NEVADA CHILD DEATH REVIEW REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: **Washoe**
Clark
Elko
Carson
Fallon
Pahrump

Contact Person:

Calendar Quarter: **QTR 1 (JAN – MAR)**
QTR 2 (APR – JUN)
QTR 3 (JUL – SEP)
QTR 4 (OCT – DEC)

Date Completed:
7/10/2022

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	14
Actual cases reviewed for the current quarter by manner of death:	
Natural	4
Accidental	2
Homicide	1
Suicide	1
Undetermined	6
TOTAL cases reviewed:	14

Mandatory Reviews Per NRS 432B.405:

(1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;	
(2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;	
(3) If the death is alleged to be from abuse or neglect of the child;	
(4) If a sibling, household member or daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including cases in which the report was unsubstantiated or the investigation is currently pending;	
(5) If the child was adopted through an agency which provides child welfare services; or	
(6) If the child died of Sudden Infant Death Syndrome.	4
Cases for which more than one of the above apply:	4

— Recommendations to Administrative Team —

Recurring Recommendations:

Please indicate if there were cases reviewed in the previous quarter or ongoing concerns regarding leading causes of death in Nevada and targeted areas for CDR as follows:

Accidental	Comments:
MVA	Washoe reviewed two motor vehicle accident deaths
Drowning	Washoe reviewed on accidental drowning
Asphyxia, co-sleeping or unsafe sleep environment	Washoe reviewed four cases which had correlation to co-sleeping/unsafe sleep.
Asphyxia, all others	
Accidents, all others	Washoe reviewed one accidental overdose
Homicide	**Comments:**
GSW	
Abuse	
Neglect	
Shaken Baby Syndrome	
Homicides, all others	Washoe reviewed one stabbing homicide case.
Suicide	**Comments:**
Asphyxia	
GSW	Washoe reviewed one suicide by gunshot wound.
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	
Natural deaths, all others	Washoe reviewed 4 natural deaths by illness which had a fatal prognosis.
Undetermined	**Comments:**
Undetermined	

New Recommendations:

Recommendations should relate to specific observations and conclusions drawn from the case review process. Please prioritize your recommendations to those in which 3 or more cases this quarter, or cumulatively, demonstrate a trend related to this specific recommendation. If no trend has been identified but the team feels the recommendation must be made, the Administrative Team will assess and determine priority status. Please do not submit recommendations that have been previously identified unless additional gaps relating to this recommendation have occurred. The recommendation format is as follows:

Recommendation 1:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:
Washoe County reviewed three cases involving accidental deaths with unsafe sleep environments. There have been past recommendations regarding education for the public for safe sleep which are still in place, however, Washoe is looking to expand education.
Define the problem by summarizing related risk factors and required protective factors:
The death review team has determined that individual discussions and education is most effective when helping parents understand the importance of safe sleep.
Provide related case data: Is there more than one case or additional data that substantiates this problem?
Washoe County has reviewed 4 cases related to unsafe sleep in the last quarter. There is ongoing data to support that unsafe sleep deaths are reviewed each quarter.
Concisely state the recommendation for change:
Request local pediatricians to provide safe sleep education as recommended by the AAP.
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
The team is recommending that education be provided to all families with new infants by their pediatrician's office. Statistics need to be shared with pediatricians regarding how common unsafe sleep deaths are in Washoe County.
Identify existing community or statewide efforts the Team are aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:
CPS workers and hospital staff are providing this education already in the community, looking to expand it to increase the amount of education going into the community.
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?
All pediatric offices of Washoe County.

Change focus: Please place an X to indicate on what type of change(s) this recommendation focuses.

X	Strengthening parent/caregiver knowledge and skills
X	Public awareness and promoting community education
X	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

Recommendation 2:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:

Washoe County reviewed three cases involving unsafe sleep environments. There have been past recommendations regarding education for the public for safe sleep, however, Washoe is looking to provide statistics on safe sleep education literature.
Define the problem by summarizing related risk factors and required protective factors:
During conversations with families who are victims of safe sleep deaths, the team has determined that although parents know about safe sleep, they dismiss it because they don't believe it can happen to them. The public doesn't have a good understanding of the commonality of unsafe sleep deaths.
Provide related case data: Is there more than one case or additional data that substantiates this problem?
Washoe continues to review unsafe sleep deaths, including 4 this quarter.
Concisely state the recommendation for change:
Recommendation to add state-specific statistics to Nevada Cribs for Kids brochures and literature.
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
Revise safe sleep information and brochures to provide statistic information.
Identify existing community or statewide efforts the Team are aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:
Additional information added to education literature
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?
Cribs for Kids

Change focus: Please place an X to indicate on what type of change(s) this recommendation focuses.

X	Strengthening parent/caregiver knowledge and skills
X	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation

Recommendation 3:

Brief summary of case details that led to this recommendation. Please be reminded that no specific identifying information or details compromising confidentiality should be included:
Define the problem by summarizing related risk factors and required protective factors:
Provide related case data: Is there more than one case or additional data that substantiates this problem?
Concisely state the recommendation for change:
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
Identify existing community or statewide efforts the Team are aware of that may already be contributing to the change. Please provide staff names and contact information where applicable for known programs:
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Change focus: Please place an X to indicate on what type of change(s) this recommendation focuses.

	Strengthening parent/caregiver knowledge and skills
	Public awareness and promoting community education
	Educating child welfare staff, service providers, law enforcement, and/or others
	Changing organizational policies and practices
	Fostering coalitions and networks
	Mobilizing neighborhoods and communities
	Influencing laws and legislation