STATE OF NEVADA

DIVISION OF CHILD AND FAMILY SERVICES

2019 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 2019 Statewide Child Death Report:

2019 Executive Committee to Review Death of Children

2022 Executive Committee to Review Death of Children

Division of Child and Family Services (DCFS)

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EXECUTIVE SUMMARY

The purpose of this report is to provide comprehensive 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.

WHY IS CHILD DEATH PREVENTION IMPORTANT?

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.

WHERE DOES NEVADA'S CHILD DEATH DATA COME FROM?

The 2019 child deaths were reviewed by Nevada's regional child death review (CDR) teams, which are organized and operational pursuant to Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 4095. (See Appendix D.) In 2019, there were six regional CDR teams in the state that conducted child death reviews.

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 Executive Committee to Review the Death of Children (Executive Committee) is the statewide group that provides coordination, oversight, and training to the regional CDR teams. The Executive Committee reviews reports and recommendations from the regional teams and advocates for improvements to laws, policies, protocols, and practices related to the prevention of child deaths. Additionally, the Executive Committee compiles and distributes this statewide annual report. Finally, the Executive Committee makes decisions about funding initiatives to prevent child deaths based on the analyses of the annual data.

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

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.

The Executive Committee funds annual public awareness campaigns for the prevention of child death in cooperation with community-based organizations, focused on the leading preventable causes of death.

WHAT ARE THE LEADING CAUSES OF CHILD DEATH IN NEVADA?

Excluding natural and undetermined deaths, in 2019, the four leading causes of death were:

1. Accidents caused by unintentional asphyxia
2. Homicides caused by assault, weapon, or a person's body part
3. Accidents caused by drowning
4. Suicides caused by hanging

HOW DOES CHILD DEATH IN NEVADA COMPARE WITH THE UNITED STATES AS A WHOLE?

	Nevada	United States
Number of child deaths in 2019	268	34,602[1]
Number of child deaths in 2018	272	35,454[2]
Change in number of child deaths from 2018 to 2019	Decrease of 4 (1.5%)	Decrease of 852 (2.4%)
Infant mortality rate per 1,000 live births in 2019[3]	5.7	5.6
Age group experiencing largest number of child deaths in 2019	Under 1 year	Under 1 year[4]
Leading cause of child death in 2019	Natural	Natural

[1] National Center for Injury Prevention and Control (2020). *Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2018* [custom data query]. Retrieved February 25, 2022 from http://www.cdc.gov/injury/wisqars/index.html

[2] National Center for Injury Prevention and Control (2019). *Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2017* [custom data query]. Retrieved February 25, 2022 from http://www.cdc.gov/injury/wisqars/index.html

[3] Centers for Disease Control (2021). *Infant Mortality 2019*. Retrieved February 25, 2022 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

[4] National Center for Injury Prevention and Control (2020). *Web-based Injury Statistics Query and Reporting System: 20 Leading Causes of Death, United States, 2018* [custom data query]. Retrieved February 25, 2022 from http://www.cdc.gov/injury/wisqars/index.html

DATA OVERVIEW

DATA SOURCES

All Nevada data in this report are derived from the regional CDR teams, which collect and enter data into an electronic case reporting system maintained by the National Center for Fatality Review and Prevention (CFRP). Based on the multidisciplinary reviews conducted for child deaths that occurred in calendar year 2019, there were a total of 268 child deaths that 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 Nevada Revised Statutes (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.[5] 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 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.

Review Requirements

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 4095. State-mandated child death reviews include the following:

- Reviews requested by adults related to the child within one year of the date of death.
- Children who were in the custody of a child welfare agency or whose family received services from such an agency.
- Children who died from alleged abuse or neglect.
- Children whose siblings, household members, or day care providers were subject to an abuse or neglect investigation within the previous 12 months.
- Children who were adopted through a child welfare agency.
- Children who died from Sudden Infant Death Syndrome (SIDS).

Deaths Reviewed vs. Deaths not Reviewed

Each of the six regional CDR teams reviews all coroner-referred child deaths within their region that meet the above criteria. 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.

[5] National Center for Health Statistics. (2020). *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*. Retrieved April 22, 2020 from

https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202020%20release%20of%20ICD-10-CM

OVERVIEW OF DEATHS

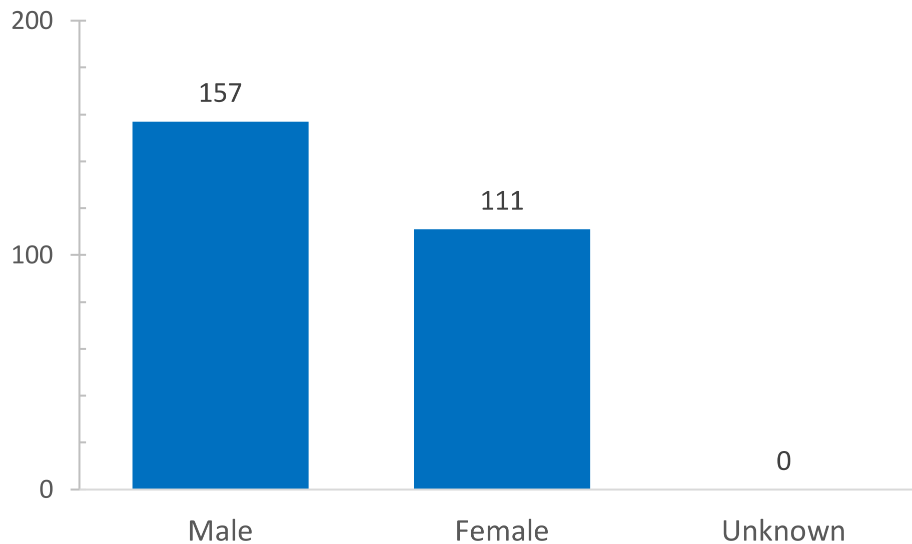
In 2019, the Nevada regional CDR teams reviewed the deaths of 268 children under 18 years of age. In the sections that follow, the overall demographics and manner of these deaths are reviewed.

DEMOGRAPHICS

The data used for this report come from the National Fatality Review Case Reporting System, 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.

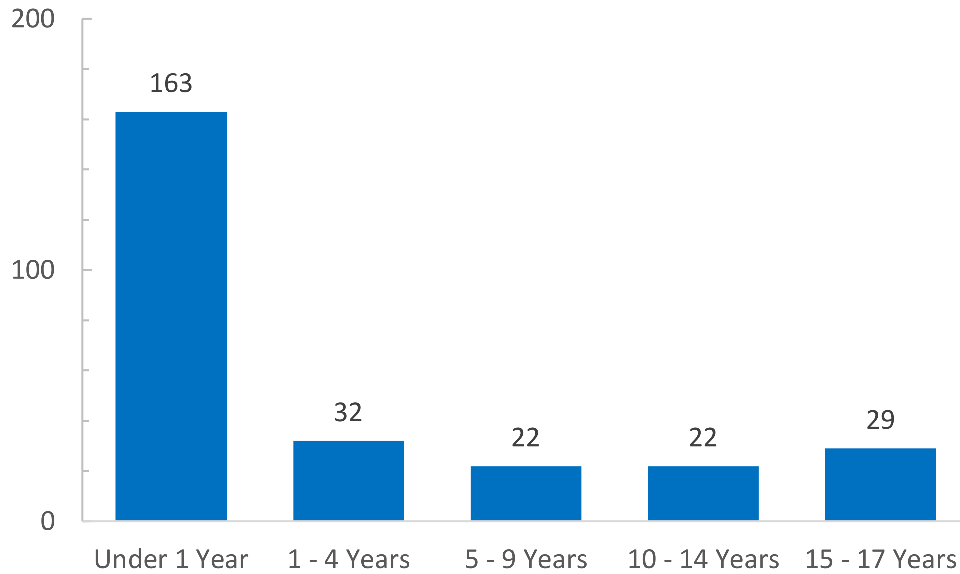
As seen in Figure 1, there were more child deaths in Nevada in 2019 among males as compared to females.

Figure 1. Number of child deaths in Nevada in 2019 by sex of decedent.



