NEVADA CHILD DEATH REVIEW REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: **Washoe**
Clark
Rural Region

Contact Person:
Dawn L. Davidson

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

Date Completed: **June 15, 2021**

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	140
Actual cases reviewed for the current quarter by manner of death:	
Natural	109
Accidental	14
Homicide	9
Suicide	5
Undetermined	3
TOTAL cases reviewed:	140

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;	0
(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;	1
(3) If the death is alleged to be from abuse or neglect of the child;	8
(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
(5) If the child was adopted through an agency which provides child welfare services; or	0
(6) If the child died of Sudden Infant Death Syndrome.	0
Cases for which more than one of the above apply:	2

— 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	2 cases reviewed during this quarter were due to a motor vehicle accident.
Drowning	4 cases reviewed during this quarter were due to drowning.
Asphyxia, co-sleeping or unsafe sleep environment	3 cases reviewed during this quarter were due to unsafe sleep.
Asphyxia, all others	1 case was reviewed in which positional asphyxia was the result of a seizure, which caused her to remain in a compromising breathing position.
Accidents, all others	2 cases reviewed during this quarter was due to Fentanyl Intoxication. The team is in contact with the Narcotics Task Force to track spikes in Fentanyl deaths and trace sources of Fentanyl.
Homicide	**Comments:**
GSW	3 cases reviewed during this quarter were due to gunshot wounds.
Abuse	5 cases reviewed during this quarter were due to blunt force injury.
Neglect	
Shaken Baby Syndrome	
Homicides, all others	
Suicide	**Comments:**
Asphyxia	3 cases reviewed during this quarter used hanging as a mechanism.
GSW	2 cases reviewed during this quarter used firearms as a mechanism.
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	
Natural deaths, all others	2 cases reviewed during this quarter were a result of insufficiently/inappropriately treated asthma.
Undetermined	**Comments:**
Undetermined	1 undetermined case reviewed includes an infant that was placed in an unsafe sleep position and/or an unsafe sleep environment.

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:
This quarter, a homicide case was reviewed in which the mother, the perpetrator, had been diagnosed with postpartum depression and "short psychosis" with hallucinations and homicidal ideation.
Define the problem by summarizing related risk factors and required protective factors:
Related risk factors include 1) Children in custody of parents or guardians diagnosed with severe postpartum depression/psychosis, especially if they display homicidal threats and ideations. Protective factors include: 1) Monitoring parents with postpartum depression/psychosis.
Provide related case data: Is there more than one case or additional data that substantiates this problem?
There was one case reviewed during this quarter that substantiates this problem; however, there have been other cases that involved homicides in which parents showed concerning behavior due to psychiatric conditions.
Concisely state the recommendation for change:
The Clark CDR Team recommends educating medical professionals including pediatricians, family practitioners, psychiatrists, psychologists, and those at behavioral health facilities on notifying Child Protective Services when a parent or guardian is diagnosed with severe postpartum depression/psychosis, even if there are no explicit verbalizations that threaten the child.
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
Collaboration with medical professionals to implement protective factors if a child's parent or guardian is diagnosed with postpartum depression/psychosis or other concerning psychiatric conditions.
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:
Child Protective Services and social work safety assessments already exist to help monitor families at risk of abuse and neglect.
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?
This recommendation should be focused on medical professionals that treat children and families.

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
X	Educating child welfare staff, service providers, law enforcement, and/or others
X	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:
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

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
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