— DRAFT —

MINUTES

of the

Executive Committee to Review the Death of Children Meeting

held on

October 4, 2021

via teleconference

Microsoft Teams

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

1. Call to Order, Roll Call, Introductions

Jessica Freeman called the meeting to order at 3:02 PM.

Executive Committee Members, Staff and Guests:

- Dr. Andrew Eisen, Valley Health Systems
- Paul Schubert, HCQC
- Vickie Ives, DPBH - MCH
- Molly Blanchette, DCFS
- Lisa Sherych, DPBH
- Jessica Freeman, DCFS
- Elizabeth Holka, NICRP

2. Initial Public Comment

No comments.

3. For Possible Action: Approval of meeting minutes from July 21, 2021.

No discussion.

MOTION: Made by Dr. Andrew Eisen, seconded by Lisa Sherych, to approve the July 21, 2021 meeting minutes.

UNANIMOUS ROLL CALL VOTE; MOTION CARRIED.

4. 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.
    - Finalize the outline for the meeting with medical professionals, and who should attend.

Jessica Freeman opened the meeting by pulling up the questions that were developed during the previous HCQC meeting. It was decided in the most recent Executive Committee meeting, held on August 18, 2021, that this subcommittee would determine the next steps forward in developing this recommendation. More specifically, the objective of this meeting was to create an outline for the next meeting in addition to deciding on who to invite for input on this recommendation. Jessie pulled up the following questions:

- 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?

Dr. Eisen stated that he thought the fourth bullet point, specifically the question "who is notified of the findings", was not needed. He suggested that a better question or suggestion might be when a report to Child Protective Services should be made. Dr. Eisen also suggested that the word "injuries" in the second bullet should be changed to "findings". As stated by Dr. Eisen, the biggest question that needed to be answered during today's meeting is what the subcommittee and larger Executive Committee were hoping to accomplish. The best method moving forward would be to put together an outline in addition to any details regarding the policy, after which HCQC could take over in an official capacity.

It was confirmed by subcommittee members that the following should be contacted for input:

- University Medical Center- Dr. Jay Fisher
- Sunrise Hospital
- Summerlin Hospital – Dr. Sandra Horning
- 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 he would reach out to Dr. Fisher and Dr. Horning to see if they would be willing to participate. Additionally, Dr. Eisen said that he would attempt to reach out to contacts from Sunrise Hospital and St. Rose Hospital. Lisa Sherych stated that she would contact Michael from the Nevada Division of Public and Behavioral Health to see who could be a potential contact regarding this recommendation for both Renown Regional Medical Center and the Rural Regional Medical Center. Bother Lisa and Dr. Eisen stated that they would send Jessica Freeman their contact information for the above-mentioned physicians. Additionally, Lisa and Dr. Eisen agreed to notify the physicians to expect an email with a link to a doodle poll, which will determine when the next subcommittee meeting will be scheduled.

Dr. Eisen stated that some hospitals have protocols in place, which means that there is some variation in procedures. The main purpose of this subcommittee and recommendation is to establish a process or protocol for non-pediatric medical facilities in cases where children present to these locations. Additionally, the goal is to increase resources and findings to these medical facilities if and when they are needed. Dr. Eisen concluded that the subcommittee will need to create two different protocols: one for pediatric hospitals and one for non-pediatric medical facilities. Jessica also stated that she has

gathered some research articles from the American Academy Of Pediatrics that might include helpful information pertaining to this recommendation.

Lisa Sherych inquired if it would be worthwhile to include processes for victims of human trafficking in this recommendation. Dr. Eisen concurred that this was an important endeavor, however, that this specific recommendation wasn't the appropriate avenue for that endeavor, as there are different considerations to include for that population. Dr. Eisen further stated that Dr. Derek Meeks, a physician at Boulder City Hospital, is leading efforts to provide resources for both staff and patients in emergency departments and urgent care facilities throughout the state advocating for victims of human trafficking. Dr. Eisen also said that Dr. Meeks teaches at Torro University and that he and his students have been doing a lot of the leg work for this effort.

Vickie Ives asked Molly Blanchette who is heading up the Commercial Sexual Exploitation of Children (CSEC) work for the Family Programs Office at DCFS (FPO) and wanted to make sure that they had a connection with Dr. Meeks. Jessica Freeman stated that she would reach out to Molly and find out whether there was such a connection. Dr. Eisen stated that he could connect Lisa Sherych and Dr. Meeks if she'd like. Lisa stated that she would appreciate having contact with Dr. Meeks. Lisa stated that she would also like to connect Dr. Meeks with a contact in either the attorney general's office or a legal representative at some point. Dr. Eisen stated that it would be helpful to note what information needs to be gathered in order to assist in criminal and/or dependency proceedings.

Vickie Ives asked if there was a way to easily query the data from the local child death review teams in order to see how frequently fatalities resulting from serious/abusive injuries occur. Specifically, Vickie wanted to know how often a recommendation pertaining to abusive injuries/neglect is generated and if local child death review teams keep a record of children with serious/abusive injuries with multiple emergency room visits. Jessica Freeman stated that she didn't think that those parameters would be captured in the state child welfare database, but that maybe such parameters might be captured in the National Center for Fatality Review and Prevention. Elizabeth Holka stated that she didn't think there were any data points in the National Center for Fatality Review and Prevention data tool that collected this information, however, there might be relevant information in the quarterly reports issued by child death review teams. Dr. Eisen stated that analyzing data from child death review teams would only capture a fraction of the children that are hospitalized for abusive/serious injuries, and child death review teams only review fatalities. Jessica state that she, Dawn, and Elizabeth could look at the National Center for Fatality Review and Prevention database to see if there were any relevant questions that could help answer Vickie's question. The subcommittee agreed that collecting data on children who present to the emergency room with abusive and serious injuries, including those that don't result in a fatality, is worth consideration. Vickie stated that she would reach out to Jen Thompson to see if she has any information regarding the collection of this data.

NO MOTION MADE.

5. Final Public Comment

No comments.

6. Adjournment

The meeting was adjourned at 3:36 PM.