STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

2022 STATEWIDE CHILD DEATH REPORT

Submitted by:
The Executive Committee to Review the Death of Children

Special thanks go to the following who contributed to complete the 2022 Statewide Child Death Report:

The Executive Committee to Review the Death of Children

Division of Child and Family Services (DCFS), Nevada's Department of Health and Human Services

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Table of Contents

List of Figures

List of Tables

EXECUTIVE SUMMARY

Most child deaths, with the exception of natural and undetermined deaths, are preventable. A child's death is a tragic loss to the family and the community and can also be an indicator regarding the health of the community. Understanding why a child dies can help prevent the deaths of other children and improve health outcomes and overall child safety.

Different age groups of children and adolescents are at risk for different types of death. Infants and young children are at greater risk of accidental asphyxia deaths, which often result from unsafe sleeping environments and parents sharing a bed with their children. Adolescents are at greater risk of motor vehicle accidents, suicide, and drug overdoses. All age groups are at risk of drowning, especially children between ages one and four.

The purpose of this report is to provide information regarding the circumstances by which children die in Nevada, in order to prevent future child deaths and improve the health and safety of children in the state.

WHERE DOES NEVADA'S CHILD DEATH DATA COME FROM?

The scope of information included in this report is limited to those child deaths which were reviewed by child death review teams pursuant to Nevada Revised Statutes (NRS) 432B.403 through NRS 432B.4095. In accordance with NRS 432B.405(1)(c), an agency which provides child welfare services shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:

1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;

2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;

3) If the death is alleged to be from abuse or neglect of the child;

4) If a sibling, household member or day care provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending;

5) If the child was adopted through an agency which provides child welfare services; or

6) If the child died of Sudden Infant Death Syndrome.

HOW DO THE REGIONAL CHILD DEATH REVIEW TEAMS AND THE EXECUTIVE COMMITTEE WORK TO PREVENT CHILD DEATHS?

The 2022 child deaths were reviewed by Nevada's seven regional child death review (CDR) teams (see Appendix D.) The two urban teams, Clark and Washoe, reviewed child deaths in the major population centers of the state, in the areas of Las Vegas and Reno, respectively. The teams in the rural areas reviewed child deaths in all other counties.

The regional CDR teams submit recommendations to the Executive Committee to improve laws, policies, and practices that may help prevent child death. The Executive Committee primarily works with state, county, and local agencies to make internal or systemic changes that focus on increased safety for children.

Pursuant to Section 2 of NRS 432B.409, the Executive Committee to Review the Death of Children (Executive Committee) is the statewide group that:

1) Adopts statewide protocols for the review of the death of a child;

2) Adopts regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;

3) Adopts bylaws to govern the management and operation of the Executive Committee;

4) Appoints one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS432B.405;

5) Oversees training and development of multidisciplinary teams to review the death of children;

6) Compiles and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes; and

7) Carries out the duties specified in NRS 432B.408, which are to:

    a. Review the report and recommendations of a multidisciplinary team to review the death of a child pursuant to NRS 432B.409; and

    b. Respond in writing to the multidisciplinary team within 90 days after receiving the report.

Finally, pursuant to Section 3 of NRS 432B.409, the Executive Committee makes decisions about funding initiatives to prevent child deaths based on the analyses of the annual data.

WHAT ARE THE LEADING CAUSES OF CHILD DEATH IN NEVADA?

Excluding natural and undetermined deaths, in 2022, the four leading causes of death were:

1. Motor vehicle accidents
2. Accidents caused by asphyxia
3. Homicides caused by bodily force or weapons
4. Drowning accidents

How does child death in Nevada compare with the United States as a whole?

	Nevada	United States
Number of child deaths in 2022	257*	36,871[1]
Number of child deaths in 2021	278*	35,654[1]
Change in number of child deaths from 2021 to 2022	Decrease of 21 (-14.7%)	Increase of 1217 (3.4%)
Infant mortality rate per 1,000 live births in 2022	4.49[2]	5.60[3]
Age group experiencing largest number of child deaths in 2022	Under 1 year	Under 1 year
Leading manner of child death in 2022	Natural	Natural
*Number of child deaths reviewed by regional teams		

There were 291 child deaths in Nevada in 2022. As seen in the table above, the regional child death review teams reviewed 257 (88.3%) of these deaths. The remainder of this report focuses on this subset of child deaths.

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[1] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved September 6, 2024 from http://wonder.cdc.gov/ucd-icd10-expanded.html

[2] Centers for Disease Control (2023). *Infant Mortality*. Retrieved September 5, 2024 from https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

[3] Ely, D. M. & Driscoll, A. K. (2023). Infant mortality in the United States: Provisional data from the 2022 period linked birth/infant death file. National Center for Health Statistics. Vital Statistics Rapid Release; no 33. Hyattsville, MD: National Center for Health Statistics. DOI: https://doi.org/10.15620/cdc:133699

Data Overview

Data Sources

All Nevada data in this report are derived from the regional CDR teams, which collect and enter data into the National Fatality Review Case Reporting System (NFR-CRS) maintained by the National Center for Fatality Review and Prevention (NCFRP). Based on the data in the NFR-CRS, there were 257 child deaths that occurred in calendar year 2022 and were reviewed in the state. These fatalities include children and adolescents from birth through 17 years of age.

Data Confidentiality

Portions of the collective information and data contained in this report were compiled from child records that are confidential and contain information that is protected from disclosure to the public, pursuant to the NRS and federal laws and regulations.

Data Limitations

- Some child deaths are not reviewed by the regional CDR teams. While the teams review all coroner-referred deaths, there may be some cases where the death certificate is issued by a private attending physician (non-coroner-referred) and is not referred to a team for review. Additionally, some deaths of out-of-state residents may not be processed through a Nevada coroner or medical examiner.

- Although a national data instrument is used for the collection of data, there may be inconsistencies at the regional CDR team level in terms of how these data are collected and entered.

- The data entered into the database are based on the documentation provided to the teams and information obtained during the review process. Unfortunately, for some cases, this information is very limited which leads to several variables in the data system being recorded as "unknown" or "missing."

- There may be data errors due to problems with a child's name. The most common issue occurs with infants who are not given a name at the time of their death and are assigned a designation such as "baby boy" or "baby girl." When a death certificate is issued, in most cases, a name is given, which creates discrepancies in the data. These cases are examined, and attempts are made to reconcile these differences, but not all discrepancies can be corrected.

- There may be data errors due to coding for the cause of death. For coroner and medical examiner data, groupings are made based on International Classification of Diseases (ICD)-10 codes and information grouping details. The ICD-10 classification system is developed and published by the World Health Organization (WHO) and used to code and classify mortality data from death certificates.[1] Typically, the cause of death is entered as reported on the death certificate. However, if during the review process, additional information is obtained, the team has the ability to reclassify the cause of death. In these instances, the cause of death

[1] National Center for Health Statistics. (2024). *International Classification of Diseases, Tenth Revision (ICD-10)*. Retrieved September 6, 2024 from https://www.cdc.gov/nchs/icd/icd-10/index.html

decided by the team would be recorded in the database.

- Similarly, although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, if during the review process, additional information is obtained, the team has the ability to reclassify the manner of death. In these instances, the manner of death decided by the team would be recorded in the database.

FREQUENCY OF REVIEWS

Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region as detailed in NRS 432B.403 through NRS 432B.4095, also detailed above. In Clark County, the team meets monthly due to their high caseload. In Washoe County, the team meets every other month. In the rural areas, most of the regional CDR teams meet quarterly to review child death cases referred by coroners' offices, or as requested, in their respective regions. However, the rural regional teams might meet less frequently if no child fatalities are reported in a given quarter.

Overview of Deaths

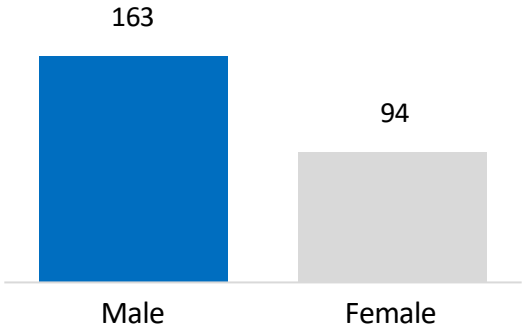
The Nevada regional CDR teams reviewed the deaths of 257 children under 18 years of age that occurred in 2022. In the sections that follow, the overall demographics and manner of these deaths are reviewed.

Demographics

The data used for this report come from the National Fatality Review Case Reporting System (NFR-CRS), which is the case reporting system used by the regional CDR teams. The response options in the system to report on a child's "sex" include, "Male," "Female," and "Unknown." Based on the available data, the terms sex, male, female, and unknown will be used in the current report.

As seen in Figure 1, there were more child deaths in Nevada in 2022 among males as compared to females.

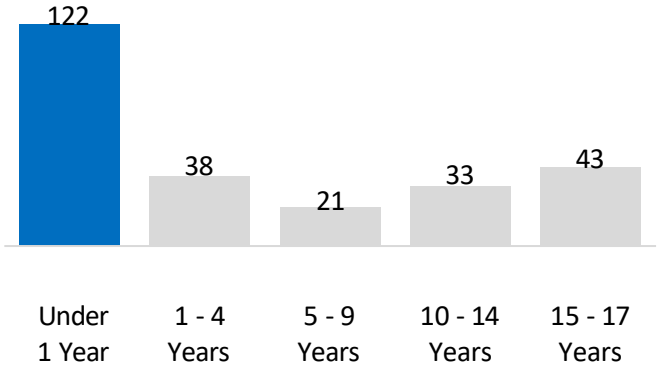
Figure 1. Number of child deaths in Nevada in 2022 by sex of decedent.



There were more child deaths among males (63.4%) as compared to females (36.6%).

As seen in Figure 2, the largest percentage of child deaths in Nevada in 2022 occurred among those less than one year of age (47.5%).

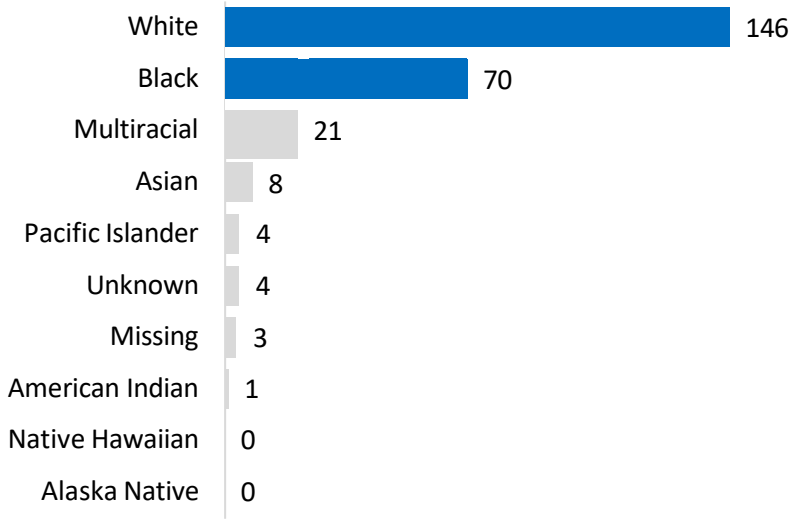
Figure 2. Number of child deaths in Nevada in 2022 by age category of decedent.