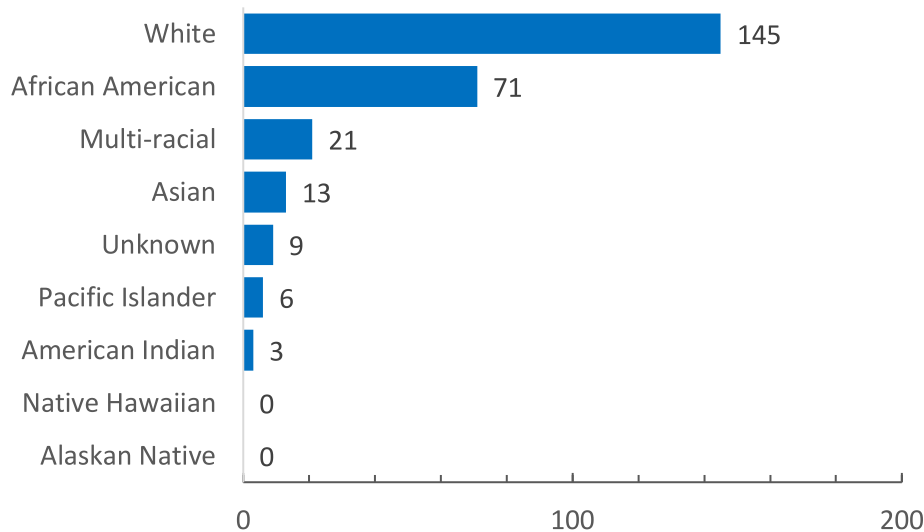
As seen in Figure 2, the majority of child deaths in Nevada in 2019 occurred among those less than one year of age (60.8%).

Figure 2. Number of child deaths in Nevada in 2019 by age category of decedent.



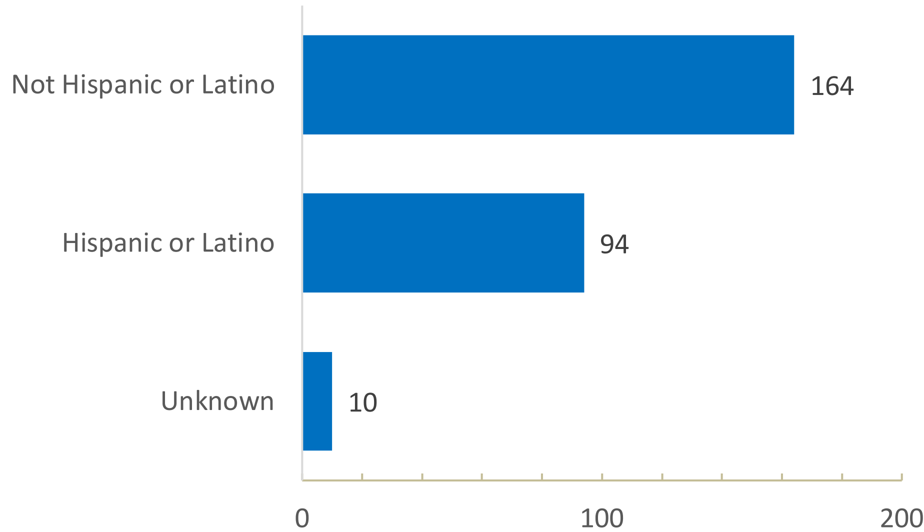
The largest percentage of child deaths in Nevada in 2019 occurred among White children (54.1%) and African American children (26.5%).

Figure 3. Number of child deaths in Nevada in 2019 by race of decedent.



The largest percentage of child deaths in Nevada in 2019 were among children not of Hispanic or Latino ethnicity (61.2%). See Figure 4.

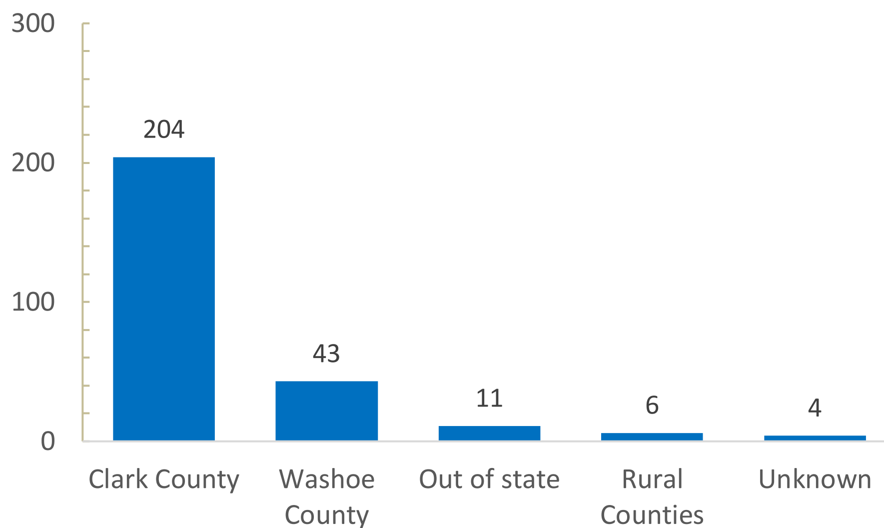
Figure 4. Number of child deaths in Nevada in 2019 by Hispanic or Latino ethnicity of decedent.



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 2019 have been combined for this report and the county of residence is referred to as the Rural Counties.

As seen in Figure 5, the largest percentage of child deaths in Nevada in 2019 occurred among those who were residents of Clark County (76.1%).

Figure 5. Number of child deaths in Nevada in 2019 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.

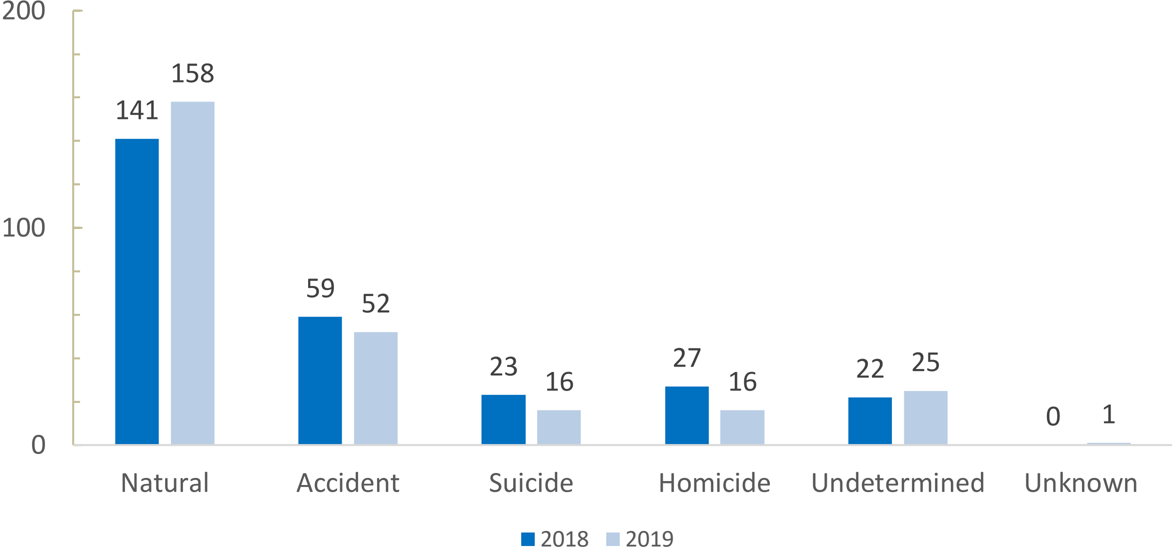
As seen in Table 1, the largest percentage of child deaths by manner in Nevada in 2019 were natural (59.0%), followed by accident (19.4%).

Table 1. Number and percent of child deaths in Nevada in 2019 by manner of death.

	Number	Percent
Natural	158	59.0%
Accident	52	19.4%
Suicide	16	6.0%
Homicide	16	6.0%
Undetermined	25	9.3%
Unknown	1	0.4%
Total	268	100%

As seen in Figure 6, there were fewer accident, suicide, and homicide child deaths in Nevada in 2019 as compared to 2018.

