

The seal of the State of Nevada is centered in the background. It features a circular border with the text "THE GREAT SEAL OF THE STATE OF NEVADA" at the top and "NEVADA" at the bottom. Inside the border, there is a central figure of a mountain range with a sun rising behind it, and a smaller scene below showing a landscape with a house and a tree. The motto "ALL FOR OUR COUNTRY" is written in a smaller circle within the seal.

STATE OF NEVADA
DIVISION OF CHILD AND
FAMILY SERVICES

**2005 STATEWIDE
CHILD DEATH REPORT**

Submitted by:

The Executive Committee to Review the Death of Children

Michelle Lucier and Cyndi Sauchak, Co-Chairs

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Data Confidentiality

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

Executive Summary

Regional child death review (CDR) teams are organized and operational in Nevada based on Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 409. There are 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 Elko, Fallon, and Pahrump Teams review child deaths in all other counties, which comprise Nevada's rural region.

Two statewide groups provide coordination and oversight for the review of child death in Nevada: 1) the Administrative Team and 2) the Executive Committee to Review the Death of Children. The Administrative Team reviews reports and recommendations from the regional CDR teams and makes decisions regarding recommendations for improvements to laws, policies, and practices. The Executive Committee makes decisions about funding initiatives to prevent child maltreatment and death, which may be based on recommendations from the Administrative Team and annual child death data analysis. Additionally, the Executive Committee adopts statewide protocols for the review of the death of children; oversees training and development for the regional CDR teams; and compiles and distributes a statewide annual report.

Based on death certificates issued by the State of Nevada in 2005, there were a total of 384 child and adolescent deaths in the state, ages birth through 17 years.¹ This is a decrease from 407 total child deaths in 2004. The greatest number of child deaths in 2005 occurred among infants less than one year of age, which is consistent with national death rates that indicate the highest rate of deaths for infants ages birth to one year. Infant mortality rates are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population), which is common for most other forms of mortality statistics. In 2005, Nevada's infant mortality rate was 5.8 per 1,000 live births. This is under the national average of 6.8 per 1,000 live births for the same year. This also represents a decrease for Nevada from the rate of 6.3 per 1,000 live births in 2004.²

During 2005, a total of 176 child deaths were reviewed by the five regional CDR teams. This is an increase from the 159 deaths reviewed in 2004. Combined evaluation of 2005 statewide vital records data and regional CDR team data shows the following four leading causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

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

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

¹ Yang, Wei. (2006). *Custom Vital Statistics Database on Child Deaths 2005*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

² Munson, M.L. and Sutton, P.D. (2006). *Births, marriages, divorces, and deaths: Provisional data for 2005*. *National Vital Statistics Reports; Vol. 54 No. 20*. Hyattsville, MD: National Center for Health Statistics.

Leading causes of homicide include abuse/neglect and gunshot wounds. Leading causes of suicide include asphyxia and gunshot wounds.

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

For the second consecutive year, the Executive Committee compiled statewide child death data from the Nevada State Health Division (NSHD) – Center for Health Data and Research. This data was then compared with case review data derived from the work of the five regional CDR teams, and analyzed to produce the *2005 Statewide Child Death Report*. Comparison of vital records data in conjunction with regional CDR team data yields more complete information on causes of death, and contributes to a more effective evaluation of causes where prevention efforts could contribute to a reduction in child deaths. This ongoing statewide data analysis, combined with regional CDR team data analysis, continues to improve the Executive Committee’s work to effectively evaluate child deaths in Nevada.

During 2005, the Executive Committee implemented its first public awareness campaign for the prevention of child death. Development of a public awareness campaign plan was completed in 2004, and the Executive Committee approved a media campaign contract with the Nevada Broadcasters Association (NBA), which has extensive experience serving government and nonprofit organizations. The initial campaign consisted of public service announcements focused on four topic areas for prevention:

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

These topic areas were based on the leading causes of child death outlined in the *2002 – 2003 Statewide Child Death Report*. The NBA broadcast a series of targeted radio and television announcements for a nine-month period across calendar years 2005 and 2006. The initial campaign will be evaluated and additional media buying will be reviewed by the Executive Committee for future public awareness campaigns.

2005 Key Findings

Total Statewide Deaths and Child Deaths Reviewed

- Total statewide child and adolescent deaths in 2005: 384
- Total child and adolescent deaths reviewed in 2005: 176

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

Leading Causes of Death: Statewide Health Division Data Versus Regional CDR Team Data

Leading Cause:	STATEWIDE HEALTH DIVISION DATA		REGIONAL CDR TEAM DATA	
	Total Deaths by Cause:	Percentage of Total Deaths:	Total Deaths by Cause:	Percentage of Total Deaths:
1. Motor vehicle accidents	45	11.7%	36	20.5%
2. All other accidents				
• Drowning	12	3.1%	7	4.0%
• Asphyxia	7	1.8%	7	4.0%
• All others	10	2.6%	10	5.7%
3. Homicide				
• GSW	6	1.6%	4	2.3%
• Abuse /neglect	6	1.6%	12	6.8%
• All others	10	2.6%	3	1.7%

	STATEWIDE HEALTH DIVISION DATA		REGIONAL CDR TEAM DATA	
Leading Cause:	Total Deaths by Cause:	Percentage of Total Deaths:	Total Deaths by Cause:	Percentage of Total Deaths:
4. Suicide				
• Asphyxia	8	2.1%	7	4.0%
• GSW	6	1.6%	4	2.3%
• All others	3	0.8%	2	1.1%
TOTAL targeted deaths:	113		92	

DATA NOTES: GSW = gunshot wounds

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

1. Looking at regional CDR team data alone, the number of accidental drownings reviewed (7) makes this cause of death appear equal to accidental asphyxia deaths (7). However, statewide data shows that total drownings (12) outnumber total asphyxia deaths (7) in 2005.
2. Looking at statewide Health Division data alone, the number of deaths by abuse or neglect (6) makes this cause of death appear equal to the number of deaths by gunshot wound (6). However, the additional amount of detail available through regional CDR team data shows that total deaths caused by abuse or neglect (12) outnumber total deaths caused by gunshot wounds (6) in 2005.

Motor vehicle accidents (MVA) are the leading cause of death, regardless of which data source is evaluated. For drownings, the statewide total is the most complete information. Conversely, for deaths by abuse or neglect, the regional CDR team data is the most complete information. This is discussed in more detail below in *Section 1* under *Detail: Deaths Caused by Abuse and Neglect*.

Statewide Data Findings

- The greatest number of Nevada child deaths in 2005 occurred among infants less than one year of age. This is consistent with national death rates, which indicate the highest rate of deaths for infants ages birth to one year.
- In 2005, Nevada's infant mortality rate was 5.8 per 1,000 live births. This is under the national average of 6.8 per 1,000 live births for the same year. This also represents a decrease for Nevada from the rate of 6.3 per 1,000 live births in 2004.
- Nevada child deaths in 2005 included more males than females. This is again consistent with national death rates, which indicate that males die at a higher rate than females.
- After natural deaths, the second most common manner of death is accidental, accounting for almost 20% of child deaths in Nevada. When infants less than one year old are separated out, accidents become the most common manner of death for children and adolescents ages

one through 17. This is consistent with national data, which shows that accidents are the leading cause of death for all age groups except infants less than one year of age.

- Motor vehicle deaths are the leading accidental cause of death for children and adolescents in Nevada. This is consistent with national data, which shows motor vehicle accidents as the leading cause of death for all Americans, ages one through 44. Motor vehicle deaths decreased notably in 2005 with a total of 45, compared with 60 in 2004.
- Accidental drownings tripled in 2005 with 12 deaths, compared with four deaths in 2004.
- Accidental asphyxia deaths decreased in 2005 with a total of seven, compared with 13 in 2004.
- Total homicides increased moderately in 2005 with a total of 22 deaths, compared with 19 in 2004. However, homicides from gunshot wounds decreased considerably in 2005 with a total of six, compared with 11 in 2004.
- Total suicides increased considerably in 2005 with a total of 17, compared with 11 in 2004. Suicides from gunshot wounds doubled from three in 2004 to six in 2005. Suicides from asphyxia increased from six in 2004 to eight in 2005.
- When comparing child deaths with the statewide population distribution of children and adolescents, the percentage of child deaths by race suggests that deaths among African American children are disproportionately high.
- African American males have the highest percentage of deaths compared with all other males in all other race categories.
- When comparing child deaths in Nevada's two largest counties (Clark and Washoe) with the statewide population distribution of children and adolescents, child deaths are slightly below the percentage of the total child population in Clark, and well below the percentage of the total child population in Washoe.
- In 2005, there was an unusually high number of homicides among infants less than one year old, for which national data does not reflect homicide in the top 10 causes of death for this age group. This ties in with the discussion below under *Detail: Deaths Caused by Abuse and Neglect*, which indicates that homicides by abuse and neglect are the leading type of homicide for 2005, as shown in the regional CDR team data.
- Females in Nevada committed suicide at a close rate with males in 2005. This is notably inconsistent with national data, which shows that males have suicide rates over four times greater than females throughout the lifespan. However, in 2004, female adolescents in Nevada committed suicide at almost twice the rate of male adolescents, which means that the gender distribution for suicide has decreased over a two-year period. A multi-year trend analysis may show that males in Nevada commit suicide at a greater rate overall when compared to females over time.
- Additionally, the same national data shows that the highest suicide rates for both males and females are among American Indians. Given Nevada's indigenous American Indian population, the one reported suicide among American Indians may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported.

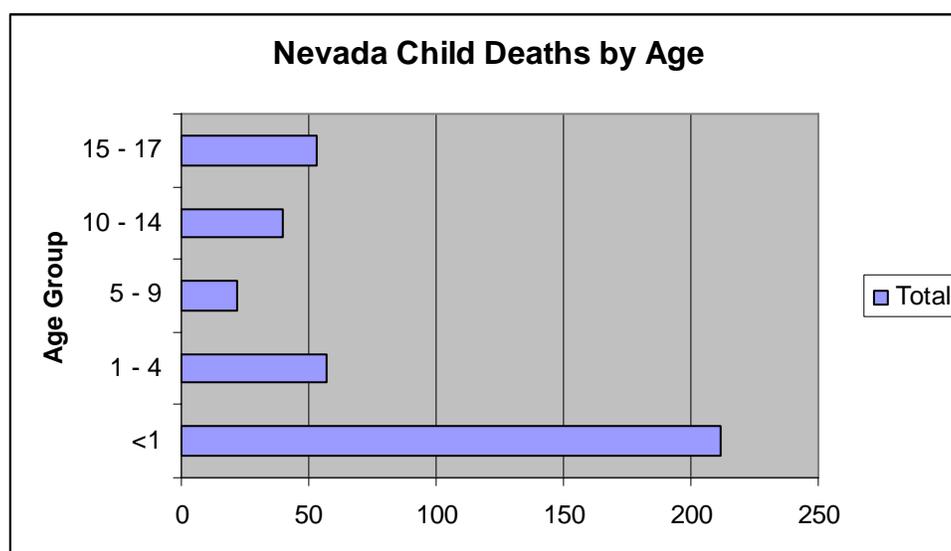
Section 1: 2005 Child Deaths in Nevada

DATA NOTE: All data in Section 1 of this report is derived from the Nevada State Health Division – Center for Health Data and Research.

Based on death certificates issued by the State of Nevada in calendar year 2005, there were a total of 384 child and adolescent deaths in the state.³ These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data. This is a decrease from 407 total deaths in 2004.

A demographic analysis of child and adolescent deaths in the state reveals a variety of comparative information and key findings as follows.

Age



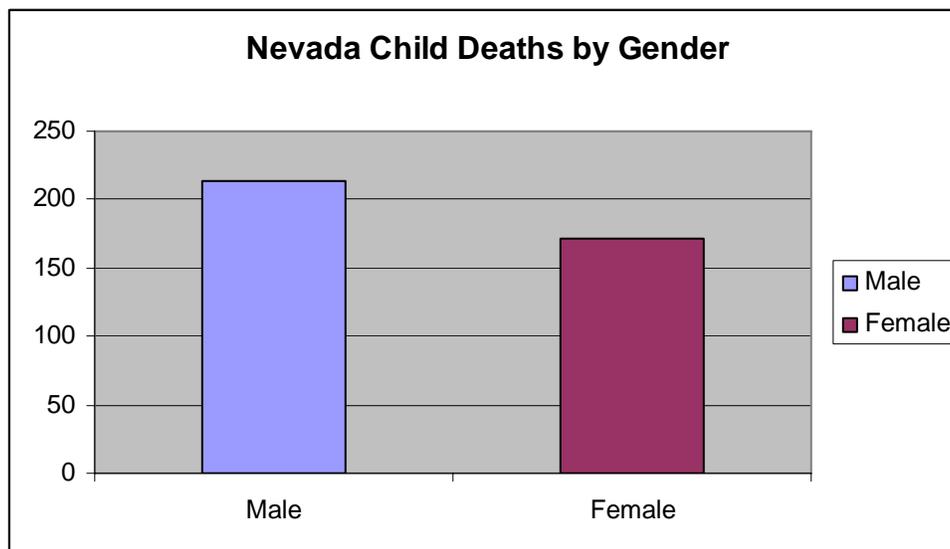
Age Group:	Total:	Percentage:
Less than 1 year old	212	55.2%
1 – 4 years	57	14.8%
5 – 9 years	22	5.7%
10 – 14 years	40	10.4%
15 – 17 years	53	13.8%
TOTAL:	384	100.0%

³ Yang, Wei. (2006). *Custom Vital Statistics Database on Child Deaths 2005*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

Findings:

- The greatest number of Nevada child deaths in 2005 occurred among infants less than one year of age. This is consistent with national death rates, which indicate the highest rate of deaths for infants ages birth to one year, at approximately 700 per 100,000 of the population.
- Nevada child death rates in other age groups are considerably lower, with the next highest age group being from 1 – 4 years of age. This is again consistent with national death rates for the same age groups, which demonstrate a similar bimodal (u-shaped) data pattern past age one, with higher death rates for the 1 – 4 age group (31.5 per 100,000), lower death rates for the 5 – 9 age group (14.7 per 100,000), and then increasing death rates through the pre-teen and teen years (19.1 per 100,000 for ages 10 – 14, 66.4 per 100,000 for ages 15 – 19).⁴ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]
- Infant mortality rates are calculated differently from death rates, and are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population). In 2005, Nevada's infant mortality rate was 5.8 per 1,000 live births. This is under the national average of 6.8 per 1,000 live births for the same year. This also represents a decrease for Nevada from the rate of 6.3 per 1,000 live births in 2004.⁵

Gender



⁴ National Center for Health Statistics. (2006). *National Vital Statistics Reports; Vol. 54 No. 13*. Retrieved February 19, 2007, from <http://www.cdc.gov/nchs/fastats/deaths.htm>.

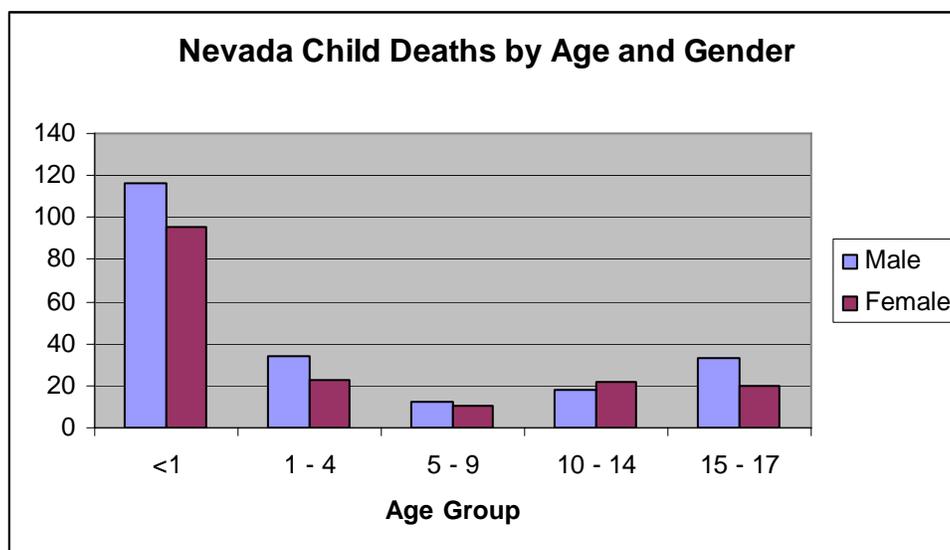
⁵ Munson, M.L. and Sutton, P.D. (2006). *Births, marriages, divorces, and deaths: Provisional data for 2005*. *National Vital Statistics Reports; Vol. 54 No. 20*. Hyattsville, MD: National Center for Health Statistics.

Gender:	Total:	Percentage:
Male	213	55.5%
Female	171	44.5%
TOTAL:	384	100.0%

Findings:

- Nevada child deaths in 2005 included more males than females. This is again consistent with national death rates, which indicate that males die at a higher rate than females.⁶

Age and Gender



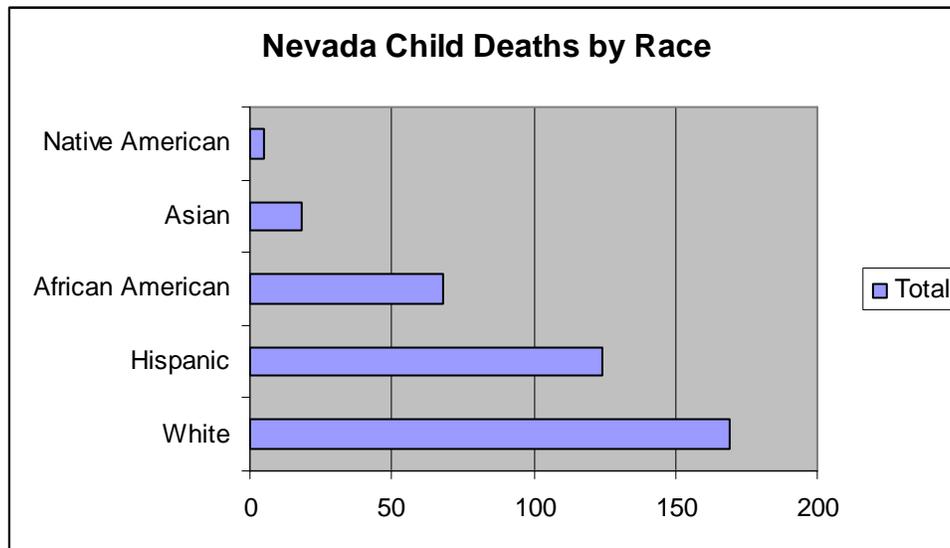
Age Group:	Male:	Female:	Male Percentage:	Female Percentage:
Less than 1 year old	116	96	54.7%	45.3%
1 – 4 years	34	23	59.6%	40.4%
5 – 9 years	12	10	54.5%	45.5%
10 – 14 years	18	22	45.0%	55.0%
15 – 17 years	33	20	62.3%	37.7%
TOTAL:	213	171		

⁶ National Center for Health Statistics. (2006). *National Vital Statistics Reports; Vol. 54 No. 13*. Retrieved February 19, 2007, from <http://www.cdc.gov/nchs/fastats/deaths.htm>.

Findings:

- Comparison by age and gender again demonstrates that males die more frequently than females, as noted above.
- For Nevada, this gender disparity is highest in the age groups from 1 – 4 years and 15 – 17 years. This is consistent with national death rates, which show a similar bimodal (u-shaped) data pattern of deaths from ages one through 19, as discussed above, with a higher number of male deaths relative to female deaths.⁷ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]
- However, for 2005, female deaths exceed male deaths for the 10 – 14 age group, which is inconsistent with national data. Other national research also indicates that gender disparity for death rates increases with age, with an increasing proportion of males dying through age 24.⁸ This suggests that for 2005, deaths for Nevada females are above average in the 10 – 14 age group.

Race



⁷ National Center for Health Statistics. (2006). *National Vital Statistics Reports; Vol. 54 No. 13*. Retrieved February 19, 2007, from <http://www.cdc.gov/nchs/fastats/deaths.htm>.