Almost half of the deaths occurred among children under 1 year of age (47.4%).

With regard to race, as seen in Figure 3, the largest percentage of child deaths in Nevada in 2022 occurred among White (56.8%) and Black children (27.2%).

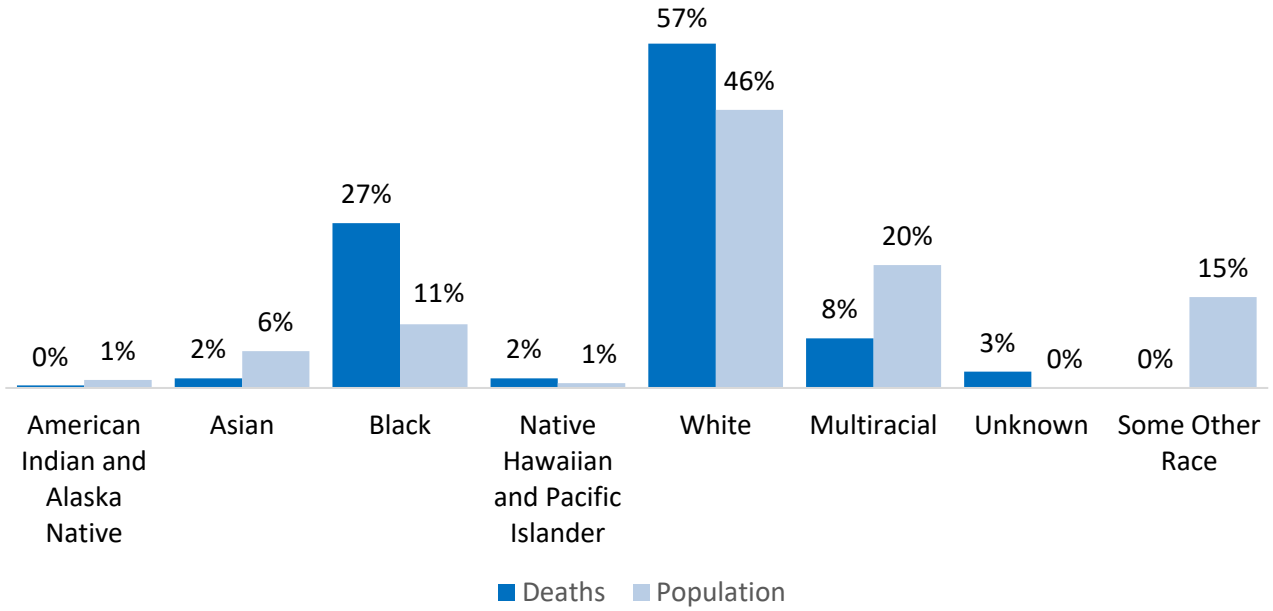
Figure 3. Number of child deaths in Nevada in 2022 by race of decedent.



As seen in Figure 4, in comparing the percentage of child deaths in Nevada in 2022 by race to the population estimates of the race of children in Nevada in 2022, the percentage of deaths among Black and White children is overrepresented.[1] Specifically, according to population estimates, Black children made up 11 percent of the child population in Nevada in 2022 but accounted for 27 percent of the deaths reviewed for this report. White children made up 46 percent of the population but accounted for 57 percent of the deaths.

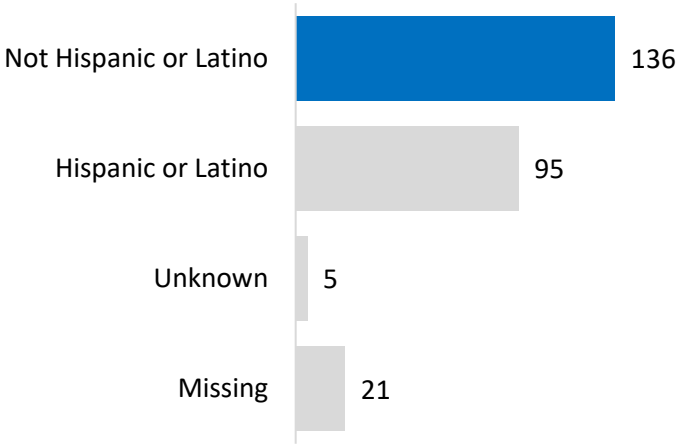
[1] U.S. Census Bureau. (2022). CHILDREN CHARACTERISTICS. *American Community Survey, ACS 5-Year Estimates Subject Tables, Table S0901*. Retrieved September 6, 2024, from https://data.census.gov/table/ACSST5Y2022.S0901?q=s0901&g=040XX00US32

Figure 4. Percent of child deaths in Nevada in 2022 by race of decedent and the race of the population under 18 years of age in Nevada in 2022.



With regard to ethnicity, the largest percentage of child deaths in Nevada in 2022 were among children not of Hispanic or Latino ethnicity (52.9%). See Figure 5.

Figure 5. Number of child deaths in Nevada in 2022 by Hispanic or Latino ethnicity of decedent.

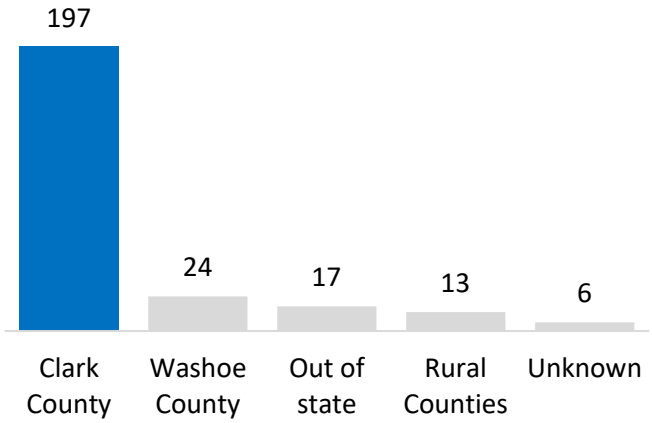


More than half of the deaths occurred among children not of Hispanic or Latino ethnicity (52.9%).

Due to the small number of child deaths that occur among children who are residents of the counties of Carson City, Churchill, Douglas, Elko, Esmeralda, Eureka, Humboldt, Lander, Lincoln, Lyon, Mineral, Nye, Pershing, Storey, and White Pine, and to maintain confidentiality, the number of child deaths that occurred in these counties in 2022 have been combined for this report and the county of residence is referred to as the Rural Counties.

As seen in Figure 6, the largest percentage of child deaths in Nevada in 2022 occurred among those who were residents of Clark County (76.7%).

Figure 6. Number of child deaths in Nevada in 2022 by county of residence of the decedent.



Manner of Death

A coroner or medical examiner lists one of five manners of death on the death certificate as follows:

1. **Natural**: Deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases.
2. **Accident**: Deaths not caused by an intent to harm.
3. **Homicide**: The killing of one human by another.
4. **Suicide**: Taking of one's own life voluntarily and intentionally.
5. **Undetermined**: Deaths where sufficient evidence or information cannot be deduced during the initial investigation, usually about intent, to assign a manner of death.

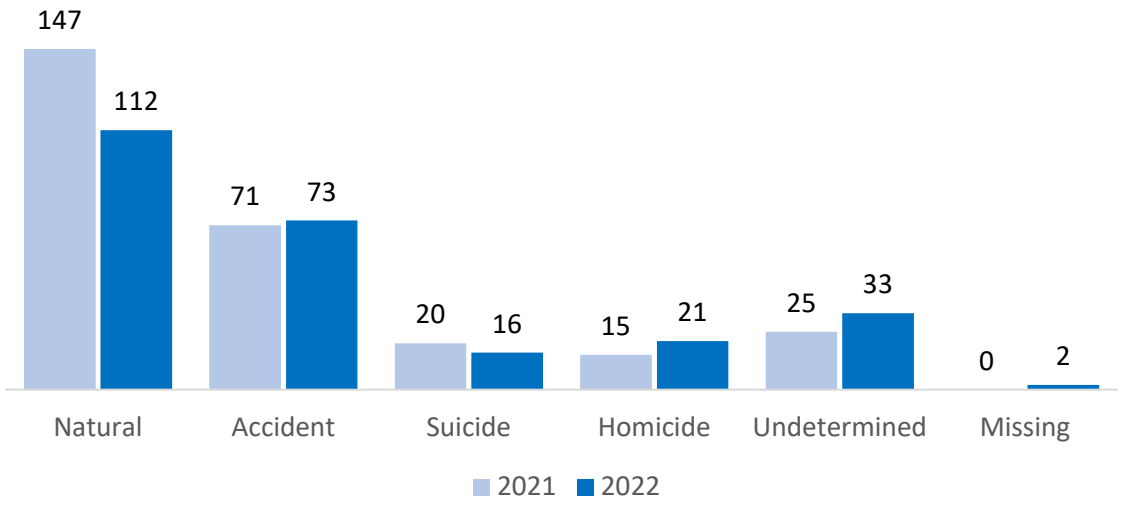
As seen in Table 1, the largest percentage of child deaths by manner in Nevada in 2022 were natural (43.6%), followed by accident (28.4%).

Table 1. Number and percent of child deaths in Nevada in 2022 by manner of death.

	Number	Percent
Natural	112	43.6%
Accident	73	28.4%
Suicide	16	6.2%
Homicide	21	8.2%
Undetermined	33	12.8%
Unknown	2	0.8%
Total	257	100%

As seen in Figure 7, there were fewer natural and suicide child deaths in Nevada in 2022 as compared to 2021 but more accident, homicide, and undetermined child deaths.

Figure 7. Number of child deaths in Nevada in 2021 and 2022 by manner of death.



Deaths by Manner

Natural

Natural deaths are those deaths that result from natural disease mechanisms and include prematurity, and Sudden Infant Death Syndrome (SIDS) cases. In 2022, the largest percentage of child deaths by manner in Nevada were natural (43.6%). As seen in Table 2 below, the majority of natural deaths occurred among children under one year of age (64.3%). Overall, the most common cause of natural death was due to prematurity (29.5%), followed by congenital anomaly (16.1%), and cardiovascular reasons (12.5%).

Table 2. Number of natural child deaths in Nevada in 2022 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asthma/Respiratory	2	3	1	2	0	8
Cancer	0	1	1	1	1	4
Cardiovascular	5	2	1	4	2	14
Congenital anomaly	14	1	0	2	1	18
COVID-19	0	0	1	0	0	1
Diabetes	0	0	0	0	0	0
HIV/AIDS	0	0	0	0	0	0
Influenza	0	0	0	0	0	0
Low birth weight	0	0	0	0	0	0
Malnutrition/dehydration	0	0	0	0	0	0
Neurological/seizure	1	1	0	0	0	2
Pneumonia	0	0	0	0	0	0
Prematurity	33	0	0	0	0	33
SIDS	0	0	0	0	0	0
Other infection	4	3	1	0	1	9
Other perinatal condition	6	0	0	0	0	6
Other medical condition	5	0	3	3	1	12
Undetermined	0	0	0	1	1	2
Missing	2	0	0	0	1	3
Total	72	11	8	13	8	112

Accident

Accident deaths are deaths not caused by an intent to harm. In 2022, there were 73 accident child deaths in Nevada. As seen in Table 3 below, the largest percentage of accident deaths (28.8%) occurred among children under one year of age. Overall, motor vehicle accidents were the most common cause of accident deaths among children in Nevada in 2022 (34.2%). The next most common causes of accident child deaths in Nevada in 2022 were asphyxia (28.8%) and drowning (19.2%).

