— FINAL —

MINUTES

of the

Executive Committee to Review the Death of Children Meeting

held on

August 18, 2021

via teleconference

Microsoft Teams

teams.bjn.vc##105936574#1171407597

Call-in number: 1(775) 321-6111; Extension: 603-222-633#

1. Call to Order, Roll Call, Introductions

Margarita De Santos began the meeting by reminding Executive Committee members of the bylaws. She reminded Executive Committee members to provide notice if they were unable to attend a meeting and wanted to send a proxy. Additionally, she gave a gentle reminder that, according to the bylaws, if a member misses two consecutive meetings without notice that is grounds for removal from the committee. Margarita called the meeting to order at 10:02 AM.

Executive Committee members present:

- Kathie McKenna, Pioneer Territory CASA
- Sharon Benson, Office of AG
- Misty Vaughan Allen, DPBH - Suicide Prevention
- Nick Czegledi, Elko County Sheriff's Office
- Margarita De Santos, SNHD
- Jessica Rogers, Las Vegas Metro Police Department
- Nancy Saitta, Retired
- Desiree Mattice, Department of Public Safety
- Megan Freeman, DCFS
- Amber Howell, Washoe County HSA
- Michelle Sandoval, DPBH - Rural Clinics

Executive Committee members absent:

- Beth Handler, HHS Director's Office
- Lisa Sherych, DPBH
- Vicki Ives, DPBH - MCH
- Breanna Jenkins, Renown
- Sheri McPartlin, CCSD
- Ross Armstrong, DCFS
- Tim Burch, Clark County DFS
- Christine Eckles, Washoe County JJ
- Stephanie Herrera, DPBH - Vital Records

Staff and guests:

- Jessica Freeman, DCFS

- Dawn Davidson, NICRP
- Julie Dickerson, Proxy for Stephanie Herrera DPBH - Vital Records
- Tami Conn, Proxy for Vicki Ives, DPBH-MCH
- Stephen Dotter, EC Budget Account
- Molly Blanchette, DCFS
- Candace Caterer, Clark County Office of the Coroner/Medical Examiner
- Jennifer Spencer, Attorney General's Office
- Lea Case, Belz & Case Government Affairs in Reno
- Paula Berry, Proxy for Christine Eckles Washoe County JJ
- Brandy Holbrook, Division of Child and Family Services, Rural Region 1

2. Initial Public Comment

No comments.

3. For Possible Action: Approval of Meeting Minutes from May 19, 2021 and June 9, 2021.

- Approval of May 19, 2021 and June 9, 2021 meeting minutes.

Sharon Benson requested that the meeting minutes be approved separately.

Margarita De Santos requested a motion to approve the meeting minutes from May 19, 2021. Misty Allen commented that her name was spelled incorrectly and that she would email the correction.

MOTION: Made by Nick Czegledi, seconded by Kathy McKenna, to approve the May 19, 2021 meeting minutes with the correction to Misty Allen's name made.

UNANIMOUS VOTE; MOTION CARRIED.

Margarita De Santos asked committee members if they had any changes for the meeting minutes for June 9, 2021. Misty Allen stated that there was also a correction to be made to her name, which she inserted into the chat box. Margarita requested a motion be made to approve the meeting minutes for June 9, 2021.

MOTION: Made by Nick Czegledi, seconded by Misty Allen, to approve the June 9, 2021 meeting minutes with the correction to Misty Allen's name made.

MAJORITY ROLL CALL VOTE; MOTION CARRIED. Sharon Benson abstained from the vote, as she was not present at the June 9, 2021 meeting.

4. For Discussion: Division of Child and Family Services (DCFS)/ Nevada Institute for Children's Research and Policy (NICRP) Child Death Review (CDR) updates

- Western Region and National CFRP Updates
- Sudden Death of the Young (SDY) Program

As stated by Jessica Freeman, there were no updates for the Western Region. Additionally, there were no National CFRP updates. Jessica stated that if any Executive Committee team members are interested in the Child Death Investigation Learning Series Online Training they could email her at jfreeman@dcfs.nv.gov for registration information. This training is free and does provide CEUs.