Figure 6. Number of child deaths in Nevada in 2018 and 2019 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 2019, the largest percentage of child deaths by manner in Nevada were natural (59.0%). As seen in Table 2 below, the majority of natural deaths occurred among children under one year of age (70.3%). Overall, the most common cause of natural death was due to “other medical condition” (25.9%), followed by congenital anomaly (17.7%), “other perinatal condition” (16.5%) and prematurity (15.8%). “Other perinatal condition” and “other medical condition” are response options in the data collection tool and include natural deaths in which the primary cause of death was due to a medical condition other than those listed in Table 2.

Table 2. Number of natural child deaths in Nevada in 2019 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Asthma/Respiratory	5	1	1	0	1	8
Cancer	0	0	1	1	2	4
Cardiovascular	6	5	1	0	0	12
Congenital anomaly	25	0	2	0	1	28
Diabetes	0	0	1	0	0	1
HIV/AIDS	0	0	0	0	0	0
Influenza	0	3	0	1	0	4
Low birth weight	0	0	0	0	0	0
Malnutrition/dehydration	0	0	0	0	0	0
Neurological/seizure	0	2	0	1	0	3
Pneumonia	2	0	0	0	0	2
Prematurity	25	0	0	0	0	25
SIDS	0	0	0	0	0	0
Other infection	2	0	1	1	0	4
Other perinatal condition	25	0	1	0	0	26
Other medical condition	21	5	4	7	4	41
Total	111	16	12	11	8	158

ACCIDENT

Accident deaths are deaths not caused by an intent to harm. In 2019, there were 52 accident child deaths reviewed in Nevada. As seen in Table 3 below, more than half (55.8%) of the accident deaths were among children less than one year of age. Overall, the most common cause of accident deaths among children in Nevada in 2019 was unintentional asphyxia (53.8%) and all but one of these deaths occurred among children under one year of age. The next most common cause of accident child deaths in Nevada in 2019 was drowning (19.2%).

Table 3. Number of accident child deaths in Nevada in 2019 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Any Medical Cause	1	0	0	0	0	1
Motor Vehicle	0	1	2	4	0	7
Fire, Burn, or Electrocution	0	0	0	0	0	0
Drowning	0	4	4	0	2	10
Unintentional Asphyxia	27	1	0	0	0	28
Assault, Weapon, or Person's Body Part	0	0	0	0	0	0
Fall or Crush	0	1	0	0	0	1
Poisoning, Overdose, or Acute Intoxication	0	1	0	0	0	1
Undetermined	0	0	0	0	0	0
Other Injury	0	0	1	0	0	1
Unknown	1	1	0	0	1	3
Total	29	9	7	4	3	52

HOMICIDE

In 2019, there were 16 homicide child deaths reviewed in Nevada. As seen in Table 4 below, the majority of the homicide child deaths were caused by assault, weapon, or a person's body part (87.5%). The largest percentage of homicide child deaths in Nevada in 2019 were among children in the 1 – 4 Years age category (37.5%) followed by children in the 15 – 17 Years age category (31.3%).

Table 4. Number of homicide child deaths in Nevada in 2019 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
Motor Vehicle	0	0	0	0	0	0
Fire, Burn, or Electrocution	0	0	1	0	0	1
Drowning	0	1	0	0	0	1
Assault, Weapon, or Person's Body Part	1	5	2	1	5	14
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	0	0	0	0	0	0
Total	1	6	3	1	5	16

SUICIDE

In 2019, there were 16 suicide child deaths reviewed in Nevada. As seen in Table 5, all of the suicide deaths occurred among children in the 10 – 14 Years and 15 – 17 Years age categories. More than half of the suicide child deaths were the result of "other injury" (56.3%). A review of these cases indicates that they were all suicide by hanging.

Table 5. Number of suicide child deaths in Nevada in 2019 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
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
Assault, Weapon, or Person's Body Part	0	0	0	3	2	5
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	2	2
Other Injury*	0	0	0	3	6	9
Total	0	0	0	6	10	16
*All suicide deaths caused by other injury were suicide deaths by hanging.						

UNDETERMINED

In 2019, there were 25 child deaths reviewed 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 (84.0%). In three of the undetermined child deaths, the death was caused by assault, weapon, or a person's body part. In 22 of the undetermined child deaths, the cause was unknown or undetermined.

Table 6. Number of undetermined child deaths in Nevada in 2019 by age category and cause.

	<1 Year	1 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 17 Years	Total
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
Assault, Weapon, or Person's Body Part	0	0	0	0	3	3
Fall or Crush	0	0	0	0	0	0
Poisoning, Overdose, or Acute Intoxication	0	0	0	0	0	0
Undetermined	1	0	0	0	0	1
Unknown	20	1	0	0	0	21
Total	21	1	0	0	3	25

For details regarding the age, gender, race, Hispanic or Latino ethnicity, and county of residence for all of the 2019 Nevada child decedents by manner, see Appendix A.

Leading Manners and Causes of Child Death

Excluding natural and undetermined manners of death, in Nevada in 2019, the four leading manners and causes of death included accidents caused by unintentional asphyxia (33.3%), homicide caused by assault, weapon, or person's body part (16.7%), accidents caused by drowning (11.9%), and suicide caused by other injury (10.7%). As noted in the previous section, Deaths by Manner, all of the suicide deaths caused by other injury were suicide deaths caused by hanging. See Table 7 for the number and percent of manner and causes of child deaths in Nevada in 2019, excluding natural and undetermined manners of death.

Table 7. Number and percent of manner and causes of child deaths in Nevada in 2019 excluding natural and undetermined manners of death.

Manner	Cause	Number	Percent
Accident	Unintentional Asphyxia	28	33.3%
Homicide	Assault, Weapon, or Person's Body Part	14	16.7%
Accident	Drowning	10	11.9%
Suicide	Other Injury*	9	10.7%
Accident	Motor Vehicle	7	8.3%
Suicide	Assault, Weapon, or Person's Body Part	5	6.0%
Accident	Unknown	3	3.6%
Suicide	Poisoning, Overdose, or Acute Intoxication	2	2.4%
Accident	Asthma/respiratory	1	1.2%
Accident	Fall or Crush	1	1.2%
Accident	Poisoning, Overdose, or Acute Intoxication	1	1.2%
Accident	Other Injury	1	1.2%
Homicide	Fire, Burn, or Electrocution	1	1.2%
Homicide	Drowning	1	1.2%
	Total	84	100%

*All suicide deaths caused by other injury were suicide deaths by hanging.

Accidents caused by unintentional asphyxia (N = 28)

All of the accident child deaths caused by unintentional asphyxia in Nevada in 2019 were sleep-related and all but one of the deaths were among children under one year of age. As seen in Table 8, there were more male children that died of unintentional asphyxia accidents in Nevada in 2019 as compared to female children.

Table 8. Number and percent of accident child deaths caused by unintentional asphyxia in Nevada in 2019 by sex of the decedent.

	Number	Percent
Male	17	60.7%
Female	11	39.3%
Unknown	0	0.0%
Total	28	100%

As seen in Table 9 below, the largest percentage of accident child deaths caused by unintentional asphyxia in Nevada in 2019 were among African American children (39.3%), followed by white children (25.0%), and multi-racial children (21.4%).

Table 9. Number and percent of accident child deaths caused by unintentional asphyxia in Nevada in 2019 by race of the decedent.

	Number	Percent
White	7	25.0%
African American	11	39.3%
Native Hawaiian	0	0.0%
Pacific Islander	2	7.1%
Asian	2	7.1%
American Indian	0	0.0%
Alaska Native	0	0.0%
Multi-racial	6	21.4%
Unknown	0	0.0%
Total	28	100%

As seen in Table 10, the majority of accident child deaths caused by unintentional asphyxia in Nevada in 2019 were among children not of Hispanic or Latino ethnicity (82.1%).

Table 10. Number and percent of accident child deaths caused by unintentional asphyxia in Nevada in 2019 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	17.9%
Not Hispanic or Latino	23	82.1%
Unknown	0	0.0%
Total	28	100%

Some of the circumstances of the accident child deaths caused by unintentional asphyxia in Nevada in 2019, 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 11.

Table 11. Circumstances of accident child deaths caused by unintentional asphyxia in Nevada in 2019.

