



STATE OF NEVADA

DIVISION OF CHILD  
AND FAMILY  
SERVICES

# **2008 STATEWIDE CHILD DEATH REPORT**

*Submitted by:*

The Executive Committee to Review the Death of Children

Troy Armstrong and Michelle Lucier, Co-Chairs

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## Data Confidentiality

**PLEASE NOTE: PORTIONS OF THE COLLECTIVE INFORMATION AND DATA CONTAINED IN THIS REPORT WERE COMPILED FROM CHILD RECORDS THAT ARE CONFIDENTIAL AND CONTAIN INFORMATION WHICH IS PROTECTED FROM DISCLOSURE TO THE PUBLIC, PURSUANT TO NEVADA REVISED STATUTES (NRS) AND FEDERAL LAWS AND REGULATIONS.**

# Executive Summary

Regional child death review (CDR) teams are organized and operational in Nevada based on Nevada Revised Statutes (NRS) chapter 432B, sections 403 through 4095. There are currently seven regional CDR teams in the state:

1. **Clark Team:** Reviews deaths in Clark County.
2. **Southern Nevada Child Fatality Task Force:** Works in Clark County to improve the investigation of child deaths by stakeholders in the CDR process.
3. **Washoe Team:** Reviews deaths in Washoe County.
4. **Elko Team (District 1 – North):** Reviews deaths in Elko, Eureka, Humboldt, Lander, Lincoln, and White Pine Counties.
5. **Carson Team (District 2 – West):** Reviews deaths in Carson City, Douglas, and Storey Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Carson Team covers Stagecoach and Dayton.
6. **Fallon Team (District 3 – East):** Reviews deaths in Churchill, Mineral, and Pershing Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Fallon Team covers Fernley, Silver Springs, and Yerington.
7. **Pahrump Team (District 4 – South):** Reviews deaths in Esmeralda and Nye Counties.

The two urban teams, Clark and Washoe, review child deaths in the major population centers of the state, centered in the areas of Las Vegas and Reno, respectively. The four rural teams review child deaths in all other counties, which comprise Nevada’s rural region. The Southern Nevada Child Fatality Task Force reviews select cases to promote process improvement for child death investigations, but is not primarily responsible for child death reviews in Clark County.

Two statewide groups provide coordination and oversight for the review of child deaths in Nevada: 1) the Administrative Team and 2) the Executive Committee to Review the Death of Children. The Administrative Team reviews reports and recommendations from the regional CDR teams and makes decisions regarding recommendations for improvements to laws, policies, and practices related to the prevention of child death. The Executive Committee makes decisions about funding initiatives to prevent child death, which may be based on recommendations from the Administrative Team and annual child death data analysis. Additionally, the Executive Committee adopts statewide protocols for the review of the death of children; oversees training and development for the regional CDR teams; and compiles and distributes this statewide annual report.

Based on death certificates issued by the State of Nevada in calendar year 2008, there were a total of 356 child and adolescent deaths in the state.<sup>1</sup> These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data. This is a decrease from 432 total child deaths in 2007. The greatest number of child deaths in 2008 occurred among infants less than one year of age, which is consistent with national death rates that indicate the highest rate of death for infants ages birth to one year. Infant mortality rates are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population), which is common for most other forms of mortality statistics. The

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<sup>1</sup> Hansen, Alicia. (2010). *Custom Vital Statistics Database on Child Deaths 2008*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

latest federal infant mortality data is from 2007. In 2007, Nevada’s infant mortality rate was 6.36 per 1,000 live births. This is below the national average of 6.75 per 1,000 live births for the same year. This also represents a slight decrease for Nevada from the rate of 6.4 per 1,000 live births in 2006.<sup>2</sup>

During 2008, a total of 363 child deaths were reviewed by the six regional CDR teams actively engaged in regular case reviews. Thanks to the efforts of the Clark CDR Team, 2008 is the first year that all coroner-referred deaths in Nevada were tracked and entered into the electronic case reporting system used to track data from the regional CDR Teams. This significant improvement in data tracking demonstrates a commitment on the part of the regional CDR teams to expand their capacity to review child deaths in Nevada and work toward increasing prevention efforts.

The difference between total deaths reported by the Nevada State Health Division (356) and the total cases reviewed by the regional CDR teams (363) is due to a variety of factors outlined in the *Data Limitations* sections of this report, located on pages 8 and 27. For 2008, this difference is mostly attributable to out-of-state residents’ motor vehicle accidents that may have not been processed through one of the regional coroners’ offices. Additional information on some of the data discrepancies is also reviewed in the *Data Inconsistencies* section on page 28.

Combined evaluation of 2008 statewide vital records data and regional CDR team data shows the following four leading manners and causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

<b>Manner</b>	<b>Leading Causes within Manner</b>
1. Non-motor vehicle accidents	Asphyxia, drowning, drug overdose
2. Motor vehicle accidents	Blunt force trauma from motor vehicle collision
3. Homicide	Gunshot wounds, abuse and neglect
4. Suicide	Gunshot wounds, asphyxia

This is the second year in which non-motor vehicle accidents are the leading manner of death for children and adolescents in Nevada. This is inconsistent with national mortality data, which shows motor vehicle accidents as the leading cause of death for all Americans, ages one through 44.<sup>3</sup> However, recent National Highway Traffic Safety Administration (NHTSA) data shows a decline in motor vehicle accident deaths nationally over the past five years,<sup>4</sup> beginning in 2005. Some research suggests this is due to the US economic downturn.<sup>5</sup> Other research suggests that this is the result of federal highway safety efforts including more drivers and passengers wearing seatbelts, enforcement of drunk driving laws, and improved vehicle safety features such as airbags.<sup>6</sup>

<sup>2</sup> Xu, JQ. et. al. (2010). *Deaths: Final data for 2007. National Vital Statistics Reports Web Release; Vol. 58 No. 19.* Hyattsville, MD: National Center for Health Statistics.

<sup>3</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>.

<sup>4</sup> Fatality Analysis Reporting System (FARS). (2010). *Fatalities and Fatality Rates, 1994 – 2008.* Retrieved September 14, 2010, from <http://www-fars.nhtsa.dot.gov/Trends/TrendsGeneral.aspx>.

<sup>5</sup> Thomas, K. (2009). *Bad Economy Drops Highway Deaths to 1960s Levels.* Associated Press.

<sup>6</sup> Thomas, K. (2010). *Highway deaths fall to lowest level since 1950.* Associated Press.

For the fifth consecutive year, the Executive Committee continues to compile statewide child death data from the Nevada State Health Division (NSHD) – Center for Health Data and Research and the CDR Case Reporting System, which is managed by the National Maternal Child Health (MCH) Center for Child Death Review. Health Division data is compared with case review data derived from the work of the six regional CDR teams, and analyzed to produce this report. Comparison of vital records data in conjunction with regional CDR team data yields more complete information on causes of death, and contributes to a more effective evaluation of causes where prevention efforts may contribute to a reduction in child deaths. This ongoing statewide data analysis, combined with regional CDR team data analysis, continues to improve the Executive Committee’s work to effectively evaluate child deaths in Nevada.

The Executive Committee also continues its annual public awareness campaigns for the prevention of child death. Highlights of past prevention efforts are included in *Section 2* of this report within the detailed reviews for leading causes of child death.

## Section 1: Statewide Data

### 2008 Child Deaths in Nevada

All data in *Section 1* of this report is derived from the Nevada State Health Division – Center for Health Data and Research. Based on death certificates issued by the State of Nevada in calendar year 2008, there were a total of 356 child and adolescent deaths in the state.<sup>7</sup> These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data.

### Nevada State Health Division Data

#### Data Limitations

There are certain limitations for the data provided by the Nevada State Health Division – Center for Health Data and Research. The data provided on death certificates issued for calendar year 2008 is raw data. This means that some records may have incomplete information related to demographics, manner of death, and cause of death. This also means that there may be a margin of error in terms of age based on date of birth and date of death, such that some records were either included or disincluded that do not belong to the age group birth through 17 years of age.

Additional data limitations include the following:

- All child deaths may not be 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 does not get 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 this data is collected and how certain questions are answered.
- Comparisons with statewide Health Division data, reviewed below, may result in errors because of problems with a child's name. This most commonly occurs with infants who are not given a name at the time of their death and assigned a designation such as "baby boy" or "baby girl." When a death certificate is issued, in most cases a name is given, thus creating discrepancies in the data. These cases are examined and attempts are made to reconcile these differences, but not all discrepancies can be corrected.
- Comparisons with statewide Health Division data, reviewed below, may also result in errors because of coding for the cause of death. For statewide 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.<sup>8</sup> For regional CDR team data, cause of death is entered as reported on the death certificate or based on findings from the multidisciplinary review process.