⁸ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Mortality: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Race:	Total:	Percentage:
White	169	44.0%
Hispanic	124	32.3%
African American	68	17.7%
Asian	18	4.7%
American Indian	5	1.3%
TOTAL:	384	100.0%

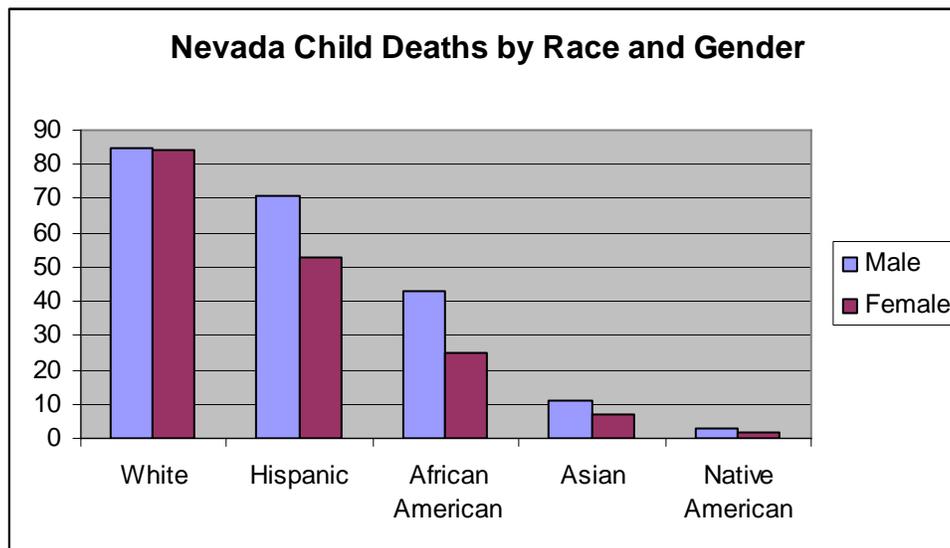
Findings:

- When comparing child deaths with the statewide population distribution of children and adolescents, the percentage of child deaths by race suggests that deaths among African American children are disproportionately high:

Race:	Percentage of child deaths:	Percentage of child and adolescent statewide population distribution: ⁹
White	44.0%	49.7%
Hispanic	32.3%	34.2%
African American	17.7%	8.5%
Asian	4.7%	6.3%
American Indian	1.3%	1.4%
TOTAL:	100.0%	100.0%

⁹ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2005 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

Race and Gender

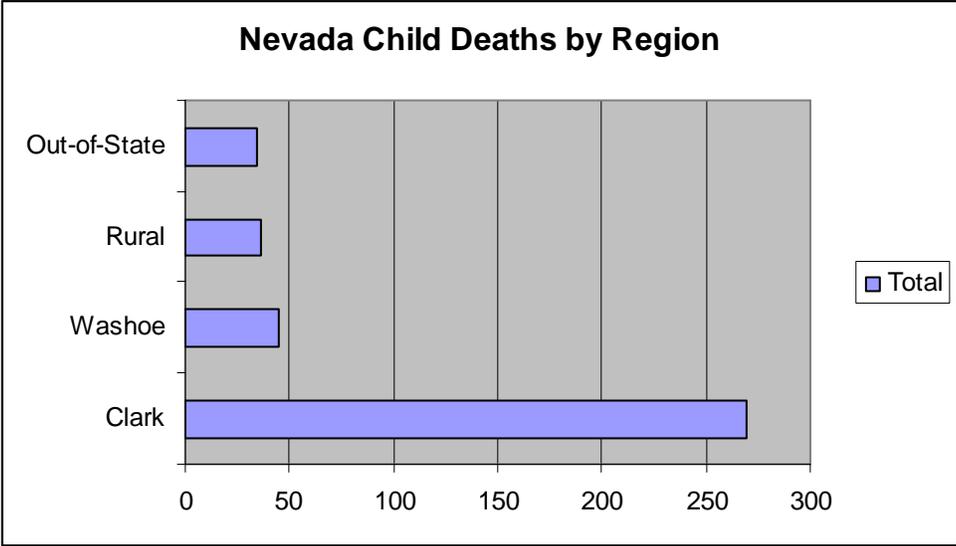


Race:	Male:	Female:	Male Percentage:	Female Percentage:
White	85	84	50.3%	49.7%
Hispanic	71	53	57.3%	42.7%
African American	43	25	63.2%	36.8%
Asian	11	7	61.1%	38.9%
American Indian	3	2	60.0%	40.0%
TOTAL:	213	171		

Findings:

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

County of Residence



County:	Total:	Percentage:	County:	Total:	Percentage:
Carson City	6	1.6%	Mineral	1	0.3%
Churchill	6	1.6%	Nye	4	1.0%
Clark	269	70.1%	Pershing	0	0.0%
Douglas	5	1.3%	Storey	0	0.0%
Elko	6	1.6%	Washoe	45	11.7%
Esmeralda	0	0.0%	White Pine	1	0.3%
Eureka	0	0.0%	Out-of-state	34	8.9%
Humboldt	2	0.5%	TOTAL:	384	100.0%
Lander	1	0.3%			
Lincoln	1	0.3%			
Lyon	3	0.8%			

Findings:

- The highest number of child deaths occurred among residents of Nevada’s two largest counties, Clark and Washoe.

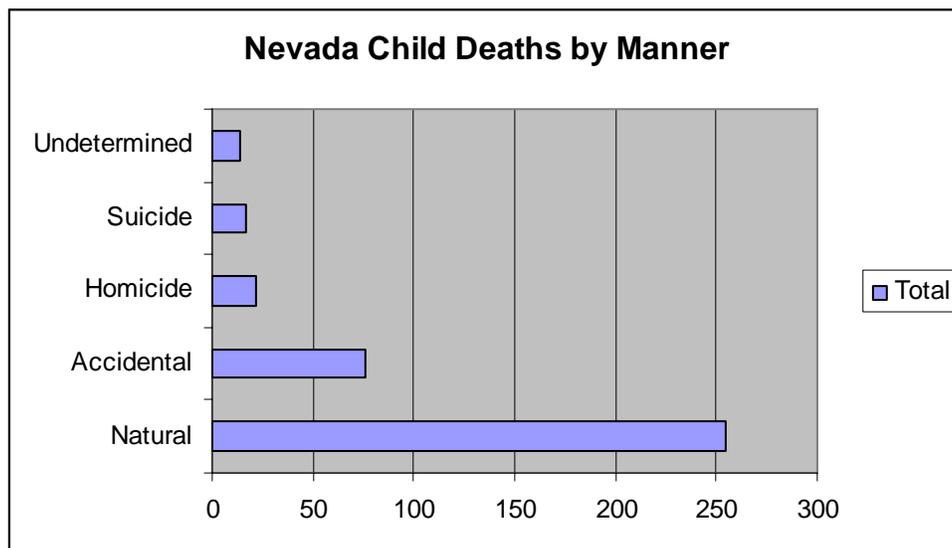
- When comparing child deaths in Nevada’s two largest counties (Clark and Washoe) with the statewide population distribution of children and adolescents, child deaths are 2.3 points below the percentage of the total child population in Clark, and 4.1 points below the percentage of the total child population in Washoe:

County:	Percentage of child deaths:	Percentage of child and adolescent statewide population distribution:
Clark	70.1%	72.4%
Washoe	11.7%	15.8%

Manner of Death

Prior to the regional CDR teams’ review and analysis of 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:

- Natural:** These are deaths that result from natural disease mechanisms and include Sudden Infant Death Syndrome (SIDS) cases.
- 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.
- Homicide:** Homicide is the killing of one human by another.
- Suicide:** Suicide is the taking of one’s own life voluntarily and intentionally.
- Undetermined:** These are deaths where sufficient evidence or information cannot be deduced during the investigation, usually about intent, to assign a manner of death.

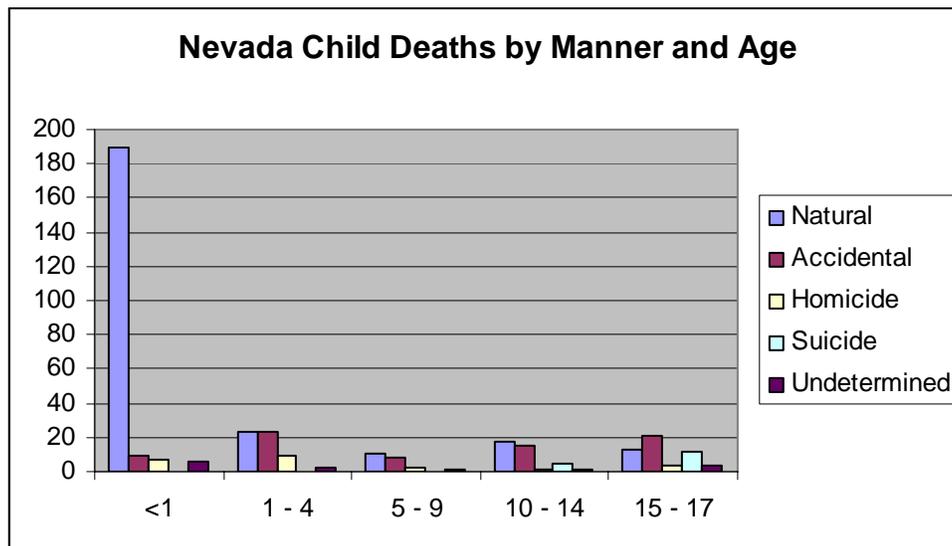


Manner of Death:	Total:	Percentage:
Natural	255	66.4%
Accidental	76	19.8%
Homicide	22	5.7%
Suicide	17	4.4%
Undetermined	14	3.6%
TOTAL:	384	100.0%

Findings:

- The greatest number of Nevada child deaths in 2005 were natural, largely due to the high incidence of natural deaths among infants less than one year of age. This is discussed in more detail below under *Manner of Death and Age*.
- The second most common manner of death is accidental, accounting for almost 20% of child deaths in Nevada. When infants less than one year old are separated out, accidents become the most common manner of death for children and adolescents ages one through 17. This is consistent with national data, which shows that accidents are the leading cause of death for all age groups except infants less than one year of age.¹⁰
- Accidental deaths represent the type of deaths where prevention efforts would most likely contribute to a reduction in fatalities. Leading causes of accidental death are discussed in more detail below in *Section 2*.

Manner of Death and Age



¹⁰ National Center for Injury Prevention and Control. (2007). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2004* [custom data query]. Retrieved January 25, 2007, from <http://www.cdc.gov/ncipc/wisqars/>.

Manner:	Less than 1	1 – 4	5 – 9	10 – 14	15 – 17
Natural	190	23	11	18	13
Accidental	9	23	8	15	21
Homicide	7	9	2	1	3
Suicide	0	0	0	5	12
Undetermined	6	2	1	1	4
TOTAL:	212	57	22	40	53

Findings:

- As noted above, the greatest number of child deaths in 2005 were natural deaths of infants less than one year of age. This is consistent with national data, which indicates that the top four causes of infant death are natural, and that natural deaths represent approximately 65% of infant deaths nationwide.¹¹
- Accidental deaths are highest in the age groups of 1 – 4 and 15 – 17, and tend to increase with age. This is consistent with national data, which shows that the leading cause of death is accidental for all age groups over one-year, and that the highest number of accidental deaths is in the age groups of 1 – 4 and 15 – 19. National data also shows a continuing increase in accidental deaths across the age groups of 5 – 9, 10 – 14, and 15 – 19, which is reflected in the Nevada data as well.¹² [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]
- Homicides occur in all age groups. Nevada homicides are highest in the age groups of less-than-one and 1 – 4, and decrease with age. This is inconsistent with national data, which shows the greatest number of homicides in the 15 – 19 age group, and a general increase in homicide deaths with age. Additionally, national data does not show homicide in the top 10 causes of death for infants less than one year old.¹³ This indicates that the number of homicides within this age group is unusually high in Nevada. This ties in with the discussion below under *Detail: Deaths Caused by Abuse and Neglect*, which indicates that homicides by abuse and neglect are the leading type of homicide for 2005, as shown in the regional CDR team data.
- Suicides occur only within the age groups of 10 – 14 and 15 – 17, and demonstrate a sharp increase with age. This is consistent with Nevada suicides in 2004, which occurred in the same age groups and demonstrated a sharp increase with age. This is also consistent with national data, which shows suicide as the third leading cause of death for the same age groups, and a substantial increase in suicides with age.¹⁴

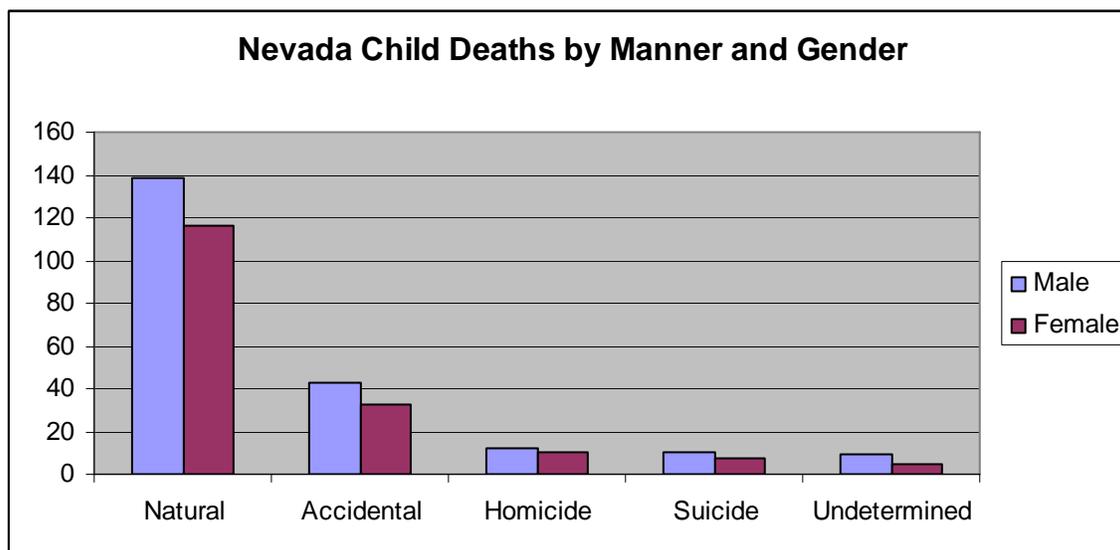
¹¹ National Center for Injury Prevention and Control. (2007). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2004* [custom data query]. Retrieved January 25, 2007, from <http://www.cdc.gov/ncipc/wisqars/>.

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

Manner of Death and Gender



Manner of Death:	Male:	Female:	Male Percentage:	Female Percentage:
Natural	139	116	54.5%	45.5%
Accidental	43	33	56.6%	43.4%
Homicide	12	10	54.5%	45.5%
Suicide	10	7	58.8%	41.2%
Undetermined	9	5	64.3%	35.7%
TOTAL:	213	171		

Findings:

- Comparing manner of death by gender again demonstrates that overall, males die more frequently than females, as discussed above.
- Females in Nevada were victims of homicide at a close rate with males in 2005. This is inconsistent with national data, which shows the overall rate of death for male homicides at almost four times that of females across the lifespan (9.4 per 100,000 population for male homicides compared with 2.6 per 100,000 for female homicides).
- Similar to homicides, females in Nevada committed suicide at a close rate with males in 2005. This is notably inconsistent with national data, which shows the rate of death for male suicides in the 15 – 19 age group at 11.6 per 100,000 population, compared with female suicides in the same age group at 2.7 per 100,000. Nationally, males have suicide rates over four times greater than females throughout the lifespan.¹⁵ Other national research shows that adolescent males are much more likely to commit suicide, while adolescent females are much

¹⁵ National Center for Health Statistics. (2005). *Health, United States, 2005, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

more likely to attempt suicide.¹⁶ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

However, in 2004, female adolescents in Nevada committed suicide at almost twice the rate of male adolescents, which means that the gender distribution for suicide has decreased over a two-year period. A multi-year trend analysis may show that males in Nevada commit suicide at a greater rate overall when compared to females over time.

Target Causes of Death for Data Comparison

Target causes of death for data comparison include the types of death where statewide data from the Nevada State Health Division can be grouped and compared with data from cases reviewed by the regional CDR teams. For statewide data, groupings are made based on International Classification of Diseases (ICD) 10 codes and information grouping details. The ICD-10 classification system is developed and published by the World Health Organization (WHO), and used to code and classify mortality data from death certificates.¹⁷ For regional CDR team data, groupings are made based on deaths required for review by NRS 432B.405, deaths commonly related to abuse and neglect, and causes of death where prevention efforts could contribute to a reduction in fatalities, such as suicides and accidental drownings.

STATEWIDE HEALTH DIVISION DATA			
Manner:	Target Cause:	Total:	Percentage:
Accidental	MVA – driver	0	0.0%
	MVA – passenger	3	0.8%
	MVA – pedestrian	14	3.6%
	MVA – motorcycle	3	0.8%
	MVA – moped	0	0.0%
	MVA – bicycle	1	0.3%
	MVA – all terrain vehicle	2	0.5%
	MVA – watercraft	1	0.3%
	MVA – all others	21	5.5%
	Asphyxia – bed	4	1.0%
	Asphyxia – food	2	0.5%
	Asphyxia – all other	1	0.3%
	Drowning – pool	6	1.6%
	Drowning – natural water	3	0.8%
	Drowning – all others	3	0.8%
	Accident – GSW	0	0.0%
	Accident – overdose	0	0.0%
	Accident – fall	5	1.3%

¹⁶ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

¹⁷ National Center for Health Statistics. (2007). *The International Classification of Diseases, Tenth Revision, (ICD-10)*. Retrieved January 26, 2007, from <http://www.cdc.gov/nchs/about/major/dvs/icd10des.htm>.

STATEWIDE HEALTH DIVISION DATA			
Manner:	Target Cause:	Total:	Percentage:
	Accident – heat exposure	1	0.3%
	Accident – all others	4	1.0%
Homicide	Homicide – GSW	6	1.6%
	Homicide – abuse	4	1.0%
	Homicide – neglect	2	0.5%
	Homicide – overdose	1	0.3%
	Homicide – fire	1	0.3%
	Homicide – all others*	8	2.1%
Suicide	Suicide – GSW	6	1.6%
	Suicide – asphyxia	8	2.1%
	Suicide – overdose	2	0.5%
	Suicide – all others*	1	0.3%
Undetermined	Overdose – undetermined	5	1.3%
	GSW – undetermined	1	0.3%
	Asphyxia – undetermined	2	0.5%
Natural	SIDS	16	4.2%
	Maternal drug use	0	0.0%
	Natural – all others	239	62.2%
–	Unknown	8	2.1%

DATA NOTES: MVA = motor vehicle accident; GSW = gunshot wound; SIDS = Sudden Infant Death Syndrome; *other homicide and suicide causes = unspecified cause in statewide data

Findings:

- Although ICD-10 codes allow for identifying MVA deaths where the adolescent was the driver, this is not reflected in the statewide data. This may be a practice issue where coroners do not enter detailed information about MVA deaths, there is a lack of specific information surrounding the circumstances of the death, or the national coding process for ICD-10 defaults to general or unspecified codes included in the *MVA - all others* category. Cases where MVA deaths involved an adolescent driver are included in the child deaths reviewed for 2005, discussed below in *Section 2*.

- Similarly, no deaths involving accidental gunshot wounds, accidental overdose, and maternal drug use are reflected in the statewide data. Again, there are ICD-10 codes available for this, and they may not be used based on coroner data entry or limited case information. These types of death are included in child deaths reviewed for 2005, and are discussed below in *Section 2*.

Leading Causes of Death

Target Causes for Prevention Efforts

The four leading causes of child death where prevention efforts could contribute to a reduction in fatalities are as follows:

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
1. Motor vehicle accidents	45	11.7%
2. All other accidents	29	7.6%
3. Homicide	22	5.7%
4. Suicide	17	4.4%
TOTAL targeted deaths:	113	

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

⇒⇒ DETAIL: Target Causes for Prevention Efforts

Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
1. Motor vehicle accidents	45	11.7%
2. All other accidents		
• Drowning	12	3.1%
• Asphyxia	7	1.8%
• All others	10	2.6%

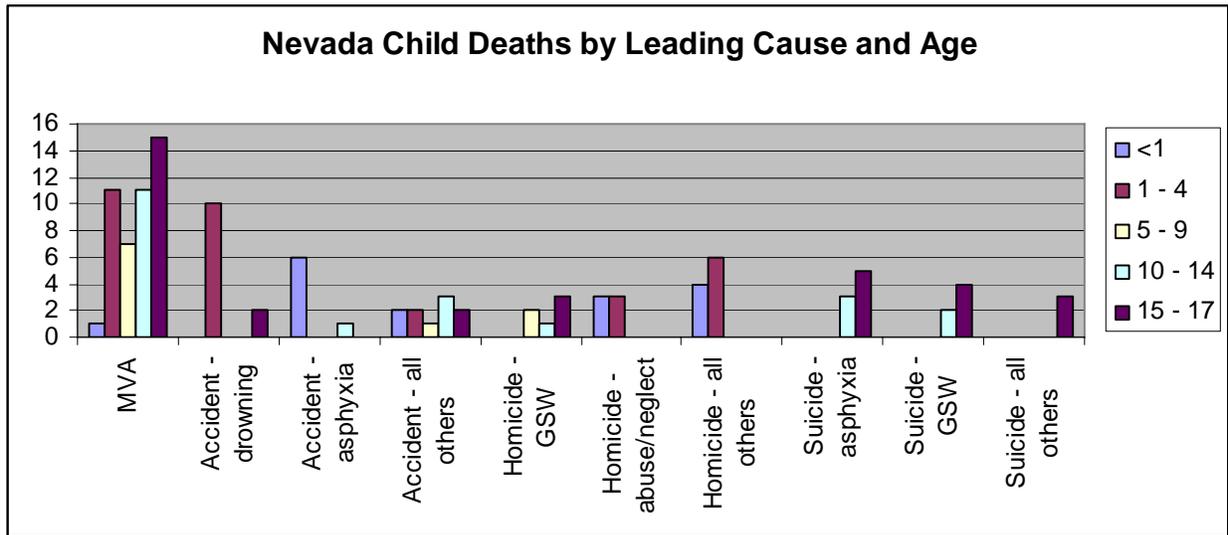
Leading Cause:	Total Deaths by Cause:	Percentage of Total Statewide Deaths:
3. Homicide		
• GSW	6	1.6%
• Abuse and neglect	6	1.6%
• All others	10	2.6%
4. Suicide		
• Asphyxia	8	2.1%
• GSW	6	1.6%
• All others	3	0.8%
TOTAL targeted deaths:	113	

Findings:

- Motor vehicle deaths are the leading accidental cause of death for children and adolescents in Nevada. This is consistent with national data, which shows motor vehicle accidents as the leading cause of death for all Americans, ages one through 44.¹⁸ Motor vehicle deaths decreased notably in 2005 with a total of 45, compared with 60 in 2004.
- Accidental drownings tripled in 2005 with 12 deaths, compared with four deaths in 2004.
- Accidental asphyxia deaths decreased in 2005 with a total of seven, compared with 13 in 2004.
- Total homicides increased moderately in 2005 with a total of 22 deaths, compared with 19 in 2004. However, homicides from gunshot wounds decreased considerably in 2005 with a total of six, compared with 11 in 2004.
- Total suicides increased considerably in 2005 with a total of 17, compared with 11 in 2004. Suicides from gunshot wounds doubled from three in 2004 to six in 2005. Suicides from asphyxia increased from six in 2004 to eight in 2005.