		Number of Cases
Objects/people found in sleeping area	Adult(s)	20
	Child(ren)	10
	Animal(s)	0
	Comforter, quilt, or other	12
	Thin blanket/flat sheet	11
	Pillow	20
	Cushion	4
	Boppy or U-shaped pillow	1
	Sleep positioner	0

	Bumper pads	0
	Clothing	0
	Crib railing/side	1
	Wall	1
	Toys	1
	Other	2
Child placed to sleep	With a pacifier	1
	On stomach	10
	On side	6
	In adult bed	17
	On couch	4
	Wrapped or swaddled in blanket	4
	On floor	0
	In car seat	0
Caregiver/supervisor fell asleep	Bottle feeding child	2
	Breastfeeding child	0
Note: More than one circumstance can apply to a case		

Homicides caused by assault, weapon, or a person's body part (N = 14)

As seen in Table 12, there were more male children (71.4%) that died of homicide caused by assault, weapon, or a person's body part in Nevada in 2019 as compared to female children (28.6%).

Table 12. Number and percent of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 by sex of the decedent.

	Number	Percent
Male	10	71.4%
Female	4	28.6%
Unknown	0	0.0%
Total	14	100%

The largest percentage of homicide child deaths caused by assault, weapon, or a person's body part were among children in the 1 – 4 years age category and the 15 – 17 years age category (both at 35.7%). See Table 13.

Table 13. Number and percent of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 by age category of the decedent.

	Number	Percent
<1 Year	1	7.1%
1 - 4 Years	5	35.7%
5 - 9 Years	2	14..3%
10 - 14 Years	1	7.1%
15 - 17 Years	5	35.7%
Total	14	100%

All of the homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 were among children that were African American (57.1%) or white (42.9%). As seen in Table 14, the majority of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 were among children not of Hispanic or Latino ethnicity (64.3%).

Table 14. Number and percent of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	5	35.7%
Not Hispanic or Latino	9	64.3%
Unknown	0	0.0%
Total	14	100%

As seen in Table 15, the largest percentage of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 were the result of a firearm (42.9%) and a person's body part (28.6%).

Table 15. Number and percent of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019 by type of weapon used.

	Number	Percent
Firearm	6	42.9%
Sharp instrument	1	7.1%
Blunt instrument	0	0.0%
Person's body part	4	28.6%
Other	0	0.0%
Unknown	3	21.4%
Total	14	100%

As seen in Table 16, in five of the homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019, a biological parent handled the fatal weapon. In four of the homicide child deaths either the mother's partner (n = 3) or the father's partner (n = 1) handled the fatal weapon.

Table 16. Person handling the fatal weapon in homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019.

	Number of Cases
Decedent (self)	0
Biological parent	5
Adoptive parent	0
Step-parent	0
Foster parent	0
Mother's partner	3
Father's partner	1
Sibling	0
Other relative	0
Friend	0

Acquaintance	1
Child's boyfriend/girlfriend	0
Institutional staff	0
Neighbor	0
Rival gang member	3
Stranger	2
Other	0
Unknown	0
Note: More than one person could have handled the weapon	

Table 17 identifies how the fatal weapon was being used at the time of homicide child deaths caused by assault, weapon, or a person's body part in Nevada in 2019.

Table 17. How the fatal weapon was being used at the time of homicide child deaths by caused by assault, weapon, or a person's body part in Nevada in 2019.

	Number of Cases
Self-injury	1
Commission of a crime	12
Drug dealing/trading	2
Drive-by shooting	1
Random violence	2
Child was a bystander	0
Argument	0
Jealousy	0
Intimate partner violence	0
Hate crime	0
Target shooting	0
Playing with the weapon	0
Weapon mistaken for a toy	0
Showing the gun to others	0
Russian Roulette	0
Gang-related activity	2
Self-defense	0
Cleaning the weapon	0
Other	0
Unknown	0
Note: More than one use can apply to a case	

ACCIDENTS CAUSED BY DROWNING (N = 10)

As seen in Table 18, there were more male children (60.0%) that died of accidents caused by drowning in Nevada in 2019 as compared to female children (40.0%).

Table 18. Number and percent of accident child deaths caused by drowning in Nevada in 2019 by sex of the decedent.

	Number	Percent
Male	6	60.0%
Female	4	40.0%
Unknown	0	0.0%
Total	10	100%

In Nevada in 2019, the majority of accident child deaths caused by drowning were among children in the 1 – 4 years age category and in the 5 – 9 years age category (both at 40.0%). See Table 19.

Table 19. Number and percent of accident child deaths caused by drowning in Nevada in 2019 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	4	40.0%
5 - 9 Years	4	40.0%
10 - 14 Years	0	0.0%
15 - 17 Years	2	20.0%
Total	10	100%

All of the accident child deaths caused by drowning in Nevada in 2019 were among children that were white (70.0%) or African American (30.0%). The majority of accident child deaths caused by drowning in Nevada in 2019 were among children not of Hispanic or Latino ethnicity (80.0%). See Table 20.

Table 20. Number and percent of accident child deaths caused by drowning in Nevada in 2019 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	2	20.0%
Not Hispanic or Latino	8	80.0%
Unknown	0	0.0%
Total	10	100%

As seen in Table 21, in all but two of the accident child deaths caused by drowning in Nevada in 2019, the drowning location was a pool, hot tub, or spa. The two accident child deaths caused by drowning in open water were among children in the 15 – 17 years age category.

Table 21. Number and percent of accident child deaths caused by drowning in Nevada in 2019 by drowning location.

	Number	Percent
Open water	2	20.0%
Pool, hot tub, spa	8	80.0%
Bathtub	0	0.0%
Bucket	0	0.0%

Well/cistern/septic	0	0.0%
Toilet	0	0.0%
Other	0	0.0%
Total	10	100%

As seen in Table 22, in the majority of the accident child deaths caused by drowning in Nevada in 2019, the child was not able to swim (70.0%). The two accident child deaths caused by drowning in which the children were able to swim were among children in the 15 – 17 years age category.

Table 22. Swimming ability of children that died in Nevada in 2019 in accidents caused by drowning.

	Number	Percent
Child was able to swim	2	20.0%
Child was not able to swim	7	70.0%
Child's swimming ability was unknown	1	10.0%
Missing	0	0.0%
Total	10	100%

Finally, as seen in Table 23, in four of the child accident deaths caused by drowning in Nevada in 2019, there were no barriers to the swimming area. In seven of the deaths, no barrier was breached, and in eight of the deaths, rescue attempts were made to save the child.

Table 23. Number of accident child deaths involving drowning in Nevada in 2019 with the listed contributing factors.

		Number of cases
Safety Factors	Child had a personal flotation device	0
	No barriers to swimming area	5
	Fence around swimming area	2
	Gate to swimming area	1
	Door to swimming area	2
	Alarm for swimming area	0
	Cover for swimming pool, hot tub, or spa	0
Safety Breaches	No barrier breached	7
	Gate left open	1
	Gate unlocked	0
	Gate latch failure	1
	Gap in gate	0
	Child climbed fence to access swimming area	0
	Gap in fence	0
	Damaged fence	0
	Fence too short	0
	Door left open	0
	Door unlocked	0
	Door broken	0
	Door screen torn	0

	Door closer failure	0
	Window left open	0
	Alarm not working	0
	Alarm not answered	0
	Cover left off	0
	Cover not locked	0
Rescue Efforts	Rescue attempt made	8
	Rescue attempt made by parent	7
	Rescue attempt made by other child	2
	Rescue attempt made by lifeguard	1
	Rescue attempt made by bystander	1
	Rescue attempt made by other	2
	Appropriate rescue equipment present	1
Note: More than one factor can apply to a case		

SUICIDES CAUSED BY HANGING (N = 9)

As seen in Table 24, there were more male children (55.6%) that died of suicide caused by hanging in Nevada in 2019 as compared to female children (44.4%).

Table 24. Number and percent of suicide child deaths caused by hanging in Nevada in 2019 by sex of the decedent.

	Number	Percent
Male	5	55.6%
Female	4	44.4%
Unknown	0	0.0%
Total	9	100%

In Nevada in 2019, all of the suicide child deaths caused by hanging occurred among children in the 10 – 14 years age category (33.3%) and the 15 – 17 years age category (66.7%). See Table 25.

Table 25. Number and percent of suicide child deaths caused by hanging in Nevada in 2019 by age category of the decedent.