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<sup>7</sup> Hansen, Alicia. (2010). *Custom Vital Statistics Database on Child Deaths 2008*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

<sup>8</sup> National Center for Health Statistics. (2009). *The International Classification of Diseases, Tenth Revision, (ICD-10)*. Retrieved August 27, 2010, from <http://www.cdc.gov/nchs/icd.htm>.

- Although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, the multidisciplinary reviews completed by the regional CDR teams provide details that allow alternative classification of the death for the purposes of this report.

## **Data Improvements**

Calendar year 2008 data includes more detailed race and ethnicity categories, which allows a direct comparison with the detailed race and ethnicity data collected by the regional CDR teams.

## Leading Manners of Death

### Target Manners for Prevention Efforts

The four leading manners of child death statewide, excluding natural and undetermined deaths, are as follows:

Leading Manner:	Total Deaths by Manner:	Percentage of Total Statewide Deaths:
1. Non-motor vehicle accidents	53	14.9%
2. Motor vehicle accidents	31	8.7%
3. Homicide	22	6.2%
4. Suicide	8	2.2%
TOTAL deaths by leading manners:	114	32.0%

For statewide data, these manners of death exclude undetermined deaths, which are difficult to target for prevention efforts due to lack of information. More detail about undetermined deaths is available based on the reviews conducted by the regional CDR teams, and additional information on these deaths is provided in *Section 2* of this report. These manners also exclude natural deaths, which are discussed separately below under *Natural Deaths*.

### DETAIL: Target Causes for Prevention Efforts

Leading Manner and Causes:	Total Deaths by Manner and Cause:	Percentage of Total Statewide Deaths:
1. Non-motor vehicle accidents	53	14.9%
• Asphyxia	13	3.7%
• Drowning	13	3.7%
• Overdose	11	3.1%
• Fall	3	0.8%
• Maternal substance use	2	0.6%
• Gunshot Wounds (GSW)	1	0.3%
• Other	2	0.6%
• Unknown	8	2.2%

#### Findings:

- Non-motor vehicle accidents (non-MVA) are the leading manner of accidental death for children and adolescents in Nevada. This is inconsistent with national mortality data, which shows motor vehicle accidents (MVA) as the leading cause of death for all Americans, ages one through 44.<sup>9</sup> However, recent National Highway Traffic Safety Administration (NHTSA) data shows a decline in MVA deaths nationally

<sup>9</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>.

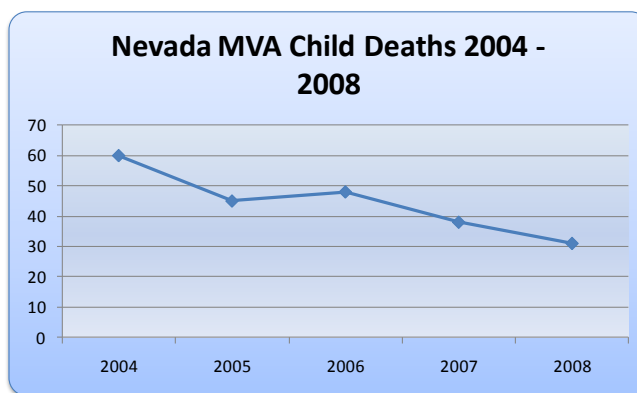
over the past five years,<sup>10</sup> beginning in 2005. Some research suggests this is due to the US economic downturn.<sup>11</sup> Other research suggests that this is the result of federal highway safety efforts including more drivers and passengers wearing seatbelts, enforcement of drunk driving laws, and improved vehicle safety features such as airbags.<sup>12</sup>

- Asphyxia deaths were the most common type of accidental death in 2008. Of the 13 deaths, 11 were related to unsafe sleep environments. Data in *Section 2* shows that many more child deaths likely involve unsafe sleep environments when investigative information from undetermined deaths is considered.
- Drownings decreased from 15 in 2007 to 13 in 2008.
- Overdose deaths increased from 3 in 2007 to 11 in 2008.

Leading Manner and Causes:	Total Deaths by Manner and Cause:	Percentage of Total Statewide Deaths:
<b>2. Motor vehicle accidents</b>	<b>31</b>	<b>8.7%</b>
• Driver	0	0.0%
• Passenger	2	0.6%
• Pedestrian	10	2.8%
• Motorcycle Driver	0	0.0%
• Motorcycle Passenger	0	0.0%
• Bicycle	3	0.8%
• All-Terrain Vehicle (ATV)	2	0.6%
• Watercraft	1	0.3%
• Unknown type	13	3.7%

**Findings:**

- Motor vehicle accident (MVA) deaths among children and adolescents have decreased notably over the past three years, especially in light of Nevada’s continued population growth:



- Over 40% of statewide MVA deaths in 2008 were classified in the “unknown type” category, demonstrating a lack of vehicle type and driver position data coding from death certificates. This may be a practice issue where coroners and medical examiners do not enter detailed information about MVA

<sup>10</sup> Fatality Analysis Reporting System (FARS). (2010). *Fatalities and Fatality Rates, 1994 – 2008*. Retrieved September 14, 2010, from <http://www-fars.nhtsa.dot.gov/Trends/TrendsGeneral.aspx>.

<sup>11</sup> Thomas, K. (2009). *Bad Economy Drops Highway Deaths to 1960s Levels*. Associated Press.

<sup>12</sup> Thomas, K. (2010). *Highway deaths fall to lowest level since 1950*. Associated Press.

deaths, or there is a lack of specific information surrounding the circumstances of the death. Greater detail is available through regional CDR team data and MVA deaths are analyzed in detail below in *Section 2* of this report.

Leading Manner and Causes:	Total Deaths by Manner and Cause:	Percentage of Total Statewide Deaths:
<b>3. Homicide</b>	<b>22</b>	<b>6.2%</b>
• Gunshot wounds	8	2.2%
• Other weapon	3	0.8%
• Abuse	1	0.3%
• Other causes	4	1.1%
• Unknown causes	5	1.4%

**Findings:**

- Total homicides increased from 19 in 2007 to 22 in 2008. Homicides from gunshot wounds decreased slightly from 9 in 2007 to 8 in 2008. A high number of deaths by gunshot wounds is consistent with national data, which shows gunshot wounds as the leading cause of homicide deaths for children and adolescents ages five through 17.<sup>13</sup>
- Abuse deaths show a considerable drop from 10 in 2007 to only 1 in 2008. Regional CDR team data shows a total of 9 deaths resulting from abuse and neglect. This inconsistency may be a result of differing criteria between the coroner and the multidisciplinary members of the regional CDR teams.

Leading Manner and Causes:	Total Deaths by Manner and Cause:	Percentage of Total Statewide Deaths:
<b>4. Suicide</b>	<b>8</b>	<b>2.2%</b>
• Gunshot wounds	3	0.8%
• Asphyxia	3	0.8%
• Other	2	0.6%

**Findings:**

- Total deaths by suicide decreased considerably from 15 in 2007 to 8 in 2008.
- Deaths by suicide resulting from gunshot wounds decreased from 7 in 2007 to 3 in 2008.
- As with other leading manners of death, greater and sometimes differing detail is available through regional CDR team data and these suicide deaths are analyzed in detail below in *Section 2*.

<sup>13</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisgars/index.html>.

