— DRAFT —

MINUTES

of the

Executive Committee to Review the Death of Children

held on

February 19, 2025

via Microsoft Teams

Meeting Link

Call-in number: 1(775) 321-6111; Extension: 930273980#

1. Call to Order

Melinda Rhoades called the meeting to order at 10:01 AM.

2. For Information Only: Roll Call

- Executive Committee members present:
  - Denise Tyre, Human Services at Washoe County
  - Amber Hurtado, Human Services at Washoe County
  - Misty Vaughan Allen, DPBH – Suicide Prevention
  - Jorge Montano, Safe Kids
  - Marla McDade Williams, HHS Director's Office
  - Melinda Rhoades, SAFY
  - Nikki Mead, Office of Vital Records
  - Megan Soracco, DCFS
  - Kathie McKenna, Advocates for Children of Rural Nevada
  - Christine Eckles, Washoe County JJ
  - Kandee Mortenson, DCFS
  - Liz Stetson, DCFS

- Executive Committee members absent:
  - Frank Prado, Clark County DFS
  - Vickie S. Ives, DPBH-MCH
  - Sheri McPartlin, CCSD
  - Cody Phinney, DPBH
  - Desiree Mattice, Department of Public Safety
  - Michelle Sandoval, DPBH – Rural Clinics
  - Kaitlynn Rodriguez, DCFS
  - Amanda Haboush-Deloye, NICRP/Prevent Child Abuse NV
  - Ernie Kazmar, Reno Law Enforcement
  - Clayden Porter, DCFS
  - Izaac Rowe, DA's office
  - Ryan Gustafson, Washoe Human Services Agency

- Staff and guests:
  - Orjola Merkaj, NICRP
  - Dawn Davidson, NICRP

- Kyra Morgan, DCFS
- Laurie Jackson, DCFS
- Megan Mapes, Nye Communities Coalition
- Michael Cason, DCFS
- Terence McAllister, Desert Valley Pediatrics
- Desiree Munoz, Community Member
- Debbie Posnien, Suicide Prevention Network
- April Stahl, DCFS
- Beverly Brown, DCFS
- 8 unidentified public attendees

3. **Initial Public Comment (Discussion only):** Action may not be taken on any matter brought up under this agenda item until scheduled on an agenda for action at a later meeting.

Melinda Rhoades stated that to provide public comment, please unmute your microphone before speaking, or you can call into this meeting by using the number 775-321-6111, with passcode number 930273980#. Persons making comments will be asked to begin by stating their name for the record and to spell their last name.

There was no public comment.

4. **For Information Only:** Review the purpose of the Executive Committee to Review the Death of Children

Beverly Brown stated that the Executive Committee should have received an attachment containing the statutes that govern this committee. According to NRS 432B.408, the Executive Committee is responsible for reviewing and responding to the reports and recommendations provided by the Child Death Review (CDR) team. Additionally, under NRS 432B.409, the committee's responsibilities include adopting statewide protocols for reviewing child deaths, developing regulations to implement these statutes, and establishing bylaws to guide the management and operation of the committee. The committee is also tasked with appointing one or more multidisciplinary teams to conduct child death reviews, overseeing the training and development of these teams, and compiling and distributing a statewide annual report that includes statistics and recommendations for regulatory and policy changes. She stated that the Executive Committee may notice slight adjustments to the agenda, which are intended to ensure that our activities align with our statutory authority and maintain compliance with established guidelines.

5. **For Possible Action:** Discussion and possible action to approve November 20, 2024, meeting minutes

Melinda Rhoades asked if there was comment or discussion pertaining to the November 20, 2024 meeting minutes. There was no comment or discussion.

- MOTION: Made by Kandee Mortenson seconded by Kathie McKenna to approve the meeting minutes from November 20, 2024.
  UNANIMOUS VOTE; MOTIONED CARRIED.

6. **For Information Only:** Discussion of the Review of Death of Children Account 432B.409 funding and the 2025 Notice of Funding Opportunity Timeline

Beverly Brown stated that this agenda item is focused on reviewing the Death of Children Account and the 2025 Notice of Funding Opportunity (NOFO) timeline. She stated that she received the completed NOFO applications. She stated that the next steps involve emailing the Executive Committee to ask volunteers to participate in a subcommittee to review the applications and provide recommendations. These recommendations will be presented to this committee at the May meeting, where the final decision on funding allocations will be made.

Jorge Montano asked how to move forward if someone is interested in joining the subcommittee. Beverly Brown stated that the subcommittee should be comprised of voting members, but everyone else is still welcome to attend. She stated that if any voting members were interested in joining the subcommittee, they should email her.

7. **For Possible Action:** Consideration, discussion, and possible approval of the 2022 Statewide Child Death Report

Beverly Brown stated that everyone on the Executive Committee should have received the 2022 Child Death Review report and had the opportunity to review it. She asked if anyone had any discussion or suggestions for changes to the report. Kyra Morgan stated she had reviewed previous reports that included more information on the recommendations that were written in the report. She stated that considering the purpose of this committee, it would be beneficial to include similar insights in future reports. Beverly asked the Executive Committee how they would like to proceed with the 2022 report.