	Number	Percent
<1 Year	0	0.0%
1 - 4 Years	0	0.0%
5 - 9 Years	0	0.0%
10 - 14 Years	3	33.3%
15 - 17 Years	6	66.7%
Total	9	100%

All of the suicide child deaths caused by hanging in Nevada in 2019 were among white children (77.8%) and African American and Pacific Islander children (both at 11.1%).

The largest percentage of suicide child deaths caused by hanging in Nevada in 2019 were among children not of Hispanic or Latino ethnicity (55.6%). See Table 26.

Table 26. Number and percent of suicide child deaths caused by hanging in Nevada in 2019 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	3	33.3%
Not Hispanic or Latino	5	55.6%
Unknown	1	11.1%
Total	9	100%

For suicide child deaths caused by hanging in Nevada in 2019, the history of the decedents with regard to mental health, maltreatment, crime, and school are provided in Table 27.

Table 27. History of decedents in suicide child deaths caused by hanging in Nevada in 2019.

		Number of cases
Mental Health	Received prior mental health service	3
	Was receiving mental health services	3
	On medications for mental illness	2
	History of use or substance abuse	1
Maltreatment	History of child maltreatment	2
	History of child maltreatment – Physical	2
	History of child maltreatment – Neglect	1
	History of child maltreatment – Sexual	1
	History of child maltreatment – Emotional/Psychological	0
	History of child maltreatment – Unknown	0
Crime	Delinquent or criminal history	0
	Spent time in juvenile detention	0
School	Problems in school	2
	Problems in school – Academic	1
	Problems in school – Truancy	0
	Problems in school – Suspensions	1
	Problems in school – Behavioral	1
	Problems in school – Expulsions	0
	Problems in school – Other	2

Details regarding the circumstances of the suicide child deaths caused by hanging in Nevada in 2019 can be seen in Table 28. The most common circumstance was that the child had communicated their suicidal thoughts or intentions.

Table 28. Circumstances of suicide child deaths caused by hanging in Nevada in 2019.

	Number of cases
Communicated suicidal thoughts or intentions	6
Child talked about suicide	4
Prior attempts were made	2
Suicide was completely unexpected	2
Child had a history of running away	0
Child had a history of self-mutilation	4
Child had history of suicide of a peer, friend, or family member	1
Suicide was part of a murder/suicide	1
Suicide was part of a suicide pact	0
Suicide was part of a suicide cluster	0
Note: More than one circumstance can apply to a case	

For the suicide child deaths caused by hanging in Nevada in 2019, the types of life stressors that the decedents had recently experienced can be seen in Table 29. The most common type of life stressors experienced were family discord, argument with parents/caregivers, breakup with boyfriend/girlfriend, new school, and rape/sexual abuse.

Table 29. Types of life stressors in the recent history of decedents in suicide child deaths caused by hanging in Nevada in 2019.

	Number of cases
Family discord	2
Argument with parents/caregivers	2
Parents’ divorce/separation	1
Parents’ incarceration	0
Argument with boyfriend/girlfriend	1
Breakup with boyfriend/girlfriend	2
Social discord	0
Argument with friends	0
Rumor mongering	0
Bullying as victim	0
Bullying as perpetrator	0
Cyberbullying as victim	0
Cyberbullying as perpetrator	0
Peer violence as victim	0
Peer violence as perpetrator	0
School failure	0
New school	2
Pressure to succeed at school	1
Extracurricular school activities	1

Other serious school problems	0
Pregnancy	0
Previous abuse	1
Rape/sexual abuse	2
Problems with the law	0
Drugs/alcohol	0
Sexual orientation/gender identity issues	0
Isolation	0
Job problems	0
Money problems	0
Involvement in computer or video gaming	0
Restrictions of technology	0
Social media	1
Involvement with the Internet	0
Note: More than one type can apply to a case	

DEATHS IN WHICH THERE WAS ABUSE OR NEGLECT, MATERNAL SUBSTANCE USE, OR CPS INVOLVEMENT

DEATHS IN WHICH ABUSE OR NEGLECT CAUSED OR CONTRIBUTED TO THE DEATH

In Nevada in 2019, there were 80 deaths in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death. As seen in Table 30, the largest percentage of these deaths were accidents (48.8%) followed by undetermined deaths (22.5%).

Table 30. 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 2019 by manner of death.

	Number	Percent
Natural	8	10.0%
Accident	39	48.8%
Suicide	3	3.8%
Homicide	11	13.8%
Undetermined	18	22.5%
Unknown	1	1.3%
Total	80	100%

As seen in Table 31, there were more deaths of male children (61.3%) than of female children (38.8%) in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the death.

Table 31. 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 2019 by sex of the decedent.

	Number	Percent
Male	49	61.3%
Female	31	38.8%
Unknown	0	0.0%
Total	80	100%

In Nevada in 2019, the majority 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 (65.0%). See Table 32.

Table 32. 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 2019 by age category of the decedent.

	Number	Percent
<1 Year	52	65.0%
1 - 4 Years	13	16.3%
5 - 9 Years	10	12.5%
10 - 14 Years	1	1.3%
15 - 17 Years	4	5.0%
Total	80	100%

As seen in Table 33 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 white children (47.5%) followed by African American children (36.3%).

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 2019 by race of the decedent.

	Number	Percent
White	38	47.5%
African American	29	36.3%
Native Hawaiian	0	0.0%
Pacific Islander	2	2.5%
Asian	3	3.8%
American Indian	1	1.3%
Alaska Native	0	0.0%
Multi-racial	7	8.8%
Unknown	0	0.0%
Total	80	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 2019 were among children not of Hispanic or Latino ethnicity (75.0%). See Table 34.

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 2019 by Hispanic or Latino ethnicity of the decedent.

	Number	Percent
Hispanic or Latino	20	25.0%
Not Hispanic or Latino	60	75.0%
Unknown	0	0.0%
Total	80	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 2019 are shown in Table 35. Other abuse was indicated in five deaths and beating/kicking was indicated in four deaths. “Other abuse” is a

response option in the data collection tool and includes types of abuse not listed in Table 35. In Nevada in 2019, these types of abuse specifically included assault, blunt force injuries, forcible drowning, arson, and unspecified blunt force trauma.

Table 35. 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 2019.

		Number of Cases
Type of Abuse	Abusive head trauma	2
	Chronic Battered Child Syndrome	3
	Beating/kicking	4
	Scalding/burning	0
	Munchausen Syndrome by Proxy	0
	Sexual assault	0
	Other abuse*	5
	Unknown abuse	1
Type of Neglect	Exposure to hazards	2
	Failure to provide necessities – Food	0
	Failure to provide necessities – Shelter	0
	Failure to provide necessities – Other**	2
	Failure to seek/follow treatment	1
	Failure to provide supervision	0
Note: More than one type of abuse or neglect can occur in a case *Cases included assault, blunt force injuries, forcible drowning, arson, and unspecified blunt force trauma **Cases included medical neglect		

Details regarding the reported events that triggered the physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2019 can be seen in Table 36.

Table 36. Events reported as triggering physical abuse in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2019.

	Number of Cases
Crying	1
Toilet training mishap	0
Disobedience	1
Feeding problems	0
Domestic argument	0
None	0
Other	2
Unknown	7
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 2019 can be seen in Table 37.

Table 37. 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 2019.

	Number of Cases
History of physical maltreatment	6
History of neglect	9
History of sexual maltreatment	0
History of emotional maltreatment	1
Note: More than one type of abuse or neglect can occur for a case.	

Table 38 details the CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2019.

Table 38. CPS involvement in cases in which abuse, neglect, poor supervision, or exposure to hazards caused or contributed to the child death in Nevada in 2019.

	Number of Cases
Evidence of prior abuse	29
CPS action taken as a result of the death	24
Open CPS case with child at time of death	0
Child ever placed in foster care	4
Note: More than one type of involvement can apply to a case	

In two of the child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2019, there was child abuse in the form of abusive head trauma. The impact of this abusive trauma is noted in Table 39.

Table 39. Abusive head trauma in cases of homicide child deaths in which abuse or neglect caused or contributed to the death in Nevada in 2019.