Candace Caterer from the Clark County Office of the Coroner/Medical Examiner stated that there was an update on the Sudden Death of the Young (SDY) Program. Candace stated that the Clark County Child Death Review Team and Child Death Investigators have been selected by the National Association of Medical Examiners (NAME) this year to present information regarding mitigating youth suicide during the COVID-19 pandemic and all of the efforts made to prevent youth suicide in Clark County. Candace said this meeting would take place in Palm Beach, Florida, during October in order for medical examiners to share information about child death prevention, specifically suicide.

5. For Possible Action: Discuss and approve response the next steps for below recommendations.

- 2018 Quarter 2- hospitals should adopt a consistent internal policy for assessment of children when they present with suspicious or serious injuries.
- Update from the subcommittee and their meeting with HCQC: Does the larger committee want to approve each step or allow the subcommittee to decide the next steps?

To recap, Jessica Freeman stated that the 2018 Quarter 2 recommendation from the Clark County Child Death Review Team recommended that hospitals should adopt a consistent internal policy for the assessment of children when they present with suspicious or serious injuries. At the most recent Executive Committee meeting, the formation of a subcommittee was approved in order to begin discussing this recommendation.

This subcommittee, the Health Care Quality and Compliance (HCQC) Subcommittee, includes Lisa Sherych, Vickie Ives, Stephanie Herrera, Dr. Andrew Eisen, and Paul Shubert. The HCQC subcommittee met on 7/21/21 to discuss next steps. The primary focus of that meeting was to identify the right medical care for children who are victims of abuse. It was recommended to begin working on the two processes that Paul Shubert suggested in his response letter to the Executive Committee. The first process suggested by Mr. Shubert is to gain compliance through collaboration with physicians and hospital associations. Dr. Andrew Eisen suggested that the Executive Committee begin by collaborating with medical experts to develop a standard set of policies. By collaborating with physicians from the

beginning there is a higher likelihood of compliance, which in turn will increase the likelihood that the hospitals would voluntarily incorporate the policies before they become regulations. This can be accomplished by convening experts to devise an outline of what the Executive Committee wants to accomplish that can be presented to the hospital associations. It was recommended to have this discussion with a representative from pediatric emergency facilities from across the state, such as University Medical Center, Sunrise Hospital, Summerlin Hospital, St. Rose Hospital, Renown Regional Medical Center, Northern Reginal Children's Advocacy Center, Southern Regional Children's Advocacy Center, and a representative from a rural hospital. During the subcommittee meeting, the following questions were posed by Dr. Eisen to begin the discussion:

1. What does the Executive Committee want to implement?
2. What injuries would trigger an assessment?
3. What would be included in this assessment?
4. Who is notified of the findings?
5. When is it necessary to transfer the child to a more specialized hospital?

Once the initial outline for the policies has been established, it was suggested to bring more professionals to the table, such as the hospital association and legal representatives. The second process suggested by Mr. Shubert is to develop codifying regulations, which would ensure that the policies would be followed by all hospitals in the state. As this is a lengthier process, it was suggested to do this concurrently with the first process. Mr. Shubert stated that he is willing to assist with this process.

During the current meeting, Jessica Freeman presented the following questions for the Executive Committee to consider:

- Are there additional questions or representatives that the Executive Committee would like the subcommittee to consider?
- Is the committee agreeable to this method outlined by the subcommittee?
- Does the committee want to approve each step and recommendation from the subcommittee, or allow the subcommittee to make decisions?

Sharon Benson and Misty Allen stated that they thought the method outlined was very good and voted to approve the method. Nick Czegledi voted to allow the subcommittee to move forward on their own and present their findings at the end to the larger Executive Committee. Sharon Benson agreed with this approach and there was no further discussion.

Margarita De Santos requested a motion to approve following the method outline by the subcommittee for moving forward on the 2018 Quarter 2 Clark County recommendation, allowing the subcommittee to make decisions regarding next steps, and then submit a final document to the collective State Executive Committee at the end.

MOTION: Made by Sharon Benson, seconded by Nick Czegledi, to approve following the method outline by the subcommittee for moving forward on the 2018 Quarter 2 Clark County recommendation, allowing the subcommittee to make decisions regarding next steps, and then submit a final document to the collective State Executive Committee at the end.

UNANIMOUS VOTE; MOTION CARRIED.