¹⁸ National Center for Injury Prevention and Control. (2007). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2004* [custom data query]. Retrieved January 26, 2007, from <http://www.cdc.gov/ncipc/wisqars/>.

Leading Cause and Age



Leading Cause:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
MVA	1	11	7	11	15
Accident - drowning	0	10	0	0	2
Accident - asphyxia	6	0	0	1	0
Accident - all others	2	2	1	3	2
Homicide - GSW	0	0	2	1	3
Homicide - abuse/neglect	3	3	0	0	0
Homicide - all others	4	6	0	0	0
Suicide - asphyxia	0	0	0	3	5
Suicide - GSW	0	0	0	2	4
Suicide - all others	0	0	0	0	3
TOTAL:	16	32	10	21	34

Findings:

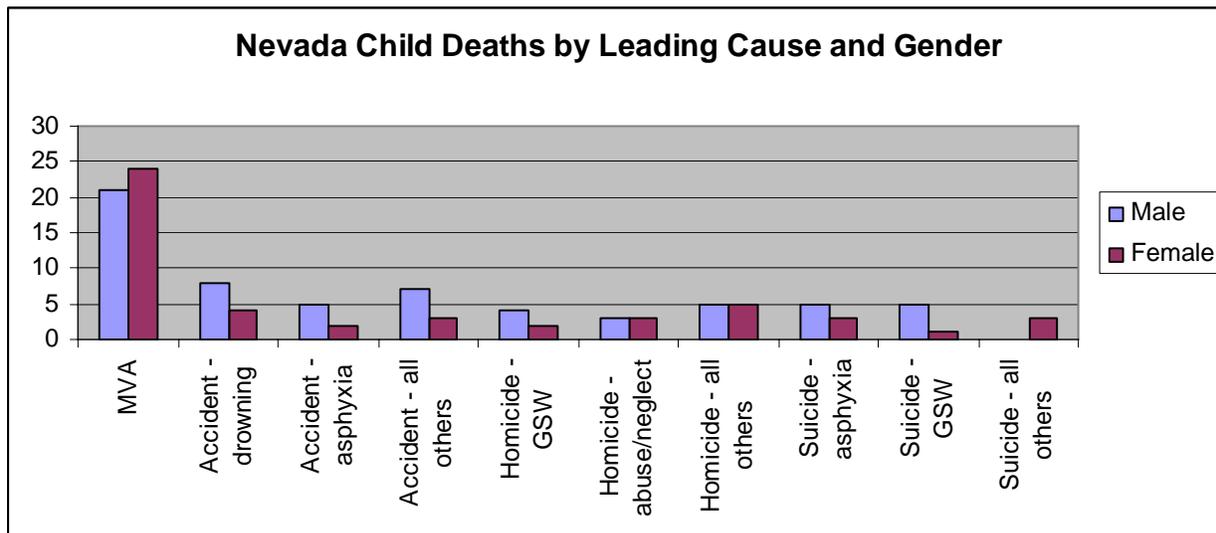
- Typically, the risk of death from motor vehicle accidents increases in direct proportion with age. National data shows that motor vehicle accidents account for almost 32% of all accidental deaths in the 1 – 4 age group, increasing to 76% of all accidental deaths in the 15 – 17 age group.¹⁹ Motor vehicle deaths increased with age for children in Nevada in 2004, following the national trend. However, in 2005 the bimodal (u-shaped) data pattern occurs again with a higher number of deaths in the 1 – 4 age group, dropping in the 5 – 9 group, then increasing through the pre-teen and teen years. Although this is consistent with other state data as discussed above, there is an unusually high number of motor vehicle deaths for children in the 1 – 4 age group when compared with national data.
- Ten of 12 accidental drownings in 2005 occurred in the 1 – 4 age group.
- Six of seven asphyxia deaths in 2005 occurred among children less than one year of age. Asphyxia deaths involving bedding decreased by half in 2005 with a total of four deaths, compared with eight in 2004. All were in the less-than-one age group.
- Homicide deaths involving firearms occurred in the 5 – 9, 10 – 14, and 15 – 17 age groups in 2005, with the greatest number in the 15 – 17 group. This is consistent with national data, which shows that deaths from firearm-related injuries increase considerably in the 15 – 19 age group.²⁰ However, because there is typically an upward trend with age, there is an unusually high number of homicides deaths involving firearms for the 5 – 9 age group. [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]
- Homicide deaths involving abuse and neglect were evenly split between the less-than-one and 1 – 4 age groups. More detail is provided below under *Deaths Caused by Abuse and Neglect*.
- Homicide deaths attributed to other causes were exclusively in the less-than-one and 1 – 4 age groups. These deaths may be related to abuse and neglect, but were not specifically coded as such with the ICD-10 classification system. More detail on deaths from abuse and neglect is provided below, and in *Section 2* of this report.
- Suicide deaths occurred exclusively in the 10 – 14 and 15 – 17 age groups. This is consistent with national data, which shows that deaths from suicide increase considerably in the pre-teen and teen years.²¹

¹⁹ National Center for Injury Prevention and Control. (2007). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2004* [custom data query]. Retrieved January 26, 2007, from <http://www.cdc.gov/ncipc/wisqars/>.

²⁰ National Center for Health Statistics. (2005). *Health, United States, 2005, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

²¹ Ibid.

Leading Cause and Gender



Leading Cause:	Male:	Female:	Male Percentage:	Female Percentage:
MVA	21	24	46.7%	53.3%
Accident - drowning	8	4	66.7%	33.3%
Accident - asphyxia	5	2	71.4%	28.6%
Accident - all others	7	3	70.0%	30.0%
Homicide - GSW	4	2	66.7%	33.3%
Homicide - abuse/neglect	3	3	50.0%	50.0%
Homicide - all others	5	5	50.0%	50.0%
Suicide - asphyxia	5	3	62.5%	37.5%
Suicide - GSW	5	1	83.3%	16.7%
Suicide - all others	0	3	0.0%	100.0%
TOTAL:	63	50		

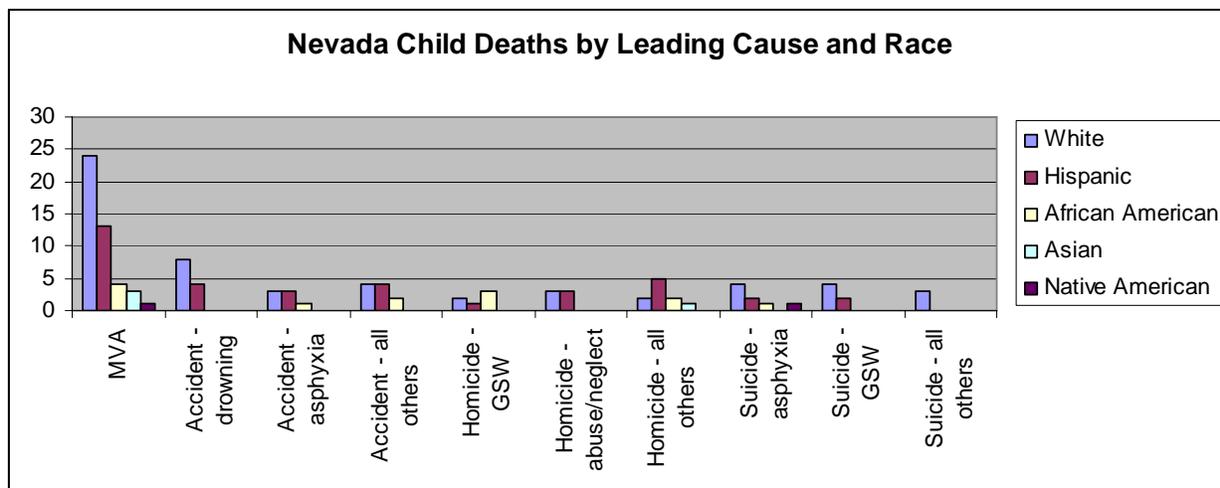
Findings:

- Comparison of leading causes by gender supports the findings outlined above in the manner of death analyses. Again, the data demonstrates that males die more frequently than females overall.
- Female deaths from motor vehicle accidents exceeded those of males in 2005, which is different from 2004 data for Nevada, and inconsistent with national data that shows males typically die at twice the rate of females in motor vehicle accidents across the lifespan.²²
- Males died at twice the rate of females for all other types of accidents in 2005.

²² National Center for Health Statistics. (2005). *Health, United States, 2005, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

- Males were victims of homicide by gunshot wound at twice the rate of females in 2005. However, there is a surprising consistency overall between males and females for other types of homicides. This is discussed above in the manner of death analyses.
- The unusually high number of female versus male suicides is also seen again here. However, as with homicides, male victims of suicide were much more likely to die from gunshot wounds than females.

Leading Cause and Race



Leading Cause:	White:	Hispanic:	African American:	Asian:	American Indian:
MVA	24	13	4	3	1
Accident - drowning	8	4	0	0	0
Accident - asphyxia	3	3	1	0	0
Accident - all others	4	4	2	0	0
Homicide - GSW	2	1	3	0	0
Homicide - abuse/neglect	3	3	0	0	0
Homicide - all others	2	5	2	1	0
Suicide - asphyxia	4	2	1	0	1
Suicide - GSW	4	2	0	0	0

Leading Cause:	White:	Hispanic:	African American:	Asian:	American Indian:
Suicide - all others	3	0	0	0	0
TOTAL:	57	37	13	4	2

Findings:

- When comparing motor vehicle accidents by race with the statewide population distribution of children and adolescents, deaths among white children are slightly above the statewide population distribution, and deaths among Hispanic children are below the statewide population distribution:

Race:	Percentage of child deaths due to MVA:	Percentage of child and adolescent statewide population distribution: ²³
White	53.3%	49.7%
Hispanic	28.9%	34.2%
African American	8.9%	8.5%
Asian	6.7%	6.3%
American Indian	2.2%	1.4%
TOTAL:	100.0%	100.0%

- Likewise, accidental deaths from asphyxia and other causes besides drowning are unusually high for Hispanics with a total of seven, the same as whites.
- Combined homicide deaths for Hispanics are disproportionately high relative to the statewide population distribution with a total of nine, compared with seven for whites.
- Similarly, combined homicide deaths for African Americans are very high relative to the statewide population distribution with a total of five, approaching the total for whites. In particular, homicides involving gunshot wounds are highest for African Americans, which is very disproportionate based on the statewide population distribution.
- Homicide deaths for Hispanics resulting from abuse or neglect are unusually high, equaling the total for whites. They likely meet or exceed those of whites based on the high number in the *other* category, because of the possible ICD-10 data coding discrepancies discussed above under *Leading Cause and Age*.
- Suicide occurs most frequently among whites. This is generally consistent with national data, which shows that whites account for the second highest suicide rate within race categories.²⁴ However, taking into account the unusually high number of female suicides in Nevada discussed above, the statewide data shows that white females account for the greatest

²³ Hardcastle, J. (2007). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2005 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

²⁴ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

number of suicides in 2005. This is not consistent with national data for females, which show American Indian and Asian females with the leading suicide death rates, respectively.²⁵

- Additionally, the same national data shows that the highest suicide rates for both males and females are among American Indians. Given Nevada’s indigenous American Indian population, the one reported suicide among American Indians may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported.

⇒⇒ **DETAIL: Deaths Caused by Abuse and Neglect**

Deaths caused by abuse and neglect may be categorized under a variety of target causes. The most visible are homicide deaths resulting from severe abuse. There are several types of death that may be determined to result from natural or accidental causes, but still involve some form of abuse and neglect. Deaths caused by abuse and neglect are determinable from Nevada State Health Division only when clearly coded as such using ICD-10 codes and information grouping details, discussed above under *Target Causes for Data Comparison*. Detail on the six homicide deaths attributed to abuse and neglect is as follows:

Ref:	Cause:	Age Group:	Gender:	Race:	County:
1	Neglect	Less than 1	Female	Hispanic	Elko
2	Neglect	1 – 4	Female	Hispanic	Clark
3	Abuse	Less than 1	Male	White	Clark
4	Abuse	Less than 1	Male	White	Clark
5	Abuse	1 – 4	Male	Hispanic	Out-of-State
6	Abuse	1 – 4	Female	White	Clark

Homicide deaths attributed to other causes besides gunshot wounds and abuse or neglect were exclusively in the less-than-one and 1 – 4 age groups. Based on the young age of the infants and children involved, these deaths may be related to abuse and neglect, but were not specifically coded as such with the ICD-10 classification system. Detail on the 10 homicide deaths attributed to other causes is as follows:

Ref:	Cause:	Age Group:	Gender:	Race:	County of Residence:
1	Homicide	Less than 1	Female	Hispanic	Clark
2	Homicide	1 – 4	Male	Black	Clark
3	Homicide	1 – 4	Female	Hispanic	Churchill
4	Homicide	Less than 1	Male	Black	Clark
5	Homicide	Less than 1	Female	White	Nye
6	Homicide	Less than 1	Female	White	Out-of-State
7	Homicide	1 – 4	Male	Asian	Nye
8	Homicide	1 – 4	Female	Hispanic	Out-of-State
9	Homicide	1 – 4	Male	Hispanic	Clark

²⁵ National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

Ref:	Cause:	Age Group:	Gender:	Race:	County of Residence:
10	Homicide	1 – 4	Male	Hispanic	Clark

Because the ICD-10 classification system is limited in its ability to specifically identify a variety of deaths that may be related to abuse and neglect, much more specific information can be gathered and analyzed through the regional CDR case review process. Evaluation of Nevada State Health Division data in conjunction with regional CDR data yields more complete information on causes of death, and allows for a more detailed review of deaths caused by abuse and neglect. This analysis is provided below under *Section 2*. When regional CDR team data is taken into account, abuse and neglect emerges as the leading cause of homicide for 2005.

⇒⇒ **DETAIL: Natural Deaths**

As discussed throughout this section, natural deaths are the leading cause of child death in the state, accounting for 62.2% of all deaths and occurring primarily in infants less than one year of age. Natural deaths are targeted for review by regional CDR teams when several types of natural causes are indicated as follows:

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

More detailed data for these types of deaths are available based on the regional CDR case review process and are discussed in detail below under *Section 2*.

Section 2: 2005 Child Deaths Reviewed

DATA NOTE: All data in Section 2 of this report is derived from the regional CDR teams, which collect and enter data into a system maintained by the National Maternal Child Health (MCH) Center for Child Death Review. Discrepancies in total number of deaths by target causes between statewide and regional data, noted above, are explained in more detail in this section.

Child Death Review Process in Nevada

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

1. Clark Team: covers Clark County and some surrounding rural counties
2. Washoe Team: covers Washoe County
3. Fallon Team: covers Carson, Churchill, Douglas, Lyon, Pershing, and Storey Counties
4. Elko Team: covers Elko, Eureka, Humboldt, Lander, Lincoln (shared), and White Pine Counties
5. Pahrump Team: covers Esmeralda, Lincoln (shared), Mineral, and Nye Counties

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

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 409. State-mandated reviews include the following:

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

Additional detail about the organization and functions of the five regional CDR teams is included in Appendix B of this report. Complete membership lists for the teams are included in Appendix C of this report.

Deaths Reviewed Versus Deaths Not Reviewed

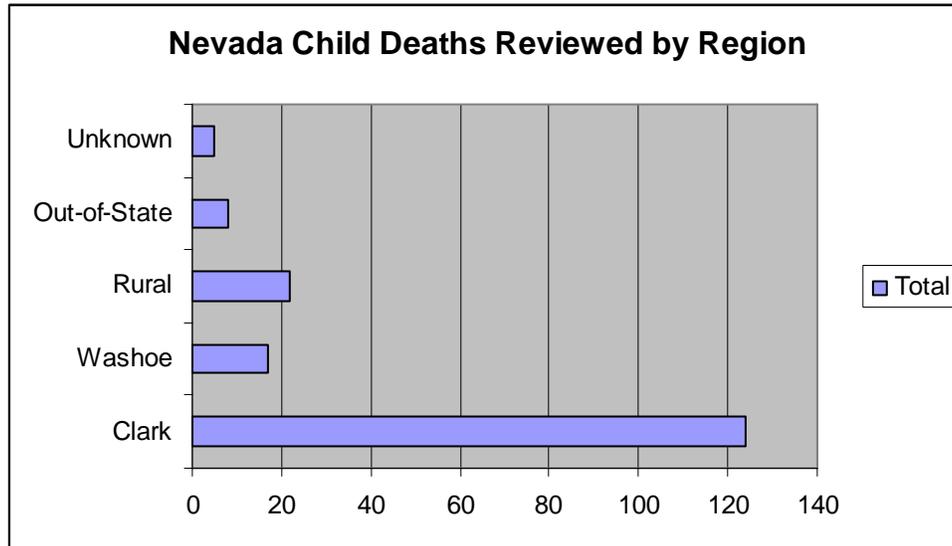
Each of the five regional CDR teams reviews all coroner-referred child deaths within their region with the exception of the Clark Team, which reviews State-mandated cases along with a selection of additional cases because of high caseload. Clark County accounts for approximately 71% of the state's population, and it is not feasible for the Clark Team to review all child deaths in the area. Currently, most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. In Clark County, the team meets monthly because of its high caseload. In the rural region, the regional teams may meet less often if coroners' reports are not received within a given quarter.

2005 Child Deaths Reviewed

During 2005, a total of 176 child deaths were reviewed by the five regional CDR teams. This is an increase from the 159 deaths reviewed in 2004. Fatalities reviewed include ages birth through 17 years. Adults ages 18 and over are not included in this data.

Regional CDR Team:	Total Cases Reviewed:	Percentage:
Clark	140	79.5%
Washoe	17	9.7%
Fallon	8	4.5%
Elko	11	6.3%
Pahrump	0	0.0%
TOTAL:	176	100.0%

County of Residence

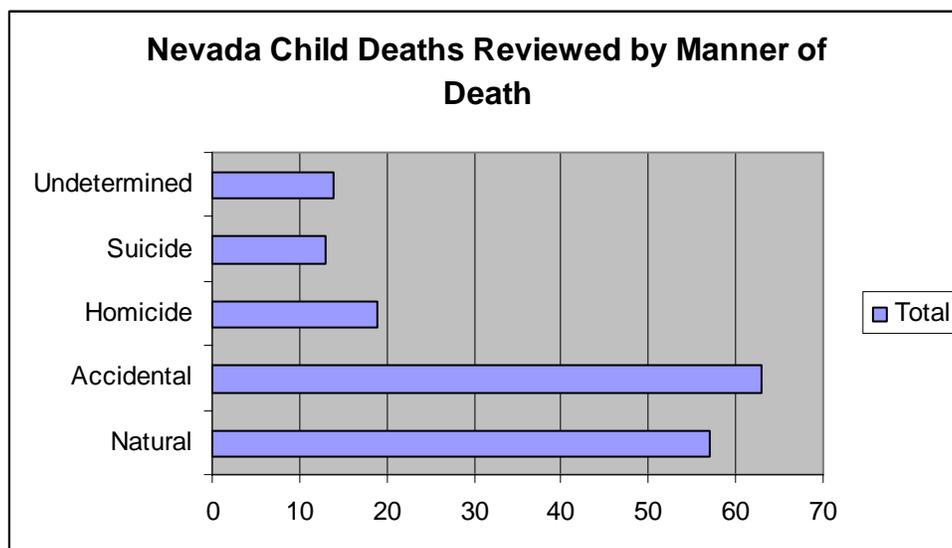


County:	Total:	Percentage:	County:	Total:	Percentage:
Carson City	5	2.8%	Mineral	0	0.0%
Churchill	0	0.0%	Nye	2	1.1%
Clark	124	70.5%	Pershing	0	0.0%
Douglas	1	0.6%	Storey	0	0.0%
Elko	7	4.0%	Washoe	17	9.7%
Esmeralda	0	0.0%	White Pine	0	0.0%
Eureka	1	0.6%			
Humboldt	3	1.7%	Out-of-state	8	4.5%
Lander	1	0.6%	Unknown	5	2.8%
Lincoln	0	0.0%			
Lyon	2	1.1%	TOTAL:	176	100.0%

Manner of Death

As noted above, 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 where sufficient evidence or information cannot be deduced during the investigation, usually about intent, to assign a manner of death.