Table 3. Number of accident child deaths in Nevada in 2022 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asphyxia	19	1	0	1	0	21
Motor Vehicle	0	7	4	5	9	25
Fire, Burn, or Electrocution	0	0	1	0	0	1
Drowning	1	7	4	1	1	14
Bodily Force or Weapon	1	0	0	0	0	1
Fall or Crush	0	1	0	0	1	2
Poisoning, Overdose, or Acute Intoxication	0	1	0	0	5	6
Other Injury	0	0	0	0	2	2
Unknown	0	0	0	0	0	0
Missing	0	0	0	1	0	1
Total	21	17	9	8	18	73

Homicide

In 2022, there were 21 homicide child deaths in Nevada. As seen in Table 4 below, more than three-fourths (76.2%) of the homicides were caused by bodily force or weapon and the largest percentage of homicide child deaths (38.1%) were among children aged 15 – 17 years old.

Table 4. Number of homicide child deaths in Nevada in 2022 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asphyxia	0	0	0	0	0	0
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	1	2	3	2	8	16
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	1	2	0	0	0	3
Other Injury	0	1	0	0	0	1
Unknown	0	1	0	0	0	1
Missing	0	0	0	0	0	0
Total	2	6	3	2	8	21

Suicide

In 2022, there were 16 suicide child deaths in Nevada. As seen in Table 5, all of the suicide deaths occurred among children aged 10– 17 years old. The largest percentage of suicide child deaths were the result of asphyxia (50.0%), followed by bodily force or a weapon (18.8%).

Table 5. Number of suicide child deaths in Nevada in 2022 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asphyxia	0	0	0	7	1	8
Motor Vehicle	0	0	0	0	1	1
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	0	0	0	0	0
Bodily Force or Weapon	0	0	0	0	3	3
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	1	1
Other Injury	0	0	0	1	1	2
Unknown	0	0	0	0	0	0
Missing	0	0	0	0	1	1
Total	0	0	0	8	8	16

UNDETERMINED

In 2022, there were 33 child deaths in Nevada in which the manner of death was undetermined. Undetermined deaths are deaths in which there is lack of sufficient evidence or information during the initial investigation, usually about intent, to assign a different manner of death. As seen in Table 6 below, the majority of the undetermined child deaths were among children under one year of age (81.8%). Further, in the majority of the undetermined child deaths (81.8%), it was undetermined if they were caused by an injury or due to a medical reason.

Table 6. Number of undetermined child deaths in Nevada in 2022 by age category and primary cause of death.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
External cause of injury	1	0	0	0	0	1
Medical condition	0	0	0	0	0	0
Undetermined if injury or medical cause	21	4	1	1	0	27
Unknown	4	0	0	0	0	4
Missing	1	0	0	0	0	1
Total	27	4	1	1	0	33

For details regarding the age, gender, race, Hispanic or Latino ethnicity, and county of residence for all of the 2022 Nevada child decedents by manner, see Appendix A.

Leading Manners and Causes of Child Death

Excluding natural, undetermined, and unknown manners of death, in Nevada in 2022, the four leading manners and causes of death included motor vehicle accidents (22.7%), accidents caused by asphyxia (19.1%), homicides caused by bodily force or weapon (14.5%), and accidents caused by drowning (12.7%). See Table 7 for the number and percent of manner and causes of child deaths in Nevada in 2022, excluding natural, undetermined, and unknown manners of death.

Table 7. Number and percent of manner and causes of child deaths in Nevada in 2022 excluding natural, undetermined, and unknown manners of death.

Manner	Cause	Number	Percent
Accident	Motor Vehicle	25	22.7%
Accident	Asphyxia	21	19.1%
Homicide	Bodily Force or Weapon	16	14.5%
Accident	Drowning	14	12.7%
Suicide	Asphyxia	8	7.3%
Accident	Poisoning, Overdose, or Acute Intoxication	6	5.5%
Homicide	Poisoning, Overdose, or Acute Intoxication	3	2.7%
Suicide	Bodily Force or Weapon	3	2.7%
Accident	Fall or crush	2	1.8%
Accident	Other Injury	2	1.8%
Suicide	Other Injury	2	1.8%
Accident	Fire, Burn, or Electrocution	1	0.9%
Accident	Bodily Force or Weapon	1	0.9%
Accident	Missing	1	0.9%
Homicide	Other Injury	1	0.9%
Homicide	Unknown	1	0.9%
Suicide	Motor Vehicle	1	0.9%
Suicide	Poisoning, Overdose, or Acute Intoxication	1	0.9%
Suicide	Missing	1	0.9%
	Total	110	100%

MOTOR VEHICLE ACCIDENTS (N = 25)

As seen in Table 8, there were four times as many male children that died of motor vehicle accidents in Nevada in 2022 as compared to female children (80.0% as compared to 20.0%).

Table 8. Number and percent of motor vehicle accident child deaths in Nevada in 2022 by sex of the decedent.

	Number	Percent
Male	20	80.0%
Female	5	20.0%
Unknown	0	0.0%
Total	25	100%

The largest percentage of motor vehicle accident child deaths were among children aged 15 – 17 years old (36.0%), followed by those aged 1 – 4 years old (28.0%). No children under the age of one died in motor vehicle accidents in Nevada in 2022. See Table 9.

Table 9. Number and percent of motor vehicle accident child deaths in Nevada in 2022 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	7	28.0%
5 - 9 Years	4	16.0%
10 - 14 Years	5	20.0%
15 - 17 Years	9	36.0%
Total	25	100%

As seen in Table 10, more than two-thirds (68.0%) of the motor vehicle accident child deaths occurred among White children. The next largest percentage of deaths occurred among Black children (16.0%).

Table 10. Number and percent of motor vehicle accident child deaths in Nevada in 2022 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	1	4.0%
Asian	2	8.0%
Black	4	16.0%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	17	68.0%
Multiracial	1	4.0%
Unknown	0	0.0%
Total	25	100%

As seen in Table 11, approximately half (48.0%) of the motor vehicle accident child deaths in Nevada in 2022 were among children of Hispanic or Latino ethnicity.

Table 11. Number and percent of motor vehicle accident child deaths in Nevada in 2022 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	12	48.0%
Not Hispanic or Latino	9	36.0%
Missing	4	16.0%
Total	25	100%

Slightly more than half (52.0%) of the motor vehicle accident child deaths in Nevada in 2022 occurred among those who were a passenger in the motor vehicle. The next largest percentage of deaths occurred among those who were pedestrians (24.0%), followed by drivers (20.0%). See Table 12.

Table 12. Number and percent of motor vehicle accident child deaths in Nevada in 2022 by position of child during the accident.

	Number	Percent
Driver	5	20.0%
Passenger	13	52.0%
On bicycle	1	4.0%
Pedestrian	6	24.0%
Unknown	0	0.0%
Total	25	100%

Details regarding the factors associated with the motor vehicle accident child deaths can be seen in Table 13. The most commonly reported factors included recklessness, speeding over the limit, and drug/alcohol use.

Table 13. Causes of motor vehicle accident child deaths in Nevada in 2022.

	Number of cases
Recklessness	10
Speeding over limit	9
Drug/alcohol use	8
Vehicle ran over child	6
Vehicle flipped over	6
Ran stop sign/red light	5
Other driver error	3
Unknown	2
Driver distraction	1
Unsafe speed for conditions	1
Car changing lanes	1
Racing	1
Other cause	1
Inexperienced driver	0
Poor sightline	0
Poor visibility	0
Road hazard	0
Electronic use	0
Poor weather	0
Note: More than one cause may apply to a case.	

Among the motor vehicle accident child deaths that occurred in Nevada in 2022, the child was responsible in four cases, the child's driver was responsible in seven cases, and the other driver was responsible in ten cases. There were two cases in which the driver responsible for the incident was unknown. Table 14 identifies some of the factors contributing to the motor vehicle accident child deaths based on who was responsible.

Table 14. Number of cases in which the following were contributing factors in motor vehicle accident child deaths in Nevada in 2022 by person responsible for the accident.

	Child Responsible	Child's Driver Responsible	Other Driver Responsible	Multiple Drivers Responsible
No license	1	1	0	0
Learners permit	0	0	0	0
Graduated license	0	0	0	0
Full license, not graduated	0	0	4	0
Full license, restricted	0	0	0	0
Suspended license	0	0	0	0
In violation of graduated license rules	0	0	0	0
Note: More than one contributing factor may apply to a case.				

ACCIDENTS CAUSED BY ASPHYXIA (N = 21)

All but two of the accident child deaths caused by asphyxia in Nevada in 2022 were sleep-related. As seen in Table 15, approximately four times as many male children died of asphyxia accidents in Nevada in 2022 as compared to female children.

Table 15. Number and percent of accident child deaths caused by asphyxia in Nevada in 2022 by sex of the decedent.

	Number	Percent
Male	17	81.0%
Female	4	19.0%
Unknown	0	0.0%
Total	21	100%

All but two of the accident child deaths caused by asphyxia were among children under one year of age (90.5%). There was one child in the 1 – 4 Years age category and one child in the 10 – 14 Years age category that died due to accidental asphyxia.

As seen in Table 16, the majority of accident child deaths caused by asphyxia in Nevada in 2022 were among Black children (42.9%) and White children (38.1%).

Table 16. Number and percent of accident child deaths in Nevada in 2022 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	9	42.9%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	8	38.1%
Multiracial	3	14.3%
Unknown	1	4.8%
Total	21	100%

As seen in Table 17, more than half (52.4%) of accident child deaths caused by asphyxia in Nevada in 2022 were among children not of Hispanic or Latino ethnicity.

Table 17. Number and percent of accident child deaths caused by asphyxia in Nevada in 2022 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	6	28.6%
Not Hispanic or Latino	11	52.4%
Unknown	2	9.5%
Missing	2	9.5%
Total	21	100%

Some of the circumstances of the accident child deaths caused by asphyxia in Nevada in 2022, including the objects found in the sleeping area, how the child was placed to sleep, and if the caregiver fell asleep feeding the child, are identified in Table 18. More than one circumstance can apply to a case.

Table 18. Circumstances of accident child deaths caused by asphyxia in Nevada in 2022.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	10
	Pillow	10
	Comforter, quilt, or other	8
	Thin blanket/flat sheet	4
	Child(ren)	4
	Bottle	3
	Other	3
	Wall	1
	Toys	1
	Nursing or U-shaped pillow	1
	Animal(s)	0
	Cushion	0
	Sleep positioner	0
	Bumper pads	0
	Clothing	0
	Crib railing/side	0
Child placed to sleep	In adult bed	13
	On stomach	4
	Wrapped or swaddled in blanket	2
	On side	1
	On couch	0
	With a pacifier	0
	On floor	0
	In car seat	0
Caregiver/supervisor fell asleep	Bottle feeding child	1
	Breastfeeding child	1

HOMICIDES CAUSED BY BODILY FORCE OR WEAPON (N = 16)

In Nevada in 2022, all but two of the child homicides caused by bodily force or a weapon occurred among male children (87.5%). See Table 19.

Table 19. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2022 by sex of the decedent.