Jorge Montano stated that he supported moving forward with this report. He asked if there had been a conversation about making these reports more current. He stated that he works in injury prevention in Washoe County and finds it challenging to use these reports effectively for prevention efforts when the data is three years old. Nikki Mead stated that the information needed to close a case comes from the coroner's office and can sometimes be delayed. Denise Tyre stated that they have had this conversation several times. There are quite a few factors that affect when the information becomes available. She stated that the timeline has improved,

as it used to take four to five years. Typically, autopsies aren't completed within the first 12 months of a death—it can take that long or even longer. Data entry doesn't begin until autopsies are finalized, and then the data needs to be checked to ensure accuracy. This process usually occurs the following year, after which the report is compiled. While expediting the process might provide more timely reports, it could compromise data accuracy. She stated that if Jorge is looking for more real-time insights, he could contact individual teams across the state to learn about their trends. She suggested participating in reviews from other counties. Jorge stated that he appreciates the input.

- MOTION: Made by Nikki Mead seconded by Meagan Soracco to approve the 2022 Child Death Review report as is with the suggestion of including more detailed recommendations for future reports.
- Abstained by Misty Allen
  UNANIMOUS VOTE; MOTIONED CARRIED.

8. **For Information Only:** Regional Child Death Review (CDR) Team 2024 Quarter 4 report out on regional trends, number of reviews, and their recommendations to the Executive Committee to Review the Death of Children

- Carson Region (Carson City, Douglas, and Storey counties)
- Clark County
- Elko/Ely Region (Elko, Eureka, Lander, and White Pine counties)
- Fallon Region (Churchill, Lander, Mineral, Pershing, and Humboldt counties)
- Nye County Region (Nye, Esmeralda, Lincoln counties)
- Lyon County
- Washoe County

Meagan Soracco stated that the Carson Region reviewed one death due to unsafe sleep factors. No recommendations were made. Denise Tyre asked the Executive Committee members who completed the report out, to specify if extrinsic or intrinsic factors cause infant deaths.

Orjola Merkaj stated that between October 1st and December 31st, the Clark team had 73 cases referred to it for review and reviewed 85 cases. They reviewed more cases than were referred to them because the review of some cases continued from previous quarters. This quarter the team reviewed 63 natural deaths, 12 accidents, which included six motor vehicle deaths, five homicides, which included four due to firearms, three suicides caused by GSW, and two undetermined deaths. Two of the deaths reviewed by the team were mandatory reviews because the deaths were alleged to be from abuse or neglect of the child. Four of the deaths required a review because the children died of SIDS. The team had no recommendations this quarter.

Liz Stenson stated that the Fallon Region reviewed one death that was from a motor vehicle accident. No recommendations were made in Quarter 4.

Nye County stated that they did not review any cases in Quarter 4.

Lyon County stated they reviewed one undetermined death. No recommendations were made in Quarter 4.

Amber Hurtado from Washoe County stated that four cases were reviewed. One case involved an accidental death, another was a suicide by gunshot, and two were undetermined infant deaths, both with only intrinsic factors identified. Some of the general trends observed in 2024 included a decrease in homicides and suicide fatalities, an increase in accidental deaths, and a decrease in safe sleep-related deaths. She stated that the Medical Examiner's (ME's) office has changed how it labels these deaths, now differentiating between intrinsic and extrinsic factors. Both of the safe sleep-related fatalities had intrinsic factors noted, meaning the ME's office could not link the deaths to bed-sharing. For the Quarter 4 recommendation, there was an accidental death case in Washoe County involving a nine-month-old who choked on a cut-up piece of apple while under the care of a caregiver. The recommendation is to reach out to pediatricians to encourage or require them to educate parents on food safety, including identifying choking hazards for children. This education should begin as soon as children are old enough to start eating solid foods and continue through well-child checkups until age four. This could include providing handouts, verbally discussing food safety, and sharing methods for offering foods to children safely. Additionally, parents should receive information about available resources to help keep their children safe.

9. **For Possible Action:** Discussion, consideration, and possible approval of the regional CDR Team 2024 Quarter 4 recommendations presented during agenda item 8.

Beverly Brown asked the Executive Committee their thoughts on Washoe County's recommendation. Denise Tyre stated that it is common to recommend education at the pediatrician level. Instead of making individual recommendations—like advising on safe sleep or food safety—the committee could consider creating a pamphlet that covers all essential safety information for children up to their first birthday. By consolidating the information, we might have more success in distributing educational materials through pediatricians' offices. Jorge Montano stated that he thinks it's a great idea to provide handouts with information and resources to pediatricians. Kyra Morgan asked if provider bulletins are done. She suggested that the committee consider using provider bulletins as a potential method to share information with pediatricians and healthcare providers. It was noted that the Division of Public and Behavioral Health (DPBH) frequently uses this approach to distribute guidelines across provider networks. Denise Tyre stated that the Executive Committee can task the jurisdictional committees or, in its responses to their recommendations, provide guidance on actions to take. For example, the committee could respond to Washoe County with suggestions for spreading awareness and facilitate this approach across different jurisdictions. Beverly stated that according to the NRS reviewed earlier, it is not within the Executive Committee's authority to take recommendations and implement them directly. Instead, the committee's role is to oversee and manage the regional teams, ensure their training, and verify that child death reviews are being completed. As Denise mentioned, the committee can respond to the Washoe County regional team and encourage them to take action—such as developing strategies to increase awareness about choking hazards for children—and collaborate with other regional

teams to expand these efforts statewide. She suggested that the Executive Committee hold a vote to determine the official response to Washoe County's recommendation.

