Steve Sisolak
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF CHILD AND FAMILY SERVICES

Helping people. It's who we are and what we do.

Cindy Pitlock, DNP
Administrator

Date: June 16, 2022
To: Insert Name/Agency Here
From: Nevada Executive Committee to Review the Death of Children Sub-Committee to Collaborate with the Bureau of Health Care Quality and Compliance (HCQC)
Re: _____

The Nevada Executive Committee to Review the Death of Children (Executive Committee) was established in 1994 with the primary goal of preventing child maltreatment and child deaths in Nevada by making recommendations for law, policy and practice changes, staff training, and public education.

Recommendations are submitted to the Executive Committee by state regional multidisciplinary child death review teams. The regional review teams review the cases of child deaths in their county (NRS 432B.403) and make recommendations to the Executive Committee based on the data/trends that are found during case review. The following recommendation was presented and reviewed by the Executive Committee.

Hospitals should adopt a consistent internal policy for assessment of children when they present with suspicious or serious injuries.

The Executive Committee reached out to the Bureau of Health Care Quality and Compliance (HCQC) to see if there would be interest in collaboration with the Executive Committee to achieve this goal. HCQC agreed to participate, and a sub-committee was formed in July 2021 to explore the best approach to achieving this recommendation. It was ascertained that the primary purpose of the sub-committee was to establish a process or protocol for non-pediatric medical facilities in cases where children present to these facilities with suspicious or serious injury, to increase resources and findings to these medical facilities when needed, and then implement this process/protocol into a set of standardized policies.

The sub-committee began discussing what questions needed to be asked & answered so a policy outline could be developed. The sub-committee then sought out representation from pediatric emergency facilities across the state to assist in the development of a protocol for non-pediatric medical facilities. Through this partnership, two child abuse tip sheets were developed to assist medical providers with assessing, testing, and when to refer to a pediatric hospital. The sub-committee is now seeking input from medical providers and facilities across the state and ask that you distribute these tip sheets to your network of providers to begin using as well as providing any feedback.

We welcome further collaboration, and should you be interested in learning more, or if you have questions, please feel to join us at our next meeting, which will be held via Microsoft Teams on _____; the link to join is here _____.
If you would like to speak further about this topic, please email _____ at _____ and a representative of the sub-committee will get back to you.

Respectfully,

The Nevada Executive Committee to Review the Death of Children Sub-Committee to Collaborate with the Bureau of Health Care Quality and Compliance (HCQC)