NEVADA CHILD DEATH REVIEW REGIONAL MDT QUARTERLY SUMMARY REPORT AND RECOMMENDATIONS

Team: **Washoe**
Clark
Rural Region

Contact Person:

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

Date Completed: **July 13, 2021**

Quarterly Statistics:

Total cases referred to the team for review for the current quarter:	12
Actual cases reviewed for the current quarter by manner of death:	
Natural	2
Accidental	5
Homicide	0
Suicide	3
Undetermined	2
TOTAL cases reviewed:	12

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;	0
(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;	1
(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:	1

— 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 County reviewed a case in which a child was in the back of a vehicle when another vehicle ran a red light at extremely high speeds and hit the vehicle.
Drowning	
Asphyxia, co-sleeping or unsafe sleep environment	
Asphyxia, all others	Washoe County reviewed a case in which an infant was laying on his back in the living room and an older sibling (toddler) was sitting/ bouncing on the infant's chest.
Accidents, all others	Washoe County reviewed three accidental overdose cases: Washoe County reviewed a case in which a teenaged male purchased what he believed was a Percocet pill from a local drug dealer. His toxicology test was positive for fentanyl and cause of death was a fentanyl overdose. Washoe County reviewed a case in which a teenager was found unresponsive in a local motel room. He had extremely high toxicology levels of fentanyl at the time of death. Washoe County reviewed a case in which a teenager had been found unresponsive in the morning after sleeping on the couch. Her toxicology screen came back negative. Medical examiner's office reported that the Yew tree is extremely poison except for the outer coating of the berries; Yew tree was found in her system.
Homicide	**Comments:**
GSW	
Abuse	
Neglect	
Shaken Baby Syndrome	
Homicides, all others	
Suicide	**Comments:**
Asphyxia	2 cases reviewed during this quarter used hanging as a mechanism.
GSW	1 case reviewed during this quarter used firearms as a mechanism.
Overdose	
Suicides, all others	
Natural	**Comments:**
Maternal drug use	
Natural deaths, all others	Washoe County reviewed a case of a child death from enlarged heart due to obesity caused by a genetic chromosomal issue Prader-Willi Syndrome.

	Washoe County reviewed a case of a child who passed away from medical complications from a Florid Lymphocytic Myocarditis (inflammation of the heart).
Undetermined	Comments:
Undetermined	Washoe County reviewed 2 incidents where co sleeping/ unsafe sleep was involved however the cause of death remains undetermined. Both of these cases involved traveling/transient families who did not have proper sleeping arrangements.

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:
The team has noticed a trend in overdoses for Fentanyl amongst the teen population. The team has identified that there is an increase in recreational use of Fentanyl amongst the population in the community.
Define the problem by summarizing related risk factors and required protective factors:
It has been identified that Fentanyl is not a part of the regular drug screen panel when testing occurs in hosptials and other settings. As the population continues to increase recreational use of Fentanyl, there has been minimal detection of this use include when infants are born positive to Fentanyl and when teens are seen in the emergency room for drug overdose.
Provide related case data: Is there more than one case or additional data that substantiates this problem?
There has been one teen fatality from what was believed to be recreational Fentanyl use. Additionally, the hospital has treated multiple teens for overdose that did not lead to death but required emergency services.
Concisely state the recommendation for change:
1. Hospital and other drug testing facilities begin to screen for Fentanyl as part of the default drug screens. 2. Increase of Narcan availability to at-risk teenage population. 3. Fentanyl drug screens are accessed when withdrawal signs are present in infants and mothers at the time of birth.
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
1. Hospitals and labs make Fentanyl drug testing part of the default drug screen panal. 2. Education of police, child welfare staff, juvenile services staff, hospital staff about the recreational use of Fentynal and dangers associated.
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:
Hospital social work has been working with hospital leadership to advocate for drug panels to include Fentanyl. WCHSA will circle back to child welfare staff to discuss Fentanyl increase in use and the option for requested testing.
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?

Recommendation format based on: Wirtz, Steve Ph.D. (2006). *Developing Effective Recommendations: Taking Findings to Action*. Sacramento, CA: Epidemiology and Prevention for Injury Control (EPIC) Branch – California Department of Health Services.

Renown Hospital, Saint Mary's Hospital, WCHSA

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:
The team reviewed a case of a child death that was sleep related of 2 young infants. The team has observed that frequently sleep related infant deaths are related to families bieng on vacation as there is less structure to their sleeping. The case reviewed this meeting, the family had been practicing safe sleep since the infant's birth, but upon visiting relatives co slept for the first time.
Define the problem by summarizing related risk factors and required protective factors:
Parents who travel with infants are more likely to co-sleep or utelize an unsafe sleeping environment due to lack of space, planning, etc.
Provide related case data: Is there more than one case or additional data that substantiates this problem?
There have been 3 recent safe sleep deaths in Washoe County where the family was on vacation or transient
Concisely state the recommendation for change:
Addition to literature and safe sleep education to include information about traveling with infants and practicing safe sleep even during travel.
Identify best practices or other solutions the Team believes are appropriate to help implement this change:
The Pack and Play is advertised as able to travel. For those who are not recipients of the cribs for kids pack and play, additional information in flyers.
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:
Recipients of cribs for kids learn about taking the pack and play while travelling.
Change partners: What persons and/or organizations does the Team believe this recommendation for change should be focused on?
Cribs for Kids, Local pediatric offices

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
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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:
Hunting weapons as danger for suicide risk and desensitivity to the concept of killing because of video game exposure. Best practices were shared from Las Vegas in regards to the outreach that has been done in the community to local gun shops. Washoe County CDR team will follow up with this next meeting to solidify recommendation.
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
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