Manner of Death:	Total:	Percentage:
Natural	57	32.4%
Accidental	63	35.8%
Homicide	19	10.8%
Suicide	13	7.4%
Undetermined	14	8.0%
Unknown	1	0.6%
Not Available	9	5.1%
TOTAL:	176	100.0%

Findings:

- Accidental deaths are the most commonly reviewed type of death by the regional CDR teams. This is consistent with the purpose of the teams outlined in Nevada Revised Statutes (NRS), because accidental deaths represent the type of deaths where prevention efforts would most likely contribute to a reduction in fatalities.

Manner of Death by Team

Manner:	Clark:	Washoe:	Fallon:	Elko:	Pahrump:
Natural	40	7	4	6	0
Accidental	58	3	1	1	0
Homicide	16	0	0	3	0
Suicide	8	4	1	0	0
Undetermined	9	2	2	1	0
Unknown	0	1	0	0	0
Not Available	9	0	0	0	0
TOTAL:	140	17	8	11	0

Findings:

- The Elko Team reviewed an unusually high number of homicides relative to the other regional CDR teams and the statewide population distribution of children and adolescents.

Target Causes of Death for Data Comparison

As noted above, target causes of death for data comparison include the types of death where statewide data from the Nevada State Health Division can be grouped and compared with data from cases reviewed by the regional CDR teams. For regional CDR team data, groupings are made based on deaths required for review by NRS 432B.405, deaths commonly related to abuse and neglect, and causes of death where prevention efforts could contribute to a reduction in fatalities such as suicides and accidental drownings.

REGIONAL CDR TEAM DATA			
Manner:	Target Cause:	Total:	Percentage:
Accidental	MVA – driver	4	2.3%
	MVA – passenger	12	6.8%
	MVA – pedestrian	12	6.8%
	MVA – motorcycle	3	1.7%
	MVA – moped	1	0.6%
	MVA – bicycle	1	0.6%
	MVA – all terrain vehicle	2	1.1%
	MVA – watercraft	1	0.6%
	MVA – all others	0	0.0%
	Asphyxia – bed	5	2.8%
	Asphyxia – food	1	0.6%
	Asphyxia – all other	1	0.6%
	Drowning – pool	5	2.8%
	Drowning – natural water	2	1.1%

REGIONAL CDR TEAM DATA			
Manner:	Target Cause:	Total:	Percentage:
	Drowning – all others	0	0.0%
	Accident – GSW	1	0.6%
	Accident – overdose	3	1.7%
	Accident – fall	3	1.7%
	Accident – heat exposure	1	0.6%
	Accident – all others	2	1.1%
Homicide	Homicide – GSW	4	2.3%
	Homicide – abuse	9	5.1%
	Homicide – neglect	3	1.7%
	Homicide – overdose	1	0.6%
	Homicide – fire	0	0.0%
	Homicide – all others	2	1.1%
Suicide	Suicide – GSW	4	2.3%
	Suicide – asphyxia	7	4.0%
	Suicide – overdose	2	1.1%
	Suicide – all others	0	0.0%
Undetermined	Overdose – undetermined	0	0.0%
	GSW – undetermined	0	0.0%
	Asphyxia – undetermined	1	0.6%
Natural	SIDS	16	9.1%
	Maternal drug use	4	2.3%
	Natural – all others	42	23.9%
–	Unknown	21	11.9%

DATA NOTES: MVA = motor vehicle accident; GSW = gunshot wound; SIDS = Sudden Infant Death Syndrome

Findings:

- Although not reflected in the statewide data, 2005 cases reviewed show four MVA deaths where the adolescent was the driver. Additional details surrounding the circumstances of the death available to the regional CDR teams make this type of death easier to identify through the regional CDR process.

- Likewise, although not reflected in the statewide data, deaths involving accidental gunshot wounds, accidental overdose, and maternal drug use are reflected in the 2005 cases reviewed. Again, additional case details make these types of deaths easier to identify.

Leading Causes of Death

Target Causes for Prevention Efforts

Based on analysis of data derived from the 176 cases reviewed by the five regional CDR teams, the four leading causes of child death where prevention efforts could contribute to a reduction in fatalities are as follows:

Leading Cause:	Total Deaths by Cause:	Percentage of Total Deaths Reviewed:
1. Motor vehicle accidents	36	20.5%
2. All other accidents	24	13.6%
3. Homicide	19	10.8%
4. Suicide	13	7.4%
TOTAL targeted deaths:	92	

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

⇒⇒ DETAIL: Target Causes for Prevention Efforts

Leading Cause:	Total Deaths by Cause:	Percentage of Total Deaths Reviewed:
1. Motor vehicle accidents	36	20.5%
2. All other accidents		
• Drowning	7	4.0%
• Asphyxia	7	4.0%
• All others	10	5.7%
3. Homicide		
• GSW	4	2.3%
• Abuse and neglect	12	6.8%
• All others	3	1.7%

Leading Cause:	Total Deaths by Cause:	Percentage of Total Deaths Reviewed:
4. Suicide		
• Asphyxia	7	4.0%
• GSW	4	2.3%
• All others	2	1.1%
TOTAL targeted deaths:	92	

DATA NOTES: GSW = gunshot wounds

Statewide Health Division Data Versus Regional CDR Team Data

Leading Cause:	STATEWIDE HEALTH DIVISION DATA		REGIONAL CDR TEAM DATA	
	Total Deaths by Cause:	Percentage of Total Deaths:	Total Deaths by Cause:	Percentage of Total Deaths:
1. Motor vehicle accidents	45	11.7%	36	20.5%
2. All other accidents				
• Drowning	12	3.1%	7	4.0%
• Asphyxia	7	1.8%	7	4.0%
• All others	10	2.6%	10	5.7%
3. Homicide				
• GSW	6	1.6%	4	2.3%
• Abuse /neglect	6	1.6%	12	6.8%
• All others	10	2.6%	3	1.7%
4. Suicide				
• Asphyxia	8	2.1%	7	4.0%
• GSW	6	1.6%	4	2.3%
• All others	3	0.8%	2	1.1%
TOTAL targeted deaths:	113		92	

DATA NOTES: GSW = gunshot wounds

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

1. Looking at regional CDR team data alone, the number of accidental drownings reviewed (7) makes this cause of death appear equal to accidental asphyxia deaths (7).

However, statewide data shows that total drownings (12) outnumber total asphyxia deaths (7) in 2005.

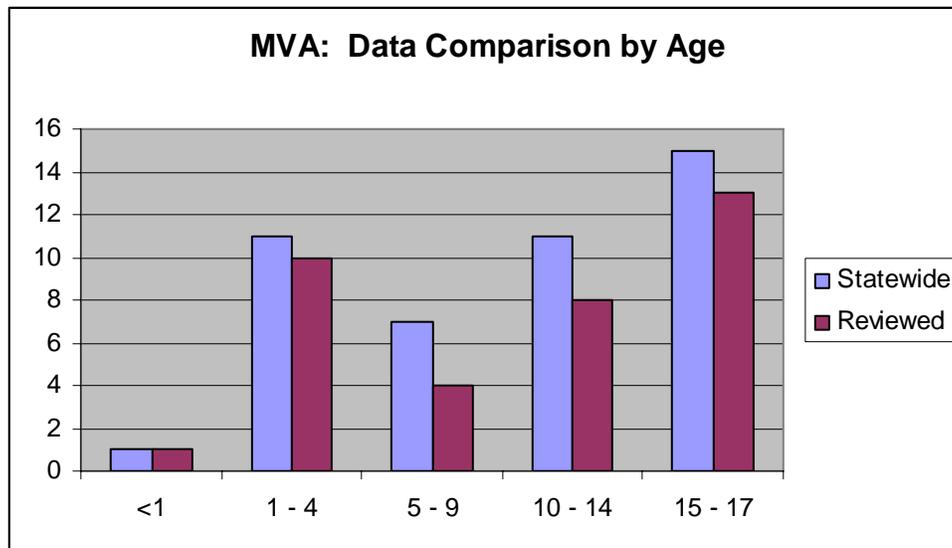
2. Looking at statewide data alone, the number of deaths by abuse or neglect (6) makes this cause of death appear equal to the number of deaths by gunshot wound (6). However, the additional amount of detail available through regional CDR team data shows that total deaths caused by abuse or neglect (12) outnumber total deaths caused by gunshot wounds (6) in 2005.

Findings:

- Motor vehicle accidents (MVA) are the leading cause of death, regardless of which data source is evaluated.
- For drownings, the statewide total is the most complete information.
- Conversely, for deaths by abuse or neglect, the regional CDR team data is the most complete information. This is discussed in more detail in *Section 1* above under *Detail: Deaths Caused by Abuse and Neglect*.

Review: Motor Vehicle Accidents

Age – Motor Vehicle Accidents

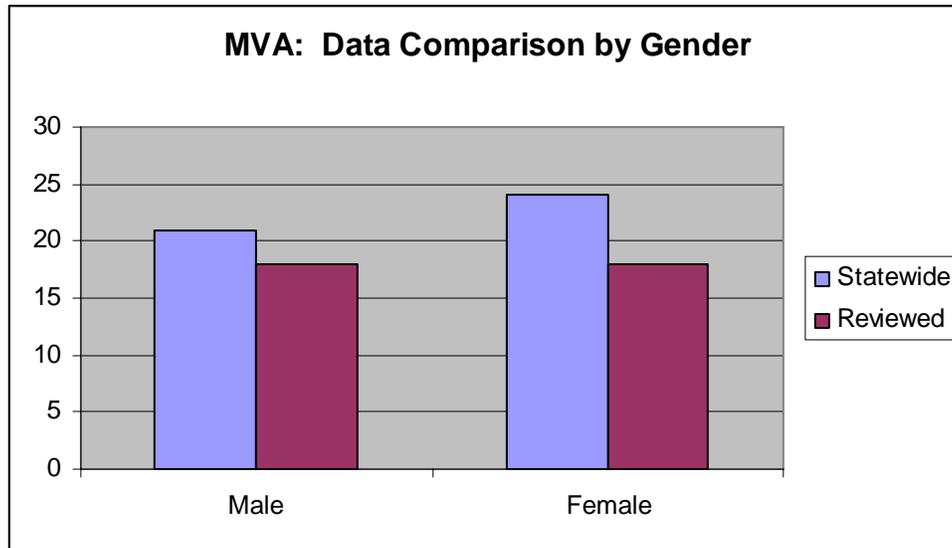


Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	1	11	7	11	15
Reviewed	1	10	4	8	13

Findings:

- Consistent with the statewide data analysis, the risk of death from motor vehicle accidents generally increases with age for children in Nevada. However, as discussed in *Section 1* for the statewide data, during 2005 there was an unusually high number of motor vehicle deaths for children in the 1 – 4 age group.

Gender – Motor Vehicle Accidents



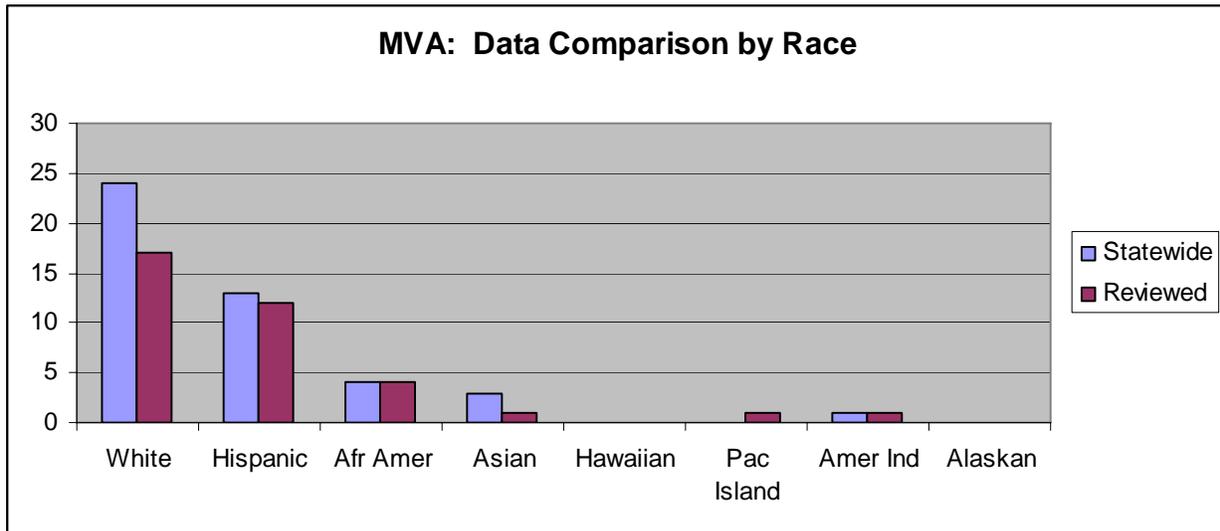
Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	21	24	46.7%	53.3%
Reviewed	18	18	50.0%	50.0%

Findings:

- As noted in *Section 1*, female deaths from motor vehicle accidents exceeded those of males statewide in 2005, which is inconsistent with 2004 data for Nevada, and with national data that shows males typically dies at twice the rate of females in motor vehicle accidents across the lifespan.²⁶ This is also reflected in 2005 cases reviewed, which show an equal number of male and female MVA deaths, whereas a higher number of males cases would be expected based on national trends and the prior year’s analysis.

²⁶ National Center for Health Statistics. (2005). *Health, United States, 2005, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

Race – Motor Vehicle Accidents



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	24	13	4	3	n/a
Reviewed	17	12	4	1	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	1	n/a
Reviewed	1	1	0

Findings:

- Much more detailed race classifications are made through the national database as a result of the regional CDR process.
- Racial distributions are roughly consistent with statewide data, with the exception of the separate race categories for Native Hawaiians, Pacific Islanders, and Native Alaskans not available through the Nevada State Health Division data system.

Contributing Factors – Motor Vehicle Accidents

Total cases reviewed: 36	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 31	Clark Team: 31
	Elko County total: 1	Elko Team: 1
	Fallon County total: 1	Fallon Team: 1
	Washoe County total: 3	Washoe Team: 3

Position of Child by Age Group:

Age Group:	Driver:	Passenger:	On Bicycle:	Pedestrian:	Unknown:	Total:
Less than 1	0	1	0	0	0	1
1 – 4	0	4	0	6	0	10
5 – 9	0	3	1	0	0	4
10 – 14	3	1	0	4	0	8
15 – 17	7	4	0	2	0	13
TOTAL:	10	13	1	12	0	36

Findings:

- Total driver deaths equal 10 in 2005, although only four are shown above under *Target Causes of Death for Data Comparison*. This is because deaths categorized for motorcycles, mopeds, and ATVs are all drivers of those vehicles.
- For 2005 cases reviewed, driver, passenger, and pedestrian deaths are roughly equivalent.
- Pedestrian deaths occurred most frequently in the 1 – 4 age group.

Position of Child by Vehicle Type:

Vehicle Type:	Driver:	Passenger:	Not in Vehicle:	Unknown:	Total:
Car	2	4	1	0	7
Van	0	4	0	0	4
SUV	1	0	0	0	1
Truck	1	2	0	0	3
Semi/Trailer	0	0	0	0	0
RV	0	0	0	0	0
Bus	0	0	0	0	0
Motorcycle	3	0	0	0	3
Tractor/Farm	0	0	0	0	0
ATV	2	0	0	0	2
Snowmobile	0	0	0	0	0

Vehicle Type:	Driver:	Passenger:	Not in Vehicle:	Unknown:	Total:
Train	0	0	0	0	0
Bicycle	0	0	1	0	1
Pedestrian	0	0	2	0	2
Other	1	1	0	0	2
Unknown	0	2	9	0	11
TOTAL:	10	13	13	0	36

Findings:

- Most MVA deaths occur in regular passenger vehicles such as cars, trucks, and vans.
- Motorcycle and ATV deaths are the next most common after passenger vehicles.
- There is considerable discrepancy in pedestrian deaths reported by age group (12) versus those reported by vehicle type (2). This suggests that data entry training needs to be increased for the regional CDR teams.

Risk Factors for Drivers Ages 14 – 17 (for all cases)

Findings:

- Seven cases were reviewed where the adolescent involved was the driver of the vehicle and risk factor detail was available.
- In four of these cases, the adolescent was determined to be at fault.
- In one case, the driver was drug or alcohol impaired.
- In one case, the driver did not have a valid driver's license.
- In four cases, there were two or more other teen passengers in the car.

Protective Measures (for all cases)

Protective Measure Present and Used <u>Correctly</u> :	Driver:	Passenger:	On Bicycle:	Pedestrian:	Unknown:
Airbag	2	1	n/a	n/a	0
Lap belt	0	1	n/a	n/a	0
Shoulder belt	1	1	n/a	n/a	0
Rear-facing child seat	0	0	n/a	n/a	0
Front-facing child seat	0	2	n/a	n/a	0
Booster seat	1	1	n/a	n/a	0
Helmet	1	0	0	0	0
Other	0	0	0	0	0

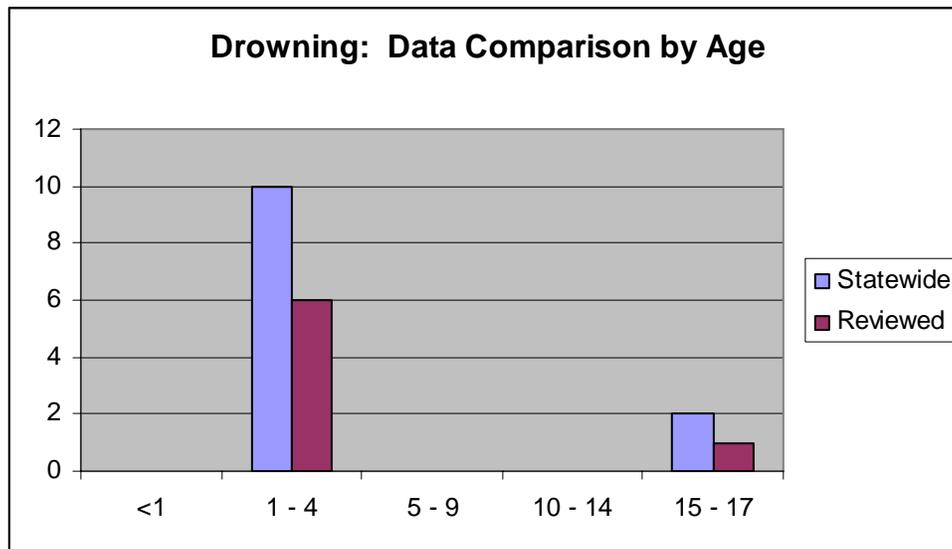
Protective Measure Present and Used <u>Incorrectly</u> :	Driver:	Passenger:	On Bicycle:	Pedestrian:	Unknown:
Airbag	0	0	n/a	n/a	0
Lap belt	0	0	n/a	n/a	0
Shoulder belt	0	0	n/a	n/a	0
Rear-facing child seat	0	0	n/a	n/a	0
Front-facing child seat	0	0	n/a	n/a	0
Booster seat	0	0	n/a	n/a	0
Helmet	0	0	0	0	0
Other	0	0	0	0	0

Protective Measure Present and <u>Not</u> Used:	Driver:	Passenger:	On Bicycle:	Pedestrian:	Unknown:
Airbag	0	0	n/a	n/a	0
Lap belt	2	1	n/a	n/a	0
Shoulder belt	2	1	n/a	n/a	0
Rear-facing child seat	0	1	n/a	n/a	0
Front-facing child seat	0	1	n/a	n/a	0
Booster seat	0	0	n/a	n/a	0
Helmet	0	0	0	0	0
Other	0	0	0	0	0

Protective Measure Needed But Not Present:	Driver:	Passenger:	On Bicycle:	Pedestrian:	Unknown:
Airbag	0	1	n/a	n/a	0
Lap belt	0	1	n/a	n/a	0
Shoulder belt	0	1	n/a	n/a	0
Rear-facing child seat	0	0	n/a	n/a	0
Front-facing child seat	0	0	n/a	n/a	0
Booster seat	0	0	n/a	n/a	0
Helmet	3	0	1	0	0
Other	0	0	0	0	0

Review: Accidents Involving Drowning

Age – Accidents Involving Drowning

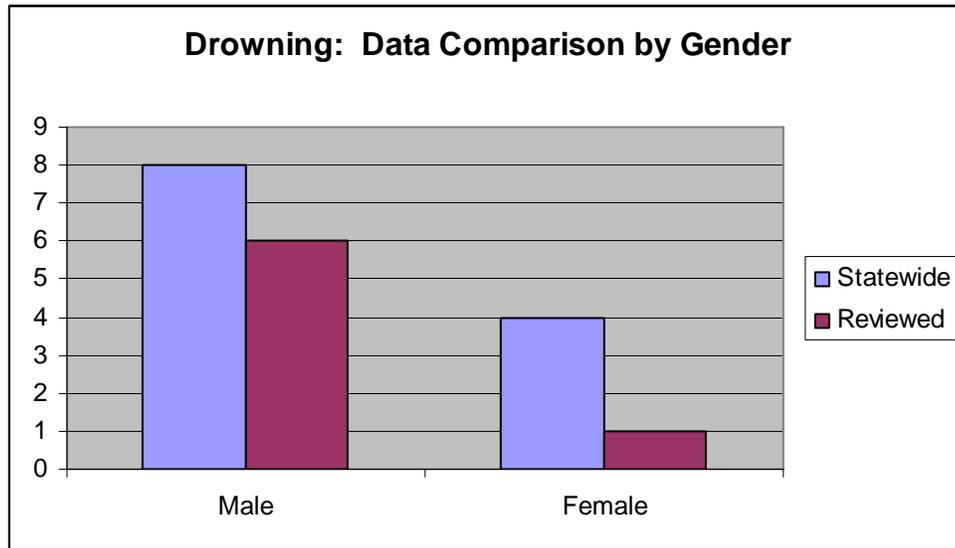


Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	0	10	0	0	2
Reviewed	0	6	0	0	1

Findings:

- Age identification is consistent between the statewide and regional CDR team data.