6. For Possible Action: Discuss and approved the response letters for the below recommendations.

- 2020 Quarter 4- Clark CDR recommends health insurance policies should not prevent individuals from filing prescriptions for mental health or physical health issues.
- 2021 Quarter 1- Clark CDR recommends that children younger than 12 years of age be routinely assessed for depression, suicidal ideation, and suicide attempts by mental health and medical professionals.

Margarita De Santos provided a summary of the 2020 Quarter 4 recommendation as follows:
The Clark County Child Death Review Team recommended that health insurance policies should not prevent individuals from filling prescriptions for mental health or physical health issues. The discussion for the recommendation was held at the last Executive Committee meeting. Beth Slamowitz, the Senior Policy Advisor of Pharmacy at Department of Health and Human Services, presented the current policies that Medicaid has in place to protect vulnerable children. Beth Slamowitz discussed the current trends that showed that children ages 0-6 years, especially foster children, were unnecessarily prescribed psychotropic medications, or were prescribed too many medications in the same class. As a result, Medicaid requires pre-authorization for psychotropic medication, although an emergency 72 hour supply can be provided while waiting for the pre-authorization. Medicaid can bypass any policy in an emergency if the psychotropic medication was prescribed by a board-certified psychiatrist. Lastly, Beth did not believe that the NV State Board of Pharmacy would provide a recommended list of medications as the draft response letter asked. Given this conversation, a motion was made to table this discussion to today's meeting and no action was taken. The Clark County Child Death Review team was updated with this information and they believe the recommendation is still warranted, as it is written. At the February 2021 meeting, it was determined that the Executive Committee would write letters to the following agencies in response to the recommendation:

- Clark County Child Death Review Team
- NV State Board of Pharmacy
- State Insurance Commissioner
- Medicaid

Jessica Freeman asked how the Executive Committee wished to proceed. Dr. Megan Freeman stated that she believes the Executive Committee should also draft a letter addressing barriers to obtaining medications for physical conditions, as dividing the request to terminate restrictions to obtaining medications from insurance companies is more likely to receive some cooperation from insurance companies than submitting the request as a whole. Dr. Freeman stated that it was very unlikely that the Executive Committee's request to remove barriers would be complied with, as the Executive Committee was basically asking for the removal of all barriers to receiving medications. By focusing on mental and behavior health, progress is more likely to be made on this recommendation. Dr. Freeman also stated that she thought the information Beth Slamowitz provided was also very helpful in providing context regarding why the review process and current barriers might be valuable in preventing harm to vulnerable populations. Dr. Freeman stated that it was still possible for the Executive Committee to make the recommendation, but that there may be no action taken on the recommendation in the end.

Making the recommendation in and of itself can draw awareness to the concern that barriers are creating undue burdens when it comes to obtaining prescriptions, and possibly pressure Medicaid and other insurance companies to make amends in the future. Candace Caterer, a member of the Clark County Child Death Review Team who was present when this recommendation was made, added that the "physical aspect" of the recommendation was added primarily as a concern of deaths due to asthma. Specifically, the team had reviewed child deaths that were caused by an inability to obtain asthma inhalers from insurance companies. Candace agreed with Dr. Freeman that a blanket recommendation for physical health conditions might not be likely to receive much action, however, stated that it might be possible to influence legislation to at least prevent barriers from obtaining inhalers for asthma. Candace stated that the Child Death Review Team in Pennsylvania was working on similar legislation at this time. As stated by Candace, law enforcement agencies congregated together and helped to enact a policy where if a child presents to a major hospital with asthma, they would be sure to leave with an inhaler. Candace also agreed that separating the mental health and physical health aspects of this recommendation may increase the likelihood of this recommendation receiving any action. In light of this information, Margarita De Santos asked if the Executive Committee wanted to specify asthma on the recommendation instead of a blanket physical health issues. Candace stated that this might be preferable. Candace asked the Executive Committee if they would like to tone down some of the language in the letter to make it more palatable to Medicaid, to which Dr. Freeman agreed. Jessica Freeman stated that she and Dawn Davidson would amend the letters to Medicaid and bring them back to the Executive Committee at the next meeting in November for approval.

NO MOTION MADE.