	Number of Cases with a yes response
For abusive head trauma, were there retinal hemorrhages?	1
For abusive head trauma, was the child shaken?	1
If the child was shaken, was there impact?	1
Note: More than one condition can apply to a case	

INFANT DEATHS IN WHICH THE MOTHER USED SUBSTANCES DURING PREGNANCY

There were 25 deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy. The manner of these deaths included natural (44.0%), accident (32.0%), undetermined (20.0%), and homicide (4.0%).

The majority of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy were among males (64.0%). See Table 40.

Table 40. Number and percent of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy by gender of decedent.

	Number	Percent
Male	16	64.0%
Female	9	36.0%
Unknown	0	0.0%
Missing	0	0.0%
Total	25	100%

As seen in Table 41, the largest percentage of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy were among white children (40.0%) and African American children (36.0%).

Table 41. Number and percent of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy by race of decedent.

	Number	Percent
White	10	40.0%
African American	9	36.0%
Asian	1	4.0%
Native Hawaiian	0	0.0%
Pacific Islander	1	4.0%
American Indian	1	4.0%
Alaskan Native	0	0.0%
Multi-racial	2	8.0%
Unknown	1	4.0%
Missing	0	0.0%
Total	25	100%

As seen in Table 42, the majority of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy were among children that were not Hispanic or Latino (68.0%).

Table 42. Number and percent of deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	7	28.0%
Not Hispanic or Latino	17	68.0%
Unknown	1	4.0%
Missing	0	0.0%
Total	25	100%

Risk factors associated with deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy can be seen in Table 43. The types of risk factors shown include those that occurred prior to pregnancy, during pregnancy, and indicate exposure to the child.

Table 43. Risk factors associated with deaths of children under 1 year of age in Nevada in 2019 in which the mother used substances during pregnancy.

		Number of Cases
Prior to Pregnancy	Mother had a history of substance use	16
	Substance use included alcohol	1
	Substance use included cocaine	0
	Substance use included marijuana	9
	Substance use included methamphetamines	5
	Substance use included opiates	4
	Substance use included prescription drugs	0
	Substance use included over-the-counter drugs	0
	Mother was a prior victim of child maltreatment	6
	Mother was a prior perpetrator of child maltreatment	13
	Mother's history included a prior child death	0
During Pregnancy	Mother smoked	10
	Mother used alcohol	4
	Mother used cocaine	1
	Mother used heroin	2
	Mother used marijuana	11
	Mother used methamphetamines	5
	Mother used opiates	4
Child Exposure	Toxicology screen completed on child	23
	Toxicology screen was negative	13
	Child tested positive for alcohol	0
	Child tested positive for cocaine	1
	Child tested positive for marijuana	2
	Child tested positive for methamphetamines	1
	Child tested positive for opiates	5
	Child tested positive for prescription drugs	0
	Child tested positive for other drugs	0
	Child test results unknown	3
Note: More than one risk factor can apply to a case.		

Deaths in which the child was involved in the Child Protective Services (CPS) System

Of the 268 child deaths in Nevada in 2019, there were 23 in which the child had been involved with the Child Protective Services (CPS) System. In 21 of these deaths, there was a past history of child maltreatment of the decedent as identified through CPS. See Table 44 for information regarding the status of the involvement of CPS with the decedent.

Table 44. Status of the involvement of Child Protective Services (CPS) System in which there was CPS involvement in Nevada in 2019.

	Number	Percent
Past history of child maltreatment as identified through CPS	21	91.3%
Past history of child maltreatment as identified through CPS and open CPS case at time of death	1	4.3%
Open CPS case at time of death	1	4.3%
Total	23	100%

As seen in Table 45, homicide deaths accounted for more than one-third (34.8%) of the child deaths in Nevada with CPS involvement in 2019. The next largest percentage of child deaths with CPS involvement were natural (30.4%).

Table 45. Number and percent of child deaths in Nevada with CPS involvement in 2019 by manner of death.

	Number	Percent
Natural	7	30.4%
Accident	3	13.0%
Suicide	3	13.0%
Homicide	8	34.8%
Undetermined	2	8.7%
Unknown	0	0.0%
Missing	0	0.0%
Total	23	100%

Among the deaths of children in which there was CPS involvement in Nevada in 2019, approximately half of the decedents were female (52.2%) and half of the decedents were male (47.8%).

In Nevada in 2019, the largest percentage of child deaths with CPS involvement occurred among those in the 15 – 17 years age category (30.4%). See Table 46.

Table 46. Number and percent of child deaths with CPS involvement in Nevada in 2019 by age category of decedent.

	Number	Percent
<1 Year	5	21.7%
1 - 4 Years	4	17.4%
5 - 9 Years	6	26.1%
10 - 14 Years	1	4.3%
15 - 17 Years	7	30.4%
Total	23	100%

The majority of child deaths with CPS involvement in Nevada in 2019 occurred among white children (60.9%) and African American children (30.4%). See Table 47.

Table 47. Number and percent of child deaths with CPS involvement in Nevada in 2019 by race of decedent.

	Number	Percent
White	14	60.9%
African American	7	30.4%
Asian	1	4.3%
Native Hawaiian	0	0.0%
Pacific Islander	0	0.0%
American Indian	0	0.0%
Alaskan Native	0	0.0%
Multi-racial	1	4.3%
Unknown	0	0.0%
Missing	0	0.0%
Total	23	100%

The majority of child deaths with CPS involvement in Nevada in 2019 occurred among those that were not Hispanic or Latino (60.9%). See Table 48.

Table 48. Number and percent of child deaths with CPS involvement in Nevada in 2019 by Hispanic or Latino ethnicity of decedent.

	Number	Percent
Hispanic or Latino	9	39.1%
Not Hispanic or Latino	14	60.9%
Unknown	0	0.0%
Missing	0	0.0%
Total	23	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 to Review of the Death of Children (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 take action on the recommendations, and notifies the regional team making the recommendation of the outcome of their recommendation.

RECOMMENDATIONS RECEIVED

During 2019, only one recommendation was made to the Executive Committee by the regional teams. It was recommended that dresser straps be added to home safety kits so that caregivers could stabilize dressers and large furniture thus preventing accident child deaths caused by large furniture overturning on young children.

ACTION TAKEN ON RECOMMENDATIONS

In discussing the recommendation that dresser straps be added to home safety kits with the regional team that made the recommendation, the Executive Committee learned that the team was able to obtain funding to make 150 safety kits and include dresser straps in each of them. Therefore, the Executive Committee notified the team that the recommendation would be closed and removed from discussion on their quarterly meeting agendas. However, the team was also informed that a request for dresser straps would be an appropriate proposal for submission when the Nevada Executive Committee to Review the Death of Children Public Awareness Notice of Funding Opportunity opens.

PUBLIC AWARENESS EFFORTS FUNDED BY THE EXECUTIVE COMMITTEE

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 to Review the Death of Children (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 NOFOs for State Fiscal Years 2019 (7/2018 – 6/2019) and 2020 (7/2019 – 6/2020) prioritized drowning and near drowning prevention, safe-sleep, and suicide prevention efforts. Below are the programs that were awarded funding in State Fiscal Years 2019 and 2020 by the Executive Committee.