## Natural Deaths

Natural deaths are the leading manner of child death in the state, accounting for 60.7% of all deaths and occurring primarily in infants less than one year of age. All natural deaths are reviewed by the regional CDR teams, and certain natural causes are focused on as follows:

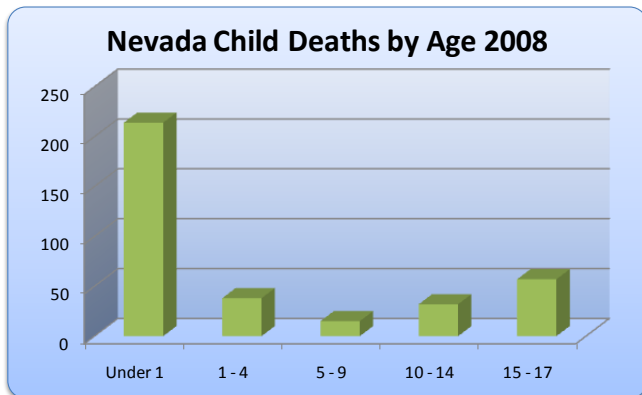
- Sudden Infant Death Syndrome (SIDS): Review of these deaths are mandated by NRS 432B.405.
- Natural deaths for children with a current or prior child protective services (CPS) history: Review of these deaths are mandated by NRS 432B.405.
- Natural causes that may be associated with abuse and/or neglect: Although a coroner or medical examiner may determine that a child death resulted from identifiable natural causes, investigation findings may suggest signs of abuse and/or neglect such as over-medication or medical neglect.
- Toxicology reports suggesting maternal drug use and drug exposure for infants: Again, although a coroner or medical examiner may determine that a child death resulted from identifiable natural causes, toxicology tests conducted at birth may suggest that maternal drug use contributed to the fatality.

More detailed data for these types of deaths are available based on the regional CDR case review process and are discussed in detail below under *Section 2* of this report.

## Basic Demographics: All Deaths

As noted above, based on death certificates issued by the State of Nevada in calendar year 2008, there were a total of 356 child and adolescent deaths in the state.<sup>14</sup> These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data.

### Age



Age Group	Total	%
Under 1	214	60.1%
1 - 4	38	10.7%
5 - 9	15	4.2%
10 - 14	32	9.0%
15 - 17	57	16.0%
TOTAL:	356	100.0%

### Deaths by Age Findings:

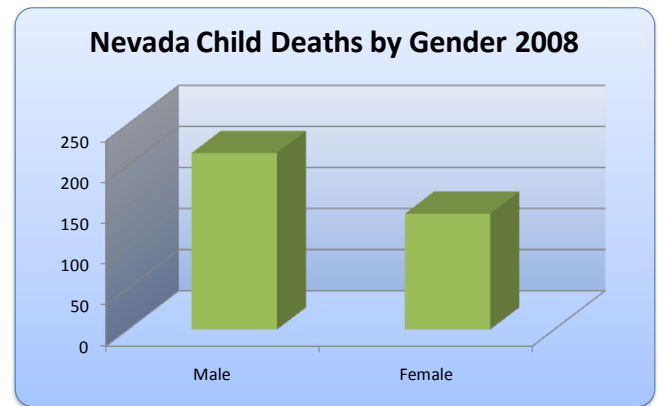
- The greatest number of child deaths in 2008 occurred among infants less than one year of age. This is consistent with national death rates for children and adolescents, which indicate the highest rate of deaths for infants ages birth to one year, at approximately 684.5 per 100,000 of the population.
- Nevada child death rates in other age groups are considerably lower, with decreasing deaths through the 5 – 9 age group, and then increasing deaths as adolescents move through their pre-teen and teen years. This u-shaped data pattern is consistent with national death rates for the same age groups.
- Infant mortality rates are calculated based on live births (rate per 1,000 live births) rather than population estimates (rate per 100,000 population), which is common for most other forms of mortality statistics. The latest federal infant mortality data is from 2007. In 2007, Nevada's infant mortality rate was 6.36 per 1,000 live births. This is below the national average of 6.75 per 1,000 live births for the same year. This also represents a slight decrease for Nevada from the rate of 6.4 per 1,000 live births in 2006.<sup>15</sup>

<sup>14</sup> Hansen, Alicia. (2010). *Custom Vital Statistics Database on Child Deaths 2008*. Carson City, NV: Nevada State Health Division, Center for Health Data and Research.

<sup>15</sup> Xu, JQ. et. al. (2010). *Deaths: Final data for 2007. National Vital Statistics Reports Web Release; Vol. 58 No. 19*. Hyattsville, MD: National Center for Health Statistics.

## Gender

Gender	Total	%
Male	215	60.4%
Female	141	39.6%
TOTAL:	356	100.0%

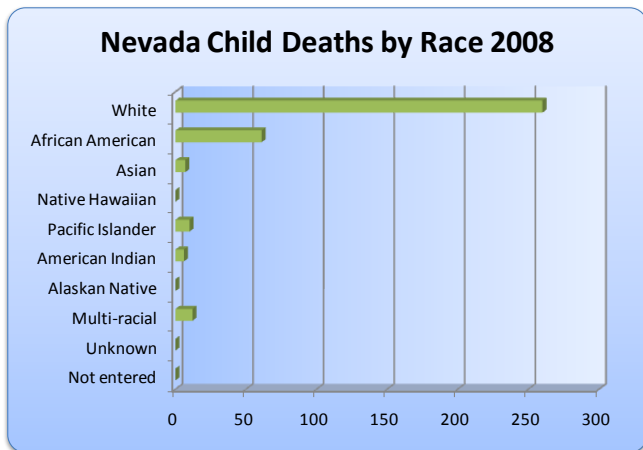


### Deaths by Gender Findings:

- Nevada child deaths in 2008 include more males than females. This is again consistent with national data, which indicates that male children and adolescents die at a higher rate than females.<sup>16</sup>

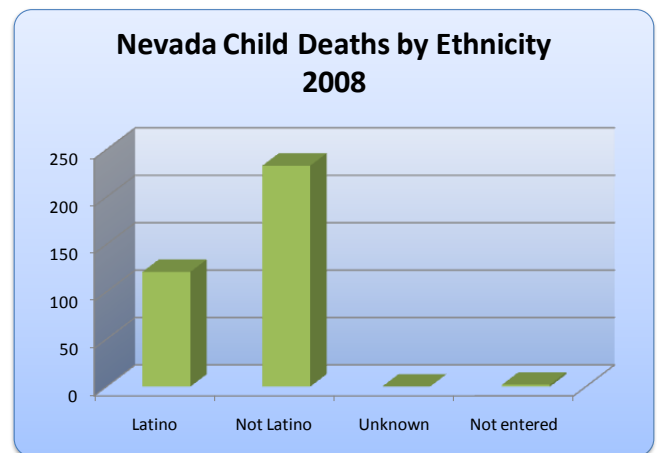
<sup>16</sup> Xu, JQ. et. al. (2010). *Deaths: Final data for 2007. National Vital Statistics Reports Web Release; Vol. 58 No. 19.* Hyattsville, MD: National Center for Health Statistics.

## Race and Ethnicity



Race Group	Total	%
White	260	73.0%
African American	61	17.1%
Asian	7	2.0%
Native Hawaiian	0	0.0%
Pacific Islander	10	2.8%
American Indian	6	1.7%
Alaskan Native	0	0.0%
Multi-racial	12	3.4%
Unknown	0	0.0%
Not entered	0	0.0%

Ethnicity	Total	%
Hispanic/Latino	121	34.0%
Not Hisp/Latino	233	65.4%
Unknown	0	0.0%
Not entered	2	0.6%
<b>TOTAL:</b>	<b>356</b>	<b>100.0%</b>



### Findings:

- Race and ethnicity findings for statewide data are detailed below in the next comparison section.

## Comparison: Statewide Population and Child Death by Race and Ethnicity

STATEWIDE POPULATION (0 – 17) <sup>17</sup>		
Race Group	Total	%
White	332,887	46.9%
Hispanic/Latino	261,333	36.8%
African American	58,638	8.3%
Asian	47,346	6.7%
American Indian	9,411	1.3%
Other	-	-
Unknown	-	-
<b>TOTAL:</b>	<b>709,615</b>	<b>100.0%</b>

STATEWIDE CHILD DEATHS		
Race Group	Total	%
White	260	73.0%
African American	61	17.1%
Asian	7	2.0%
Native Hawaiian	0	0.0%
Pacific Islander	10	2.8%
American Indian	6	1.7%
Alaskan Native	0	0.0%
Multi-racial	12	3.4%
Unknown	0	0.0%
Not entered	0	0.0%
Ethnicity	Total	%
Hispanic/Latino	121	34.0%
Not Hisp/Latino	233	65.4%