Jessica Freeman provided an update on the 2021 Q1 Clark recommendation. She indicated that during the May Executive Committee meeting, it was discussed that information that was provided by the Department of Children and Family Services and Office of Suicide Prevention at the beginning of the pandemic be redistributed, along with a link to suicide screening tools that are appropriate for children as young as 8 years old. Those that suggested redistributing the materials have not had an opportunity to meet to discuss the process, but will assist with a draft letter in response to the recommendation prior to the November meeting.

NO MOTION MADE.

7. For Possible Action: Discuss and approve the response letters for the below recommendations.

- 2021 Quarter 1- Clarification from the Elko CDR team regarding their recommendation.
- 2021 Quarter 2- Clark CDR recommends educating medical professionals on when to notify child protective services when a parent/guardian is diagnosed with severe postpartum depression/psychosis.
- 2021 Quarter 2- Washoe CDR recommends the following:

    - Hospitals and drug testing facilities begin testing for Fentanyl as part of their standard drug testing panels.
    - Narcan to be made more accessible to the at-risk teen population.
    - Hospitals should test for Fentanyl when withdrawal signs are present in mothers and infants.
- Washoe CDR recommends that information about safe sleep when traveling be included in the safe sleep education and literature information.

Dawn Davidson stated that the Quarterly Reports would be made public from now on, and that the rural teams would be combined in the report distributed to the public since those regions do not have many deaths to review. This will make specific cases less identifiable and therefore protect confidentiality.

For their 2021 Quarter 1 recommendation, the Elko Child Death Review Team recommended that gun locks and gun safety classes be required for gun owners, particularly those with children in the home. Additionally, the Elko Child Death Review Team recommended that children receive gun safety classes. Per the Executive Committee's request, clarification was received from the Elko Child Death Review Team. There were two incidents, but the recommendation stemmed from only one of those incidents, as Elko felt that only one had been preventable. The Elko Child Death Review Team recommends that gun safety classes be offered to children. The Elko Child Death Review Team may reach out to the Nevada Department of Wildlife, as they offer a hunter safety class that provides great information and is more general than just hunter safety. Dr. Freeman asked at what age children would be required to take gun safety classes; Jessica Freeman stated that Elko had not yet specified and that the Executive Committee could set those parameters once they write a response letter. Dr. Freeman also asked if there was a best practice already formed that could provide some context to the age of children gun safety classes would be recommended to. Margarita De Santos stated that the Executive Committee should again ask for clarification on the recommendation in regard to the ages of children recommended to receive gun safety training in addition to information about any existing best practices to inform this. Misty Allen also requested that the Elko Child Death Review Team submit the specific training they intend for this recommendation so that the Executive Committee could review it. Jessica Freeman added that both Clark and Washoe County Child Death teams will soon have recommendations to submit to the Executive Committee that are very similar and more formalized. Jessica posed the idea of waiting for each of the three teams to further solidify each of their recommendations so that the Executive Committee could in turn create a statewide recommendation.

NO MOTION MADE.

Moving on, Dawn Davidson presented the 2021 Q2 recommendation from the Clark Child Death Review Team which is that medical professionals should be educated on when to notify child protective professionals when a parent/guardian is diagnosed with severe postpartum depression/psychosis, even if there are no explicit verbalizations that threaten the child. Misty Allen requested additional information about the context of the recommendation and how it originated. Misty stated that this recommendation seemed to be very punitive. Tami Conn, Vicki Ives' proxy, agreed that this recommendation seemed to be punitive and raised a concern that this recommendation may cause