SFY 2019 (7/2018 – 6/2019)

- Baby's Bounty ($12,500.00) – Continued funding for their Safe Sleep program
- Crisis Call Center ($12,577.00) – Support of suicide prevention and crisis intervention efforts
- Nevada Coalition for Suicide Prevention ($15,000.00) – Support safeTALK training and purchase of medication safes and gun locks
- Desert Rose Counseling ($16,465.00) – Support emergency mental health responses for the crisis stabilization of rural youth
- Renown Child Health Institute/SAFE Kids ($18,500.00)– Support the development of culturally competent materials for youth suicide prevention
- Immunize Nevada ($16,465.00)– Support community outreach events and social media
- Prevent Child Abuse Nevada ($7,150.00) – Support the Child Maltreatment Prevention and Safety Conference

SFY 2020 (7/2019 – 6/2020)

- Baby's Bounty ($10,500.00) – Continued funding for their Safe Sleep program
- DHHS-Office of Suicide Prevention ($13,140.00) – Training on safeTALK and leadership and purchase of AR-15 gun locks
- Southern Nevada Health District (SNHD) ($3,253.00) – Train-the-trainer training on safeTALK so that SNHD staff can be trained internally to help prevent suicide
- Washoe County HSA Child Suicide Awareness Prevention ($8,950.00) – PSA media campaign for children and teens in Washoe County
- Renown Health & The Child Health Institute ($15,000.00) – Increase suicide prevention outreach to Hispanic and Latino and Native American populations
- Desert Rose Counseling ($15,000.00) – Production of an episode of the Soul Survivor Nevada Docuseries to fill the gap of available suicide prevention content

- Crisis Support Services of Nevada ($10,716.50)– Continued funding for the suicide prevention call center with a focus on child suicide prevention
- Henderson Fire Department ($10,000.00)– Creation of a suicide prevention awareness program for children and adults
- Immunize Nevada, Healthy Young Nevada ($5,000.00) – Increase the number of community events for adolescents aimed at reducing the instances of diseases and disorders and increase membership in Healthy Young Nevada Youth Advisory Council
- Prevent Child Abuse Nevada ($8,800.00) – Continue efforts to provide child maltreatment prevention training to parents and professionals who work with parents

APPENDIX A: DEMOGRAPHICS OF DECEDENTS BY MANNER OF DEATH

Age Category	Natural	Accident	Suicide	Homicide	Undetermined	Unknown	Total
Under 1 Year	111	29	0	1	21	1	163
1 - 4 Years	16	9	0	6	1	0	32
5 - 9 Years	12	7	0	3	0	0	22
10 - 14 Years	11	4	6	1	0	0	22
15 - 17 Years	8	3	10	5	3	0	29
Total	158	52	16	16	25	1	268
Gender	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Male	89	29	10	11	17	1	157
Female	69	23	6	5	8	0	111
Unknown	0	0	0	0	0	0	0
Total	158	52	16	16	25	1	268
Race	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
White	86	24	13	8	13	1	145
African American	37	15	1	8	10	0	71
Asian	10	3	0	0	0	0	13
Native Hawaiian	0	0	0	0	0	0	0
Pacific Islander	3	2	1	0	0	0	6
American Indian	0	2	0	0	1	0	3
Alaskan Native	0	0	0	0	0	0	0
Multi-racial	13	6	1	0	1	0	21
Unknown	9	0	0	0	0	0	9
Total	158	52	16	16	25	1	268
Hispanic or Latino Ethnicity	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Hispanic or Latino	64	13	4	5	8	0	94
Not Hispanic or Latino	86	39	10	11	17	1	164
Unknown	8	0	2	0	0	0	10
Total	158	52	16	16	25	1	268
County of Residence	**Natural**	**Accident**	**Suicide**	**Homicide**	**Undetermined**	**Unknown**	**Total**
Clark	126	40	9	14	15	0	204
Washoe	25	7	5	1	5	0	43
Rural	2	1	1	0	1	1	6
Out of state	5	4	1	0	1	0	11
Unknown	0	0	0	1	3	0	4
Total	158	52	16	16	25	1	268

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

Natural Deaths

	Year		
Age Category	**2019**	**2018**	**2017**
Under 1 Year	111 (70.3%)	104 (73.8%)	191 (78.9%)
1 - 4 Years	16 (10.1%)	13 (9.2%)	20 (8.3%)
5 - 9 Years	12 (7.6%)	15 (10.6%)	12 (5.0%)
10 - 14 Years	11 (7.0%)	3 (2.1%)	10 (4.1%)
15 - 17 Years	8 (5.1%)	6 (4.3%)	9 (3.7%)
Total	158 (100%)	141 (100%)	242 (100%)
Gender	**2019**	**2018**	**2017**
Male	89 (56.3%)	86 (61.0%)	133 (55.0%)
Female	69 (43.7%)	54 (38.3%)	106 (43.8%)
Unknown	0 (0.0%)	1 (0.7%)	3 (1.2%)
Total	158 (100%)	141 (100%)	242 (100%)
Race	**2019**	**2018**	**2017**
White	86 (54.4%)	96 (68.1%)	107 (44.2%)
African American	37 (23.4%)	24 (17.0%)	43 (17.8%)
Asian	10 (6.3%)	5 (3.5%)	17 (7.0%)
Native Hawaiian	0 (0.0%)	1 (0.7%)	2 (0.8%)
Pacific Islander	3 (1.9%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	1 (0.7%)	2 (0.8%)
Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi-racial	13 (8.2%)	10 (7.1%)	24 (9.9%)
Unknown	9 (5.7%)	4 (2.8%)	47 (19.4%)
Total	158 (100%)	141 (100%)	242 (100%)
Hispanic or Latino Ethnicity	**2019**	**2018**	**2017**
Hispanic or Latino	64 (40.5%)	62 (44.0%)	74 (30.6%)
Not Hispanic or Latino	86 (54.4%)	74 (52.5%)	124 (51.2%)
Unknown	8 (5.1%)	5 (3.5%)	44 (18.2%)
Total	158 (100%)	141 (100%)	242 (100%)
County of Residence	**2019**	**2018**	**2017**
Clark	126 (79.7%)	120 (85.1%)	192 (79.3%)
Washoe	25 (15.8%)	18 (12.8%)	26 (10.7%)
Rural	2 (1.3%)	1 (0.7%)	11 (4.5%)
Out of state	5 (3.2%)	2 (1.4%)	12 (5.0%)
Unknown	0 (0.0%)	0 (0.0%)	1 (0.4%)
Total	158 (100%)	141 (100%)	242 (100%)

Accident Deaths

	Year		
Age Category	**2019**	**2018**	**2017**
Under 1 Year	29 (55.8%)	28 (47.5%)	22 (37.3%)
1 - 4 Years	9 (17.3%)	10 (16.9%)	12 (20.3%)
5 - 9 Years	7 (13.5%)	5 (8.5%)	5 (8.5%)
10 - 14 Years	4 (7.7%)	4 (6.8%)	9 (15.3%)
15 - 17 Years	3 (5.8%)	12 (20.3%)	11 (18.6%)
Total	52 (100%)	59 (100%)	59 (100%)
Gender	**2019**	**2018**	**2017**
Male	29 (55.8%)	43 (72.9%)	30 (50.8%)
Female	23 (44.2%)	16 (27.1%)	29 (49.2%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	52 (100%)	59 (100%)	59 (100%)
Race	**2019**	**2018**	**2017**
White	24 (46.2%)	37 (62.7%)	33 (55.9%)
African American	15 (28.8%)	11 (18.6%)	11 (18.6%)
Asian	3 (5.8%)	0 (0.0%)	5 (8.5%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	2 (3.8%)	1 (1.7%)	0 (0.0%)
American Indian	2 (3.8%)	1 (1.7%)	0 (0.0%)
Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi-racial	6 (11.5%)	9 (15.3%)	6 (10.2%)
Unknown	0 (0.0%)	0 (0.0%)	4 (6.8%)
Total	52 (100%)	59 (100%)	59 (100%)
Hispanic or Latino Ethnicity	**2019**	**2018**	**2017**
Hispanic or Latino	13 (25.0%)	15 (25.4%)	18 (30.5%)
Not Hispanic or Latino	39 (75.0%)	43 (72.9%)	38 (64.4%)
Unknown	0 (0.0%)	1 (1.7%)	3 (5.1%)
Total	52 (100%)	59 (100%)	59 (100%)
County of Residence	**2019**	**2018**	**2017**
Clark	40 (76.9%)	50 (84.7%)	42 (71.2%)
Washoe	7 (13.5%)	5 (8.5%)	5 (8.5%)
Rural	1 (1.9%)	4 (6.8%)	7 (11.9%)
Out of state	4 (7.7%)	0 (0.0%)	5 (8.5%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	52 (100%)	59 (100%)	59 (100%)