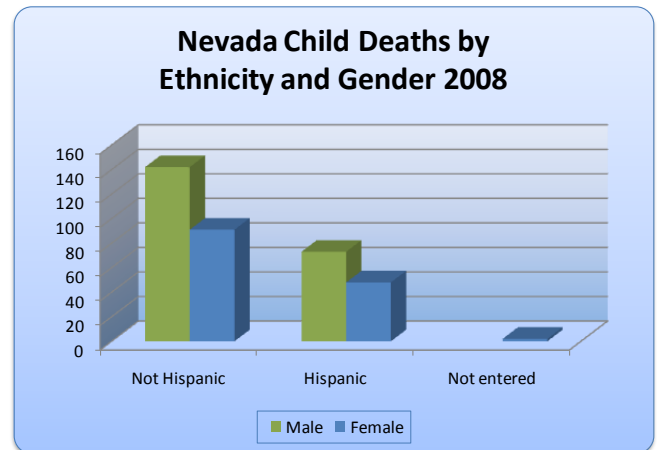
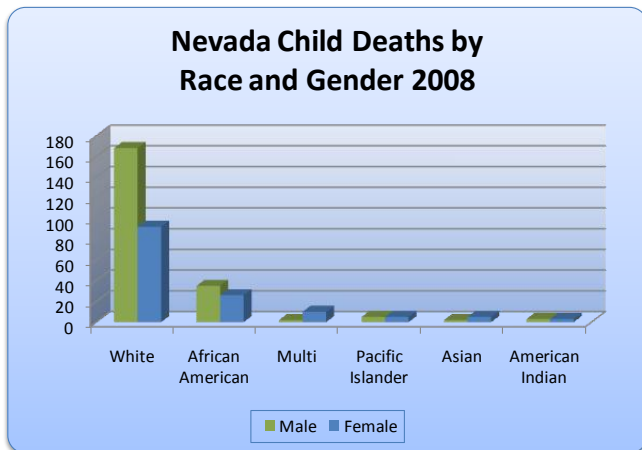
### Findings:

- For whites and Hispanics/Latinos, comparison data is confounded because the State Demographer counts Hispanics/Latinos as a race category, whereas child death data separates Hispanics/Latinos out as an ethnicity, per federal standards. To accommodate this comparison, white and Hispanic/Latino race categories can be combined from the statewide population data, yielding a total white population of 83.7%. This indicates that child deaths among whites are less frequent at 73%, which is consistent with data from prior years. Likewise, child deaths among Hispanics/Latinos are below the statewide population distribution when comparing the race and ethnicity data at 36.8% versus 34%.
- For African Americans, 2008 child deaths are disproportionately higher than the statewide population distribution at 17.1% versus 8.3%. In terms of infant mortality, this consistent with national data, which shows that African Americans have a higher overall infant mortality rate than whites (14.5 deaths per 1,000 live births for African Americans versus 5.6 deaths per 1,000 live births for whites).<sup>18</sup> However, for some specific causes of death detailed in *Section 2*, African American deaths are disproportionately higher, which indicates that child deaths among African Americans are more frequent for certain causes and may benefit from increased prevention efforts.

<sup>17</sup> Hardcastle, J. (2008). *Nevada's Age, Sex, Race and Hispanic Origin Estimates For 2008 [custom database stratified by age]*. Reno, NV: Nevada State Demographer.

<sup>18</sup> Xu, JQ. et. al. (2010). *Deaths: Final data for 2007. National Vital Statistics Reports Web Release; Vol. 58 No. 19*. Hyattsville, MD: National Center for Health Statistics.

## Comparison: Race, Ethnicity, and Gender



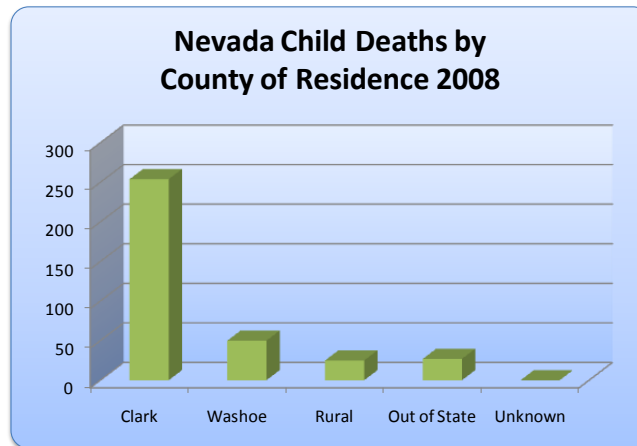
Race Group	Male	Female	Male %	Female %
White	168	92	78.1%	65.2%
African American	35	26	16.3%	18.4%
Asian	2	5	0.9%	3.5%
Native Hawaiian	0	0	0.0%	0.0%
Pacific Islander	5	5	2.3%	3.5%
American Indian	3	3	1.4%	2.1%
Alaskan Native	0	0	0.0%	0.0%
Multi-racial	2	10	0.9%	7.1%
Unknown	0	0	0.0%	0.0%
Not entered	0	0	0.0%	0.0%
<b>TOTAL:</b>	<b>252</b>	<b>180</b>	<b>100.0%</b>	<b>100.0%</b>

Ethnic Group	Male	Female	Male %	Female %
Hispanic/Latino	73	48	34.0%	34.0%
Not Hispanic/Latino	142	91	66.0%	64.5%
Not entered	0	2	0.0%	1.4%

### Findings:

- Comparison by race, ethnicity, and gender again demonstrates that in general, males die more frequently than females (based on raw numbers).
- Non-white females die more frequently within their gender group compared with non-white males.

## County of Residence



County	Total	%	County	Total	%
Clark	254	71.3%	Lincoln	0	0.0%
Washoe	50	14.0%	Lyon	3	0.8%
Carson City	2	0.6%	Mineral	0	0.0%
Churchill	2	0.6%	Nye	5	1.4%
Douglas	4	1.1%	Pershing	0	0.0%
Elko	4	1.1%	Storey	0	0.0%
Esmeralda	1	0.3%	White Pine	0	0.2%
Eureka	0	0.0%	Unknown	0	0.0%
Humboldt	3	0.8%	Out-of-state	27	7.6%
Lander	1	0.3%			
<b>TOTAL:</b>				<b>356</b>	<b>100.0%</b>

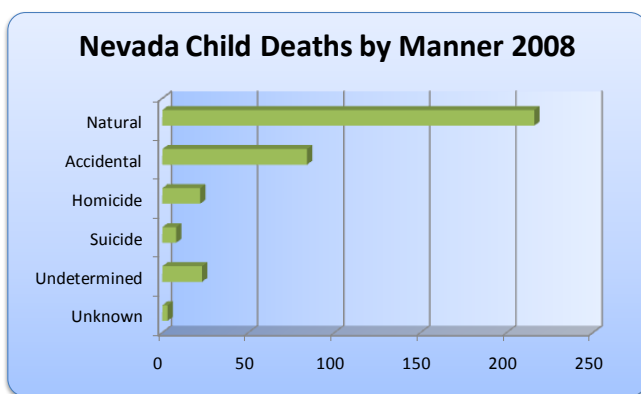
### Findings:

- The highest number of child deaths occurred among residents of Nevada's two largest counties, Clark and Washoe.
- Clark County's child and adolescent population accounts for 74.4% of the statewide child and adolescent population. With Clark County child deaths at 71.3% of total deaths in 2008, this means the proportion of child deaths in Clark County is below average based on the total child and adolescent population.
- Washoe County's child and adolescent population accounts for 15.0% of the statewide child and adolescent population. With Washoe County child deaths at 14.0% of total deaths in 2008, this means the proportion of child deaths in Washoe County is below the average based on the total child and adolescent population.
- Out-of-state deaths include children who are not Nevada residents that die while they are visiting the state.

## Manner of Death

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

1. **Natural:** These are deaths that result from natural disease mechanisms and include prematurity, intra-uterine fetal demise, and Sudden Infant Death Syndrome (SIDS) cases.
2. **Accidental:** These are deaths where there was not any intent to cause harm to another person and include causes such as motor vehicle accidents, asphyxia, and drowning.
3. **Homicide:** Homicide is the killing of one human by another.
4. **Suicide:** Suicide is the taking of one's own life voluntarily and intentionally.
5. **Undetermined:** These are deaths where sufficient evidence or information cannot be deduced during the initial investigation, usually about intent, to assign a manner of death.



