deaths by County

County	*2002*	*2003*
Clark	58	65
Washoe	3	7
Lyon	6	1
Elko	4	0
Humboldt	0	1
TOTAL:	71	74

Detail: Five-Year Trend in Leading Causes of Accidental Deaths

Cause	*1999*	*2000*	*2001*	*2002*	*2003*
Motor Vehicle Accidents	10	47	31	41	34
Asphyxia	12	7	5	13	18
Drowning	11	9	8	5	11
TOTAL:	33	63	44	59	63



Deaths from motor vehicle accidents have demonstrated a "see-saw" variation between 2000 and 2003, remaining within a range of 30 to 50 deaths per year. Deaths from asphyxia have increased between 2001 and 2003, and deaths from drowning demonstrated a sharp increase between 2002 and 2003, as discussed above.

Detail: Comparison of State and National Leading Causes of Accidental Death

Nevada Leading Causes of Accidental Death 2002 – 2003	*National Leading Causes of Accidental Death 2002 (ages zero to one year)* [13]	*National Leading Causes of Accidental Death 2002 (ages one to 19 years)* [14]
1. Motor Vehicle Accidents	1. Suffocation (asphyxia)	1. Motor Vehicle Accidents
2. Asphyxia	2. Motor Vehicle Accidents	2. Drowning
3. Drowning	3. Drowning	3. Fires/burns
	4. Fires/burns	4. Poisoning
	5. Poisoning	5. Suffocation (asphyxia)

[13] National Center for Injury Prevention and Control. (2004). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2002* [custom data query]. Retrieved November 29, 2004, from http://www.cdc.gov/ncipc/wisqars/.
[14] Ibid.

Homicide Deaths

Year	*Number Due To Abuse and Neglect*	*Number Not Due To Abuse and Neglect*	*Total Homicides*
2002	3	14	17
2003	9	7	16
TOTAL:	12	21	33

Homicide Deaths by County

County	*2002*	*2003*
Clark	16	13
Washoe	1	1
Mineral	0	1
Elko	0	1
TOTAL:	17	16

Homicide Deaths by City

City	*2002*	*2003*
Las Vegas	11	9
North Las Vegas	2	3
Henderson	0	1
Sparks	1	1
Hawthorne	0	1
Mesquite	1	0
Wells	0	1
Out-of-state	2	0
TOTAL:	17	16

Detail: Homicide Deaths by Individual Case – Due To Abuse and Neglect

2002

Gender	*Age*	*Cause*
Male	7 months	Blunt force trauma
Female	1 year	Failure to thrive
Female	2 years	Unspecified child abuse
TOTAL:		3

2003

Gender	*Age*	*Cause*
Male	2 months	Cerebral injuries
Male	8 months	Blunt force trauma
Female	1 year	Unspecified head trauma
Female	2 years	Thermal injury
Male	3 years	Blunt force trauma to abdomen
Female	3 years	Multiple stab wounds, left alone
Male	3 years	Blunt force trauma to abdomen
Female	4 years	Struck in head with baseball bat
Male	8 years	Struck in head with baseball bat
TOTAL:		9

Detail: Homicide Deaths by Individual Case – Not Due To Abuse and Neglect

2002

Gender	*Age*	*Cause*
Female	3 years	Gunshot wound to chest
Female	9 years	Gunshot wound to chest
Female	14 years	Gunshot wound to head
Male	14 years	Gunshot wound to chest
Male	15 years	Gunshot wound to head
Male	15 years	Asphyxia
Male	16 years	Multiple gunshot wounds
Male	16 years	Gunshot wound to head
Male	17 years	Multiple gunshot wounds
Male	17 years	Motor vehicle accident – pedestrian

Gender	*Age*	*Cause*
Male	17 years	Asphyxia
Female	17 years	Multiple stab wounds
Male	17 years	Gunshot wound to head
Female	17 years	Asphyxia
TOTAL:		14

2003

Gender	*Age*	*Cause*
Male	11 years	Gunshot wound to torso
Female	13 years	Gunshot wound to head
Male	14 years	Multiple gunshot wounds
Male	16 years	Gunshot wound to head
Male	16 years	Blunt force trauma to head
Male	16 years	Shot by robbery victim
Male	16 years	Shot by assailant
TOTAL:		7

Suicide Deaths

Year	*Total Suicides*	*Youngest Age at Death*
2002	9	9 years
2003	11	14 years
TOTAL:	20	

Suicide deaths account for 20 of the 304 child deaths reviewed during 2002 and 2003. Nevada has been ranked number one in suicides nationally from 1996 through 1999, dropped one rank each year from 2000 through 2002, and currently ranks the fourth highest in the nation. [15] According to the National Center for Injury Prevention and Control, suicide is the third leading cause of death in adolescents and young adults ages 15 to 24, and in 2001 approximately 86% of total suicides nationally were males. Suicide rates are highest among Caucasians and American Indian males. [16] Of the 20 cases reviewed in Nevada, 65% (13 of 20) were male. Of these males, more than half were Caucasian (7 of 13).

