— DRAFT —

MINUTES

of the

Executive Committee to Review the Death of Children Meeting

held on

July 21, 2021

via teleconference

Lifesize Software

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Call-in number: 1(775) 321-6111; Extension: 780-360-060#

1. Call to Order, Roll Call, Introductions

Stephanie Herrera called the meeting to order at 1:30 PM.

Executive Committee Members, Staff and Guests:

- Stephanie Herrera, DPBH - Vital Records
- Dr. Andrew Eisen, Valley Health Systems
- Paul Shubert, HCQC
- Vickie Ives, DPBH - MCH
- Lisa Sherych, DPBH
- Jessica Freeman, DFS
- Elizabeth Holka, NICRP

2. Initial Public Comment

No comments.

3. For Possible Action: Discuss and approve the next steps for the below recommendation.

- 2018 Quarter 2: Hospitals should adopt a consistent internal policy for the assessment of children when they present with suspicious or serious injuries.

Jessica Freeman opened the meeting by summarizing how the 2018 Quarter 2 recommendation developed and why this subcommittee was formed. She asked Dr. Eisen to provide the subcommittee with some context for this recommendation.

Dr. Eisen stated that the 2018 Quarter 2 recommendation was generated by the Clark County Child Death Review team after the team reviewed cases where children presented to the emergency room with obvious abusive injuries, were sent home and later succumbed to those injuries. He stated that hospitals do not have consistent policies for evaluating signs of child abuse, especially hospitals that do not have a pediatric unit. Dr. Eisen stated that he has previously attempted to gather physicians together in order to begin a discussion regarding the standardization of policies in assessing children with suspicious or serious injuries, however, it has proven to be difficult. He further stated that he has found it necessary for hospitals to develop protocols for determining if an injury qualifies as suspicious.

Dr. Eisen suggested that the Executive Committee should develop a uniform set of standardized policies for assessing suspicious or serious injuries in children that can subsequently be shared with all hospitals in the state of Nevada. Dr. Eisen also discussed making an observation that general emergency rooms seem to require of a set of standardized policies more than pediatric departments do, as pediatric departments typically have more knowledge in detecting abusive injuries in children. Due to this, he stated that Pediatric ER doctors would be a valuable resource in devising the details for this recommendation.

Paul Shubert from the Bureau of Health Care Quality and Compliance (HCQC) reiterated what he stated in a letter he submitted earlier to the Executive Committee. In summary, Paul stated that there were basically two ways to implement a set of standardized policies in assessing children who present with suspicious or serious injuries. The first way is to gain compliance through collaboration with physicians and hospital associations. Per Paul, this is the quickest and friendliest way. The second way is to have regulations approved, which would be the lengthier process of the two options. Paul added that any regulations generated from this recommendation would be well received; however, these regulations would still require work with the industry for compliance, which is why this way would entail a longer process.

Dr. Eisen interjected that these two processes are not mutually exclusive and that it is possible to collaborate with physicians while also codifying regulations. He stated that a team effort would increase buy-in for the set of policies that are ultimately developed from this recommendation. Dr. Eisen further stated that, even though it may be a lengthier process, codifying regulations for a set of standardized policies may be more appreciated by hospitals, as regulations may be easier to follow and implement. Dr. Eisen suggested that the Executive Committee begin the process of implementing policies and regulations by first creating a set of standard policies to present to hospitals and other relevant medical facilities.

Vicki Ives stated that it was also possible to leverage any existing standards and joint commissions. She gave an example of a former policy at UMC. A training used to be available for medical workers to learn how to identify abuse and neglect, however, this training was discontinued after the departure of the expert who was in charge of training everyone. Vicki stated that the Executive Committee could possibly work on reestablishing this policy in addition to other similar policies. Dr. Eisen stated that he has extensive experience in recognizing abusive injuries in children and that the expert formerly employed at UMC had previously attended his residency program. He stated that he is available and willing to help with this type of training should he be requested to do so. He also added that he helped draft the language that is in the current legislation regarding detecting and reporting child abuse and neglect.

Dr. Eisen also stated that Nevada needs standards of care, perhaps like the rest of the country. For example, there are policies in other states where if a child presents to the emergency room with suspected abuse and they have a sibling at home, especially a non-verbal sibling, that sibling is automatically assessed for abuse through a skeletal survey.

Lisa Sherych stated that engaging hospital associations for this recommendation would be highly beneficial, as they would be more enthusiastic about implementing any policies developed if they had a say so in their development. Dr. Eisen agreed with this sentiment but also suggested that, in collaborating with medical experts to develop the standard set of policies, the Executive Committee shouldn't focus exclusively on hospital associations like the NHA. He reiterated that the first step in developing and implementing a set of standardized policies was to begin by convening experts to devise

an outline in order to have something concreate to present to Nevada hospitals. He posed the following questions for the individuals who will ultimately work on developing this outline:

- What do we want to implement?
- What injuries would trigger an assessment?
- What would be included in this assessment?
- Who is notified of the findings?
- When is it necessary to transfer the child to a more specialized hospital?

Vicki Ives and Jessica Freeman volunteered to reach out to national and federal partners to see if there were any resources for creating an outline of a set of standardized policies to evaluate children who present with suspicious or serious injuries. Jessica stated that she would check the National Center for Fatality Review and Prevention for guidelines. Dr. Eisen said that the American Academy of Pediatrics has some good resources for this as well.

Paul Shubert agreed that the Executive Committee should set the foundation and outline the set of policies first, and emphasized the need to include enough expertise in the process in order to create well-informed policies. Paul stated that the first focus should be identifying the right medical care for the children who are determined to be victims of abuse.

Dr. Eisen added that the Executive Committee should request the participation of one representative from pediatric emergency facilities from across the state of Nevada to help develop an outline for this set of policies. He suggested the following facilities:

- University Medical Center
- Sunrise Hospital
- Summerlin Hospital
- St. Rose Hospital
- Renown Regional Medical Center
- Southern and Northern Regional Children's Advocacy Center
- A representative from a rural hospital

Dr. Eisen stated that after an initial outline for the set of policies is established using representatives from the above list, then the Executive Committee could inquire about bringing in professionals from additional areas of expertise for input.

Vickie Ives stated that it might be helpful to also recruit representatives from the Attorney General and District Attorney's offices for input in the proposed set of standardized policies. Dr. Eisen said that these representatives' input for the set of policies would likely facilitate prosecution in cases where abuse is detected. The DA's office may have specific input in what areas may be helpful to identify during an evaluation for abuse in order to more easily press charges once abuse is detected. However, Dr. Eisen stated that the Executive Committee should first instead focus on establishing an outline of the set of policies using more relevant medical expertise and then possibly include input from legal representatives.

Paul Shubert added that it is also possible to develop protocols and regulations simultaneously, and that the combination of the two might prove to be most effective. He said that he would also be working on regulations while the Executive Committee was working on moving forward with this recommendation.

Paul Shubert further stated that it may ultimately be necessary to create legislation and other statutory changes in certain situations, for example, the policy for sibling assessments that was brought up by Dr. Eisen.

Jessica Freeman stated that she would take this discussion back to the larger Executive Committee in order to determine the next steps for moving forward with this recommendation.

No motions made.

13. Final Public Comment

No comments.

14. Adjournment

It was stated by Stephanie Herrera that the next meeting for the Executive Committee would be held on August 18, 2021 at 10 AM.

The meeting was adjourned at 2:01 PM.