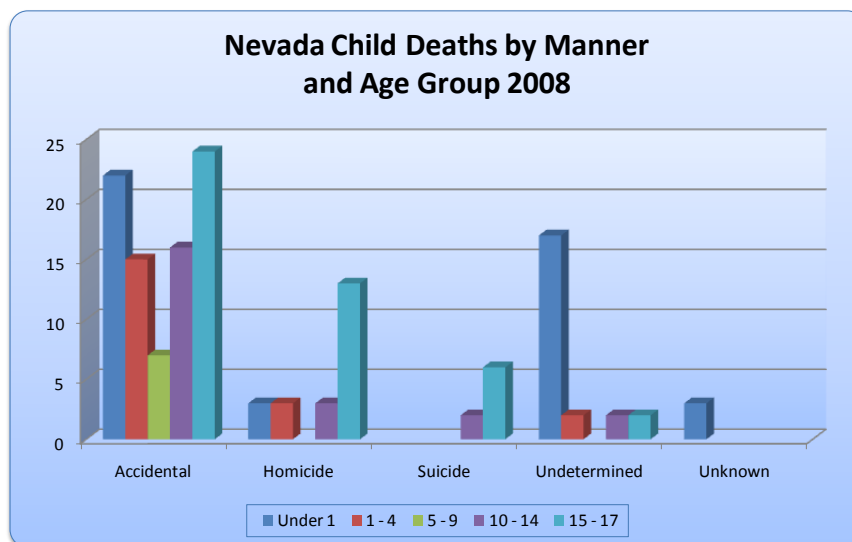
Manner	Total	%
Natural	216	60.7%
Accidental	84	23.6%
Homicide	22	6.2%
Suicide	8	2.2%
Undetermined	23	6.5%
Unknown	3	0.8%
<b>TOTAL:</b>	<b>356</b>	<b>100.0%</b>

### Findings:

- The greatest number of child deaths in 2008 was natural, largely due to the high incidence of natural deaths among infants less than one year of age, as discussed earlier in this section.
- The second most common manner of death is accidental, accounting for over 23% of child deaths in Nevada. When infants less than one year of age are separated out, accidents become the most common manner of death for children and adolescents ages one through 17. This is consistent with national data, which shows that accidents (unintentional injuries) are the leading cause of death for all age groups except infants less than one year of age.<sup>19</sup>
- Accidental deaths represent the type of deaths where prevention efforts would most likely contribute to a reduction in fatalities. Leading causes of accidental death are discussed in more detail below and in *Section 2* of this report.

<sup>19</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisgars/index.html>.

## Comparison: Manner of Death and Age



\*This chart excludes natural deaths to facilitate a more meaningful comparison across other manners of death

Manner	Less than 1	1 – 4	5 – 9	10 – 14	15 – 17
Natural	169	18	8	9	12
Accidental	22	15	7	16	24
Homicide	3	3	0	3	13
Suicide	0	0	0	2	6
Undetermined	17	2	0	2	2
Unknown	3	0	0	0	0
<b>TOTAL:</b>	<b>214</b>	<b>38</b>	<b>15</b>	<b>32</b>	<b>57</b>

### Findings:

#### Natural Deaths

- As noted above, the greatest number of child deaths in 2008 was natural deaths of infants less than one year of age. This is consistent with national data, which indicates that the top four causes of infant death are natural, and these natural deaths represent approximately 51% of infant deaths nationwide.<sup>20</sup>

#### Undetermined Deaths

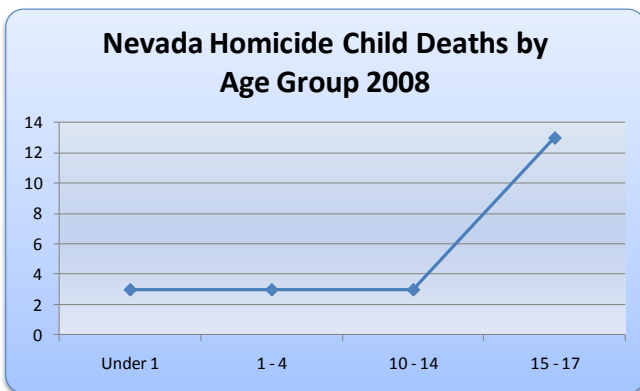
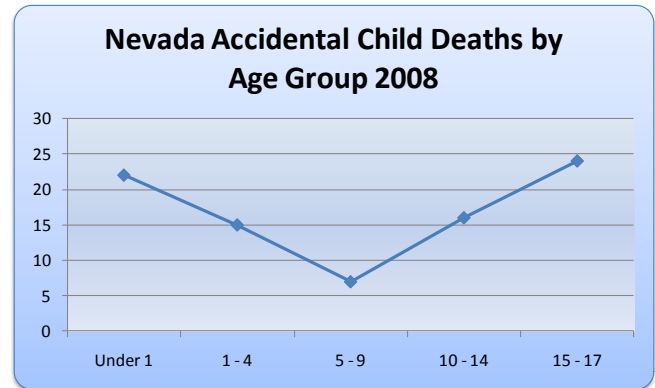
- Undetermined deaths are also most common in infants less than one year of age, likely due to the broad array of possible infant mortality causes, difficulty identifying causes for sudden unexplained infant deaths (SUIDs), and uncertain circumstances surrounding accident, abuse, and neglect deaths.

<sup>20</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007, Under 1* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisgars/index.html>.

## Accidental Deaths

Accidental deaths tend to follow a u-shaped pattern across age groups, with the highest number of deaths in the age groups of 1 – 4 and 15 – 17, and the lowest in the age group of 5 – 9. Accidental deaths also tend to increase with age.

This is consistent with national data, which shows that the leading causes of death are accidental for all child and adolescent age groups over one-year, the highest number of accidental deaths is in the age groups of 1 – 4 and 15 – 17, and the lowest in the age group of 5 – 9. National data also shows that accidental deaths tend to increase overall with age.<sup>21</sup>



## Homicide Deaths

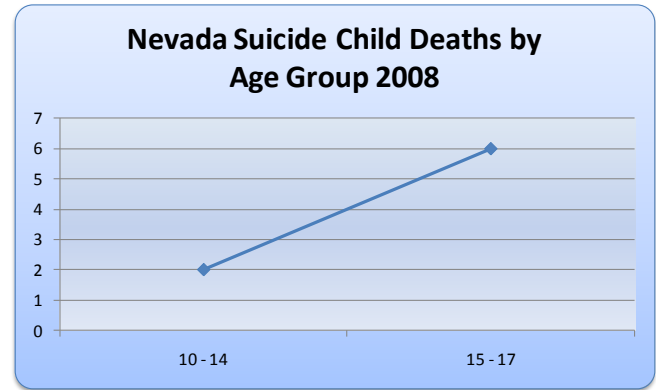
- Homicides in 2008 occurred in all age groups. Over time, homicide deaths in Nevada have also tended to follow a u-shaped pattern across age groups, with the highest in the age groups of under 1 and 15 – 17. During 2008, however, there were a lower number of homicide deaths in the under 1 age group, which results from the reduction in deaths by abuse and neglect shown by Health Division data. However, regional CDR team data shows a higher number of homicide deaths in this age group, which is discussed in more detail in *Section 2* of this report.
- Homicide deaths tend to increase as adolescents move through their pre-teen and teen years, which is consistent with national data.<sup>22</sup>

<sup>21</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>.

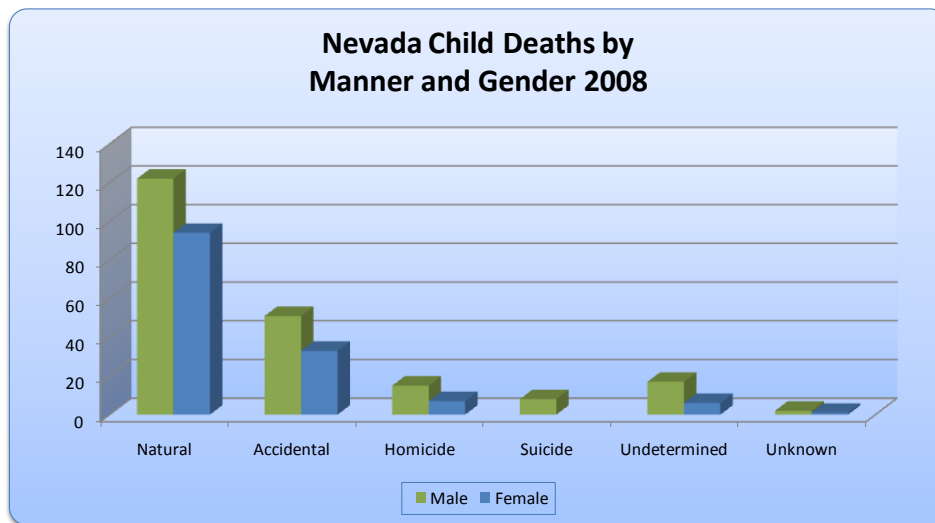
<sup>22</sup> Ibid.