women to be more likely to withhold information from their healthcare providers regarding postpartum depression symptoms in fear of getting reported to Child Protective Services. Dr. Freeman agreed with this sentiment and said she felt very concerned about these unintended consequences. Dr. Freeman further stated that there was already a lot of stigma surrounding postpartum depression in addition to other mental health conditions. She stated that she lives in Henderson, where the case that generated this recommendation occurred, and that this event was incredibly shocking to the community. She stated that while this event was terribly upsetting, the risk of disincentivizing women should be strongly considered. Notifying Child Protective Services after a parent is diagnosed with severe postpartum depression or psychosis could result in adding quite a bit of stress to the family in an already difficult situation. Misty Allen suggested that educating mothers about mental health treatment and resources could provide better support and may be more effective than reporting mothers to Child Protective Services whenever they're diagnosed with severe postpartum depression or psychosis. Dr. Freeman asked the Executive Committee if they would instead also like to encourage screening for postpartum depression and other mental health conditions for mothers. She stated that hospitals already screen for this at the time of birth, but that this might not be an ideal time for screening as family is experiencing a lot of stress. Dr. Freeman suggested screening at either a postpartum or pediatrician visit 6-8 weeks after the infant is born and then ensure that mothers have access to the appropriate mental health services they might require. Margarita De Santos said that she believed Medicaid will reimburse pediatricians to conduct these screenings on mothers and reiterated that these methods seem to be preferable to the punitive actions suggested by the current recommendation. Margarita also stated that there are a number of mothers who do not keep postpartum appointments due to the extra stress of having a new infant, however, who will almost always keep pediatrician appointments; thus, screening at pediatrician appointments might be preferable to screening at OBGYN appointments. Misty Allen stated that she knew that the Maternity Mortality Review Committee is also looking into encouraging screenings like these, so the Executive Committee may be interested in supporting some of their recommendations. Tami Conn, who is also a part of the Maternal Mortality Review Committee, confirmed that this was one of their recommendations and that it was forwarded to Legislative Counsel Bureau in December of 2020. However, Tami said that she did not think there was specific language regarding maternal screening for postpartum depression at pediatrician appointments, but instead language encouraging screening at the mother's OBGYN appointments. Jessica Freeman asked the Executive Committee if they wanted to submit a letter encouraging screens for postpartum depression and an increase in the availability of mental health resources to either HCQC, hospital associations, or the state board of health. Margarita De Santos suggested that the Executive Committee may be able to submit a letter to the local branch of the American Academy of Pediatrics and also possibly the Medical Society, as some children may be seen by a family practice physician instead of specifically a pediatrician. Molly Blanchette added that she had recently had an infant and that she herself had been screened for post-partum depression each time she had gone to take her infant to her pediatrician. Tami Conn suggested that the Clark County Child Death Review Team could possibly modify this recommendation to notify Child Protective Services if a mother has explicit verbalizations threatening the child instead of immediately notifying Child Protective Services as soon as there is a diagnosis of postpartum depression. Sharon Benson stated that, in order for Child Protective Services to take any action, there would have to be a threat to the child's wellbeing, and that a diagnosis of postpartum depression or psychosis would not give the agency the authority to respond with an investigation. Margarita suggested that the Executive Committee could send a letter back to the Clark County Child Death Review Team notifying them that the diagnosis of postpartum depression on its own is not enough for Child Protective Services to respond with an investigation, and that there has to be some sort of risk of harm or neglect to the child to warrant an investigation. Margarita also said that a statement should be included about the added stigma against postpartum depression and psychosis

caused by this recommendation might prevent mothers from seeking help, and that a push for more resources for those who test positive for postpartum depression and psychosis might be more effective. Jessica stated that she would work on response letters as such and would report back to the team in November for approval. Jessica requested additional resources from Tami and Dr. Freeman to be inserted into the response letters.

NO MOTION MADE.