Gender – Accidents Involving Drowning

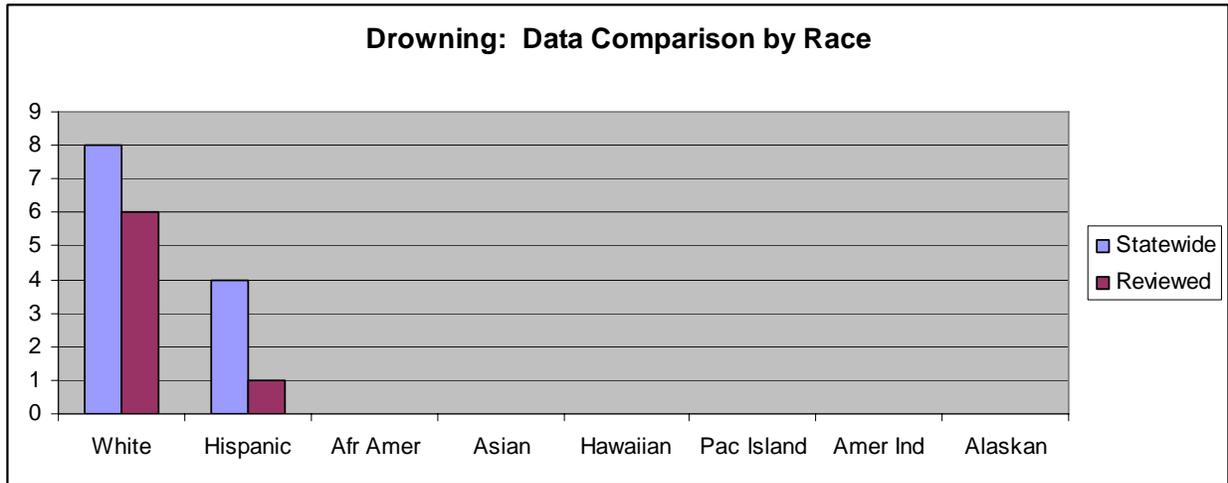


Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	8	4	66.7%	33.3%
Reviewed	6	1	85.7	14.3%

Findings:

- Gender identification is consistent between the statewide and regional CDR team data.
- Statewide, males died at twice the rate of females for drowning deaths in 2005.

Race – Accidents Involving Drowning



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	8	4	0	0	n/a
Reviewed	6	1	0	0	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	0	n/a
Reviewed	0	0	0

Findings:

- Race identification is consistent between the statewide and regional CDR team data.

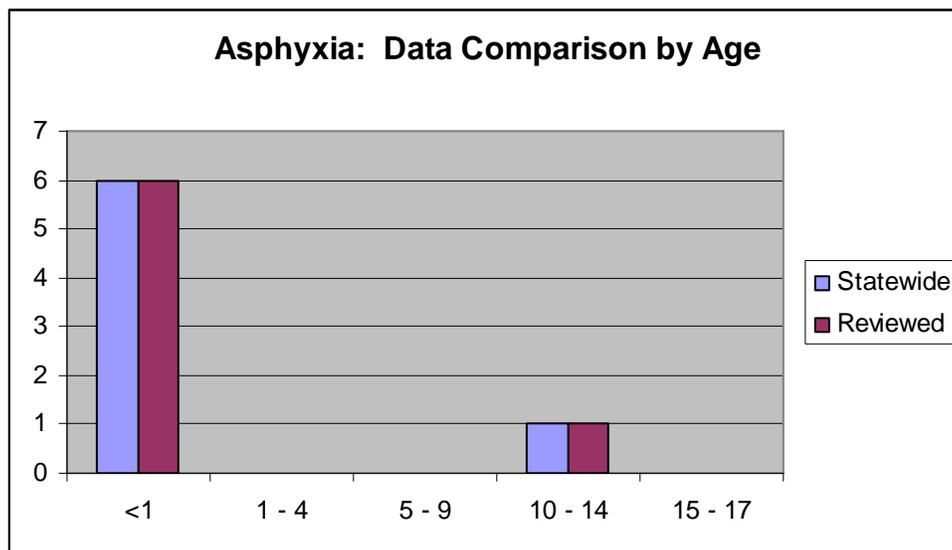
Contributing Factors – Drowning

Total cases reviewed: 7	Drowning deaths in swimming pool, hot tub, or spa: 5	
	Drowning deaths in natural water, including lake, river, pond, or creek: 2	
	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 7	Clark Team: 7

Factor:	Detail:
Child was wearing a flotation device:	Yes: 0 No: 7
Child was able to swim:	Yes: 1 No: 6
Barriers to water in place:	Yes: 4 No: 3
Child was unsupervised, but required supervision:	Yes: 2 No: 5
Child was impaired by drugs or alcohol:	Yes: 1 No: 6
Child's supervisor was impaired by drugs or alcohol:	Yes: 0 No: 7

Review: Accidents Involving Asphyxia

Age – Accidents Involving Asphyxia

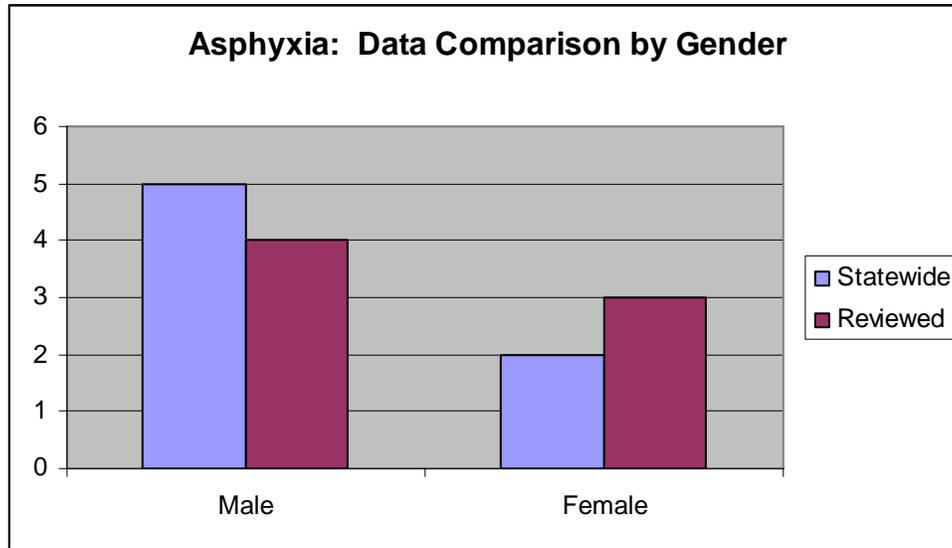


Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	6	0	0	1	0
Reviewed	6	0	0	1	0

Findings:

- Age identification is consistent between the statewide and regional CDR team data.
- Most asphyxia deaths occur among infants less than one year of age.

Gender – Accidents Involving Asphyxia

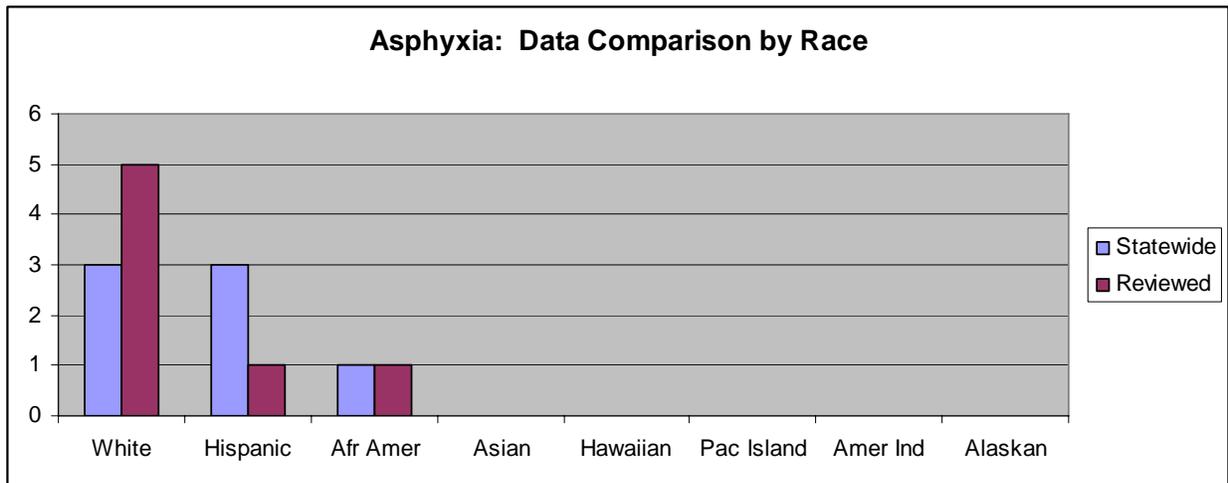


Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	5	2	71.4%	28.6%
Reviewed	4	3	57.1%	42.9%

Findings:

- There is a discrepancy in gender identification between the statewide and regional CDR team data.
- Statewide, males died at approximately twice the rate of females for asphyxia deaths in 2005.

Race – Accidents Involving Asphyxia



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	3	3	1	0	n/a
Reviewed	5	1	1	0	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	0	n/a
Reviewed	0	0	0

Findings:

- Statewide data shows whites and Hispanics evenly divided for asphyxia deaths, which would indicate that asphyxia deaths are unusually high for Hispanics based on the statewide child and adolescent population distribution.
- However, regional CDR team data shows the majority of asphyxia victims as white. This indicates that there are racial classification problems either with the statewide data or regional CDR team data.

Contributing Factors – Asphyxia

Total cases reviewed: 7	Asphyxia resulting from overlay or bedding: 5
	Asphyxia resulting from choking: 2

	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 7	Clark Team: 7

<u>Factor:</u>	<u>Detail:</u>
Place of death:	Child's home: 5 Relative's home: 1 Unknown: 1
911 called?	Yes: 7 No: 0
CPR performed before emergency medical services (EMS) arrived?	Yes: 4 No: 1 Unknown: 2
EMS arrived on scene?	Yes: 6 No: 0 Unknown: 1
Child's activity at time of death:	Sleeping – overlay deaths: 5 Eating – choking deaths: 1 Sleeping – choking deaths: 1
CPS record check conducted as a result of the death?	Yes: 5 No: 0 Unknown: 2
Investigation found evidence of prior abuse?	Yes: 0 No: 5 Unknown: 2
Asphyxia cause:	Bedding or overlay: 5 Choking – food: 1 Choking – gastric contents: 1
Child history of seizures?	Yes: 0 No: 1 Unknown: 6
Child history of apnea?	Yes: 0 No: 1 Unknown: 5 Incomplete: 1

Factor:	Detail:
Was the Heimlich Maneuver attempted?	Yes: 0 No: 2 Unknown: 5
Sleeping location for incident: (6 of 7 deaths while sleeping)	Queen bed: 1 Full-size mattress: 2 Twin mattress: 2 Crib: 1
Position child was put to sleep: (6 of 7 deaths while sleeping)	Back: 4 Stomach: 1 Unknown: 1
Position child was found: (6 of 7 deaths while sleeping)	Back: 2 Stomach: 2 Unknown: 2
Child's usual sleeping place: (6 of 7 deaths while sleeping)	Twin mattress: 1 Crib: 1 Bassinet: 2 Unknown: 2
Child's usual sleeping position: (6 of 7 deaths while sleeping)	Back: 0 Stomach: 1 Unknown: 4 Incomplete: 1
Sleeping environment when child was found: (6 of 7 deaths while sleeping)	Face and body unobstructed: 2 Under other co-sleeping children: 3 Under other co-sleeping adults: 0 Rolled into pillow: 1
Child fell asleep while feeding? (6 of 7 deaths while sleeping)	Yes: 1 No: 3 Unknown: 2
Child sleeping with other people or animals? (6 of 7 deaths while sleeping)	Adults only: 0 Adults and children: 2 Children only: 2 No: 2

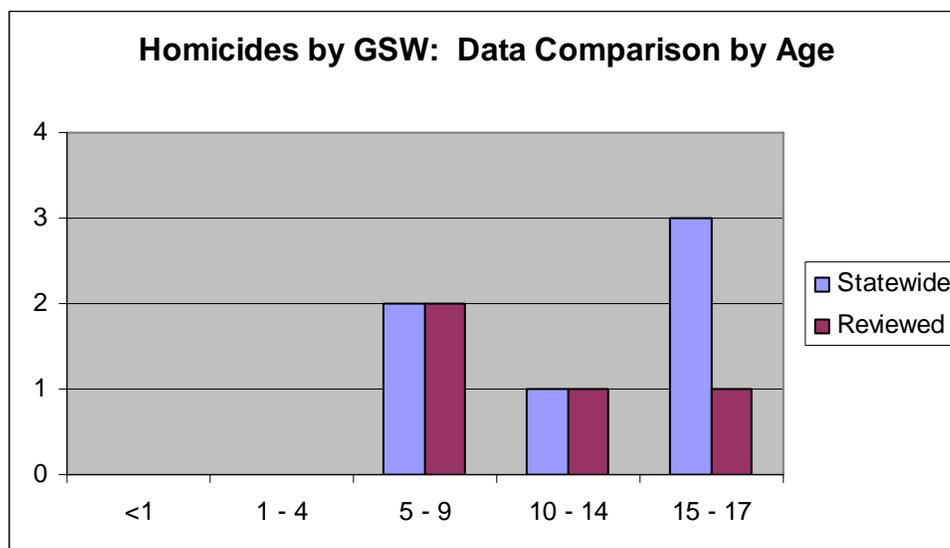
Factor:	Detail:
Did the death occur as a consequence of a problem with a consumer product?	Yes: 0 No: 5 Unknown: 1 Incomplete: 1
Did the death occur during a commission of a crime other than the incident causing the death?	Yes: 0 No: 5 Unknown: 1 Incomplete: 1

Findings:

- Co-sleeping was a factor in four of the six sleeping deaths, and responsible for three of the six.
- Bedding was a factor in and responsible for one of the six sleeping deaths.
- One child was placed to sleep on his/her stomach.

Review: Homicides by Gunshot Wound (GSW)

Age – Homicides by GSW

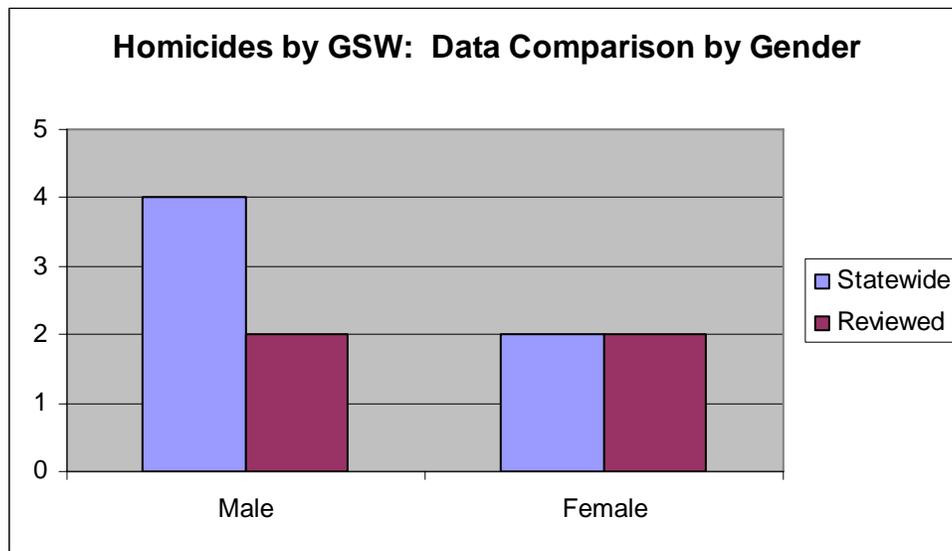


Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	0	0	2	1	3
Reviewed	0	0	2	1	1

Findings:

- Age identification is consistent between the statewide and regional CDR team data.
- As noted above, national data shows that deaths from firearm-related injuries increase considerably in the 15 – 19 age group.²⁷ [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.] However, because there is typically an upward trend with age, it is unusual that there is a higher number of homicides deaths involving firearms for the 5 – 9 age group compared with the 10 – 14 age group. Regional CDR team data also shows a high number of deaths in this age group.

Gender – Homicides by GSW



Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	4	2	66.7%	33.3%
Reviewed	2	2	50.0%	50.0%

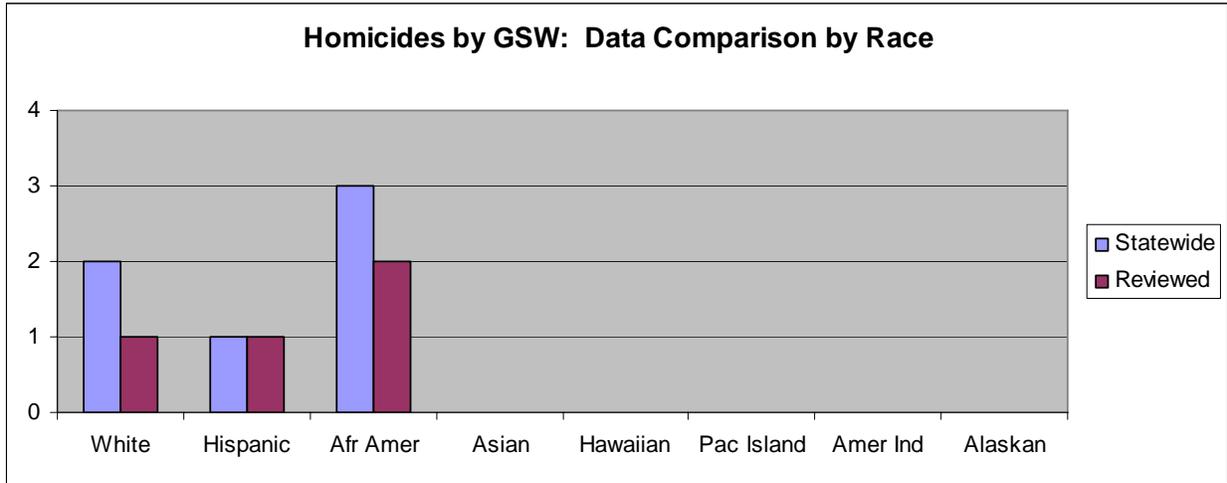
Findings:

- Gender identification is consistent between the statewide and regional CDR team data.
- When examining statewide data, male deaths are twice that of females, which is consistent with national data that shows male homicide death rates are much higher than that of females.
- Conversely, regional CDR team data shows male and female homicides by GSW as equal. This reflects the unusually balanced distribution of homicides between males and females for

²⁷ National Center for Health Statistics. (2005). *Health, United States, 2005, With Chartbook on Trends in the Health of Americans*. Hyattsville, MD: National Center for Health Statistics.

2005, which is inconsistent with national trends. This is discussed in *Section 1* above under *Manner of Death and Gender*.

Race – Homicides by GSW



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	2	1	3	0	n/a
Reviewed	1	1	2	0	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	0	n/a
Reviewed	0	0	0

Findings:

- Race identification is consistent between the statewide and regional CDR team data.
- As noted above, homicides involving gunshot wounds are highest for African Americans, which is very disproportionate based on the statewide child and adolescent population distribution.