Suicide Deaths

	Year		
Age Category	**2019**	**2018**	**2017**
Under 1 Year	0 (0.0%)	0 (0.0%)	0 (0.0%)
1 - 4 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)
5 - 9 Years	0 (0.0%)	0 (0.0%)	0 (0.0%)
10 - 14 Years	6 (37.5%)	9 (39.1%)	3 (18.8%)
15 - 17 Years	10 (62.5%)	14 (60.9%)	13 (81.3%)
Total	16 (100%)	23 (100%)	16 (100%)
Gender	**2019**	**2018**	**2017**
Male	10 (62.5%)	15 (65.2%)	14 (87.5%)
Female	6 (37.5%)	8 (34.8%)	2 (12.5%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	23 (100%)	16 (100%)
Race	**2019**	**2018**	**2017**
White	13 (81.3%)	15 (65.2%)	11 (68.8%)
African American	1 (6.3%)	4 (17.4%)	2 (12.5%)
Asian	0 (0.0%)	3 (13.0%)	1 (6.3%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	1 (6.3%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi-racial	1 (6.3%)	0 (0.0%)	2 (12.5%)
Unknown	0 (0.0%)	1 (4.3%)	0 (0.0%)
Total	16 (100%)	23 (100%)	16 (100%)
Hispanic or Latino Ethnicity	**2019**	**2018**	**2017**
Hispanic or Latino	4 (25.0%)	7 (30.4%)	6 (37.5%)
Not Hispanic or Latino	10 (62.5%)	16 (69.6%)	10 (62.5%)
Unknown	2 (12.5%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	23 (100%)	16 (100%)
County of Residence	**2019**	**2018**	**2017**
Clark	9 (56.3%)	19 (82.6%)	11 (68.8%)
Washoe	5 (31.3%)	2 (8.7%)	3 (18.8%)
Rural	1 (6.3%)	1 (4.3%)	2 (12.5%)
Out of state	1 (6.3%)	1 (4.3%)	0 (0.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	23 (100%)	16 (100%)

Homicide Deaths

	Year		
Age Category	**2019**	**2018**	**2017**
Under 1 Year	1 (6.3%)	7 (25.9%)	7 (29.2%)
1 - 4 Years	6 (37.5%)	9 (33.3%)	10 (41.7%)
5 - 9 Years	3 (18.8%)	2 (7.4%)	0 (0.0%)
10 - 14 Years	1 (6.3%)	1 (3.7%)	2 (8.3%)
15 - 17 Years	5 (31.3%)	8 (29.6%)	5 (20.8%)
Total	16 (100%)	27 (100%)	24 (100%)
Gender	**2019**	**2018**	**2017**
Male	11 (68.8%)	18 (66.7%)	18 (75.0%)
Female	5 (31.3%)	9 (33.3%)	6 (25.0%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	27 (100%)	24 (100%)
Race	**2019**	**2018**	**2017**
White	8 (50.0%)	10 (37.0%)	13 (54.2%)
African American	8 (50.0%)	16 (59.3%)	9 (37.5%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi-racial	0 (0.0%)	1 (3.7%)	2 (8.3%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	27 (100%)	24 (100%)
Hispanic or Latino Ethnicity	**2019**	**2018**	**2017**
Hispanic or Latino	5 (31.3%)	8 (29.6%)	10 (41.7%)
Not Hispanic or Latino	11 (68.8%)	18 (66.7%)	13 (54.2%)
Unknown	0 (0.0%)	1 (3.7%)	1 (4.2%)
Total	16 (100%)	27 (100%)	24 (100%)
County of Residence	**2019**	**2018**	**2017**
Clark	14 (87.5%)	23 (85.2%)	17 (70.8%)
Washoe	1 (6.3%)	1 (3.7%)	2 (8.3%)
Rural	0 (0.0%)	1 (3.7%)	3 (12.5%)
Out of state	0 (0.0%)	2 (7.4%)	2 (8.3%)
Unknown	1 (6.3%)	0 (0.0%)	0 (0.0%)
Total	16 (100%)	27 (100%)	24 (100%)

Undetermined Deaths

Age Category	2019	2018	2017
Under 1 Year	21 (84.0%)	16 (72.7%)	13 (76.5%)
1 - 4 Years	1 (4.0%)	3 (13.6%)	1 (5.9%)
5 - 9 Years	0 (0.0%)	1 (4.5%)	0 (0.0%)
10 - 14 Years	0 (0.0%)	1 (4.5%)	1 (5.9%)
15 - 17 Years	3 (12.0%)	1 (4.5%)	2 (11.8%)
Total	25 (100%)	22 (100%)	17 (100%)
Gender	**2019**	**2018**	**2017**
Male	17 (68.0%)	12 (54.5%)	12 (70.6%)
Female	8 (32.0%)	10 (45.5%)	5 (29.4%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	25 (100%)	22 (100%)	17 (100%)
Race	**2019**	**2018**	**2017**
White	13 (52.0%)	12 (54.5%)	11 (64.7%)
African American	10 (40.0%)	9 (40.9%)	5 (29.4%)
Asian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Native Hawaiian	0 (0.0%)	0 (0.0%)	0 (0.0%)
Pacific Islander	0 (0.0%)	0 (0.0%)	0 (0.0%)
American Indian	1 (4.0%)	0 (0.0%)	0 (0.0%)
Alaskan Native	0 (0.0%)	0 (0.0%)	0 (0.0%)
Multi-racial	1 (4.0%)	1 (4.5%)	1 (5.9%)
Unknown	0 (0.0%)	0 (0.0%)	0 (0.0%)
Total	25 (100%)	22 (100%)	17 (100%)
Hispanic or Latino Ethnicity	**2019**	**2018**	**2017**
Hispanic or Latino	8 (32.0%)	8 (36.4%)	3 (17.6%)
Not Hispanic or Latino	17 (68.0%)	14 (63.6%)	13 (76.5%)
Unknown	0 (0.0%)	0 (0.0%)	1 (5.9%)
Total	25 (100%)	22 (100%)	17 (100%)
County of Residence	**2019**	**2018**	**2017**
Clark	15 (60.0%)	16 (72.7%)	13 (76.5%)
Washoe	5 (20.0%)	5 (22.7%)	1 (5.9%)
Rural	1 (4.0%)	0 (0.0%)	1 (5.9%)
Out of state	1 (4.0%)	0 (0.0%)	1 (5.9%)
Unknown	3 (12.0%)	1 (4.5%)	1 (5.9%)
Total	25 (100%)	22 (100%)	17 (100%)

APPENDIX C: NUMBER AND PERCENT OF CHILD DEATHS IN NEVADA IN 2019 BY DECEDENT'S COUNTY OF RESIDENCE FOR LEADING MANNERS AND CAUSES OF CHILD DEATHS

	Clark County	Washoe County	Rural Counties	Out of State	Unknown	Total
Accidents caused by unintentional asphyxia	26 (92.9%)	1 (3.6%)	0 (0.0%)	1 (3.6%)	0 (0.0%)	28 (100%)
Homicides caused by assault, weapon, or person's body part	12 (85.7%)	1 (7.1%)	0 (0.0%)	0 (0.0%)	1 (7.1%)	14 (100%)
Accidents caused by drowning	9 (90.0%)	1 (10.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	10 (100%)
Suicide caused by hanging	5 (55.6%)	3 (33.3%)	0 (0.0%)	1 (11.1%)	0 (0.0%)	9 (100%)
Deaths in which abuse or neglect caused or contributed to the death	68 (85.0%)	7 (8.8%)	2 (2.5%)	2 (2.5%)	1 (1.3%)	80 (100%)
Infant deaths in which the mother used substances during pregnancy	20 (80.0%)	5 (20.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	25 (100%)
Deaths in which the child was involved in the Child Protective Services (CPS) System	22 (95.7%)	1 (4.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	23 (100%)

APPENDIX D: NEVADA REVISED STATUTES FOR CHILD DEATH REVIEW

NRS 432B.403 Purpose of organizing child death review teams. The purpose of organizing multidisciplinary teams to review the deaths of children pursuant to NRS 432B.403 to 432B.409, 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)

NRS 432B.405 Organization of child death review teams.

1. An agency which provides child welfare services:
    a. May organize one or more multidisciplinary teams to review the death of a child; and
    b. 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 daycare provider has been the subject of a child abuse and neglect investigation within the previous 12 months, including 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 (b) 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)

NRS 432B.406 Composition of child death review teams.

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 Information available to child death review teams; sharing of certain information; subpoena to obtain information; 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 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. Any books, records or papers received by the team pursuant to the subpoena shall be deemed confidential and privileged and not subject to disclosure.
4. 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)

NRS 432B.408 Administrative team to review report 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)