- MOTION: Made by Melinda Rhoades seconded by Nikki Mead to approve the Washoe County recommendation and draft a response.
  UNANIMOUS VOTE; MOTIONED CARRIED.

10. **For Information Only:** Update the Executive Committee regarding training for the regional child death review teams.

Beverly Brown stated they contacted the National Center for Fatality Review and Prevention (NCFRP). NCFRP provided a proposed agenda which April and Beverly still have to review. The goal is to offer training to the Regional Child Death Review Teams over the summer. Once the agenda is reviewed and more information becomes available, April or Beverly will reach out to schedule the training sessions.

11. **For Information Only:** Updates to the Executive Committee on activities and spending of funds by current grantees for the prevention of child fatalities (Please see supporting materials).

- Baby's Bounty
- Community Chest
- Nevada Medical Center, Hope Means Nevada
- Suicide Prevention Network
- NyE County Communities Coalition

Beverly Brown stated that she received two grantee updates. She stated that Baby's Bounty received $20,000 and expended $20,000 on staff payroll for the Baby Bundle Program. Baby's Bounty staff collaborates with caseworkers to vet eligible applicants for the Safe Sleep and Baby Bundle program. Once applicants are approved and enrolled, Baby's Bounty staff monitors the completion of the Safe Sleep and Baby Basics courses. Clients are followed up with three- and six-month intervals to ensure proper crib usage, confirm adherence to safe practices, and provide outreach to connect families with additional resources.

Beverly Brown asked if anyone at the meeting was from Community Chest. There was no response.

Beverly Brown asked if anyone at the meeting was from Nevada Medical Center, Hope Means Nevada. There was no response.

Beverly Brown asked if anyone at the meeting was from the Suicide Prevention Network. Debbie Posnien stated that the Suicide Prevention Network received $20,000. She stated that the suicide prevention team has participated in various community-based initiatives aimed at increasing awareness of suicide prevention. These efforts focus on educating community

members, families, and youth about suicide risk factors, available resources, and how to recognize warning signs to prevent suicide. The team has also pursued educational opportunities and attended trainings to enhance and expand its programs. In September, the team collaborated with the Porch Movement on an event providing community members access to resources. The program continues strengthening its social media presence, prioritizing youth-friendly educational content and awareness. Additionally, the team has engaged in community health fairs, setting up resource tables and interacting with people to increase outreach. The program also offers teen creativity sessions where young participants engage in activities focused on coping skills and managing anxiety. The team is actively involved with the HOPE Squad in local high schools and participates in the Stop, Breathe, and Think program.

Beverly Brown asked if anyone at the meeting was from Nye Communities Coalition. Megan Mapes stated that the suicide prevention and lethal means prevention efforts have continued throughout Nye, Lincoln, and Esmeralda counties. The team participated in the Esmeralda County Health Fair, where a gun safe raffle provided an opportunity to share lethal means awareness. The team remains actively involved with the HOPE Squads in Nye County School District high schools. A budget modification was implemented to reallocate advisory stipend funds toward purchasing project supplies for the individual HOPE Squads. She stated that she coordinated with high school advisors to provide materials for large-scale HOPE Week events held throughout February and March. She stated that the team is tallying the SOS (Signs of Suicide) screening numbers from Rosemary Clark Middle School and Pahrump Valley High School to provide a final number of students screened through the program.

Denise Tyre asked Beverly Brown which grantees did the Executive Committee not receive information from. Beverly stated that no updates were received from Community Chest or Nevada Medical Center, Hope Means Nevada.

12. **Final Public Comment and Discussion:** (Action may not be taken on any matter brought up under this agenda item until scheduled on the agenda for a later meeting)

Denise Tyre stated that to provide public comment, please unmute your microphone before speaking, or you can call into this meeting by using the number 775-321-6111, with passcode number 930273980#. Persons making comments will be asked to begin by stating their name for the record and spell their last name.

Desiree Munoz stated that her nine-month-old died from choking on a piece of fruit. She expressed the need for more education on introducing solids to infants. She suggested that pediatricians provide guidance on safe foods, choking prevention, and possibly offer CPR classes or informational pamphlets. She stated that the potential benefit of government funding for anti-choking devices for families who may not be able to afford them. She stated that through Instagram, she had learned about choking prevention techniques and discovered an anti-choking device, emphasizing that if she had known about this device earlier, it might have prevented her son's death. She stated that her daughter had witnessed both her brother and a friend choking and how important it is to have anti-choking devices and education available in

schools. She believes that providing pamphlets or resources through pediatricians could help parents understand that choking is not always easily preventable.

13. Adjournment

The meeting was adjourned at 10:46 AM.