Contributing Factors – Homicides by GSW

Total cases reviewed: 4	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 4	Clark Team: 4

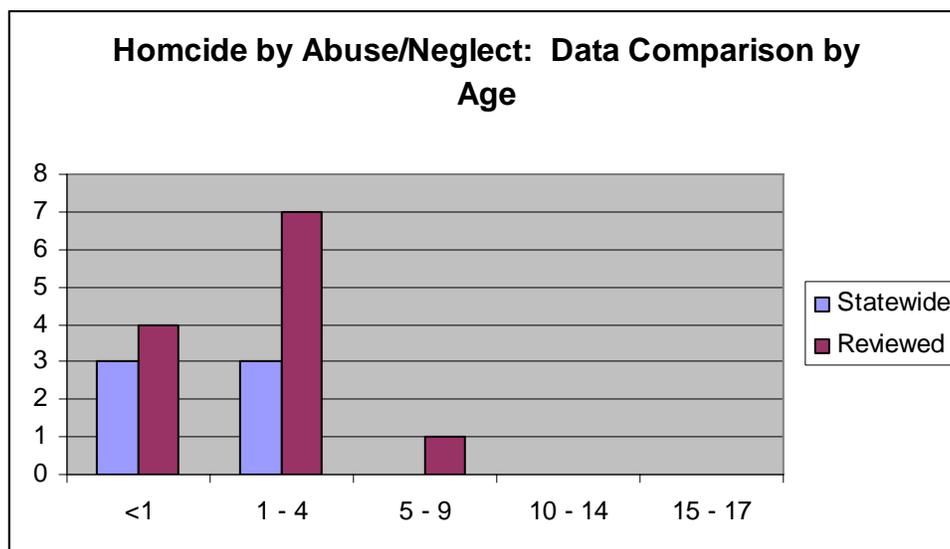
Factor:	Detail:
Place of death:	Child's home: 1 Relative's home: 1 Other: 1 Unknown: 1
911 called?	Yes: 2 No: 1 Incomplete: 1
CPR performed before emergency medical services (EMS) arrived?	Yes: 0 No: 1 Unknown: 2 Incomplete: 1
EMS arrived on scene?	Yes: 2 No: 1 Unknown: 0 Incomplete: 1
Child's activity at time of death:	Sleeping: 1 Unknown: 2 Incomplete: 1
CPS record check conducted as a result of the death?	Yes: 1 No: 0 Unknown: 2 Incomplete: 1
Investigation found evidence of prior abuse?	Yes: 0 No: 1 Unknown: 2 Incomplete: 1
Type of firearm:	Handgun: 1 Shotgun: 2 Unknown: 1

Factor:	Detail:
Was the firearm licensed?	Yes: 0 No: 0 Unknown: 3 Incomplete: 1
Firearm safety features:	Unknown: 3 Incomplete: 1
Where was the firearm stored?	Unknown: 3 Incomplete: 1
Firearm stored with ammunition?	Yes: 0 No: 0 Unknown: 3 Incomplete: 1
Firearm stored loaded?	Yes: 0 No: 0 Unknown: 3 Incomplete: 1
Owner of firearm:	Unknown, weapon found at scene: 3 Incomplete: 1
Did person using weapon have a history of weapon-related offenses?	Yes: 0 No: 0 Unknown: 3 Incomplete: 1
Does anyone in child's family have a history of weapon offenses, or die of weapons-related causes?	Yes: 0 No: 0 Unknown: 3 Incomplete: 1
Person handling weapon during incident:	Father: 2 Mother: 0 Uncle: 1 Incomplete: 1
Use of weapon during incident:	Commission of crime: 3 Incomplete: 1

Factor:	Detail:
Did the death occur during a commission of a crime other than the incident causing the death?	Yes: 0 No: 3 Unknown: 0 Incomplete: 1

Review: Homicides by Abuse and Neglect

Age – Homicides by Abuse and Neglect



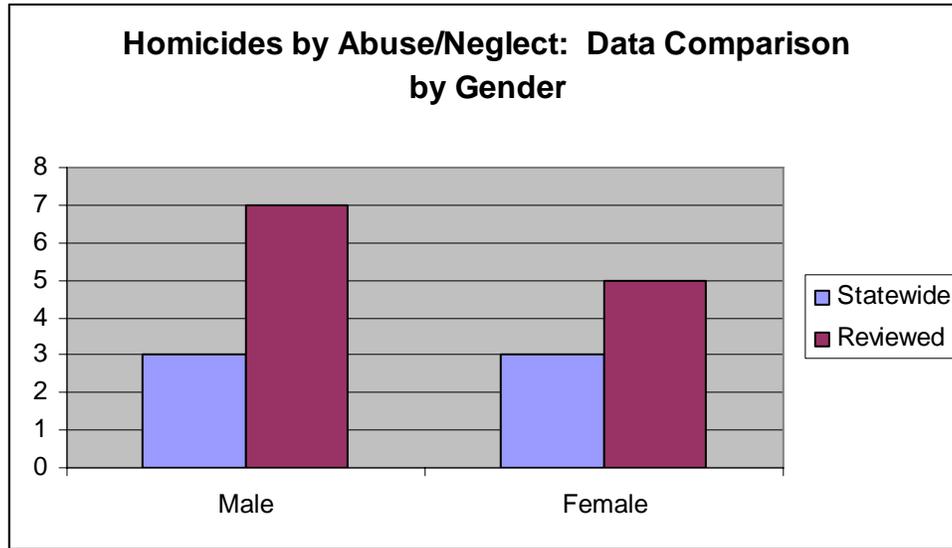
Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	3	3	0	0	0
Reviewed	4	7	1	0	0

Findings:

- As noted above, regional CDR team data shows twice as many deaths caused by abuse and neglect when compared with statewide data, for a total of 12 versus six.
- As discussed above in *Section 1* under *Detail: Deaths Caused by Abuse and Neglect*, homicides caused by abuse and neglect are the leading type of homicide for 2005, as shown in the regional CDR team data. This is because statewide homicide deaths attributed to other causes were exclusively in the less-than-one and 1 – 4 age groups. Based on the young age of the infants and children involved, these deaths may be related to abuse and neglect, but were not specifically coded as such with the ICD-10 classification system. This suggests that coroner investigations into the homicide deaths of children are less likely to identify abuse or

neglect as a cause, or coroners and private physicians are less likely to specifically enter this type of information for coding through the ICD-10 system.

Gender – Homicides by Abuse and Neglect

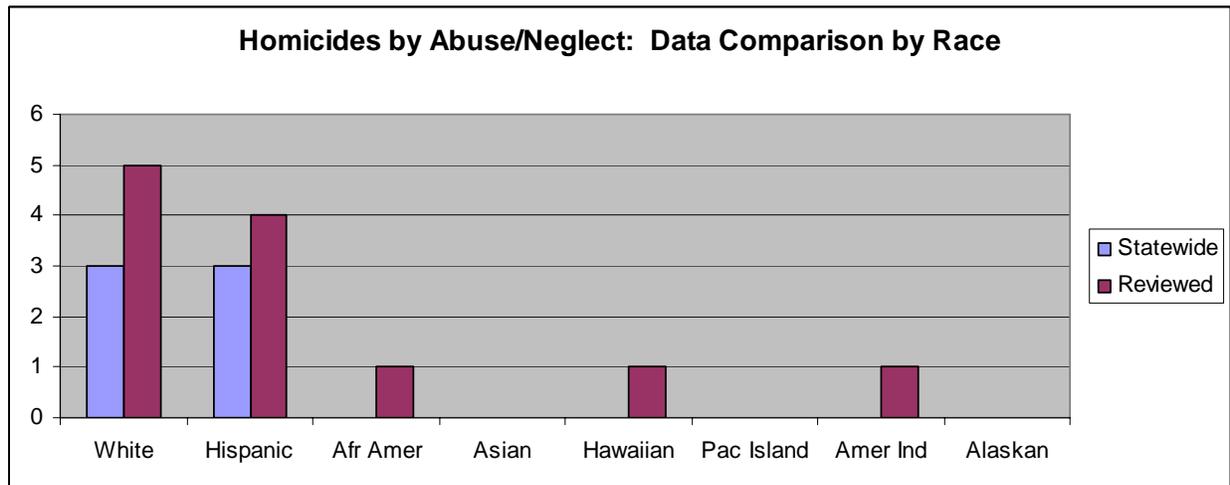


Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	3	3	50.0%	50.0%
Reviewed	7	5	58.3%	41.7%

Findings:

- When examining regional CDR team data, male homicide deaths by abuse and neglect are greater than female deaths. This is consistent with both statewide and regional team data, which shows that overall, male deaths exceed female deaths.

Race – Homicides by Abuse and Neglect



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	3	3	0	0	n/a
Reviewed	5	4	1	0	1

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	0	n/a
Reviewed	0	1	0

Findings:

- When examining regional CDR team data, deaths by abuse and neglect for Hispanics is almost equal to those for whites. This indicates an unusually high rate of abuse and neglect deaths for this race category based on the statewide population distribution.

Contributing Factors – Homicides by Abuse

Total <u>abuse</u> cases reviewed: 9	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 5	Clark Team: 9
	Nye County total: 1	
	Out-of-state resident total: 3	

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

TYPE OF ABUSE:

Physical Abuse:	Number:
• Abusive head trauma	6
• Retinal hemorrhages	2
• Shaken	2
• Chronic battered child syndrome	1
• Beating/kicking	5
• Scalding/burn	0
• Munchausen Syndrome by Proxy	0
• Other	1

PERSONS RESPONSIBLE FOR ABUSE:

Perpetrator:	Number:
• Biological parent	1
• Adoptive parent	0
• Step parent	0
• Foster parent	0
• Parent's partner	6
• Other relative	1
• Child care worker or babysitter	0
• Friend or acquaintance	0
• Other	1
• Unknown person	0

Perpetrator's Gender:	Number:
• Male	7
• Female	2
• Unknown	0

Perpetrator's Contributing Factors:	Number:
• Drug or alcohol impaired at time of incident	0
• History of substance abuse	0
• History of child maltreatment as a victim of abuse	1
• History of child maltreatment as a perpetrator of abuse	6
• History of domestic violence as a victim	2
• History of domestic violence as a perpetrator	2
• History of Post-Traumatic Stress Disorder (PTSD)	2

TRIGGERING EVENTS:

Event:	Number:
• Crying	3
• Toilet training problem	0
• Disobedience	0
• Feeding problems	0
• Domestic argument	0
• None	0
• Other	2
• Unknown event	4

TERM OF ABUSE:

Factor:	Number:
• Chronic abuse of child	1
• Pattern of abuse in family	4
• Isolated incident	0

CPS INVOLVEMENT:

Factor:	Number:
• Child was an infant born drug or alcohol exposed	1
• Open CPS case on child at time of death	0
• CPS investigation found evidence of prior abuse	4
• Child had a history of maltreatment	2
• Was the child ever placed in foster care?	0
• CPS action was taken as a result of the death	5

Contributing Factors – Homicides by Neglect

Total <u>neglect</u> cases reviewed: 3	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 1	Clark Team: 1
	Elko County total: 2	Elko Team: 2

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

TYPE OF NEGLECT:

Neglect:	Number:
• Failure to protect child from hazards	2
• Failure to provide child with necessities	1
• Medical neglect	2
• Emotional neglect	0
• Abandonment	0
• Unknown	0

PERSONS RESPONSIBLE FOR NEGLECT:

Perpetrator:	Number:
• Biological parent	3
• Adoptive parent	0
• Step parent	0
• Foster parent	0
• Parent's partner	0
• Other relative	0
• Child care worker or babysitter	0
• Friend or acquaintance	0
• Other	0
• Unknown person	0

Perpetrator's Gender:	Number:
• Male	1
• Female	2
• Unknown	0

TERM OF NEGLECT:

Factor:	Number:
• Chronic neglect of child	0
• Pattern of neglect in family	0
• Isolated incident	2

CPS INVOLVEMENT:

Factor:	Number:
• Child was an infant born drug or alcohol exposed	1
• Open CPS case on child at time of death	1
• CPS investigation found evidence of prior abuse	1
• Child had a history of maltreatment	1

• Was the child ever placed in foster care?	0
• CPS action was taken as a result of the death	2

Review: Shaken Baby Syndrome

Two of the homicide deaths by abuse reviewed in 2005 were identified as resulting from shaken baby syndrome.

Individual Case Detail

Ref:	Cause:	Age Group:	Gender:	Race:	County:
1	Homicide – abuse	Under 1	Male	African American	Clark
2	Homicide – abuse	1 – 4	Female	White	OOS

Contributing Factors – Shaken Baby Syndrome

Factor	Detail
Type of physical abuse:	Ref 1: Abusive head trauma; beating and kicking Ref 2: Abusive head trauma; beating and kicking
For abusive head trauma, were there retinal hemorrhages?	Ref 1: Unknown Ref 2: Yes
For abusive head trauma, was the child shaken?	Ref 1: Yes Ref 2: Yes
If the child was shaken, was there impact?	Ref 1: Yes Ref 2: Unknown
Events triggering physical abuse:	Ref 1: Crying Ref 2: Crying

Abusive Head Trauma

In addition to deaths identified as resulting from shaken baby syndrome, other homicide deaths associated with abusive head trauma may be associated with shaken baby syndrome.

In 2005, four other homicide deaths reviewed were associated with abusive head trauma:

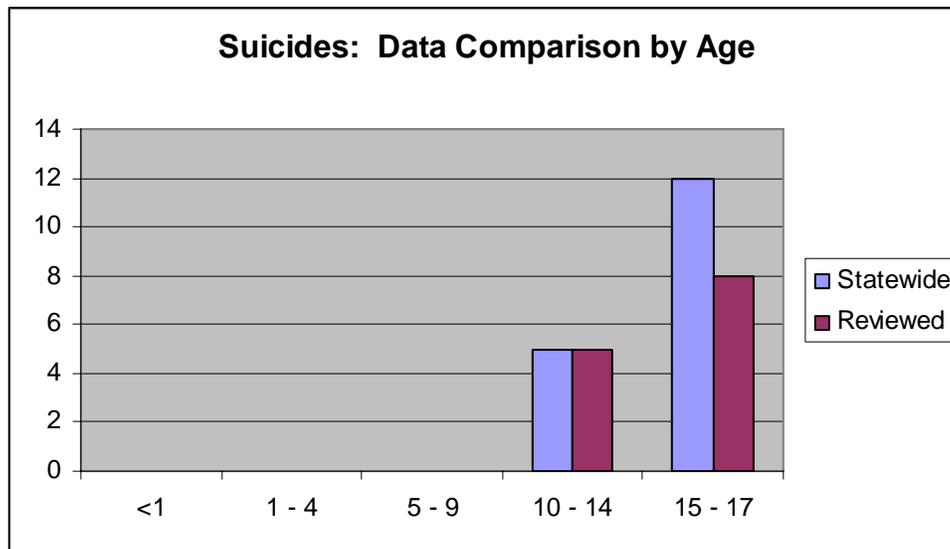
Ref:	Cause:	Age Group:	Gender:	Race:	County:
1	Homicide – abuse	Under 1	Female	White	OOS
2	Homicide – abuse	1 – 4	Female	White	Clark
3	Homicide – abuse	Under 1	Male	White	Clark
4	Homicide – abuse	1 – 4	Male	Native Hawaiian	Nye

Contributing Factors – Abusive Head Trauma

Factor	Detail
Type of physical abuse:	Ref 1: Abusive head trauma Ref 2: Abusive head trauma; abdominal injuries Ref 3: Abusive head trauma; beating and kicking Ref 4: Abusive head trauma
For abusive head trauma, were there retinal hemorrhages?	Ref 1: No Ref 2: Unknown Ref 3: Yes Ref 4: No
For abusive head trauma, was the child shaken?	Ref 1: Unknown Ref 2: Unknown Ref 3: Unknown Ref 4: Unknown
If the child was shaken, was there impact?	Ref 1: n/a Ref 2: n/a Ref 3: n/a Ref 4: n/a
Events triggering physical abuse:	Ref 1: Jealousy Ref 2: Unknown Ref 3: Crying Ref 4: Unknown

Review: Suicides by All Causes

Age – Suicides by All Causes

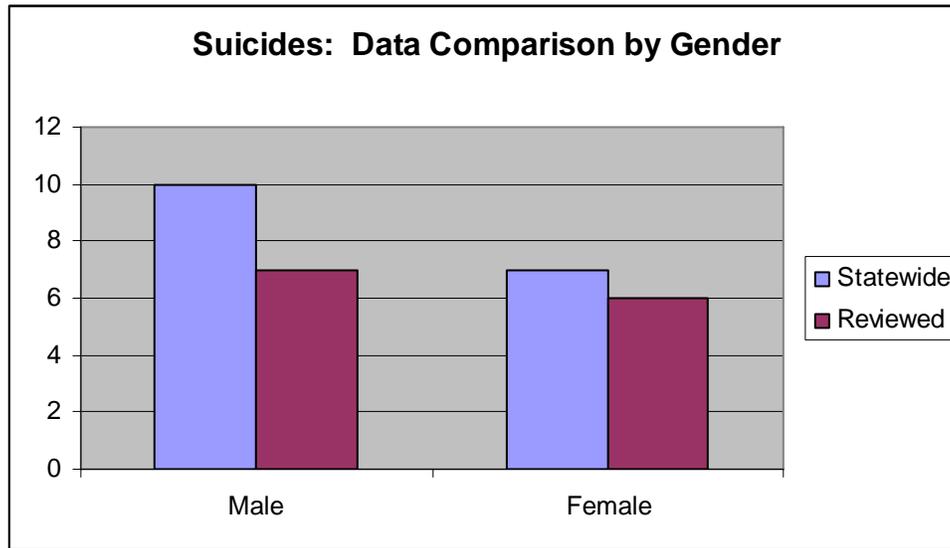


Data Source:	Less than 1:	1 – 4:	5 – 9:	10 – 14:	15 – 17:
Statewide	0	0	0	5	12
Reviewed	0	0	0	5	8

Findings:

- Age identification is consistent between the statewide and regional CDR team data.
- As noted above, suicide deaths occurred exclusively in the 10 – 14 and 15 – 17 age groups. This is consistent with national data, which shows that deaths from suicide increase considerably in the pre-teen and teen years.

Gender – Suicides by All Causes

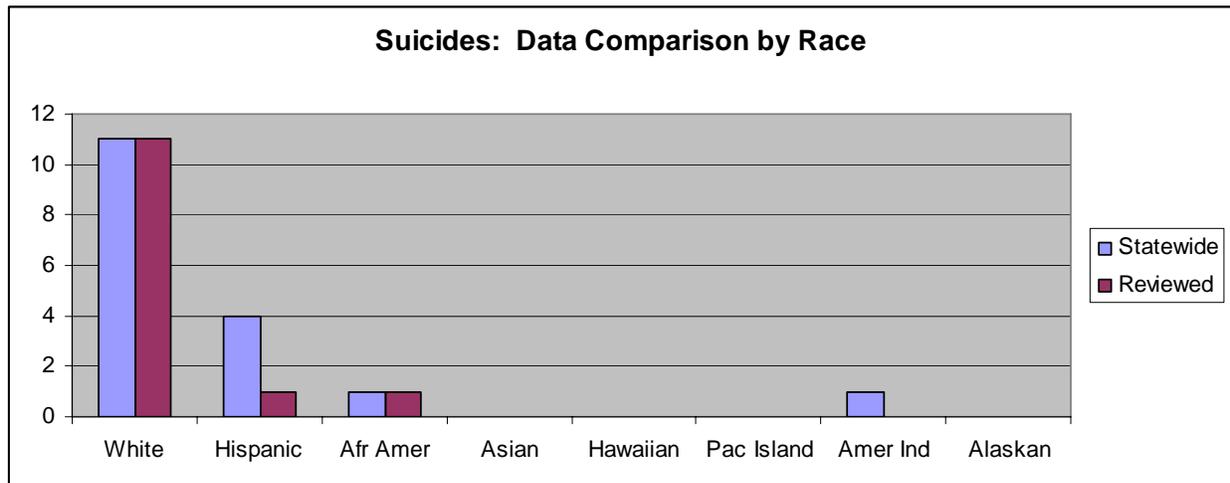


Data Source:	Male:	Female:	Male Percentage:	Female Percentage:
Statewide	10	7	58.8%	41.2%
Reviewed	7	6	53.8%	46.2%

Findings:

- As discussed above, females in Nevada committed suicide at a close rate with males in 2005. This is notably inconsistent with national data, which shows the rate of death for male suicides in the 15 – 19 age group at more than four times that of females. [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

Race – Suicides by All Causes



Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	11	4	1	0	n/a
Reviewed	11	1	1	0	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	1	n/a
Reviewed	0	0	0

Findings:

- There is a race discrepancy between the statewide and regional data for American Indians.
- As discussed in *Section 1*, suicide occurs most frequently among whites. This is generally consistent with national data, which shows that whites account for the second highest suicide rate within race categories.
- Also discussed in Section 1, national data shows that the highest suicide rates for both males and females are among American Indians. Given Nevada’s indigenous American Indian population, the one reported suicide among American Indians may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported. Incorrect classification may result from assigning race based on surnames, where they appear to indicate a certain racial background and further information is not gathered.

Method and Individual Case Detail

Ref:	Method:	Age Group:	Gender:	Race:	County:
1	GSW	10 – 14	Female	White	Clark
2	Asphyxia	10 – 14	Male	White	Washoe
3	Asphyxia	10 – 14	Male	White	Washoe
4	GSW	10 – 14	Male	White	Clark
5	Asphyxia	10 – 14	Female	White	Clark
6	Asphyxia	15 – 17	Female	White	Washoe
7	Asphyxia	15 – 17	Male	Black	Clark
8	Asphyxia	15 – 17	Female	White	Clark
9	GSW	15 – 17	Male	Hispanic	Clark
10	Overdose	15 – 17	Female	White	Clark
11	Overdose	15 – 17	Female	White	Clark
12	Asphyxia	15 – 17	Male	White	Washoe
13	GSW	15 – 17	Male	White	Carson City

Findings:

- Asphyxia was the most common method of suicide based on regional CDR team data, accounting for seven of 13 deaths reviewed. Gunshot wounds (GSW) accounted for four suicide deaths, and overdose for the remaining two. This is inconsistent with national trends, which indicate that suicide by GSW is the most common method, accounting for almost half of all completed suicides. However, the same national data indicates that suicides by GSW have decreased across the last decade, with a corresponding increase in suicides by asphyxia.²⁸ Suicides in Nevada mirror this trend toward an increase in suicides by asphyxia.
- National data also shows that females typically attempt suicide by ingesting pills, while males typically complete suicide by GSW.²⁹ This is consistent with Nevada data, which shows three of four suicides by GSW for males, and both suicides by overdose for females.