	Number	Percent
Male	14	87.5%
Female	2	12.5%
Unknown	0	0.0%
Total	16	100%

Half (50.0%) of child homicides caused by bodily force or a weapon were among children in the 15 – 17 Years age category. See Table 20.

Table 20. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2022 by age category of the decedent.

	Number	Percent
<1 Year	1	6.3%
1 - 4 Years	2	12.5%
5 - 9 Years	3	18.8%
10 - 14 Years	2	12.5%
15 - 17 Years	8	50.0%
Total	16	100%

In Nevada in 2022, the largest percentage of child homicides caused by bodily harm or weapon were among White children (50.0%) followed by Black children (43.8%). There was one Multiracial child that died of homicide caused by bodily force or a weapon. See Table 21.

Table 21. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2022 by race of the decedent

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	7	43.8%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	8	50.0%
Multiracial	1	6.3%
Unknown	0	0.0%
Total	16	100%

As seen in Table 22, half of child homicides caused by bodily force or a weapon in Nevada in 2022 were among children of Hispanic or Latino ethnicity (50.0%).

Table 22. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2022 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	8	50.0%
Not Hispanic or Latino	6	37.5%
Unknown	0	0.0%
Missing	2	12.5%
Total	16	100%

The majority of child homicides caused by bodily force or weapon in Nevada in 2022 were the result of a firearm (62.5%). See Table 23.

Table 23. Number and percent of child homicides caused by bodily force or a weapon in Nevada in 2022 by type of weapon used.

	Number	Percent
Firearm	10	62.5%
Knife/Sharp instrument	2	12.5%
Bodily Force	0	0.0%
Rope	0	0.0%
Other	0	0.0%
Unknown	0	0.0%
Missing	4	25.0%
Total	16	100%

As seen in Table 24, in eight of the child homicides caused by a firearm, the firearm was stored loaded and in seven of the child homicides caused by a firearm, the owner of the firearm was unknown.

Table 24. Circumstances related to child homicides caused by a firearm in Nevada in 2022.

Storage	Firearm loaded	8
	Firearm kept locked	0
Owner of firearm	Caregiver	3
	Other family member	0
	Stranger	0
	Other	0
	Unknown	7
Note: More than one circumstance can apply to a case.		

Table 25 identifies how the fatal weapon was being used at the time of the child homicides caused by bodily force or a weapon in Nevada in 2022.

Table 25. How the fatal weapon was being used at the time of the child homicides caused by bodily force or a weapon in Nevada in 2022.

	Number of Cases
Self-injury	0
Commission of a crime	0
Drug dealing/trading	0
Drive-by shooting	0
Random violence	0
Child was a bystander	0
Argument	1
Jealousy	0
Intimate partner violence	1
Hate crime	0
Bullying	0
Hunting	0
Target shooting	0
Playing with the weapon	3
Showing the gun to others	1
Russian Roulette	0
Gang-related activity	1
Self-defense	0
Cleaning the weapon	0
Other	2
Unknown	3
Note: More than one use can apply to a case.	

ACCIDENTS CAUSED BY DROWNING (N = 14)

As seen in Table 26, there were two more male children than female children that died of an accident caused by drowning in Nevada in 2022.

Table 26. Number and percent of accident child deaths caused by drowning in Nevada in 2022 by sex of the decedent.

	Number	Percent
Male	8	57.1%
Female	6	42.9%
Unknown	0	0.0%
Total	14	100%

In Nevada in 2022, half (50.0%) of accident child deaths caused by drowning were among children aged 1 – 4 years old. The next largest percentage of drowning deaths were among children aged 5 – 9 years old (28.6%). See Table 27.

Table 27. Number and percent of accident child deaths caused by drowning in Nevada in 2022 by age category of the decedent.

	Number	Percent
<1 Year	1	7.1%
1 - 4 Years	7	50.0%
5 - 9 Years	4	28.6%
10 - 14 Years	1	7.1%
15 - 17 Years	1	7.1%
Total	14	100%

Table 28. Number and percent of accident child deaths caused by drowning in Nevada in 2022 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	5	35.7%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	7	50.0%
Multiracial	2	14.3%
Unknown	0	0.0%
Total	14	100%

Table 29. Number and percent of accident child deaths caused by drowning in Nevada in 2022 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	2	14.3%
Not Hispanic or Latino	12	85.7%
Unknown	0	0.0%
Total	14	100%

As seen in Table 30, the location of the majority (78.6%) of accident child deaths caused by drowning in Nevada in 2022 was a pool, hot tub, or spa.

Table 30. Number and percent of accident child deaths caused by drowning in Nevada in 2022 by drowning location.

	Number	Percent
Open water	0	0.0%
Pool, hot tub, spa	11	78.6%
Bathtub	2	14.3%
Other	1	7.1%
Total	14	100%

As seen in Table 31, in the majority of the accident child deaths caused by drowning in Nevada in 2022, the swimming ability of the child was unknown (57.1%) and in less than one-third of the cases (28.6%), the child was not able to swim.

Table 31. Swimming ability of children that died in Nevada in 2022 in accidents caused by drowning.

	Number	Percent
Child was able to swim	0	0.0%
Child was not able to swim	4	28.6%
Child's swimming ability was unknown	8	57.1%
Missing	2	14.3%
N/A	0	0.0%
Total	14	100%

Finally, as seen in Table 32, in eight of the child accident deaths caused by drowning in Nevada in 2022, there were no barriers to the swimming area. In 11 of the deaths, rescue attempts were made to save the child.

Table 32. Number of accident child deaths involving drowning in Nevada in 2022 with the listed contributing factors

		Number of cases
Safety Factors	Child had a personal flotation device	0
	No barriers to swimming area	8
	Fence around swimming area	3
	Gate to swimming area	0
	Door to swimming area	0
	Alarm for swimming area	0
	Cover for swimming pool, hot tub, or spa	0
Safety Breaches	Gate left open	0
	Gate unlocked	0
	Gate latch failure	0
	Gap in gate	0
	Child climbed fence to access swimming area	0
	Gap in fence	1
	Damaged fence	1
	Fence too short	0
	Door left open	0
	Door unlocked	0
	Door broken	0
	Door screen torn	0
	Door self-closer failure	0
	Alarm not working	0
	Alarm not answered	0
	Cover left off	0
	Cover not locked	0
Rescue Efforts	Rescue attempt made	11
	Rescue attempt made by parent/relative	6
	Rescue attempt made by other child	1
	Rescue attempt made by lifeguard	1
	Rescue attempt made by bystander	1
	Rescue attempt made by other adult	1
	Rescue attempt made by other	0
	Appropriate rescue equipment present	0
Note: More than one factor can apply to a case.		

Deaths in which there was Abuse or Neglect, Substance Use During Pregnancy, or CPS Involvement

Deaths in which abuse or neglect caused or contributed to the death

In Nevada in 2022, there were 89 deaths in which abuse (n = 9), neglect (n = 24), poor/absent supervision (n = 21), or exposure to hazards (n = 35) caused or contributed to the death. Abuse is any injury inflicted on a child by a parent or caregiver. The parent or caregiver may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment. Neglect is failure on the part of a parent, caregiver, or supervisor to provide for the shelter, safety, supervision and nutritional needs of the child that results in harm to the child. Poor/absent supervision is failure on the part of the parent, caregiver, or supervisor to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death. Exposure to hazards refers to behavior by a parent, caregiver, or supervisor that exposes a child to a hazard that poses a threat of harm to the child but does not meet the criteria to be classified as child neglect (Appendix E).

As seen in Table 33, for child deaths in which abuse, neglect, poor/absent supervision, or exposure to hazards caused or contributed to the death, slightly more than half (51.7%) were accidents followed by undetermined deaths (22.5%) and homicides (20.2%).

Table 33. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 by manner of death.

	Number	Percent
Natural	3	3.4%
Accident	46	51.7%
Suicide	2	2.2%
Homicide	18	20.2%
Undetermined	20	22.5%
Unknown	0	0.0%
Total	89	100%

As seen in Table 34, there were more deaths of male children (76.4%) than of female children (23.6%) in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death.

Table 34. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 by sex of the decedent.

	Number	Percent
Male	68	76.4%
Female	21	23.6%
Unknown	0	0.0%
Total	89	100%

In Nevada in 2022, the largest percentage of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among children under one year of age (39.3%), followed by those aged 1 – 4 years old (27.0%).

Table 35. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 by age category of the decedent.

	Number	Percent
<1 Year	35	39.3%
1 - 4 Years	24	27.0%
5 - 9 Years	10	11.2%
10 - 14 Years	8	9.0%
15 - 17 Years	12	13.5%
Total	89	100%

As seen in Table 36 below, the largest percentage of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death were among Black children (42.7%) followed by White children (36.0%).

Table 36. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 by race of the decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	4	4.5%
Black	38	42.7%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	32	36.0%
Multiracial	13	14.6%
Unknown	2	2.2%
Total	89	100%

The majority of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 were among children not of Hispanic or Latino ethnicity (60.7%). See Table 37.

Table 37. Number and percent of child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	29	32.6%
Not Hispanic or Latino	54	60.7%
Unknown	4	4.5%
Missing	2	2.2%
Total	89	100%

The types of abuse and neglect indicated in the child deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death in Nevada in 2022 are shown in Table 38. Neglect by exposure to hazards was indicated in 14 deaths. These hazards included sleep environment hazards, fire hazards, unsecured medication/poison, firearm hazards, and motor vehicle hazards. Neglect by failure to provide supervision was indicated in 10 deaths. Other abuse was indicated in five deaths and included blunt force injuries, poisoning, and use of a weapon.

Table 38. Types of abuse and neglect in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022.

		Number of Cases
Type of Abuse	Abusive head trauma	3
	Chronic Battered Child Syndrome	0
	Beating/kicking	1
	Scalding/burning	0
	Munchausen Syndrome by Proxy	0
	Sexual assault	0
	Other abuse*	5
	Unknown abuse	1
Type of Neglect	Failure to provide necessities – Food	0
	Failure to provide necessities – Shelter	0
	Failure to provide necessities – Other	0
	Failure to seek/follow treatment	3
	Failure to provide supervision	10
	Emotional	0
	Abandonment	1
	Exposure to hazards**	14

Note: More than one type of abuse or neglect can occur in a case.
*Cases included blunt force injuries (1), poisoning (1), and use of a weapon (3)
**Cases included sleep environment hazards (7), fire hazards (1), unsecured medication/poison (1), firearm hazards (2), and motor vehicle hazards (3)

As seen in Table 39, in four of the cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022, the event that prompted the physical abuse was reported as unknown and data were not reported for the other cases.

Table 39. Events reported as prompting physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022.

	Number of Cases
Crying	0
Toilet training mishap	0
Disobedience	0
Feeding problems	0
Domestic argument	0
None	0
Other	0
Unknown	4
Note: More than one event can be reported for a case.	

The historical type of abuse or neglect experienced by the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022 can be seen in Table 40.

Table 40. History of abuse and neglect of the decedent in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022.

	Number of Cases
History of physical maltreatment	11
History of neglect	20
History of sexual maltreatment	0
History of emotional maltreatment	0
Note: More than one type of abuse or neglect can occur for a case.	

Table 41. CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2022.

	Number of Cases
CPS action taken as a result of the death	48
Open CPS case with child at time of death	1
Child ever placed in foster care	2
Note: More than one type of involvement can apply to a case.	