Next, Dawn Davidson stated that the 2021 Quarter 2 Washoe recommendation was generated due to a trend in overdoses for fentanyl in teens in addition to an overall increase in recreational fentanyl use in the community. As a result, the Washoe County Child Death Review Team recommended that hospitals and drug testing facilities begin testing for fentanyl as part of their standard drug testing panels, that Narcan be made more accessible to the at-risk teenage population, and that hospitals should test for fentanyl when withdrawal signs are present in mothers and infants. Dr. Freeman stated that she had just seen an article in a spike in fentanyl deaths in Las Vegas, and said that encouraging awareness regarding this issue would be beneficial. Paula Berry, a clinical social worker, concurred that the issues of increased fentanyl use is definitely a trend that should be addressed. She stated that there have been numerous cases where youth have come in and were not aware that they had ingested fentanyl despite having admitted to using illicit substances such as methamphetamine, cocaine, and marijuana. Paula stated that these youth will begin experiencing withdrawal symptoms and then test positive for fentanyl. There has also been an increase in fentanyl overdoses among youth who are involved in the juvenile justice system for both those who are on probation and parole. Paula stated her support for all of the recommendations. Dawn Davidson stated that she was working on a project with the Southern Nevada Health District on their Overdose Data to Action Grant that was received through the CDC. She stated that Southern Nevada was engaging in similar activities and that there was also a statewide grant that was being utilized to try to combat this issue. Jessica Freeman asked Paula Berry if fentanyl testing is an extra cost on top of standard drug tests that are administered. Paula clarified that she did not think fentanyl tests are much more expensive than general drug tests, but that it has not been an issue for her agency to incorporate the fentanyl testing. She stated that these tests have been really useful for her agency in allowing them to catch and intervene when juveniles are withdrawing from fentanyl, especially when juveniles are unaware that they have ingested fentanyl. Margarita De Santos added that, especially down in Clark County, fentanyl seemed to be a contaminant in other recreational drugs and that there are numerous cases where individuals did not realize they had taken fentanyl. Misty Allen thanked Dawn for mentioning the Overdose Data to Action Grant and asked if the project she was managing tracked syndromic surveillance data to show immediate hotspots of fentanyl overdoses. Dawn replied that she believes that individuals on the project are working on obtaining syndromic surveillance data through High Intensity Drug Tracking Areas Program (HIDTA). She clarified that HIDTA monitors the prevalence of different drugs in the community, which substances are being used more frequently, and overdoses. Jessica stated that there seemed to be a consensus that the Executive Committee wanted to move forward with this recommendation and reach out to the above mentioned agencies that are currently engaged in similar work. After reaching out and assessing what resources are available, the Executive Committee could make a recommendation for support or advocate for additional measures that could be taken to combat this issue. Tami Conn suggested that the Executive Committee reach out to SAPTA (Substance Abuse Prevention and Treatment Agency) and specifically contact Stephanie Woodard. Tami also suggested that the Executive Committee contact the Office of Public Health Investigations and Epidemiology (OPHIE) for syndromic surveillance. Given this, Jessica stated that response letters to these agencies would then be drafted and then brought back to the Executive Committee in the November meeting.

NO MOTION MADE.

Dawn Davidson stated that another Washoe County Child Death Review Team 2021 Q2 recommendation was that information about safe sleep when traveling be included in the safe sleep education and literature materials. This recommendation was generated after a case review of an infant death where unsafe sleep practices were engaged in due to travel. Dawn stated that the family for this case had normally practiced safe sleep, however, had co-slept the night of the infant's death for the first time as there was no crib available at the location they traveled to. Margarita De Santos stated that she did not think the safe sleep education information and literature in regard to travel would differ much from the general information already distributed, as the general literature already advocates for safe sleep spaces each and every time without any exceptions. Margarita suggested it might be possible to make an addition to the existing material to emphasize the necessity of a safe sleep environment, even when traveling. Sharon Benson concurred that it would be useful to add statements specifying that parents should be mindful of arranging for safe sleep environments anywhere that's outside of their normal routine. Dawn clarified that, in their recommendation report, Washoe stated their intention to add similar language to the existing literature. Margarita De Santos and Sharon Benson both agreed that the addition of this language would be beneficial. Sharon also raised a concern about trying to avoid lengthening the literature too much, as parents may have a declined interest in reading the material as a result. Tami Conn added that the agency she works for, the Department of Public and Behavioral Health, Maternal and Child Health, has a program that distributes portable cribs to families with infants called "Cribs for Kids" once a training is completed. Tami also mentioned that Michigan State University conducted similar programs and campaigns to educate the public about safe sleep conditions during travel. Margarita brought up that a lot of hotels will offer pack n' plays if notified ahead of time. Jessica Freeman stated that she would draft a letter stating the above information that will be presented to the Executive Committee for review in the November meeting. Jessica reminded the Executive Committee that they approved funding for Washoe's safe sleep efforts in the June meeting earlier this year. Margarita requested that Washoe County Child Death Review Team be notified of similar campaigns/efforts conducted in other states in order to inform their recommendation. Jessica also reminded the Executive Committee that October is safe sleep awareness month and said that the Executive Committee was partnering with the Maternal Mental Health agencies in order to raise awareness through social media campaigns.

NO MOTION MADE.

8. For Possible Action: Review the recent legislative changes to the Open Meeting Law Requirements and approve meeting platform.

- Physical locations are no longer required, and meetings can be held virtually, if all voting members agree to be on camera.
- Does the Executive Committee want to continue to offer a physical location, go entirely virtual, or offer both?