Contributing Factors – Suicide

Total cases reviewed: 13	Suicides resulting from asphyxia: 7
	Suicides resulting from GSW: 4
	Suicides resulting from overdose: 2

²⁸ American Association of Suicidology. (2006). *Youth Suicide Fact Sheet*. Washington, DC: American Association of Suicidology.

²⁹ Ibid.

	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Carson City total: 1	Clark Team: 8
	Clark County total: 8	Fallon Team: 1
	Washoe County total: 4	Washoe Team: 4

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

CHILD HISTORY:

Factor:	Number:
• History of substance abuse	3
• Drug or alcohol impaired at time of incident	2
• History of mental illness	2
• Child had transgendered identity	0
• Child was gay, lesbian, bisexual, or questioning orientation	1
• Child had a criminal history of delinquency	4
• Child spent time in juvenile detention	2
• Detailed case information not available	5

CIRCUMSTANCES SURROUNDING EVENT:

Factor:	Number:
• Child left a note	3
• Child talked about suicide	4
• Prior suicide threats were made	5
• Prior suicide attempts were made	2
• Suicide was completely unexpected	2
• Child had received prior mental health services	2
• Child was receiving mental health services at time of death	0
• Child was on medication(s) for mental illness	2
• Issues prevented child from receiving mental health services	0
• Child had a history of running away	0
• Child had a history of self-mutilation	2
• History of suicides in family present	0
• Suicide was part of a murder-suicide	0
• Suicide was part of a suicide pact	0
• Suicide was part of a suicide cluster	0
• Detailed case information not available	5

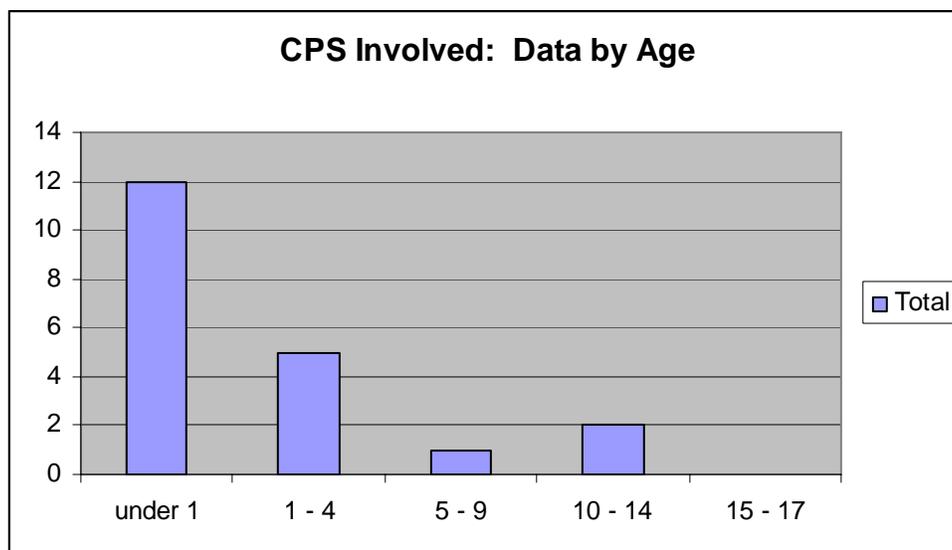
CPS INVOLVEMENT:

Factor:	Number:
• Open CPS case on child at time of death	0
• CPS investigation found evidence of prior abuse	0
• Child had a history of maltreatment	0
• Was the child ever placed in foster care?	0
• Adolescent had a history of intimate partner violence as a victim	0
• Adolescent had a history of intimate partner violence as a perpetrator	0
• Detailed case information not available	5

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

During 2005, 20 out of 176 cases reviewed included children with a current or prior child protective services (CPS) history. CPS involvement is not tracked by the Nevada State Health Division, therefore statewide comparison data cannot be used.

Age – CPS Involved

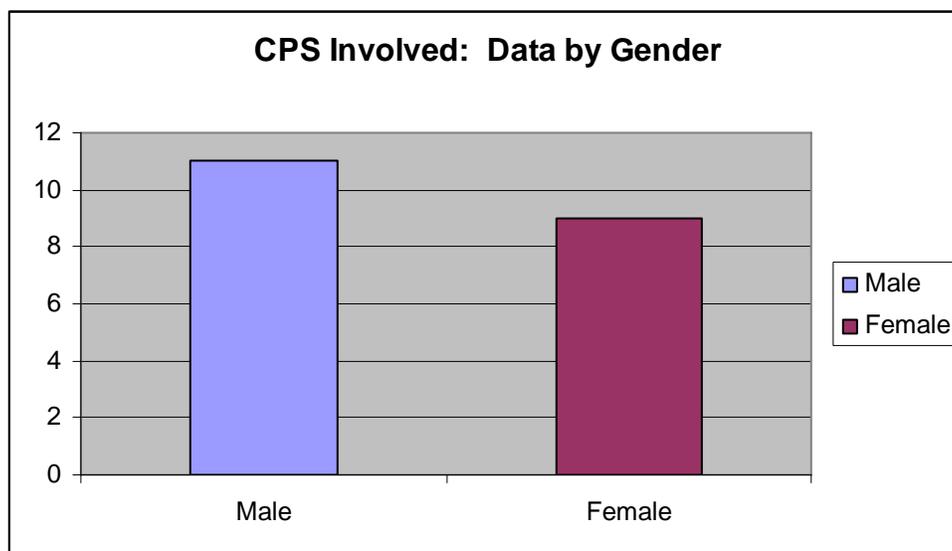


Age Group:	Total:	Percentage:
Less than 1 year old	12	60.0%
1 – 4 years	5	25.0%
5 – 9 years	1	5.0%
10 – 14 years	2	10.0%
15 – 17 years	0	0.0%
TOTAL:	20	100.0%

Findings:

- The greatest number of deaths for children involved in the CPS system occurred for those less than one year of age, followed by children in the 1 – 4 age group. Together, these two age groups account for 85% of CPS involved deaths.

Gender – CPS Involved

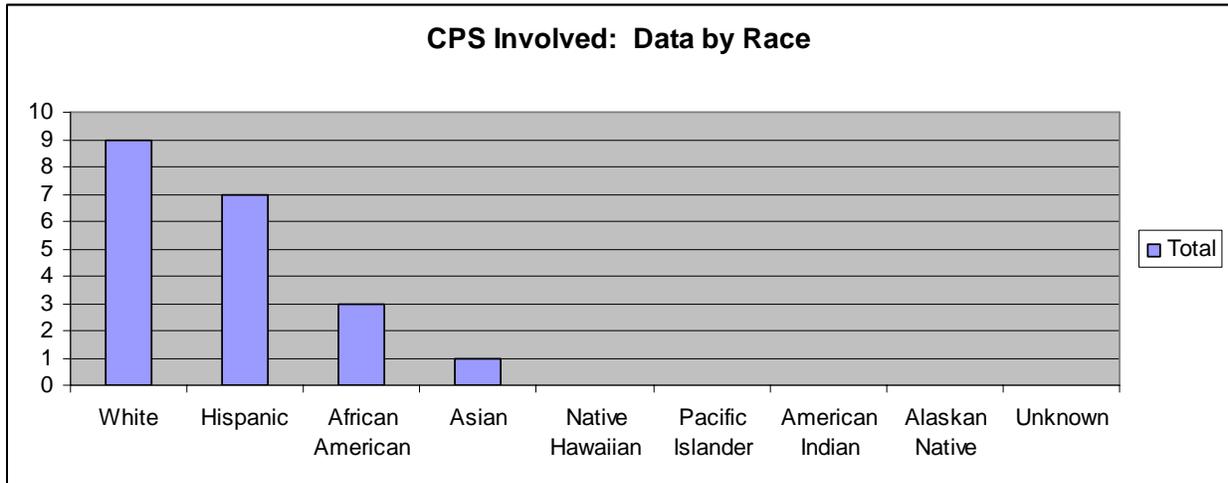


Gender:	Total:	Percentage:
Male	11	55.0%
Female	9	45.0%
TOTAL:	20	100.0%

Findings:

- Child deaths with a current or prior CPS history include more males than females. This is again consistent with national and statewide data reviewed throughout this report, which indicates that males die at a higher rate than females in general.

Race – CPS Involved

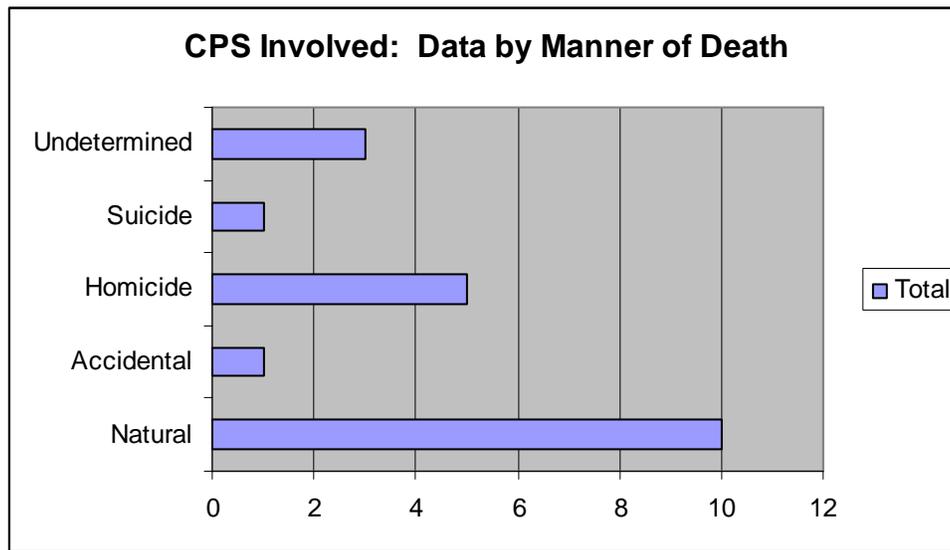


Race:	Total:	Percentage:
White	9	45.0%
Hispanic	7	35.0%
African American	3	15.0%
Asian	1	5.0%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
American Indian	0	0.0%
Alaskan Native	0	0.0%
Unknown	0	0.0%
TOTAL:	20	100.0%

Findings:

- African American children with a current or prior CPS history died at a disproportionately higher rate than other races in 2005, based on the statewide child and adolescent population data reviewed throughout this report. African Americans represent 8.5% of the state's population, yet account for 15% of child deaths with a CPS history.

Manner of Death – CPS Involved



Manner of Death:	Total CPS Involved:	Percentage of Total CPS Involved by Manner:	Percentage of Statewide Total by Manner:
Natural	10	50.0%	66.4%
Accidental	1	5.0%	19.8%
Homicide	5	25.0%	5.7%
Suicide	1	5.0%	4.4%
Undetermined	3	15.0%	3.6%
TOTAL:	20	100.0%	100.0%

Findings:

- Children with a current or prior CPS history died at a disproportionately higher rate by homicide in 2005, when compared with statewide data. Similarly, an undetermined manner of death was disproportionately high for children who were CPS involved.

Individual Case Detail

Ref:	Cause:	Age Group:	Gender:	Race:	County:
1	Natural	Under 1	Male	Hispanic	Clark
2	Natural	Under 1	Male	White	Clark
3	Natural	Under 1	Female	Black	Clark
4	Unknown	Under 1	Female	White	Clark
5	Homicide – neglect	Under 1	Female	Hispanic	Elko

Ref:	Cause:	Age Group:	Gender:	Race:	County:
6	SIDS	Under 1	Male	Hispanic	Unknown
7	Natural	Under 1	Male	Hispanic	Clark
8	Maternal drug	Under 1	Female	White	Clark
9	Natural	Under 1	Female	White	Clark
10	Unknown	Under 1	Female	White	Clark
11	Unknown	Under 1	Female	White	Washoe
12	Natural	Under 1	Female	Hispanic	Unknown
13	Homicide – other	1 – 4	Male	Black	Clark
14	Natural	1 – 4	Male	Asian	Clark
15	Natural	1 – 4	Male	White	Washoe
16	Homicide – abuse	1 – 4	Male	Hispanic	OOS
17	Homicide – other	1 – 4	Male	Hispanic	Elko
18	Homicide – neglect	5 – 9	Male	White	Elko
19	Natural	10 – 14	Female	Black	Clark
20	Suicide - asphyxia	10 – 14	Male	White	Washoe

Findings:

- Out of 12 homicides caused by abuse and neglect, based on regional CDR team data, one abuse case and two neglect cases were for children with a current or prior CPS history.
- For the two homicides by other causes, in the 1 – 4 age group, poor or absent supervision by the children’s caregivers was the cause in one case, and a contributing factor in another.
- Maternal drug use accounts for one death among children with a current or prior CPS history. Additional detail on deaths resulting from maternal drug use is provided below under *Review: Maternal Drug Use*.
- SIDS accounts for one death among children with a current or prior CPS history. Additional detail on SIDS deaths is provided below under *Review: Sudden Infant Death Syndrome (SIDS)*.

Residence Type

Ref:	Residence Type:	Ref:	Residence Type:
1	Licensed foster home	11	Unknown
2	Parental home	12	Parental home
3	Licensed foster home	13	Parental home
4	Parental home	14	Unknown
5	Other – Unlicensed Child Care	15	Parental home
6	Parental home	16	Unknown
7	Parental home	17	Unknown
8	Parental home	18	Unknown
9	Licensed foster home	19	Licensed foster home
10	Other – Hospice	20	Unknown

Findings:

- Most children with a current or prior CPS history died in their parental home, for a total of eight out of 20.
- Four children with a current or prior CPS history died in a licensed foster care home.

Review: Sudden Infant Death Syndrome (SIDS)

SIDS deaths are required for regional CDR team review by NRS 432B.405, and so data gathered by the regional CDR teams for this cause of death should be representative of statewide data.

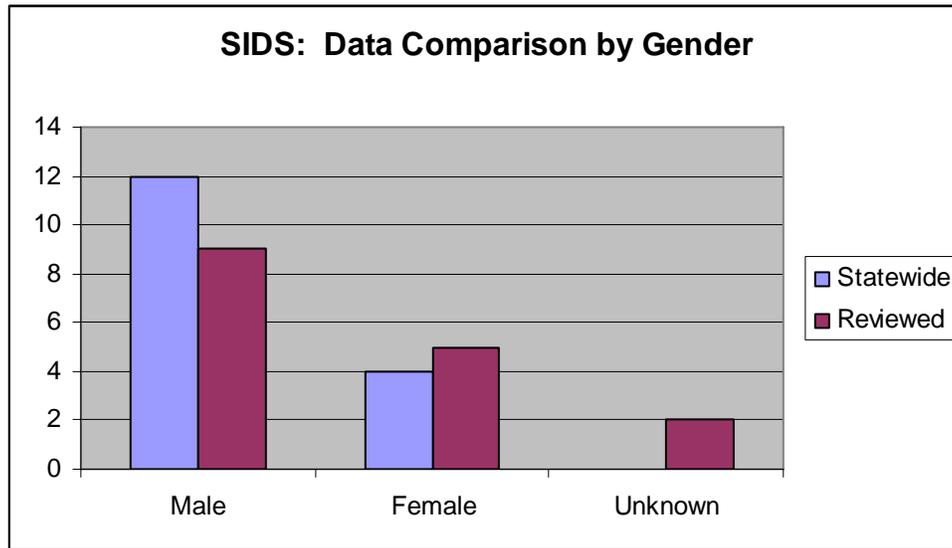
When ranked in conjunction with other leading causes of death, SIDS is the fifth leading cause of child death after suicides. However, there is no known cause for SIDS, although it is associated with several risk factors, discussed below under *Contributing Factors*.

Age – SIDS

By definition, all SIDS deaths occur in infants less than one year of age.³⁰

³⁰ Centers for Disease Control and Prevention. (2007). *Sudden Infant Death Syndrome (SIDS): Home*. Retrieved February 19, 2007, from <http://www.cdc.gov/SIDS/index.htm>.

Gender – SIDS

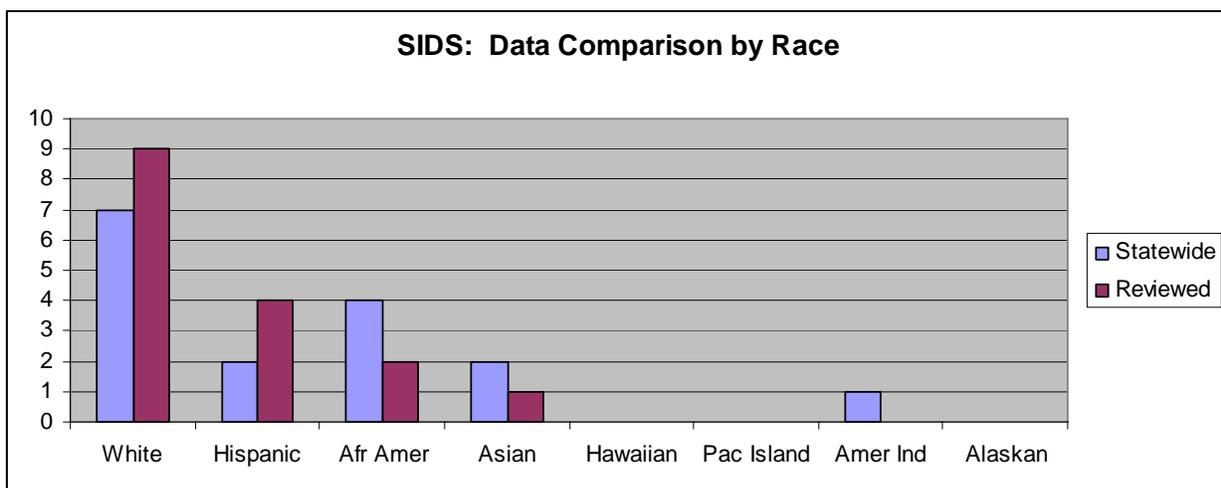


Data Source:	Male:	Female:	Unknown:	Male Percentage:	Female Percentage:	Unknown Percentage:
Statewide	12	4	0	75.0%	25.0%	0.0%
Reviewed	9	5	2	56.3%	31.3%	12.5%

Findings:

- There are discrepancies between the statewide data and regional CDR team data for female victims of SIDS, and for unknown gender.

Race – SIDS



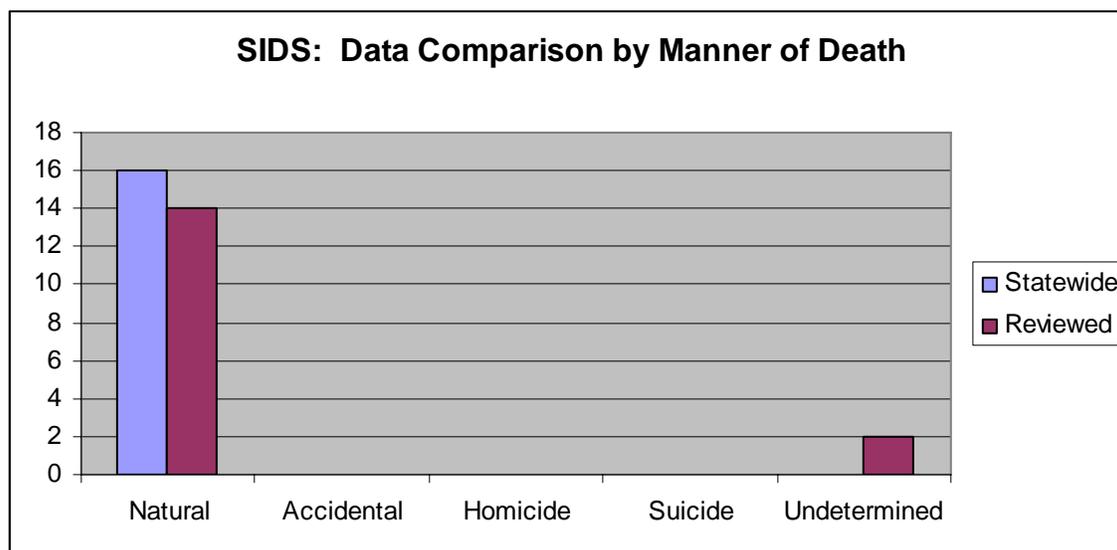
Data Source:	White:	Hispanic:	African American:	Asian:	Native Hawaiian
Statewide	7	2	4	2	n/a
Reviewed	9	4	2	1	0

Data Source:	Pacific Islander:	American Indian:	Native Alaskan:
Statewide	n/a	1	n/a
Reviewed	0	0	0

Findings:

- There are considerable discrepancies between the statewide data and regional CDR team data for all race categories.
- Based on statewide data, SIDS deaths for African American infants are disproportionately high, accounting for 25% of all deaths caused by SIDS, while representing 8.5% of the statewide child and adolescent population distribution.

Manner of Death – SIDS



Data Source:	Natural:	Accidental:	Homicide:	Suicide:	Undetermined:
Statewide	16	0	0	0	0
Reviewed	14	0	0	0	2

Findings:

- There are discrepancies between the statewide data and regional CDR team data for undetermined manner of death, with two classifications of SIDS in this category for the regional CDR team data. Both cases with an undetermined manner of death have many characteristics of SIDS, although this was not concluded to be the definitive cause of death by the regional CDR teams.