In three of the child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2022, there was child abuse in the form of abusive head trauma. However, as seen in Table 42, in these three cases, there were no retinal hemorrhages, and the children were not shaken.

Table 42. Abusive head trauma in cases of homicide child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2022.

	Number of Cases with a yes response
For abusive head trauma, were there retinal hemorrhages?	0
For abusive head trauma, was the child shaken?	0
If the child was shaken, was there impact?	N/A
Note: More than one condition can apply to a case.	

INFANT DEATHS IN WHICH THE CHILDBEARING PARENT USED SUBSTANCES DURING PREGNANCY

There were 13 deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy. The manner of these deaths included natural (30.8%), undetermined (30.8%), accident (30.8%), and homicide (7.8%).

The majority (84.6%) of the deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy were among males. See Table 43.

Table 43. Number and percent of deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy by gender of decedent.

	Number	Percent
Male	11	84.6%
Female	2	15.4%
Unknown	0	0.0%
Total	13	100%

As seen in Table 44, the largest percentage of deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy were among Black children (46.2%), followed by White children (23.1%), and multiracial children (23.1%).

Table 44. Number and percent of deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy by race of decedent.

	Number	Percent
Alaska Native	0	0.0%
American Indian	0	0.0%
Asian	0	0.0%
Black	6	46.2%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
White	3	23.1%
Multiracial	3	23.1%
Unknown	1	7.7%
Missing	0	0.0%
Total	13	100%

As seen in Table 45, more than half (53.8%) of deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy were among children that were not Hispanic or Latino.

Table 45. Number and percent of deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances during pregnancy by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	3	23.1%
Not Hispanic or Latino	7	53.8%
Unknown	2	15.4%
Missing	1	7.7%
Total	13	100%

Risk factors associated with deaths of children under 1 year of age in Nevada in 2022 in which the childbearing parent used substances can be seen in Table 46. The types of risk factors shown include those that occurred prior to pregnancy, during pregnancy, and if there was exposure to the child.

DEATHS IN WHICH THE CHILD WAS INVOLVED IN THE CHILD PROTECTIVE SERVICES (CPS) SYSTEM

Of the 257 child deaths that occurred in Nevada in 2022, there were 29 in which the child had been involved with the CPS system. In 28 of these deaths, there was a past history of child maltreatment of the decedent as identified through CPS. See Table 46 for information regarding the status of the involvement of CPS with the decedent.

Table 46. Status of the involvement of Child Protective Services (CPS) System in which there was CPS involvement in Nevada in 2022.

	Number	Percent
Past history of child maltreatment as identified through CPS	27	93.1%
Past history of child maltreatment as identified through CPS and open CPS case at time of death	1	3.5%
Open CPS case at time of death	1	3.5%
Total	29	100%

As seen in Table 47, the largest percentage of child deaths in Nevada with CPS involvement in 2022 were due to accidents (44.8%).

In Nevada in 2022, the largest percentage of child deaths with CPS involvement occurred among those less than one year of age (37.9%). See Table 48.

Table 46. Number and percent of child deaths in Nevada with CPS involvement in 2022 by manner of death.

	Number	Percent
Natural	2	6.9%
Accident	13	44.8%
Suicide	2	6.9%
Homicide	6	20.7%
Undetermined	6	20.7%
Unknown	0	0.0%
Total	29	100%

The majority of deaths of children in which there was CPS involvement in Nevada in 2022, occurred among males (79.3%).

In Nevada in 2022, the largest percentage of child deaths with CPS involvement occurred among those less than one year of age (37.9%).

Table 47. Number and percent of child deaths with CPS involvement in Nevada in 2022 by age category of decedent.

	Number	Percent
<1 Year	11	37.9%
1 - 4 Years	8	27.6%
5 - 9 Years	4	13.8%
10 - 14 Years	4	13.8%
15 - 17 Years	2	6.9%
Total	29	100%

All of the child deaths with CPS involvement in Nevada in 2022 occurred among White children (48.3%), Black children (44.8%), and Multiracial children (6.9%).

The largest percentage of child deaths with CPS involvement in Nevada in 2022 occurred among those that were not Hispanic or Latino (58.6%).

Table 48. Number and percent of child deaths with CPS involvement in Nevada in 2022 by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	9	31.0%
Not Hispanic or Latino	17	58.6%
Unknown	2	6.9%
Missing	1	3.5%
Total	29	100%

Regional Team Recommendations

Each of the regional child death review teams in Nevada are responsible for completing and submitting a quarterly report form to the Executive Committee. The form requires the team to report the number of cases reviewed each quarter by manner and leading cause of death and the number of cases requiring a mandatory review as outlined in NRS 432B.405. The form also allows the team to submit recommendations aimed at improving laws, policies, and practices to support the safety of children and prevent future child deaths. In submitting recommendations, teams are instructed to:

1) Submit recommendations related to specific observations and conclusions drawn from the case review process;
2) Prioritize recommendations based on case trends (three or more cases within the quarter or cumulatively); and
3) Not submit recommendations that have already been made unless additional gaps are identified.

The Executive Committee reviews the regional team recommendations quarterly, determines whether and how to act on the recommendations, and notifies the regional team making the recommendation of the outcome of their recommendation.

Recommendations Received

There were four recommendations made to the Executive Committee by the regional teams in 2022. The recommendations are listed below, and the action taken on each is described in the next section.

1) Request that local pediatricians provide safe sleep education as recommended by the American Academy of Pediatrics (AAP).
2) Add state-specific statistics to Nevada Cribs for Kids brochures and literature.
3) Provide community education, through public service announcements and/or a campaign, geared toward private homeowners, pool contractors, and home inspectors about:
    a. Entrapment hazards in pools and spas were installed before 2007; and
    b. The importance of retrofitting older pools and spas with devices to alleviate these hazards.
4) Provide parenting programs for young parents, create programs that support young adults who are expecting or have infants, teach all areas of parenting to include safe sleep, provide community educational opportunities for shelters of all kinds that would potentially house infants, educate “house managers” so they can assist parents in their facilities, educate other agencies that work with young adults on safe sleep to include Juvenile Probation, Schools, etc.

ACTION TAKEN ON RECOMMENDATIONS

Below are the actions taken to date by the Executive Committee regarding each recommendation received in 2022.

1) Request that local pediatricians provide safe sleep education as recommended by the AAP.

After discussing this recommendation, the Executive Committee developed a letter for Nevada pediatricians, nurse practitioners, Advance Practice Registered Nurses, Doctor of Nursing Practice, Certified Nurses Midwives, other midwives, lactation consultants, and doulas. The letter explained the recommendations received by the Executive Committee, encouraged the recipients to provide safe sleep education and implement policies to discuss safe sleep practices with patients at specific appointments, and provided local data on unsafe sleep and resources to promote safe sleep. This letter was submitted for distribution through the listserv of the Bureau of Health Care Quality and Compliance, Division of Public and Behavioral Health, Department of Health and Human Services. After the letter was sent, the Executive Committee voted to close this recommendation. Below are the resources provided in the letter.

- Maternal and Child Health Data Dashboard
- Nevada Child Death Report
- Updated safe sleep guidelines
- Eunice Kennedy Shriver National Institute on Child Health and Human Development
- REMSA
- Baby's Bounty

The Executive Committee determined that adding state-specific statistics to the brochures and literature would not be practical because they would quickly become outdated. The Executive Committee did not pursue this recommendation.

2) Community education, through public service announcements and/or a campaign, geared toward private homeowners, pool contractors, and home inspectors about

a. Entrapment hazards in pools and spas installed before 2007; and

b. The importance of retrofitting older pools and spas with devices to alleviate these hazards.

The Executive Committee invited a member of the Southern Nevada Child Drowning Prevention Coalition to speak at one of the quarterly meetings to discuss this recommendation and opportunities for collaboration. During the quarterly meeting to which the coalition member was invited, a representative for this member discussed the Float Like a Duck Campaign and existing materials and resources but stressed the need for funding. The Executive Committee voted to close this recommendation, revisit it when the notice of funding became available, and consider having Float Like a Duck present information in the future.

After learning of the closure of this recommendation, the team making the recommendation took action on their own. Specifically, the team identified the entrapment education resources listed below and asked the Southern Nevada Health District to add them to the Drowning Prevention section of their website, which they did and can be found here: https://www.southernnevadahealthdistrict.org/Health-Topics/drowning-prevention/

Entrapment Education Resources:

- English PSA: https://www.youtube.com/watch?v=YTQEQERpfog
- Spanish PSA: https://www.youtube.com/watch?v=EwDYNSc7FpQ
- Consumer Educational Brochure: Simple Water Safety Steps Save Lives in English and Spanish

3) Provide parenting programs for young parents, create programs that support young adults who are expecting or have infants, teach all areas of parenting to include safe sleep, provide community educational opportunities for shelters of all kinds that would potentially house infants, educate "house managers" so they can assist parents in their facilities, educate other agencies that work with young adults on safe sleep to include Juvenile Probation, Schools, etc.

The Executive Committee identified free recorded training videos on safe sleep available from Baby's Bounty and Washoe County. Links to the Baby's Bounty website and the Washoe County video were shared with the regional team submitting this recommendation and with the Executive Committee members who were encouraged to share the links with local agencies. The Executive Committee then voted to close this recommendation. The links to the resources are provided below.

Baby's Bounty:

- Safe sleep basics class is available for free in English and Spanish online at https://www.babysbounty.org under baby bundle and education.
- In person training may also be coordinated with Baby's Bounty as community partners deem appropriate as there is an associated fee.

Washoe County YouTube video: https://www.youtube.com/watch?v=Dr2l_ccjkMY

Public Awareness Efforts Funded by the Executive Committee

Section 3 of NRS 432B.409 establishes the creation of the Review of Death of Children Account in the State General Fund. One dollar of the fee associated with the purchase of a certificate of death through the state registrar funds this account. The Executive Committee uses these funds to support efforts to prevent child deaths. Each year, the Executive Committee posts a Notice of Funding Opportunity (NOFO) for competitive applications to prevent the death of children with funding priorities based on the leading causes of death in Nevada. The NOFO for State Fiscal Year 2022 (7/2021 – 6/2022) prioritized safe sleep, and suicide prevention efforts. The NOFO for State Fiscal Year 2023 (7/2022 – 6/2023) prioritized suicide prevention, safe sleep, and injury prevention. Below are the programs that were awarded funding in State Fiscal Years 2022 and 2023 by the Executive Committee.

SFY 2022 (7/2021 – 6/2022)

- Community Chest ($26,716.00) – Provide programming and services to youth to increase protective factors and reduce the risk of depression and suicide and provide home visiting to rural families to promote safe sleep.

- Crisis Call Center ($22,007.00) – Expand the current texting and call line and provide follow-up calls to youth who consent to follow-up services.

- NyE Communities Coalition ($32,290.00) – Work with community partners to provide parents, especially teens or young adults, with safe sleep education, provide brief safe sleep interventions in the community, educate the community about suicide prevention and mental health, and expand suicide prevention clubs in schools.

- Washoe County HSA ($35,000.00) – Raise awareness about infant safe sleep practices, with an emphasis on younger parents and parents-to-be through billboards, social media, movie theater ads, and a month-long awareness campaign in October.

- Suicide Prevention Network ($35,000.00) – Increase protective factors to reduce the risk of suicide among youth and hold town hall sessions to develop community competence in suicide awareness, prevention, intervention, mental wellness, positivity, resilience, and coping skills.