Margarita De Santos reported to the Executive Committee that AB 253 was approved during the past legislative session. The requirement of having a physical location for public meetings is no longer mandatory, which allows for the continuation of virtual platforms to be used. Virtual platforms can only be used if the committee can post notice and all supporting documentation to a website. The Executive

Committee does have access to a website to post supporting materials: https://dcfs.nv.gov/Programs/CWS/CPS/2021MeetingsAndAgendas/. To provide the utmost transparency to the public, all voting members would need to have their cameras turned on for the duration of the meeting, if the committee chooses to go virtual or offer a hybrid option. Margarita asked the Executive Committee how they wanted to proceed. Kathy McKenna raised a concern that the bandwidth required to have all voting members visible through camera throughout the meeting might cause frequent technical difficulties. Nick Czegledi stated his preference for a physical location. Sharon Benson stated that a hybrid may be ideal. Misty Allen also stated that a hybrid option sounded ideal. Margarita De Santos asked present voting members if they all had the capability to participate in meetings via video and Detective Rogers reported that she did not have the capability. Sharon stated that voting Executive Committee members might not be required to keep the video on if the platform is hybrid, however, video for voting members is best to increase transparency. Desiree Mattice clarified that cameras would be required to remain on for the duration of the meeting if the meeting was exclusively virtual. Sharon Benson stated that AB 253 stated there was an exception for technical issues that arose. A consensus was made that the Executive Committee desired to continue to use a hybrid model to participate in future meetings. As stated by Jessica Freeman, no motion was required as the Executive Committee decided to continue to use a hybrid platform option and nothing was changed.

NO MOTION WAS MADE.

9. For Possible Action: Review bylaws and determine course for co-chair office.

- Per Article 3, Officers and Elections of the bylaws, 3.3 and 3.4 provide specific language regarding the co-chair's terms of office and election process. Currently both officers are ending their first year this November. How does the committee want to proceed?

Margarita De Santos read the following bylaws to the Executive Committee.

Article 3- Officers and Elections. 3.3 Terms of Office; the term of office for each Co-Chair shall be two years. Each officer shall serve until the election of a successor.

Article 3- Officers and Elections. 3.4 Officer Nominations and Elections; Elections for Executive Committee offices shall be held at the first regularly scheduled meeting falling on or after October 1 at the end of the current officers' two-year term. Elections will be staggered such that only one new Co-Chair is elected each year, while the remaining Co-Chair completes his or her two year term. A Nominating Subcommittee established by the Executive Committee may nominate candidates for open office positions, or Executive Committee members may make nominations from the floor. Each office shall be voted upon separately. If more than two nominees are selected for a single office, the lowest vote recipient shall be eliminated during each round of voting necessary until only two nominees remain. Nominees for offices who receive a majority vote for the office available shall be declared elected to that office, effective within 30 days of the meeting at which the election occurred.

Margarita noted that the current co-chairs have completed their first year, therefore both positions would be up for election next year. Then she asked the Executive Committee how they wanted to

proceed. She asked the Executive Committee if they would like to elect one new co-chair at the upcoming November meeting, which would require nominations today, or nominations and voting at the November meeting. The Executive Committee also had the option to elect one co-chair next year and extend the term of the other co-chair. This would require one co-chair to serve a three-year term and require the Executive Committee to amend the bylaws and elect two new co-chairs next year. This would also place the Executive Committee in the same position in the future or require a permanent change to the bylaws. Margarita stated that both Stephanie Herrera and she were happy to oblige whatever the Executive Committee decided. Jessica Freeman stated that the purpose of staggering co-chairs was to ensure that the Executive Committee always had one co-chair with experience. Sharon Benson said that staggering co-chairs to ensure experience seemed to be ideal. Jessica also clarified that this was a practice that the Executive Committee has kept in previous years, though both of the current co-chairs were recently appointed last year. Members of the Executive Committee collectively decided to elect one co-chair next year and extend the term of the other co-chair so that they would have a three-year term. Margarita requested a motion to elect one co-chair next year and extend the term of the other co-chair to three years.

MOTION: Made by Nick Czegledi, seconded by Kathie McKenna, to elect one co-chair next year and extend the term of the other co-chair to three years.