[15] McIntosh, J. (1998 – 2004). *Rate, Number, and Ranking of Suicide for Each USA State (1996 – 2002)*. Washington, DC: American Association of Suicidology.
[16] National Center for Injury Prevention and Control. (2004). *Suicide: Fact Sheet*. Retrieved November 29, 2004 from http://www.cdc.gov/ncipc/factsheets/suifacts.htm.

Detail: Suicide Deaths by Individual Case

2002

Age	*Race*	*Gender*	*City*	*County*
9 years	Caucasian	Male	Reno	Washoe
12 years	Caucasian	Male	Dayton	Storey
14 years	Caucasian	Male	Fernley	Lyon
14 years	Caucasian	Female	Henderson	Clark
15 years	Caucasian	Female	Las Vegas	Clark
15 years	African-American	Male	North Las Vegas	Clark
16 years	African-American	Male	Las Vegas	Clark
16 years	African-American	Male	Las Vegas	Clark
16 years	Hispanic	Male	Las Vegas	Clark
TOTAL:		9		

2003

Age	*Race*	*Sex*	*City*	*County*
14 years	Caucasian	Male	Henderson	Clark
14 years	Asian/Pacific Islander	Female	Henderson	Clark
14 years	Caucasian	Male	Las Vegas	Clark
15 years	Caucasian	Female	Reno	Washoe
16 years	Caucasian	Male	Las Vegas	Clark
16 years	Hispanic	Female	Las Vegas	Clark
16 years	Caucasian	Male	Winnemucca	Humboldt
17 years	African-American	Male	North Las Vegas	Clark
17 years	African-American	Male	Reno	Washoe
17 years	Caucasian	Female	Sandy Valley	Clark
17 years	Caucasian	Female	Las Vegas	Clark
TOTAL:		11		

Undetermined Deaths

There were eleven undetermined deaths reviewed by regional CDR teams in 2002: 10 in Clark County and one in Lyon County. There were seven undetermined deaths reviewed in 2003: six in Clark County and one in Washoe County.

Deaths Due to Child Maltreatment

During 2002, the regional CDR teams determined that in 17 of the 152 cases reviewed, child death could have been prevented if the children were not victims of abuse or neglect. In 2003, there were 29 of 152 cases where child death could have been prevented if abuse or neglect were not a factor.

Child abuse or neglect was found as a contributing factor in many deaths whether the manner of death was determined to be natural, accidental, or a homicide. In some cases where the child died from a natural cause, it was determined that the family ignored signs that the child was sick and did not seek medical treatment. Timely and appropriate medical treatment might have prevented the child's death.

In the accidental death cases reviewed, preventable causes of death included drowning and drug overdose. In several cases, the natural mother abused controlled substances that resulted in a premature birth, or resulted in a drug overdose for the child after birth.

One of the suicide cases involved a 17-year-old female who had attempted suicide on several occasions. Subsequently, her parents left a loaded weapon in an accessible location, thinking she would not kill herself in this manner. Recognition of suicide ideation and safety precautions may have prevented this death.

Recommendations

2004 Recommendations

The Following are recommendations from the Statewide Child Death Review Team set forth for 2004:

1. Multidisciplinary teams should use the National Child Death Review Report Form as their data instrument to ensure that data collection is uniform. Teams should be trained to use the web-based instrument.

2. Completion of a protocol for the Administrative Team and the Executive Committee to Review the Death of Children.

3. Development of training to address public education concerns as well as training for regional CDR teams and professional staff.

4. Development of a training manual with a glossary of terms to be created for the distribution to all regional CDR team members.

Follow-Up on 2002 – 2003 Recommendations

1. **That the State Child Death Review Subcommittee makes recommendations for new laws relating to child death reviews. The main goal of these new laws will be to mandate team participation and the availability of records. This will strengthen the review process and help eliminate the cursory paper review of child deaths that currently exists.**

RESULTS: The Statewide Child Death Review Subcommittee had the opportunity to work with Assemblywoman Sheila Leslie in developing Assembly Bill (AB) 381, which resulted in several new statutes on child death review added to NRS Chapter 432.B, sections 403 through 409. The new laws became effective July 1, 2003. The statutes include the purpose, organization, and composition of child death review teams; the role of the Administrative Team; the establishment, composition, and duties of the Executive Committee to Review the Death of Children; and the creation of and use of money in the Review of Death of Children Account. The new legislation also defines information available to the regional CDR teams, the sharing of certain information, and the confidentiality of information.