- Nevada Medical Center ($66,850.00) – Increase the awareness of comprehensive mental health and suicide prevention information and resources accessible by youth/teens and their families and enhance awareness of crisis intervention, mental health therapeutic and support services, and counseling service information by disseminating mental health information and resources.

- Children's Cabinet ($82,137.00) – Expand programming to prevent youth suicide by providing parents of those identified as at-risk with support and education and training school staff to facilitate suicide prevention workshops.

SFY 2023 (7/2022 – 6/2023)

- Baby's Bounty ($30,000.00) – Promote safe sleep through programming which includes an interactive online course, offered in English and Spanish, which demonstrates basic infant care, promotes practices that reduce SIDS, and provides attendees with a rear-facing car seat and additional baby supplies.

- Children's Cabinet ($40,000.00) – Prevent youth suicide by co-facilitating and/or providing workshops to parents and teens in Washoe County, Lyon County, and surrounding areas adapting the workshop materials in order to provide the workshop to the Native American Community.

- Clark County DFS ($37,500.00) – Educate the community on safe sleep through a media campaign, to include online media, print, radio, and television.

- Community Chest ($15,000.00) – Provide programming and services to youth to increase protective factors and reduce depression and suicide, provide home visiting to rural families to promote safe sleep, and provide injury prevention education to families.

- Las Vegas Center for Spiritual Living ($15,000.00) – Support the Nevada Office of Suicide Prevention through the purchase of medication safes, gun locks, and tables (for trainings).

- NyE Communities Coalition ($15,000.00) – Educate parents and caregivers on safe sleep, including the risks of co-sleeping through instruction, brief interventions, and print and social media. Prevent youth suicide through screenings, educating the community about suicide prevention and mental health through local television, radio, and social media outlets, and partnering with the Nye County School District's Suicide Prevention Club.

- Suicide Prevention Network ($15,000.00) – Provide suicide awareness, prevention, intervention, education, and support services to Douglas County, Carson City, and surrounding areas.

- Washoe County Human Services Agency ($32,500.00) – Raise awareness about infant safe sleep practices, with an emphasis on younger parents and parents-to-be through billboards, social media, movie theater ads, and a month-long awareness campaign in October.

APPENDIX A: DEMOGRAPHICS OF DECEDENTS BY MANNER OF DEATH

Age Category	Natural	Accident	Suicide	Homicide	Undetermined	Unknown	Total
Under 1 Year	72 (64.3%)	21 (28.8%)	0 (0.0%)	2 (9.5%)	27 (81.8%)	0 (0.0%)	122 (47.5%)
1 - 4 Years	11 (9.8%)	17 (23.3%)	0 (0.0%)	6 (28.6%)	4 (12.1%)	0 (0.0%)	38 (14.8%)
5 - 9 Years	8 (7.1%)	9 (12.3%)	0 (0.0%)	3 (14.3%)	1 (3.0%)	0 (0.0%)	21 (8.2%)
10 - 14 Years	13 (11.6%)	8 (11.0%)	8 (50.0%)	2 (9.5%)	1 (3.0%)	0 (0.0%)	33 (12.8%)
15 - 17 Years	8 (7.1%)	18 (24.7%)	8 (50.0%)	8 (38.1%)	0 (0.0%)	2 (100%)	43 (16.7%)
Total	112 (100%)	73 (100%)	16 (100%)	21 (100%)	33 (100%)	2 (100%)	257 (100%)
Gender	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Male	55 (49.1%)	51 (69.9%)	12 (75.0%)	18 (85.7%)	25 (75.8%)	2 (100%)	163 (63.4%)
Female	57 (50.9%)	22 (30.1%)	4 (25.0%)	3 (14.3%)	8 (24.2%)	0 (0.0%)	94 (36.6%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	112 (100%)	73 (100%)	16 (100%)	21 (100%)	33 (100%)	2 (100%)	257 (100%)
Race	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	1 (1.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.4%)
Asian	1 (0.9%)	3 (4.1%)	3 (18.8%)	0 (0.0%)	0 (0.0%)	1 (50.0%)	8 (3.1%)
Black	24 (21.4%)	22 (30.1%)	4 (25.0%)	8 (38.1%)	12 (36.4%)	0 (0.0%)	70 (27.2%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	4 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (1.6%)
White	70 (62.5%)	39 (53.4%)	9 (56.3%)	12 (57.1%)	16 (48.5%)	0 (0.0%)	146 (56.8%)
Multiracial	9 (8.0%)	6 (8.2%)	0 (0.0%)	1 (4.8%)	5 (15.2%)	0 (0.0%)	21 (8.2%)
Unknown	4 (3.6%)	2 (2.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (50.0%)	7 (2.7%)
Total	112 (100%)	73 (100%)	16 (100%)	21 (100%)	33 (100%)	2 (100%)	257 (100%)
Hispanic or Latino Ethnicity	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Hispanic or Latino	48 (42.9%)	26 (35.6%)	4 (25.0%)	10 (47.6%)	7 (21.2%)	0 (0.0%)	95 (37.0%)
Not Hispanic or Latino	58 (51.8%)	38 (52.1%)	10 (62.5%)	8 (38.1%)	22 (66.7%)	0 (0.0%)	136 (52.9%)
Unknown	6 (5.4%)	9 (12.3%)	2 (12.5%)	3 (14.3%)	4 (12.1%)	2 (100%)	26 (10.1%)
Total	112 (100%)	73 (100%)	16 (100%)	21 (100%)	33 (100%)	2 (100%)	257 (100%)
County of Residence	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Clark	97 (86.6%)	51 (69.9%)	9 (56.3%)	15 (71.4%)	24 (72.7%)	0 (0.0%)	197 (76.7%)
Washoe	7 (6.3%)	7 (9.6%)	5 (31.3%)	3 (14.3%)	2 (6.1%)	0 (0.0%)	24 (9.3%)
Rural	2 (1.8%)	4 (5.5%)	0 (0.0%)	0 (0.0%)	6 (18.2%)	1 (50.0%)	13 (5.1%)
Out of state	6 (5.4%)	7 (9.6%)	0 (0.0%)	2 (9.5%)	1 (3.0%)	1 (50.0%)	17 (6.6%)
Unknown	0 (0.0%)	4 (5.5%)	2 (12.5%)	1 (4.8%)	0 (0.0%)	0 (0.0%)	6 (2.3%)
Total	112 (100%)	73 (100%)	16 (100%)	21 (100%)	33 (100%)	2 (100%)	257 (100%)

APPENDIX B: DEMOGRAPHICS OF DECEDENTS FOR EACH MANNER OF DEATH BY YEAR

Natural Deaths

	Year				
Age Category	**2022**	**2021**	**2020**	**2019**	**2018**
Under 1 Year	72 (64.3%)	104 (70.8%)	72 (58.5%)	111 (70.3%)	104 (73.8%)
1 - 4 Years	11 (9.8%)	13 (8.8%)	13 (10.6%)	16 (10.1%)	13 (9.2%)
5 - 9 Years	8 (7.1%)	13 (8.8%)	9 (7.3%)	12 (7.6%)	15 (10.6%)
10 - 14 Years	13 (11.6%)	9 (6.1%)	17 (13.8%)	11 (7.0%)	3 (2.1%)
15 - 17 Years	8 (7.1%)	8 (5.4%)	12 (9.8%)	8 (5.1%)	6 (4.3%)
Total	112 (100%)	147 (100%)	123 (100%)	158 (100%)	141 (100%)
Gender	**2022**	**2021**	**2020**	**2019**	**2018**
Male	55 (49.1%)	80 (54.4%)	73 (59.3%)	89 (56.3%)	86 (61.0%)
Female	57 (50.9%)	67 (45.6%)	49 (39.8%)	69 (43.7%)	54 (38.3%)
Unknown	0 (0.0%)	0 (0.0%)	1 (0.8%)	0 (0.0%)	1 (0.7%)
Total	112 (100%)	147 (100%)	123 (100%)	158 (100%)	141 (100%)
Race	**2022**	**2021**	**2020**	**2019**	**2018**
White	70 (62.5%)	70 (47.6%)	64 (52.0%)	86 (54.4%)	96 (68.1%)
Black	24 (21.4%)	42 (28.6%)	35 (28.5%)	37 (23.4%)	24 (17.0%)
Asian	1 (0.9%)	3 (2.0%)	5 (4.1%)	10 (6.3%)	5 (3.5%)
Native Hawaiian	0 (0.0%)	1 (0.7%)	1 (0.8%)	0 (0.0%)	1 (0.7%)
Pacific Islander	4 (3.6%)	2 (1.4%)	1 (0.8%)	3 (1.9%)	0 (0.0%)
American Indian	0 (0.0%)	2 (1.4%)	2 (1.6%)	0 (0.0%)	1 (0.7%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	9 (8.0%)	7 (4.8%)	7 (5.7%)	13 (8.2%)	10 (7.1%)
Unknown	4 (3.6%)	20 (13.6%)	8 (6.5%)	9 (5.7%)	4 (2.8%)
Total	112 (100%)	147 (100%)	123 (100%)	158 (100%)	141 (100%)
Hispanic or Latino Ethnicity	**2022**	**2021**	**2020**	**2019**	**2018**
Hispanic or Latino	48 (42.9%)	45 (30.6%)	46 (37.4%)	64 (40.5%)	62 (44.0%)
Not Hispanic or Latino	58 (51.8%)	71 (48.3%)	70 (56.9%)	86 (54.4%)	74 (52.5%)
Unknown	6 (5.4%)	31 (21.1%)	7 (5.7%)	8 (5.1%)	5 (3.5%)
Total	112 (100%)	147 (100%)	123 (100%)	158 (100%)	141 (100%)
County of Residence	**2022**	**2021**	**2020**	**2019**	**2018**
Clark	97 (86.6%)	113 (76.9%)	99 (80.5%)	126 (79.7%)	120 (85.1%)
Washoe	7 (6.3%)	21 (14.3%)	18 (14.6%)	25 (15.8%)	18 (12.8%)
Rural	2 (1.8%)	8 (5.4%)	0 (0.0%)	2 (1.3%)	1 (0.7%)
Out of state	6 (5.4%)	3 (2.0%)	6 (4.9%)	5 (3.2%)	2 (1.4%)
Unknown	0 (0.0%)	2 (1.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	112 (100%)	147 (100%)	123 (100%)	158 (100%)	141 (100%)