## Suicide Deaths

- Suicides occur only within the age groups of 10 – 14 and 15 – 17, and demonstrate a sharp increase with age. This is consistent with national data, which shows suicide as the fourth leading cause of death for the 10 – 14 age group, the third leading cause for the 15 – 17 age group, and a substantial increase in suicides with age.<sup>23</sup>



## Comparison: Manner of Death and Gender



Manner of Death:	Male:	Female:	Male %	Female %
Natural	122	94	56.7%	66.7%
Accidental	51	33	23.7%	23.4%
Homicide	15	7	7.0%	5.0%
Suicide	8	0	3.7%	0.0%
Undetermined	17	6	7.9%	4.3%
Unknown	2	1	0.9%	0.7%
<b>TOTAL:</b>	<b>215</b>	<b>141</b>	<b>100.0%</b>	<b>100.0%</b>

<sup>23</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisgars/index.html>.

## Findings:

### Natural Deaths

- Comparing manner of death by gender again demonstrates that overall, males die more frequently than females, as discussed above. Also, natural causes are again seen to be the leading manner of death for both males and females when compared with other manners of death within their respective gender groups.

### Accidental Deaths

- As noted above, when natural deaths are separated out, accidental deaths become the leading manner of death for children and adolescents. Accidental deaths represent the type of deaths where prevention efforts would most likely contribute to a reduction in fatalities. Leading causes of accidental death are discussed in more detail in *Section 2* of this report.

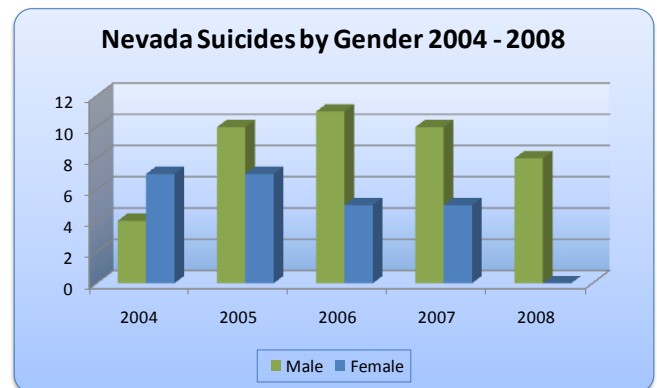
### Homicide Deaths

- Males in Nevada were victims of homicide at more than twice the rate of females in 2008. This is a departure from the previous year's data where males died by homicide at four times the rate of females. This is inconsistent with national data, which also shows the overall rate of death for male homicides at nearly four times that of females across the lifespan (9.7 per 100,000 population for male homicides compared with 2.5 per 100,000 for female homicides).<sup>24</sup>

### Suicide Deaths

- For the first time since this report has been published by the Executive Committee, no females died by suicide in 2008. This is unusual because across the past five years, females in Nevada died by suicide at a rate much closer to that of males in Nevada. Based on this trend, prior years' data has been inconsistent with national data, which shows the rate of male deaths by suicide in the 15 – 19 age group at four times that of females (11.5 per 100,000 population for male suicides compared with 2.8 per 100,000 for female suicides).<sup>25</sup> Other national research shows that adolescent males are much more likely to complete suicide, while adolescent females are much more likely to attempt suicide.<sup>26</sup> [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

This trend of higher female deaths by suicide has now disappeared across the past four years, where in 2004 female adolescents in Nevada died by suicide at almost twice the rate of male adolescents:



<sup>24</sup> National Center for Health Statistics. (2010). *Health, United States, 2009, With Special Feature on Medical Technology*. Hyattsville, MD: National Center for Health Statistics.

<sup>25</sup> Ibid.

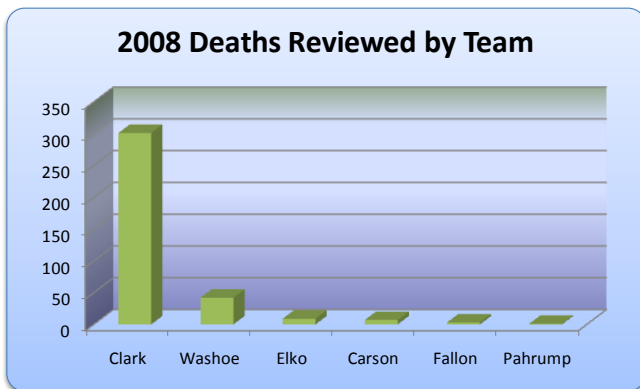
<sup>26</sup> National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

## Section 2: Regional CDR Team Data

### 2008 Child Deaths in Nevada

All data in *Section 2* of this report is derived from the regional CDR teams, which collect and enter data into an electronic case reporting system maintained by the National Maternal Child Health (MCH) Center for Child Death Review. Based on the multidisciplinary reviews conducted for child deaths that occurred in calendar year 2008, there were a total of 363 child and adolescent deaths in the state. These fatalities include children and adolescents ages birth through 17 years. Adults ages 18 and over are not included in this data.

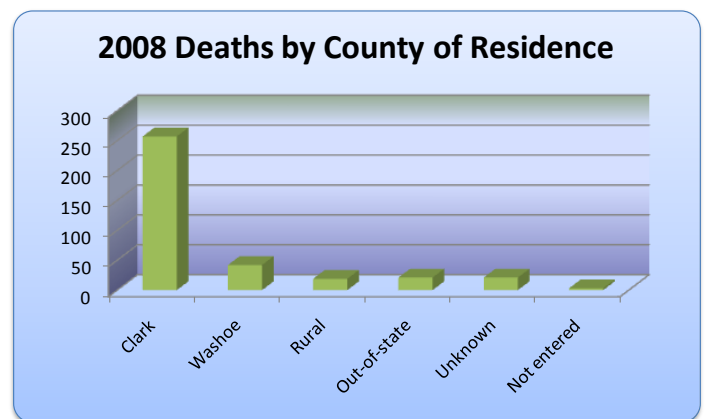
### Child Deaths Reviewed by Team



Team	Cases	%
Clark	301	82.9%
Washoe	42	11.6%
Elko	9	2.5%
Carson	7	1.9%
Fallon	3	0.8%
Pahrump	1	0.3%
<b>TOTAL:</b>	<b>363</b>	<b>100.0%</b>

### Child Deaths Reviewed by County of Residence

County	Total	%
Clark	257	70.8%
Washoe	42	11.6%
Carson City	6	1.7%
Churchill	2	0.6%
Elko	6	1.7%
Eureka	1	0.3%
Lander	1	0.3%
Lyon	2	0.6%
Nye	1	0.3%
Out-of-state	21	5.8%
Unknown	21	5.8%
Not entered	3	0.8%
<b>TOTAL:</b>	<b>363</b>	<b>100.0%</b>



**DATA NOTES:** There are discrepancies between the number of child deaths reviewed by team versus county because in some cases children who reside in a certain county may be reviewed by a different team. Additionally, teams may review

cases involving out-of-state residents, or cases involving an unknown county of residence, all of which can affect the total by team compared with the total by county.

## Regional CDR Team Data

### Death Reviews Required by State Law

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 from 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).

Additional detail about the organization and functions of the seven regional CDR teams is included in Appendix A of this report.

### Deaths Reviewed Versus Deaths Not Reviewed

Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region with one exception: The Southern Nevada Child Fatality Task Force reviews only select cases in its work to improve the investigation of child deaths by stakeholders in the CDR process.

In Clark County, the team meets monthly because of its high caseload. The Southern Nevada Child Fatality Task Force meets every other month. 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 may meet less frequently if no child fatalities are reported in a given quarter.

## Data Limitations

As with statewide child death data, there are certain limitations for the data collected by Nevada's regional CDR teams:

- All child deaths may not be 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 does not get 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 this data is collected and how certain questions are answered.
- Comparisons with statewide Health Division data, reviewed below, may result in errors because of problems with a child's name. This most commonly occurs with infants who are not given a name at the time of their death and assigned a designation such as "baby boy" or "baby girl." When a death certificate is issued, in most cases a name is given, thus creating discrepancies in the data. These cases are examined and attempts are made to reconcile these differences, but not all discrepancies can be corrected.
- Comparisons with statewide Health Division data, reviewed below, may also result in errors because of coding for the cause of death. For statewide 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.<sup>27</sup> For regional CDR team data, cause of death is entered as reported on the death certificate or based on findings from the multidisciplinary review process.
- Although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, the multidisciplinary reviews completed by the regional CDR teams provide details that allow alternative classification of the death for the purposes of this report.