Contributing Factors – SIDS

Total cases reviewed: 16	<u>County of residence:</u>	<u>Reviewed by team:</u>
	Clark County total: 11	Clark Team: 12
	Humboldt County total: 1	Elko Team: 1
	Lyon County total: 1	Fallon Team: 1
	Washoe County total: 2	Washoe Team: 2
	Unknown County total: 1	

Factor:	Detail:
Place of death:	Child’s home: 13 Licensed foster care home: 1 Licensed child care home: 1 Incomplete: 1
911 called?	Yes: 16 No: 0 Incomplete: 1
CPR performed before emergency medical services (EMS) arrived?	Yes: 12 No: 2 Unknown: 1 Incomplete: 1
EMS arrived on scene?	Yes: 13 No: 1 Unknown: 1 Incomplete: 1

Factor:	Detail:
Child's activity at time of death:	Sleeping: 14 Unknown: 1 Incomplete: 1
CPS record check conducted as a result of the death?	Yes: 10 No: 2 Unknown: 3 Incomplete: 1
Investigation found evidence of prior abuse?	Yes: 0 No: 11 Unknown: 4 Incomplete: 1
Child exposed to second-hand smoke?	Yes: 1 Frequency for yes: Occasionally No: 6 Unknown: 7 Incomplete: 2
Child was overheated?	Yes: 0 No: 4 Unknown: 10 Incomplete: 2
Child history of seizures?	Yes: 0 No: 11 Unknown: 3 Incomplete: 2
Child history of apnea?	Yes: 0 No: 10 Unknown: 4 Incomplete: 2
Sleeping location for incident:	Parent's bed: 1 Queen bed: 2 Full-size mattress: 6 Crib: 3 Bassinette: 3 Incomplete: 1

Factor:	Detail:
Position child was put to sleep:	Back: 5 Stomach: 3 Side: 2 Unknown: 5 Incomplete: 1
Position child was found:	Back: 5 Stomach: 6 Side: 0 Unknown: 3 Incomplete: 2
Child's usual sleeping place:	Queen bed: 0 Full-size mattress: 4 Crib: 4 Bassinet: 3 Unknown: 4 Incomplete: 1
Child's usual sleeping position:	Back: 5 Stomach: 2 Side: 1 Unknown: 6 Incomplete: 2
Child in new environment?	Yes: 2 No: 7 Unknown: 6 Incomplete: 1
Sleeping environment when child was found:	Face and body unobstructed: 8 On face: 1 On side: 1 Between parents: 1 Pressed into mattress: 1 Pressed into pillow: 1 Unknown: 1 Incomplete: 2
Child fell asleep while feeding?	Yes: 4 No: 8 Unknown: 3 Incomplete: 1

Factor:	Detail:
Child sleeping with other people or animals?	Adults only: 6 Adults and children: 2 Children only: 1 Unknown: 4 Incomplete: 3
Did the death occur as a consequence of a problem with a consumer product?	Yes: 0 No: 13 Unknown: 0 Incomplete: 3
Did the death occur during a commission of a crime other than the incident causing the death?	Yes: 0 No: 15 Unknown: 0 Incomplete: 1

Information on SIDS risk reduction is included in Appendix A of this report.

Review: Maternal Drug Use

Statewide data showed no deaths by maternal drug use in 2005, therefore statewide comparison data cannot be used. Regional CDR team data showed a total of four deaths caused by maternal drug use.

Individual Case Detail

Ref:	Manner:	Age Group:	Gender:	Race:	County:
1	Accidental	Under 1	Female	Hispanic	Clark
2	Accidental	Under 1	Male	White	Clark
3	Accidental	Under 1	Female	White	Clark
4	Natural	Under 1	Female	White	Elko

Contributing Factors – Maternal Drug Use

Factor:	Detail:
Caregiver has a history of drug use?	Ref 1: Yes, methamphetamine Ref 2: Unknown Ref 3: Yes, methamphetamine and prescription drugs Ref 4: Yes, alcohol, methamphetamine, and prescription drugs

Factor:	Detail:
Caregiver has a history of child maltreatment?	Ref 1: Unknown Ref 2: Yes, neglect as a victim Ref 3: Unknown Ref 4: Unknown
Caregiver has prior child deaths?	Ref 1: No Ref 2: No Ref 3: Unknown Ref 4: No
Caregiver has delinquent criminal history?	Ref 1: Yes, drugs Ref 2: Unknown Ref 3: Unknown Ref 4: Yes, drugs
Toxicology screen completed on child?	Ref 1: Yes, positive for methamphetamine Ref 2: Unknown Ref 3: Unknown Ref 4: Yes, positive for methamphetamine
Primary cause of death:	Ref 1: Acute methamphetamine intoxication due to maternal drug use. Ref 2: Abruption of placenta; mother smoked cocaine during pregnancy. Ref 3: Stillborn due to mother's drug use during pregnancy. Ref 4: Maternal methamphetamine intoxication.

Prematurity and Other Perinatal Conditions

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

In 2005, a total of 11 child deaths reviewed were caused by prematurity or other perinatal conditions:

Ref:	Manner:	Age Group:	Gender:	Race:	County:
1	Natural	Under 1	Male	White	Clark
2	Natural	Under 1	Female	White	Clark
3	Natural	Under 1	Male	White	Washoe
4	Natural	Under 1	Female	White	Clark
5	Natural	Under 1	Male	White	Clark
6	Natural	Under 1	Female	Hispanic	Unknown
7	Natural	Under 1	Female	Amer Indian	Elko
8	Natural	Under 1	Male	White	Humboldt
9	Natural	Under 1	Male	White	Clark
10	Natural	Under 1	Female	White	Clark
11	Natural	Under 1	Female	Amer Indian	Elko

Contributing Factors – Prematurity and Other Perinatal Conditions

For all of the information below, the caregiver is the biological mother of the child except for reference case six, in which the child was placed in a foster home:

Factor:	Detail:
Caregiver has a history of drug use?	Ref 1: Yes, cocaine, methamphetamine, and other street drugs Ref 2: Yes, methamphetamine Ref 3: No Ref 4: Yes, methamphetamine Ref 5: No Ref 6: No Ref 7: Yes, alcohol and other street drugs Ref 8: No Ref 9: Unknown Ref 10: Yes, methamphetamine Ref 11: Yes, alcohol and methamphetamine
Caregiver has a history of child maltreatment?	Ref 1: Incomplete Ref 2: Yes, physical abuse as a victim Ref 3: No Ref 4: Yes, neglect as a perpetrator Ref 5: Unknown Ref 6: Yes, sexual abuse as a victim Ref 7: Yes, neglect as a perpetrator Ref 8: No Ref 9: Unknown Ref 10: Yes, neglect as a perpetrator

Factor:	Detail:
Caregiver has prior child deaths?	Ref 11: No Ref 1: Incomplete Ref 2: Yes Ref 3: No Ref 4: No Ref 5: No Ref 6: Unknown Ref 7: No Ref 8: Yes Ref 9: Unknown Ref 10: No Ref 11: No
Caregiver has delinquent criminal history?	Ref 1: Incomplete Ref 2: Unknown Ref 3: Unknown Ref 4: Incomplete Ref 5: Unknown Ref 6: No Ref 7: Yes, drugs Ref 8: No Ref 9: Unknown Ref 10: Unknown Ref 11: Unknown
Toxicology screen completed on child?	Ref 1: Yes, positive for cocaine, methamphetamine, and other street drugs Ref 2: Yes, positive for methamphetamine Ref 3: No Ref 4: Unknown Ref 5: Unknown Ref 6: Yes, unknown results Ref 7: Unknown Ref 8: No Ref 9: No Ref 10: Unknown Ref 11: Yes, negative
Primary cause of death:	Ref 1: Prematurity Ref 2: Prematurity Ref 3: Prematurity Ref 4: Prematurity Ref 5: Prematurity Ref 6: Prematurity

Factor:	Detail:
	Ref 7: Prematurity Ref 8: Prematurity Ref 9: Other perinatal condition: spontaneous abortion Ref 10: Other perinatal condition: intrauterine fetal demise Ref 11: Other perinatal condition: pulmonary hypoplasia

Findings:

- In more than half the cases, the primary caregiver had a history of drug use.
- In almost half the cases, the primary caregiver had a history of child maltreatment, either as a victim or as a perpetrator.
- In only four of the cases was a toxicology screen completed on the child, with two of the four showing positive results.

Section 3: Recommendations Based on Data Findings

Suicide

Recommendation 1: The high rate of completed suicides by females for the past two years suggests that specific outreach to pre-teen and teen females in Nevada should be considered in order to improve statewide suicide prevention efforts.

Background: Females in Nevada committed suicide at a close rate with males in 2005. This is notably inconsistent with national data, which shows that males have suicide rates over four times greater than females throughout the lifespan. However, in 2004, females in Nevada committed suicide at almost twice the rate of males, which means that the gender distribution for suicide has decreased over a two-year period. A multi-year trend analysis may show that males in Nevada commit suicide at a greater rate overall when compared to females over time.

Recommendation 2: The high rate of completed suicides by youth ages 10 – 14 suggests that specific outreach to pre-teen and teen youth in Nevada should be considered in order to improve statewide suicide prevention efforts. Outreach and educational efforts should also be considered for parents and guardians of children in this age group, as well as others who play a significant role in their lives, such as teachers or counselors.

Background: In 2004, there were a total of three suicides in the 10 – 14 age group. In 2005, this increased to a total of five. The Executive Committee supports early prevention efforts for pre-teen and teen youths in order to help decrease the number of completed suicides in this younger age group.

Recommendation 3: A formal interface with tribal governments, tribal healthcare systems, and Indian Health Services (IHS) in the state should be considered in order to obtain more complete data surrounding suicide.

Background: National data shows that the highest suicide rates for both males and females are among American Indians. Given Nevada's indigenous American Indian population, the one reported suicide among American Indians for 2005 may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported.

Accidents – Asphyxia Deaths Caused by Co-Sleeping

Recommendation 4: There is a demonstrated need for continued prevention efforts related to the dangers of parents and siblings co-sleeping with infants and young children, along with the promotion of safe sleeping environments.

Background: In 2004, there were a total of five asphyxia deaths associated with co-sleeping. In 2005, there were a total of four. The Executive Committee supports ongoing public awareness, education, and prevention efforts for families with infants and young children in order to help decrease the number of deaths associated with co-sleeping.

Data Collection

Recommendation 5: There is a demonstrated need for increased data entry training and/or additional case detail gathering through the regional CDR process that should be addressed with available training funds and staff resources.

Background: Review of motor vehicle accident (MVA) data demonstrates a high number of unknown vehicle types in the data for position of child by vehicle type. Additionally, there is a small amount of information available for MVA protective measures, out of 36 cases reviewed. Similarly, review of gunshot wound (GSW) data demonstrates a high number of unknown and incomplete entries for risk factors. This is also true for suicide risk factors as well.

The Executive Committee recognizes two important factors related to this recommendation: 1) 2005 was the first year the new national data instrument was used, and the regional CDR teams may need additional time to familiarize themselves with all of the data sections in order to fully utilize the instrument. 2) The lack of available data may also suggest that more information needs to be gathered by accident investigators, or that law enforcement's involvement in the regional CDR team process may need to be increased.

Recommendation Follow-Up

The Executive Committee to Review the Death of Children will follow up on the above recommendations within its available resources and lawful authority. Recommendations may be referred to the Administrative Team to Review the Death of Children, if appropriate, and collaborations may be established with other agencies and organizations in order to complete actions related to the recommendations.

Appendix A

SIDS Risk Reduction

The American Academy of Pediatrics (AAP) identifies 11 recommendations to reduce the primary risk factors that are associated with SIDS deaths, although the cause is unknown:³¹

1. **Back to sleep:** Infants should be placed for sleep in a supine position (wholly on the back) for every sleep. Side sleeping is not as safe as supine sleeping and is not advised.
2. **Use a firm sleep surface:** Soft materials or objects such as pillows, quilts, comforters, or sheepskins should not be placed under a sleeping infant. A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
3. **Keep soft objects and loose bedding out of the crib:** Soft objects such as pillows, quilts, comforters, sheepskins, stuffed toys, and other soft objects should be kept out of an infant's sleeping environment. If bumper pads are used in cribs, they should be thin, firm, well secured, and not "pillow-like." In addition, loose bedding such as blankets and sheets may be hazardous. If blankets are to be used, they should be tucked in around the crib mattress so that the infant's face is less likely to become covered by bedding. One strategy is to make up the bedding so that the infant's feet are able to reach the foot of the crib (feet to foot), with the blankets tucked in around the crib mattress and reaching only to the level of the infant's chest. Another strategy is to use sleep clothing with no other covering over the infant or infant sleep sacks that are designed to keep the infant warm without the possible hazard of head covering.
4. **Do not smoke during pregnancy:** Maternal smoking during pregnancy has emerged as a major risk factor in almost every epidemiologic study of SIDS. Smoke in the infant's environment after birth has emerged as a separate risk factor in a few studies, although separating this variable from maternal smoking before birth is problematic. Avoiding an infant's exposure to second-hand smoke is advisable for numerous reasons in addition to SIDS risk.
5. **A separate but proximate sleeping environment is recommended:** The risk of SIDS has been shown to be reduced when the infant sleeps separately in the same room as the mother. A crib, bassinet, or cradle that conforms to the safety standards of the Consumer Product Safety Commission and ASTM (formerly the American Society for Testing and Materials) is recommended. Although bed-sharing rates are increasing in the United States for a number of reasons, including facilitation of breastfeeding, the task force concludes that the evidence is growing that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface and, therefore, recommends that infants not bed share during sleep. Infants may be brought into bed for nursing or comforting

³¹ American Academy of Pediatrics. (2005). *PEDIATRICS Vol. 116 No. 5: The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk*. Elk Grove Village, IL: American Academy of Pediatrics.

- but should be returned to their own crib or bassinet when the parent is ready to return to sleep. The infant should not be brought into bed when the parent is excessively tired or using medications or substances that could impair his or her alertness. The task force recommends that the infant's crib or bassinet be placed in the parents' bedroom, which, when placed close to their bed, will allow for more convenient breastfeeding and contact. Infants should not bed share with other children. Because it is very dangerous to sleep with an infant on a couch or armchair, no one should sleep with an infant on these surfaces.
6. **Consider offering a pacifier at nap time and bedtime:** Although the mechanism is not known, the reduced risk of SIDS associated with pacifier use during sleep is compelling, and the evidence that pacifier use inhibits breastfeeding or causes later dental complications is not. Until evidence dictates otherwise, the task force recommends use of a pacifier throughout the first year of life according to the following procedures: 1) The pacifier should be used when placing the infant down for sleep and not be reinserted once the infant falls asleep. If the infant refuses the pacifier, he or she should not be forced to take it. 2) Pacifiers should not be coated in any sweet solution. 3) Pacifiers should be cleaned often and replaced regularly. 4) For breastfed infants, delay pacifier introduction until 1 month of age to ensure that breastfeeding is firmly established.
 7. **Avoid overheating:** The infant should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult. Overbundling should be avoided, and the infant should not feel hot to the touch.
 8. **Avoid commercial devices marketed to reduce the risk of SIDS:** Although various devices have been developed to maintain sleep position or to reduce the risk of rebreathing, none have been tested sufficiently to show efficacy or safety.
 9. **Do not use home monitors as a strategy to reduce the risk of SIDS:** Electronic respiratory and cardiac monitors are available to detect cardiorespiratory arrest and may be of value for home monitoring of selected infants who are deemed to have extreme cardiorespiratory instability. However, there is no evidence that use of such home monitors decreases the incidence of SIDS. Furthermore, there is no evidence that infants at increased risk of SIDS can be identified by in-hospital respiratory or cardiac monitoring.
 10. **Avoid development of positional plagiocephaly:** 1) Encourage "tummy time" when the infant is awake and observed. This will also enhance motor development. 2) Avoid having the infant spend excessive time in car-seat carriers and "bouncers," in which pressure is applied to the occiput. Upright "cuddle time" should be encouraged. 3) Alter the supine head position during sleep. Techniques for accomplishing this include placing the infant to sleep with the head to one side for a week and then changing to the other and periodically changing the orientation of the infant to outside activity (e.g., the door of the room). 4) Particular care should be taken to implement the aforementioned recommendations for infants with neurologic injury or suspected developmental delay. 5) Consideration should be given to early referral of infants with plagiocephaly when it is evident that conservative measures have been ineffective. In some cases, orthotic devices may help avoid the need for surgery.

11. **Continue the Back to Sleep campaign:** Public education should be intensified for secondary care-givers (child care providers, grandparents, foster parents, and babysitters). The campaign should continue to have a special focus on the black and American Indian/Alaska Native populations. Health care professionals in intensive care nurseries, as well as those in well-infant nurseries, should implement these recommendations well before an anticipated discharge.

Appendix B

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
- Collecting data and completing trends analysis surrounding child death
- Reviewing laws, policies, and practices
- Addressing statewide staff training needs
- Addressing public awareness and education needs

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

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

1. Clark Team: covers Clark County
2. Washoe Team: covers Washoe County
3. Fallon Team: covers Carson, Churchill, Douglas, Lyon, Pershing, and Storey Counties
4. Elko Team: covers Elko, Eureka, Humboldt, Lander, Lincoln (shared), and White Pine Counties
5. Pahrump Team: covers Esmeralda, Lincoln (shared), 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, most of the regional teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. In Clark County, the team meets monthly because of its high caseload. In the rural region, the regional teams may meet less often if coroners' reports are not received within a given quarter.

During 2002, the Statewide CDR Subcommittee developed recommendations for new laws relating to child death review. A primary goal was to give the 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. 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.

Appendix C

Child Death Review Team Members

Clark County Team

Campbell, Elena <i>Nellis Air Force Base</i>	Monohan, Lt. Tom <i>LVMPD Homicide</i>
Cosgrove, Jeannie <i>Safe Kids Coalition</i>	Murphy, Michael <i>Clark County Coroner's Office</i>
Courtney, Francis <i>Public Health</i>	New, Judy <i>Clark County Department of Family Services CPS</i>
Cummings, Karen <i>Special Children's Clinic</i>	Rader, Vicki <i>Clark County Department of Family Services CPS</i>
Eisen, Andrew M.D. <i>University of Nevada School of Medicine</i>	Sauchak, Cyndi <i>LVMPD Abuse/Neglect Unit</i>
Fanning, Maureen <i>Public Health</i>	Schmidt, Edith M.D. <i>Sunrise Hospital</i>
Hancock, Marion <i>Sunrise Hospital</i>	Sigdestad, Karin M.D. <i>Special Children's Clinic</i>
Herndon, Doug <i>District Attorney's Office</i>	Simms, Larry M.D. <i>Coroner's Office</i>
Lipscomb, Diane M.D. <i>Sunrise Hospital</i>	Worrell, Rexene <i>Coroner's Office</i>
Magleby, Suzanne <i>Clark County Department of Family Services</i>	Zbiegien, Michael M.D. <i>Sunrise Hospital</i>
Martin, Jon <i>North Las Vegas Police</i>	
Mehta, Neha M.D. <i>Sunrise Hospital</i>	

Washoe County Team

Clark, Ellen M.D.

Washoe Medical Center

Kohls, Joanne

Washoe Medical Center

Druckman, Rebecca

Washoe County Deputy District Attorney

Lucier, Michelle

Washoe County Department of Social Services

Evans, Doug

Reno Police Department

Marsh, Jeanne

Washoe County Department of Social Services

Frank, Barry

Washoe Medical Center

Mayeroff, Meredith

Washoe County Department of Social Services

Fricke, Carolyn

Washoe County School District

McCarty, Vernon

Washoe County Coroner

Gavin, Art

Paramedic

McDonald, Bill

CASA

Hayden, Kelly

Washoe County Sheriff's Office

Miller, Tom

Sparks Police Department

Hunter, Candace

Washoe County District Health Department

Olsen, Alane

Washoe County Coroner's Office

Fallon Team

>> Covers Carson, Churchill, Douglas, Lyon, Pershing, and Storey Counties

Churchill County:

Bowmer, Linda

Youth Parole Officer

Richardson, Tami

Juvenile Probation

Coke, Dolly

Fallon Mental Health

Shyne, Frank

Fallon Police Department

East, Ray

Fallon Paiute Law Enforcement

Smith, Russell

Churchill County District Attorney

Ingram, Richard

Churchill County Sheriff's Office

Stadler, Shelly

Churchill Community Hospital

Mallory, Art
District Attorney

McDonald, Arlene
Churchill Community Hospital

Phillips, Bob
Churchill School District

Richardson, James
Adult Parole and Probation

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

Kollege, Jan
Mt. Grant General Hospital

Montoya, Julian
Mental Health Counselor

Munger, Richard
Mt. Grant General Hospital

Oberhansil, Sandy
Juvenile Probation Department

Stuart, Jim
Churchill County Sheriff's Office

Syriac, Shelly
Churchill Community Hospital

Warner, Richard
Fallon Naval Criminal Investigative Services

Hagen, Steve
Juvenile Probation

Hoferer, Rob
Mineral County Sheriff's Department

Horton, Charlie
CAHS

Jackson, Joann
Family Resource Center

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

Elko Team

>> Covers Elko, Eureka, Humboldt, Lander, Lincoln (shared), 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

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

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

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

Pahrump Team

>> Covers Esmeralda, Lincoln (shared), Mineral, and Nye Counties

NOTE: The Pahrump CDR Team was not established until December, 2005, and all 2005 child deaths for this region were referred for review by the Clark CDR Team.