Accident Deaths

	Year				
Age Category	**2022**	**2021**	**2020**	**2019**	**2018**
Under 1 Year	21 (28.8%)	29 (40.9%)	10 (19.6%)	29 (55.8%)	28 (47.5%)
1 - 4 Years	17 (23.3%)	11 (15.5%)	9 (17.6%)	9 (17.3%)	10 (16.9%)
5 - 9 Years	9 (12.3%)	7 (9.9%)	3 (5.9%)	7 (13.5%)	5 (8.5%)
10 - 14 Years	8 (11.0%)	6 (8.5%)	7 (13.7%)	4 (7.7%)	4 (6.8%)
15 - 17 Years	18 (24.7%)	18 (25.4%)	22 (43.1%)	3 (5.8%)	12 (20.3%)
Total	73 (100%)	71 (100%)	51 (100%)	52 (100%)	59 (100%)
Gender	**2022**	**2021**	**2020**	**2019**	**2018**
Male	51 (69.9%)	47 (66.2%)	36 (70.6%)	29 (55.8%)	43 (72.9%)
Female	22 (30.1%)	24 (33.8%)	15 (29.4%)	23 (44.2%)	16 (27.1%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	73 (100%)	71 (100%)	51 (100%)	52 (100%)	59 (100%)
Race	**2022**	**2021**	**2020**	**2019**	**2018**
White	39 (53.4%)	37 (52.1%)	36 (70.6%)	24 (46.2%)	37 (62.7%)
Black	22 (30.1%)	20 (28.2%)	10 (19.6%)	15 (28.8%)	11 (18.6%)
Asian	3 (4.1%)	3 (4.2%)	2 (3.9%)	3 (5.8%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	2 (2.8%)	0 (0.0%)	2 (3.8%)	1 (1.7%)
American Indian	1 (1.4%)	0 (0.0%)	1 (2.0%)	2 (3.8%)	1 (1.7%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	6 (8.2%)	6 (8.5%)	1 (2.0%)	6 (11.5%)	9 (15.3%)
Unknown	2 (2.7%)	3 (4.2%)	1 (2.0%)	0 (0.0%)	0 (0.0%)
Total	73 (100%)	71 (100%)	51 (100%)	52 (100%)	59 (100%)
Hispanic or Latino Ethnicity	**2022**	**2021**	**2020**	**2019**	**2018**
Hispanic or Latino	26 (35.6%)	27 (38.0%)	16 (31.4%)	13 (25.0%)	15 (25.4%)
Not Hispanic or Latino	38 (52.1%)	38 (53.5%)	34 (66.7%)	39 (75.0%)	43 (72.9%)
Unknown	9 (12.3%)	6 (8.5%)	1 (2.0%)	0 (0.0%)	1 (1.7%)
Total	73 (100%)	71 (100%)	51 (100%)	52 (100%)	59 (100%)
County of Residence	**2022**	**2021**	**2020**	**2019**	**2018**
Clark	51 (69.9%)	53 (74.7%)	34 (66.7%)	40 (76.9%)	50 (84.7%)
Washoe	7 (9.6%)	9 (12.7%)	7 (13.7%)	7 (13.5%)	5 (8.5%)
Rural	4 (5.5%)	3 (4.2%)	1 (2.0%)	1 (1.9%)	4 (6.8%)
Out of state	7 (9.6%)	6 (8.5%)	8 (15.7%)	4 (7.7%)	0 (0.0%)
Unknown	4 (5.5%)	0 (0.0%)	1 (2.0%)	0 (0.0%)	0 (0.0%)
Total	73 (100%)	71 (100%)	51 (100%)	52 (100%)	59 (100%)

Suicide Deaths

	Year				
Age Category	**2022**	**2021**	**2020**	**2019**	**2018**
Under 1 Year	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
1 - 4 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
5 - 9 Years	0 (0.0%)	0 (0.0%)	2 (11.8%	0 (0.0%)	0 (0.0%)
10 - 14 Years	8 (50.0%)	6 (30.0%)	5 (29.4%)	6 (37.5%)	9 (39.1%)
15 - 17 Years	8 (50.0%)	14 (70.0%)	10 (58.8%)	10 (62.5%)	14 (60.9%)
Total	16 (100%)	20 (100%)	17 (100%)	16 (100%)	23 (100%)
Gender	**2022**	**2021**	**2020**	**2019**	**2018**
Male	12 (75.0%)	16 (80.0%)	15 (88.2%)	10 (62.5%)	15 (65.2%)
Female	4 (25.0%)	14 (20.0%)	2 (11.8%)	6 (37.5%)	8 (34.8%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	20 (100%)	17 (100%)	16 (100%)	23 (100%)
Race	**2022**	**2021**	**2020**	**2019**	**2018**
White	9 (56.3%)	11 (55.0%)	12 (70.6%)	13 (81.3%)	15 (65.2%)
Black	4 (25.0%)	6 (30.0%)	2 (11.8%)	1 (6.3%)	4 (17.4%)
Asian	3 (18.8%)	1 (5.0%)	1 (5.9%)	0 (0.0%)	3 (13.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	0 (0.0%)	2 (10.0%)	2 (11.8%)	1 (6.3%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.3%)
Total	16 (100%)	20 (100%)	17 (100%)	16 (100%)	23 (100%)
Hispanic or Latino Ethnicity	**2022**	**2021**	**2020**	**2019**	**2018**
Hispanic or Latino	4 (25.0%)	8 (40.0%)	8 (47.1%)	4 (25.0%)	7 (30.4%)
Not Hispanic or Latino	10 (62.5%)	10 (50.0%)	9 (52.9%)	10 (62.5%)	16 (69.6%)
Unknown	2 (12.5%)	2 (10.0%)	0 (0.0%)	2 (12.5%)	0 (0.0%)
Total	16 (100%)	20 (100%)	17 (100%)	16 (100%)	23 (100%)
County of Residence	**2022**	**2021**	**2020**	**2019**	**2018**
Clark	9 (56.3%)	13 (65.0%)	15 (88.2%)	9 (56.3%)	19 (82.6%)
Washoe	5 (31.3%)	5 (25.0%)	1 (5.9%)	5 (31.3%)	2 (8.7%)
Rural	0 (0.0%)	1 (5.0%)	0 (0.0%)	1 (6.3%)	1 (4.3%)
Out of state	0 (0.0%)	1 (5.0%)	1 (5.9%)	1 (6.3%)	1 (4.3%)
Unknown	2 (12.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	20 (100%)	17 (100%)	16 (100%)	23 (100%)

Homicide Deaths

	Year				
Age Category	**2022**	**2021**	**2020**	**2019**	**2018**
Under 1 Year	2 (9.5%)	1 (6.7%)	5 (22.7%)	1 (6.3%)	7 (25.9%)
1 - 4 Years	6 (28.6%)	4 (26.7%)	2 (9.1%)	6 (37.5%)	9 (33.3%)
5 - 9 Years	3 (14.3%)	3 (20.0%)	1 (4.5%)	3 (18.8%)	2 (7.4%)
10 - 14 Years	2 (9.5%)	1 (6.7%)	3 (13.6%)	1 (6.3%)	1 (3.7%)
15 - 17 Years	8 (38.1%)	6 (40.0%)	11 (50.0%)	5 (31.3%)	8 (29.6%)
Total	21 (100%)	15 (100%)	22 (100%)	16 (100%)	27 (100%)
Gender	**2022**	**2021**	**2020**	**2019**	**2018**
Male	18 (85.7%)	13 (86.7%)	17 (77.3%)	11 (68.8%)	18 (66.7%)
Female	3 (14.3%)	2 (13.3%)	5 (22.7%)	5 (31.3%)	9 (33.3%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	21 (100%)	15 (100%)	22 (100%)	16 (100%)	27 (100%)
Race	**2022**	**2021**	**2020**	**2019**	**2018**
White	12 (57.1%)	5 (33.3%)	12 (54.5%)	8 (50.0%)	10 (37.0%)
Black	8 (38.1%)	6 (40.0%)	10 (45.5%)	8 (50.0%)	16 (59.3%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	1 (4.8%)	3 (20.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)
Unknown	0 (0.0%)	1 (6.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	21 (100%)	15 (100%)	22 (100%)	16 (100%)	27 (100%)
Hispanic or Latino Ethnicity	**2022**	**2021**	**2020**	**2019**	**2018**
Hispanic or Latino	10 (47.6%)	8 (53.3%)	4 (18.2%)	5 (31.3%)	8 (29.6%)
Not Hispanic or Latino	8 (38.1%)	7 (46.7%)	18 (81.8%)	11 (68.8%)	18 (66.7%)
Unknown	3 (14.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (3.7%)
Total	21 (100%)	15 (100%)	22 (100%)	16 (100%)	27 (100%)
County of Residence	**2022**	**2021**	**2020**	**2019**	**2018**
Clark	15 (71.4%)	12 (80.0%)	16 (72.7%)	14 (87.5%)	23 (85.2%)
Washoe	3 (14.3%)	1 (6.7%)	6 (27.3%)	1 (6.3%)	1 (3.7%)
Rural	0 (0.0%)	0 (0.0%	0 (0.0%)	0 (0.0%)	1 (3.7%)
Out of state	2 (9.5%)	2 (13.3%)	0 (0.0%)	0 (0.0%)	2 (7.4%)
Unknown	1 (4.8%)	0 (0.0%)	0 (0.0%)	1 (6.3%)	0 (0.0%)
Total	21 (100%)	15 (100%)	22 (100%)	16 (100%)	27 (100%)

Undetermined Deaths

	Year				
Age Category	**2022**	**2021**	**2020**	**2019**	**2018**
Under 1 Year	27 (81.8%)	20 (80.0%)	23 (82.1%)	21 (84.0%)	16 (72.7%)
1 - 4 Years	4 (12.1%)	2 (8.0%)	3 (10.7%)	1 (4.0%)	3 (13.6%)
5 - 9 Years	1 (3.0%)	1 (4.0%)	0 (0.0%)	0 (0.0%)	1 (4.5%)
10 - 14 Years	1 (3.0%)	0 (0.0%)	1 (3.6%)	0 (0.0%)	1 (4.5%)
15 - 17 Years	0 (0.0%)	2 (8.0%	1 (3.6%)	3 (12.0%)	1 (4.5%)
Total	33 (100%)	25 (100%)	28 (100%)	25 (100%)	22 (100%)
Gender	**2022**	**2021**	**2020**	**2019**	**2018**
Male	25 (75.8%)	13 (52.0%)	17 (60.7%)	17 (68.0%)	12 (54.5%)
Female	8 (24.2%)	12 (48.0%)	11 (39.3%)	8 (32.0%)	10 (45.5%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	33 (100%)	25 (100%)	28 (100%)	25 (100%)	22 (100%)
Race	**2022**	**2021**	**2020**	**2019**	**2018**
White	16 (48.5%)	10 (40.0%)	18 (64.3%)	13 (52.0%)	12 (54.5%)
Black	12 (36.4%)	12 (48.0%)	8 (28.6%)	10 (40.0%)	9 (40.9%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (4.0%)	0 (0.0%)
Alaska Native	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multiracial	5 (15.2%)	3 (12.0%)	1 (3.6%)	1 (4.0%)	1 (4.5%)
Unknown	0 (0.0%)	0 (0.0%)	1 (3.6%)	0 (0.0%)	0 (0.0%)
Total	33 (100%)	25 (100%)	28 (100%)	25 (100%)	22 (100%)
Hispanic or Latino Ethnicity	**2022**	**2021**	**2020**	**2019**	**2018**
Hispanic or Latino	7 (21.2%)	9 (36.0%)	9 (32.1%)	8 (32.0%)	8 (36.4%)
Not Hispanic or Latino	22 (66.7%)	15 (60.0%)	19 (67.9%)	17 (68.0%)	14 (63.6%)
Unknown	4 (12.1%)	1 (4.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	33 (100%)	25 (100%)	28 (100%)	25 (100%)	22 (100%)
County of Residence	**2022**	**2021**	**2020**	**2019**	**2018**
Clark	24 (72.7%)	21 (84.0%)	19 (67.9%)	15 (60.0%)	16 (72.7%)
Washoe	2 (6.1%)	2 (8.0%)	5 (17.9%)	5 (20.0%)	5 (22.7%)
Rural	6 (18.2%)	1 (4.0%)	1 (3.6%)	1 (4.0%)	0 (0.0%)
Out of state	1 (3.0%)	1 (4.0%)	2 (7.1%)	1 (4.0%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	1 (3.6%)	3 (12.0%)	1 (4.5%)
Total	33 (100%)	25 (100%)	28 (100%)	25 (100%)	22 (100%)