2. **That a new improved data collection tool be implemented. This will ensure that all the local teams collect the same data that can be used to educate local agencies involved in the protection of children.**

RESULTS: To ensure that all regional CDR teams collect the same data, the child death review data tool was revised to capture new language on the preventability of child death in 2002. This tool continues to be used to collect data. Starting in January, 2005, the regional CDR teams will begin using the web-based National Child Death Review Report Form.

3. **That a policies and procedures manual be written and distributed to local teams.**

RESULTS: The University of Nevada, Las Vegas (UNLV) Center for Business and Economic Research developed a child death review curriculum with policy recommendations for improvement of the existing child death review process and current information about practice, policies, laws, and recommendations for an improved understanding of the roles of each professional involved in the child death review process. The completed draft was distributed to all regional CDR team members in June, 2002.

4. **That the State Child Death Review Subcommittee will submit a proposal to access grant funding through the University of Nevada, Las Vegas to initiate a child death review research project to develop a uniform child death review curriculum.**

RESULTS: The Statewide Child Death Review Subcommittee made recommendations to the UNLV Title IV-E Research and Project Grant Committee for child death curriculum, policy, and procedure development. The recommendation was approved and a grant was awarded to the UNLV Center for Business and Economic Research. A child death review curriculum was developed that includes standardized definitions, as described under recommendation three above. This project began in September, 2001, and was completed in June, 2002.

5. **That a training manual with a glossary of terms be created for the distribution to all local team members.**

RESULTS: Through the same funding obtained as a result of recommendation four above, a training manual with a glossary of terms was created by the UNLV Center for Business and Economic Research. The completed draft was distributed to all regional CDR team members in June, 2002, and provided the basis for individual team training.

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 in order to coordinate the statewide activities of child welfare agencies involved in the review of child death. 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
- Data collection and 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, five regional CDR teams are required to review local child deaths throughout the State of Nevada as follows:

1. Clark County Team
2. Washoe County Team
3. Carson City Team: covers Carson City, Douglas, Lyon, and Storey Counties
4. Elko Team: covers Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties
5. Fallon Team: covers Churchill, Esmeralda, Mineral, and Nye Counties

Within the rural region, the Elko Team is subdivided into three local teams: 1) The Elko Team, which covers Elko County; 2) the Ely Team, which covers Eureka, Lincoln, and White Pine Counties; and 3) the Tri-County Team, which covers Humboldt, Lander, and Pershing Counties. Similarly, the Fallon Team is also subdivided into three local teams: 1) The Churchill County Team, 2) the Mineral County Team, and 3) the Nye/Esmeralda County Team. Each of these covers their respective counties.

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 71% 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, the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. 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 five 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, which includes statistics and recommendations for regulatory and policy changes. 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.