## Data Improvements

Thanks to the efforts of the Clark CDR Team, 2008 is the first year that all coroner-referred deaths in Nevada were tracked and entered into the electronic case reporting system. Per above, the Clark CDR Team does not review all deaths, but does maintain data tracking for all coroner-referred deaths as of 2008. This change means that all statewide coroner-referred child deaths in Nevada are tracked by the regional CDR teams in the centralized electronic case reporting system. Based on this, complete datasets from the Health Division and the regional CDR teams can be compared in order to contribute to regular data cleaning efforts and yield better data analysis.

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<sup>27</sup> National Center for Health Statistics. (2009). *The International Classification of Diseases, Tenth Revision, (ICD-10)*. Retrieved August 27, 2010, from <http://www.cdc.gov/nchs/icd.htm>.

## Data Inconsistencies

Analysis of data inconsistencies between statewide Health Division data and regional CDR team data is focused on the four leading manners and causes of death:

Leading Manners and Causes:	STATEWIDE HEALTH DIVISION DATA		REGIONAL CDR TEAM DATA	
	Total Deaths by Cause:	Percentage of Total Deaths:	Total Deaths by Cause:	Percentage of Total Deaths:
<b>1. Non-motor vehicle accidents</b>	<b>53</b>	<b>14.9%</b>	<b>54</b>	<b>14.9%</b>
• Asphyxia	13	3.7%	17	4.7%
• Drowning	13	3.7%	12	3.3%
• Overdose	11	3.1%	11	3.0%
• All others	16	4.5%	14	3.9%
<b>2. Motor vehicle accidents</b>	<b>31</b>	<b>8.7%</b>	<b>26</b>	<b>7.2%</b>
• Driver	0	0.0%	4	1.1%
• Passenger	2	0.6%	7	1.9%
• Pedestrian	10	2.8%	8	2.2%
• Bicycle	3	0.8%	5	1.4%
• ATV	2	0.6%	0	0.0%
• Watercraft	1	0.3%	1	0.3%
• Other	0	0.0%	1	0.3%
• Unknown	13	3.7%	0	0.0%
<b>3. Homicide</b>	<b>22</b>	<b>6.2%</b>	<b>23</b>	<b>6.3%</b>
• GSW	8	2.2%	11	3.0%
• Other weapon	3	0.8%	3	0.8%
• Abuse	1	0.3%	5	1.4%
• Neglect	0	0.0%	1	0.3%
• Other causes	4	1.1%	3	0.8%
• Unknown causes	5	1.4%	0	0.0%
<b>4. Suicide</b>	<b>8</b>	<b>2.2%</b>	<b>7</b>	<b>1.9%</b>
• GSW	3	0.8%	4	1.1%
• Asphyxia	3	0.8%	2	0.6%
• Overdose	2	0.6%	1	0.3%
<b>TOTAL targeted deaths:</b>	<b>114</b>	<b>32.0%</b>	<b>110</b>	<b>30.3%</b>

There are three key variances when comparing leading manners and causes of death between statewide Health Division data and the regional CDR team data:

1. Fewer motor vehicle accident deaths were reviewed by the regional CDR teams than were reported by the Health Division. This discrepancy is likely due to out-of-state motorists whose deaths were not processed and referred by a Nevada coroner or medical examiner. However, driver position data is more easily and consistently obtained by the regional CDR teams, as seen by the large number of unknown motor vehicle deaths in Health Division data.
2. Based on statewide Health Division data alone, it appears that the total number of deaths by abuse or neglect is only 1. However, the additional amount of detail available through regional CDR team data shows that total deaths caused by abuse or neglect is actually 6. Three other non-homicide

deaths are attributed to abuse and neglect by the regional CDR teams, for a total of 9 deaths in 2008. This discrepancy demonstrates one of the primary purposes of the regional CDR teams, which is to take a multidisciplinary approach to child death review in order to make broader determinations about causes of death that can contribute to prevention efforts.

3. Total deaths by leading manners and causes differ between statewide Health Division data (114) and regional CDR team data (110) because of the various factors discussed above under *Deaths Reviewed Versus Deaths Not Reviewed and Data Limitations*.

Regardless of which data source is evaluated, the following are the four leading manners and causes of death for children and adolescents ages birth through 17 years, excluding natural deaths:

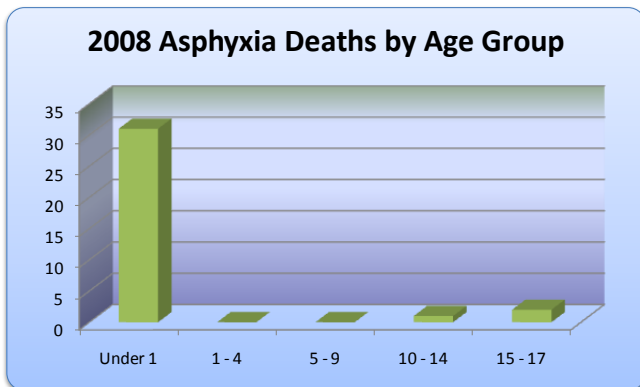
<b>Manner</b>	<b>Leading Causes within Manner</b>
1. Non-motor vehicle accidents	Asphyxia, drowning, drug overdose
2. Motor vehicle accidents	Blunt force trauma from motor vehicle collision
3. Homicide	Gunshot wounds, abuse and neglect
4. Suicide	Gunshot wounds, asphyxia

## Review: Accidents and Other Deaths Involving Asphyxia

In addition to the 17 asphyxia deaths determined to be accidental based on manner of death, this review section of the report includes an additional 17 undetermined deaths with circumstances indicating that these deaths were also likely due to asphyxia. This determination was made during analysis completed for the purpose of this report.

Reviewed by Team		County of Residence	
Carson	0	Clark	27
Clark	28	Elko	1
Elko	1	Washoe	5
Fallon	0	Out-of-state	1
Pahrump	0		
Washoe	5		
<b>TOTAL:</b>	<b>34</b>	<b>TOTAL:</b>	<b>34</b>

## Basic Demographics

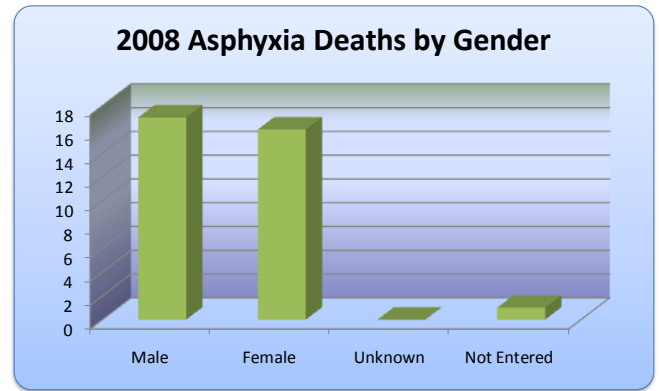


Age Group	Total
Under 1	31
1 - 4	0
5 - 9	0
10 - 14	1
15 - 17	2

## Findings:

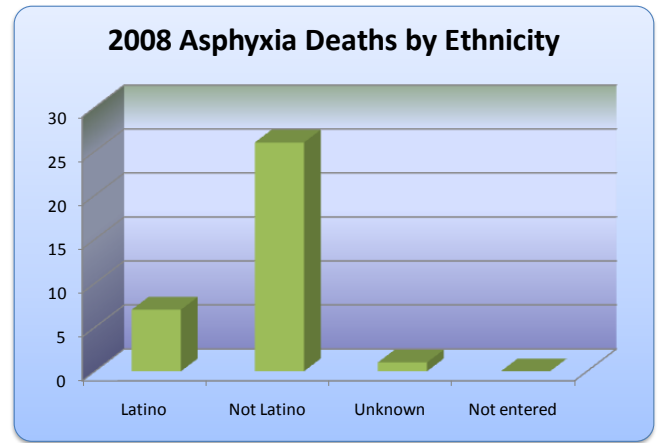
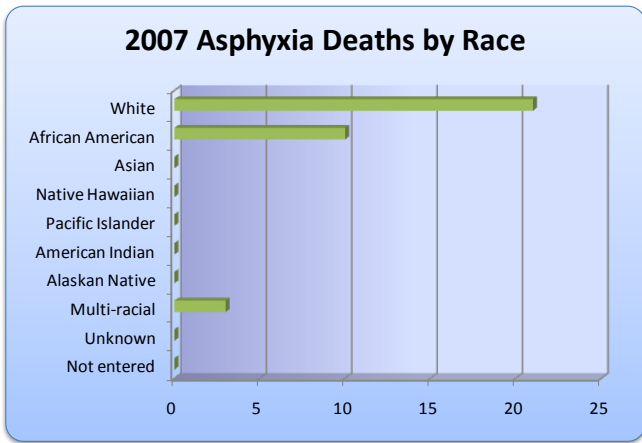
- 91% (31 of 34) of asphyxia deaths in 2008 occurred among infants less than one year of age.