APPENDIX C: NUMBER AND PERCENT OF CHILD DEATHS IN NEVADA IN 2022 BY DECEDENT'S COUNTY OF RESIDENCE FOR CATEGORIES OF DEATHS REVIEWED IN THIS REPORT

	Clark County	Washoe County	Rural Counties	Out of State	Unknown	Total
Motor vehicle accidents	16 (64.0%)	3 (12.0%)	2 (8.0%)	3 (12.0%)	1 (4.0%)	25 (100%)
Accidents caused by asphyxia	17 (81.0%)	2 (9.5%)	0 (0.0%)	1 (4.8%)	1 (4.8%)	21 (100%)
Homicides caused by bodily force or weapon	12 (75.0%)	2 (12.5%)	0 (0.0%)	2 (12.5%)	0 (0.0%)	16 (100%)
Accidents caused drowning	10 (71.4%)	0 (0.0%)	1 (7.1%)	2 (14.3%)	1 (7.1%)	14 (100%)
Deaths in which abuse or neglect caused or contributed to the death	77 (86.5%)	2 (2.3%)	1 (1.1%)	7 (7.9%)	2 (2.3%)	89 (100%)
Infant deaths in which the childbearing parent used substances during pregnancy	12 (92.3%)	1 (7.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	13 (100%)
Deaths in which the child was involved in the Child Protective Services (CPS) System	25 (86.2%)	1 (3.5%)	1 (3.5%)	1 (3.5%)	1 (3.5%)	29 (100%)

APPENDIX D: NEVADA REVISED STATUTES FOR CHILD DEATH REVIEW

NRS 432B.403 Purpose of organizing. The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.4095, inclusive, is to:

1. Review the records of selected cases of deaths of children under 18 years of age in this State;
2. Review the records of selected cases of deaths of children under 18 years of age who are residents of Nevada and who die in another state;
3. Assess and analyze such cases;
4. Make recommendations for improvements to laws, policies and practice;
5. Support the safety of children; and
6. Prevent future deaths of children. (Added to NRS by 2003, 863; A 2007, 1508)

NRS 432B.405 Appointment; circumstances for organization.

1. The director or other authorized representative of an agency which provides child welfare services:

(a) May provisionally appoint and organize one or more multidisciplinary teams to review the death of a child;

(b) Shall submit names to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 for review and approval of persons whom the director or other authorized representative recommends for appointment to a multidisciplinary team to review the death of a child; and

(c) Shall organize one or more multidisciplinary teams to review the death of a child under any of the following circumstances:

(1) Upon receiving a written request from an adult related to the child within the third degree of consanguinity, if the request is received by the agency within 1 year after the date of death of the child;

(2) If the child dies while in the custody of or involved with an agency which provides child welfare services, or if the child's family previously received services from such an agency;

(3) If the death is alleged to be from abuse or neglect of the child;

(4) If a sibling, household member or day care provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including, without limitation, cases in which the report was unsubstantiated or the investigation is currently pending;

(5) If the child was adopted through an agency which provides child welfare services; or

(6) If the child died of Sudden Infant Death Syndrome.

2. A review conducted pursuant to subparagraph (2) of paragraph (c) of subsection 1 must occur within 3 months after the issuance of a certificate of death.

(Added to NRS by 1993, 2051; A 2001 Special Session, 47; 2003, 864; 2007, 1508)

NRS 432B.406 Composition.

1. A multidisciplinary team to review the death of a child that is organized by an agency which provides child welfare services pursuant to NRS 432B.405 must include, insofar as possible:

(a) A representative of any law enforcement agency that is involved with the case under review;

(b) Medical personnel;

(c) A representative of the district attorney's office in the county where the case is under review;

(d) A representative of any school that is involved with the case under review;

(e) A representative of any agency which provides child welfare services that is involved with the case under review; and

(f) A representative of the coroner's office.

2. A multidisciplinary team may include such other representatives of other organizations concerned with the death of the child as the agency which provides child welfare services deems appropriate for the review.

(Added to NRS by 2003, 863)

NRS 432B.407 Access to information; sharing of certain information; subpoena to obtain information; use of data collected; confidentiality of information.

1. A multidisciplinary team to review the death of a child is entitled to access to:

(a) All investigative information of law enforcement agencies regarding the death;

(b) Any autopsy and coroner's investigative records relating to the death;

(c) Any medical or mental health records of the child; and

(d) Any records of social and rehabilitative services or of any other social service agency which has provided services to the child or the child's family.

2. Each organization represented on a multidisciplinary team to review the death of a child shall share with other members of the team information in its possession concerning the child who is the subject of the review, any siblings of the child, any person who was responsible for the welfare of the child and any other information deemed by the organization to be pertinent to the review.

3. A multidisciplinary team to review the death of a child may, if appropriate, meet and share information with:

(a) A multidisciplinary team to review the death of the victim of a crime that constitutes domestic violence organized or sponsored pursuant to NRS 217.475; or

(b) The Committee on Domestic Violence appointed pursuant to NRS 228.470.

4. A multidisciplinary team to review the death of a child may petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team. Except as otherwise provided in NRS 239.0115, any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.

5. A multidisciplinary team to review the death of a child may use data collected concerning the death of a child for the purpose of research or to prevent future deaths of children if the data is aggregated and does not allow for the identification of any person.

6. Except as otherwise provided in this section, information acquired by, and the records of, a multidisciplinary team to review the death of a child are confidential, must not be disclosed, and are not subject to subpoena, discovery or introduction into evidence in any civil or criminal proceeding.

(Added to NRS by 2003, 863; A 2007, 2106; 2011, 739; 2013, 438; 2017, 2466)

NRS 432B.4075 Authority of Administrator to organize multidisciplinary team to oversee review conducted by child death review team; access to information and privileges.

1. The Administrator of the Division of Child and Family Services may organize a multidisciplinary team to oversee any review of the death of a child conducted by a multidisciplinary team that is organized by an agency which provides child welfare services pursuant to NRS 432B.405.

2. A multidisciplinary team organized pursuant to subsection 1 is entitled to the same access and privileges granted to a multidisciplinary team to review the death of a child pursuant to NRS 432B.407.

(Added to NRS by 2007, 1500)

NRS 432B.408 Executive Committee to Review the Death of Children to review and respond to report and recommendations of child death review team.

1. The report and recommendations of a multidisciplinary team to review the death of a child must be transmitted for review to the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409.

2. The Executive Committee shall review the report and recommendations and respond in writing to the multidisciplinary team within 90 days after receiving the report.

(Added to NRS by 2003, 864; A 2013, 438)

NRS 432B.409 Establishment, composition and duties of Executive Committee to Review the Death of Children; creation of and use of money in Review of Death of Children Account.

1. The Administrator of the Division of Child and Family Services shall establish an Executive Committee to Review the Death of Children, consisting of:

(a) Representatives from multidisciplinary teams formed pursuant to paragraph (a) of subsection 1 of NRS 432B.405 and NRS 432B.406, vital statistics, law enforcement, public health and the Office of the Attorney General.

(b) Administrators of agencies which provide child welfare services, and agencies responsible for mental health and public safety, to the extent that such administrators are not already appointed pursuant to paragraph (a). Members of the Executive Committee who are appointed pursuant to this paragraph shall serve as nonvoting members.

2. The Executive Committee shall:

(a) Adopt statewide protocols for the review of the death of a child;

(b) Adopt regulations to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive;

(c) Adopt bylaws to govern the management and operation of the Executive Committee;

(d) Appoint one or more multidisciplinary teams to review the death of a child from the names submitted to the Executive Committee pursuant to paragraph (b) of subsection 1 of NRS 432B.405;

(e) Oversee training and development of multidisciplinary teams to review the death of children;

(f) Compile and distribute a statewide annual report, including statistics and recommendations for regulatory and policy changes; and

(g) Carry out the duties specified in NRS 432B.408.

3. The Review of Death of Children Account is hereby created in the State General Fund. The Executive Committee may use money in the Account to carry out the provisions of NRS 432B.403 to 432B.4095, inclusive.

(Added to NRS by 2003, 864; A 2007, 1509; 2013, 439)

NRS 432B.4095 Civil penalty for disclosure of confidential information; authority to bring action; deposit of money.

1. Each member of a multidisciplinary team organized pursuant to NRS 432B.405, a multidisciplinary team organized pursuant to NRS 432B.4075 or the Executive Committee to Review the Death of Children established pursuant to NRS 432B.409 who discloses any confidential information concerning the death of a child is personally liable for a civil penalty of not more than $500.

2. The Administrator of the Division of Child and Family Services:

(a) May bring an action to recover a civil penalty imposed pursuant to subsection 1 against a member of a multidisciplinary team organized pursuant to NRS 432B.4075 or the Executive Committee; and

(b) Shall deposit any money received from the civil penalty with the State Treasurer for credit to the State General Fund.

3. Each director or other authorized representative of an agency which provides child welfare services that organized a multidisciplinary team pursuant to NRS 432B.405:

(a) May bring an action to recover a civil penalty pursuant to subsection 1 against a member of the multidisciplinary team; and

(b) Shall deposit any money received from the civil penalty in the appropriate county treasury. (Added to NRS by 2007, 1500; A 2013, 439)

APPENDIX E: DEFINITIONS OF CHILD ABUSE, NEGLECT, POOR SUPERVISION AND EXPOSURE TO HAZARDS USED BY THE NATIONAL FATALITY REVIEW CASE REPORTING SYSTEM (NFR-CRS)

Abuse	Any injury inflicted on a child by a parent or caregiver. The parent or caretaker may not have intended to hurt the child, rather the injury may have resulted from over-discipline or physical punishment. Physical abuse can be the result of punching, beating, kicking, biting, burning, shaking, or otherwise harming a child.
Neglect	A failure on the part of a parent/caregiver/supervisor to provide for the shelter, safety, supervision and nutritional needs of the child that results in harm to the child. Child neglect includes physical, medical, supervisory, and emotional neglect.
Poor/Absent Supervision	Parent/caregiver/supervisor's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death. This category is typically used when poor or absent supervision causes or contributes to injury death in a young child and the team does not feel that the lapse in supervision meets criteria to be classified as child neglect. For example, a single childbearing parent with a toddler is home from work, sick. Since they are home, they do not take their child to child care, or arrange alternative supervision. They are taking medication for their illness that makes them sleepy. While sleeping during the day, their toddler leaves the house and is struck by a car in the street.
Exposure to Hazards	Refers to behavior by a parent/caregiver/supervisor that expose a child to hazard(s) that pose a threat of harm to the child, but team does not feel that the circumstances meet the criteria to be classified as child neglect. This includes hazards in the sleep environment, fire/burn, poisoning, firearm, water/drowning, and motor vehicle hazards. Substance abuse by the childbearing parent during pregnancy should be checked only if an infant died from a medical cause of death and substance use by the childbearing parent during pregnancy was documented and felt to cause or contribute to the death.