Child Death Review Team Members

Clark County Team

Anderson, Debbie
North Las Vegas Police

Campbell, Elena
Nellis Air Force Base

Cosgrove, Jeannie
Safe Kids Coalition

Courtney, Francis
Public Health

Cummings. Karen
Special Children's Clinic

Eisen, Andrew M.D.
University of Nevada School of Medicine

Fanning, Maureen
Public Health

Flud, Ron
Coroner's Office

Hancock, Marion
Sunrise Hospital

Herndon, Doug
District Attorney's Office

Jones, Kari M.D.
Sunrise Hospital

Lipscomb, Diane M.D.
Sunrise Hospital

Magleby, Suzanne
Clark County Department of Family Services

Martin, Jon
North Las Vegas Police

Mehta, Neha M.D.
Sunrise Hospital

Monohan, Lt. Tom
LVMPD Homicide

New, Judy
Clark County Department of Family Services CPS

Rader, Vicki
Clark County Department of Family Services CPS

Sauchak, Cyndi
LVMPD Abuse/Neglect Unit

Schmidt, Edith M.D.
Sunrise Hospital

Scotellaro, Margaret M.D.
Sunrise Hospital

Sigdestad, Karin M.D.
Special Children's Clinic

Simms, Larry M.D.
Coroner's Office

Worrell, Rexene
Coroner's Office

Zbiegien, Michael M.D.
Sunrise Hospital

Washoe County Team

Clark, Ellen M.D.
Washoe Medical Center

Druckman, Rebecca
Washoe County Deputy District Attorney

Evans, Doug
Reno Police Department

Frank, Barry
Washoe Medical Center

Fricke, Carolyn
Washoe County School District

Gavin, Art
Paramedic

Hayden, Kelly
Washoe County Sheriff's Office

Hunter, Candace
Washoe County District Health Department

Kohls, Joanne
Washoe Medical Center

Lucier, Michelle
Washoe County Department of Social Services

Marsh, Jeanne
Washoe County Department of Social Services

Mayeroff, Meredith
Washoe County Department of Social Services

McCarty, Vernon
Washoe County Coroner

McDonald, Bill
CASA

Miller, Tom
Sparks Police Department

Olsen, Alane
Washoe County Coroner's Office

Carson City Team

>> Covers Carson City, Douglas, Lyon, and Storey Counties

Abserasturi, Ruth
Carson City School District

Arndell, Sgt.
Lyon County Sheriff's Office

Bayer, Chris
CASA

Beseler, Ruth
Coroner's Office

Church, Pam
Carson City Sheriff's Office

Claassen, Sharon
Carson City District Attorney

Fabrizius, Vicki
Division of Child and Family Services

Hall, Rob
Lyon County Sheriff's Office

Molina, Kathy
Carson Tahoe Hospital

Numes, Norm
Carson City Coroner's Office

Carson City Team (continued)

Pittsley, Alice
Division of Child and Family Services

Elko Team

>> Covers Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties

Allison, Dave
Humboldt County District Attorney

Bauer, Bill
Carlin Police Department

Cavanaugh, Antionette
Elko County School District

Cline, Bill
Lander County Coroner

Dinwiddie, Kevin M.D.

Forgeron, Hy
Battle Mountain District Attorney

Griener, Gretchen

Harris, Neil
Elko County Sheriff

Hill, Gene
Humboldt County Sheriff's Office

Jonas, Ilene
Division of Child and Family Services

Morris, Clair
Elko Police Department

Norton, Deb
Division of Child and Family Services

Power, Carrie
Public Health Nurse

Robb, Larry
Division of Child and Family Services

Schott-Bernius, Martha
NEIS

Shirley, Jim
Pershing County District Attorney

Skinner, Ron
Pershing County Sheriff's Office

Webb, Bill
Elko County Coroner

Woodbury, Gary
Elko District Attorney

Fallon Team

>> Covers Churchill, Esmeralda, Mineral, and Nye Counties

Churchill County:

Bowmer, Linda
Youth Parole Officer

Coke, Dolly
Fallon Mental Health

East, Ray
Fallon Paiute Law Enforcement

Ingram, Richard
Churchill County Sheriff's Office

Mallory, Art
District Attorney

McDonald, Arlene
Churchill Community Hospital

Phillips, Bob
Churchill School District

Richardson, James
Adult Parole and Probation

Richardson, Tami
Juvenile Probation

Shyne, Frank
Fallon Police Department

Smith, Russell
Churchill County District Attorney

Stadler, Shelly
Churchill Community Hospital

Stuart, Jim
Churchill County Sheriff's Office

Syriac, Shelly
Churchill Community Hospital

Warner, Richard
Fallon Naval Criminal Investigative Services

Mineral County:

Baker, Clyde
Mineral High School

Bishop, Betty
Mineral County School District

Cook, Steve
Mineral County School Administrator

Emm, Cheri
Mineral County District Attorney

Farrall, Juanita
Mineral County Junior High School

Hagen, Steve
Juvenile Probation

Hoferer, Rob
Mineral County Sheriff's Department

Horton, Charlie
CAHS

Jackson, Joann
Family Resource Center

Mineral County (continued):

Kollege, Jan
Mt. Grant General Hospital

Montoya, Julian
Mental Health Counselor

Munger, Richard
Mt. Grant General Hospital

Oberhansil, Sandy
Juvenile Probation Department

Richardson, James
Adult Parole and Probation

Schott, Susan
Family Resource Center

Smith, Kristy
Mineral County High School

Torres, Connie
Public Health Nurse

Nye/Esmeralda County:

Cameron, Karen
WIC

Cobb, Debbie
UNCE

Ebeling, Corrie
Mental Health

Elgan, Kenneth
Esmeralda County Sheriff's Office

Ennis, Beth
Public Health Nurse

Floto, Barbar
Tonopah High School

Friel, John
Nye County District Attorney

Greber, Curly
Nye County Juvenile Probation

Howerton, Lynna
Silver Rim Elementary School

Jordan, Curtis
Esmeralda County School District

Kryder, Joy
Nye County Health and Human Services

McBride, Brent
Tonopah Middle and Elementary School

Phillips, Tony
Nye County Sheriff's Office

Scoccia, Vincent
Nye Regional Medical Center

Shaffer, William
Esmeralda County District Attorney

Walker, Kay
Nye County School District

Watts, Debbie
Round Mountain High School