UNANIMOUS VOTE; MOTION CARRIED.

10. For Discussion: Top four manners/causes of death in children in Nevada.

- Unsafe Sleep
- Suicide
- Drowning
- Homicide

The following was stated by Margarita De Santos. Per the Department of Health and Human Services Office of Analytics, there were a total of 12 youth suicides that were Nevada residents in the year of 2021 as of 08/05/2021: 10 male deaths and 2 female deaths. This data is preliminary and subject to change. Unsafe sleep death statistics are usually provided annually by the federally available data from the Maternal and Child Health Bureau to the Executive Committee around the months of March or April. At this time, there was no information available regarding the statistics of unsafe sleep deaths for the year of 2021. Margarita further stated that the Executive Committee's partners at Public and Behavioral Health may have data regarding all causes of death for adolescent mortality as well as the motor vehicle mortality, which will be available at the Executive Committee's November meeting. Jessica Freeman directed the Executive Committee's attention to the suicide education and resources provided, including the links to the Nevada Office of Suicide Prevention, Nevada Children's Mobile Crisis Response Team, and the advertising campaign promoting awareness of the Children's Mobile Crisis Team. These resources have not changed since the Executive Committee's May meeting.

At the Executive Committee's May meeting, a request to develop a recommendation to address child homicide prevention was made. Jessica Freeman asked the Executive Committee how they want to address this and if they want to create a sub-committee to begin looking into this. Jessica also asked the Executive Committee if they would prefer to set data parameters and go from there. Desiree Mattice

stated that it might be ideal to analyze the data, examine trends, and then proceed with possible recommendations so that the Executive Committee could produce more specific, focused recommendations rather than general, nebulous ones. Sharon Benson shared her concern about generating ambiguous recommendations and stated that a subcommittee might be more effective in producing informed recommendations. Jessica also agreed with this sentiment and stated that she would work with Dawn Davidson to analyze the trends in homicides using NICRP's acquired data and have data parameters ready to present in the Executive Committee's November meeting. Jessica said that it should be noted that, due to the burden involved in collecting, analyzing, and cleaning all of the data, the annual report is always a few years behind. Jessica mentioned that the 2018 Annual Report would be ready to present to the Executive Committee in the upcoming November meeting. Dawn agreed to collect information regarding youth homicides in recent years and also brought up the trend in firearms and how different regional Child Death Review teams had generated recommendations to try and address this issue. Jessica asked for the Executive Committee to confirm that their preferred approach would be to narrow the parameters of the homicide data, bring back this information to the Executive Committee in November, at which point a subcommittee could be established to generate recommendations given this information. Dawn emphasized the need to keep in mind the data lag in the homicide information that the Executive Committee would be able to obtain at this time. Even though current data is constantly being entered into the National Center for Fatality Review and Prevention database, it still needs to be cleaned, assessed for accuracy, and at this time would not be reliable enough to include in the data parameters being set. Dawn stated that she would feel most confident utilizing 2018 statewide data in order to set data parameters at this point in time. There was no further discussion.

NO MOTION MADE.

11. Final Public Comment

Margarita De Santos asked if there was any public comments to be made at this time.

Sharon Benson made an announcement regarding the victims of human trafficking project, specifically, the supporting our survivors group. There will be a golf tournament held on October 14 at Lake Rich Golf Course in Reno, Nevada in order to fundraise. Sharon invited committee members to participate, sponsor, or involve themselves in the event however they would like.

Misty Allen, with the Office of Suicide Prevention, announced that September is suicide prevention month. She asked members of the Executive Committee to contact the Nevada Coalition for Suicide if anyone was interested in the agency's activities around the state, especially on September 11, when Reno is holding an event for first responders with military and veterans' groups.

Jessica Freeman reiterated that October is safe sleep awareness month and reminded the group of the social media campaign that will take place during that time.

12. Adjournment

It was stated by Margarita De Santos that the next meeting of the Executive Committee will be held on November 17, 2021 at 10am. Margarita requested a motion to adjourn the Executive Committee meeting for August 19, 2021.

MOTION: Made by Kathie McKenna, seconded by Nick Czegledi, to adjourn the Executive Committee meeting for August 19, 2021.

UNANIMOUS VOTE; MOTION CARRIED

The meeting was adjourned at 11:41 AM.