Gender	Total
Male	17
Female	16
Unknown	0
Not Entered	1



**Findings:**

- Half (17 of 34) of asphyxia deaths in 2008 occurred among males. This is a decrease from prior years' data, which typically showed a higher rate of asphyxia deaths among males.



Race Group	Total	Race Group	Total
White	21	American Indian	0
African American	10	Alaskan Native	0
Asian	0	Multi-racial	3
Native Hawaiian	0	Unknown	0
Pacific Islander	0	Not entered	0

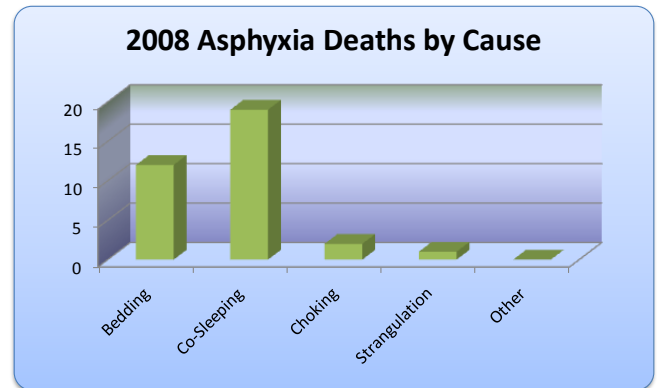
Ethnicity	Total	Ethnicity	Total
Latino	7	Unknown	1
Not Latino	26	Not entered	0

## Findings:

- 29% (10 of 34) of asphyxia deaths in 2008 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.3%, and indicates that prevention efforts may need to be increased for this population.
- Approximately 21% (7 of 34) of asphyxia deaths in 2008 occurred among Hispanics and Latinos. This is lower than the statewide population distribution for Hispanics and Latinos at 36.8%.

## Contributing Factors

Cause	Total
Bedding	12
Co-sleeping	19
Choking	2
Strangulation	1
Other	0



## Findings:

- 91% (31 of 34) of asphyxia deaths in 2008 were caused by unsafe sleeping environments due to excessive bedding, wedging, or adults/children co-sleeping with children, which can result in rolling over or onto the child and causing suffocation (overlay). 35% (12 of 34) of these unsafe sleeping deaths were caused by excessive bedding or objects placed with children in their sleeping environment. 56% (19 of 34) of these unsafe sleeping deaths were caused by adults or children co-sleeping with children.

## Unsafe Sleeping Death Risk Factors

More than one cause may apply to more than one case, therefore total causes exceed the total of 34 asphyxia cases reviewed.

Factor	Total
Child put to sleep in an adult bed	13
Child put to sleep on a couch	2
Child put to sleep on the floor	1
Child put to sleep on stomach	10
Child found with blanket	11
Child found with pillow	10
Child found with comforter	2
Child found with toy(s)	4
Child found with loose clothing in sleeping area	1
Child co-sleeping with another adult	17

Factor	Total
Child co-sleeping with another child	8
Child co-sleeping with an animal	0

### Other Asphyxia Death Detail

Detail	Total
Choking: Child choked on food or vomit	2
Strangled: Child was strangled by a rope, cord, or string	1

### Related Public Awareness Efforts by the Executive Committee

Starting in SFY 2007, the Executive Committee funded the printing of bilingual brochures intended to educate parents of newborn infants and young children about safe sleeping environments. These were distributed to 30 hospitals statewide for inclusion in new birth packets and/or distribution through labor and delivery units. From SFY 2008 through the present, the Executive Committee continues brochure distribution by fulfilling refill requests for participating hospitals. Also during SFY 2009, distribution was expanded to child welfare agencies and foster parents, as well as Family Resource Centers, Family-to-Family programs, and Women, Infants, and Children (WIC) Offices statewide. The safe sleeping brochure is also available through partner websites including: [www.canpreventnv.org](http://www.canpreventnv.org)

During SFY 2010, the Executive Committee also contributed funding to a *Cribs for Kids* pilot project through the Nevada State Health Division, which is working in partnership with the WIC Program, Washoe County Health District (WCHD), and St. Mary's Hospital. SAFE Kids, a national prevention group, was accepted as the provider for the related curriculum training curriculum. The goal is to provide new moms with pack-and-play cribs and information on safe sleeping for new babies, along with SIDS prevention.

## Review: Undetermined Deaths

Although the coroner or medical examiner may conclude that the manner of death is undetermined in some cases, the reviews completed by the regional CDR teams may result in the classification of a cause of death based on the additional case details obtained by the team and/or the consensus of the multidisciplinary partners. This difference of opinion regarding cause of death is expected given the multidisciplinary approach to death reviews implemented by the regional CDR teams.

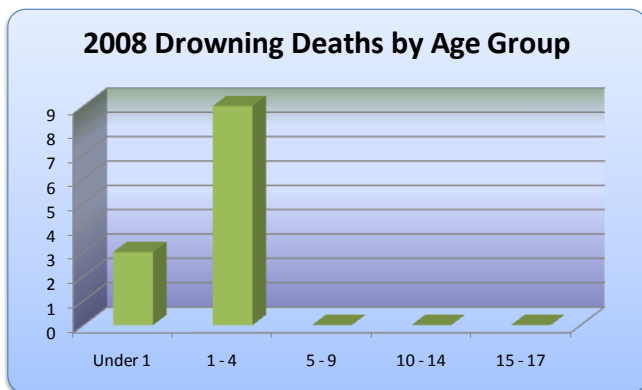
There were a total of 24 deaths with an undetermined manner reviewed in 2008. As noted above, 17 of these were likely asphyxia deaths related to unsafe sleeping environments, choking, or strangulation. The remaining 7 deaths have likely causes as follows:

Manner	Likely Cause	Detail	Total
Undetermined	Asphyxia related to sleeping	Outlined above	17
Undetermined	Overdose	Alcohol poisoning	2
Undetermined	Natural	Congenital abnormalities	1
Undetermined	Undetermined	History of asthma	1
Undetermined	Undetermined	OTC meds given to child under one year of age	1
Undetermined	Undetermined	Low blood glucose level	1
Undetermined	Undetermined	Breathing problems	1

## Review: Accidents Involving Drowning

Reviewed by Team		County of Residence	
Carson	0	Clark	10
Clark	11	Churchill	1
Elko	0	Out-of-state	1
Fallon	1		
Pahrump	0		
Washoe	0		
<b>TOTAL:</b>	<b>12</b>	<b>TOTAL:</b>	<b>12</b>

### Basic Demographics

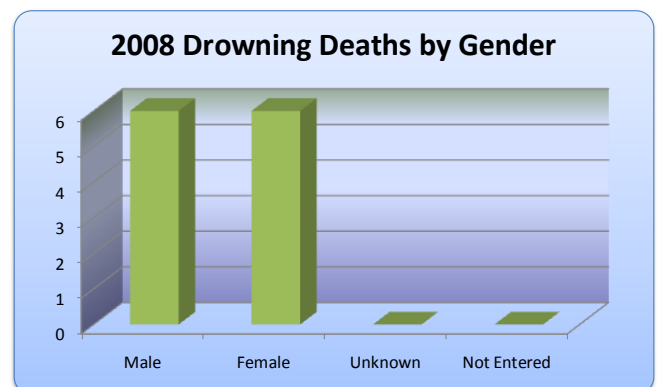


Age Group	Total
Under 1	3
1 - 4	9
5 - 9	0
10 - 14	0
15 - 17	0

### Findings:

- 75% (9 of 12) of all drownings in 2008 occurred among children 1 to 4 years of age. This underscores the importance of public awareness efforts regarding pool and water safety for parents and other caregivers with young children.

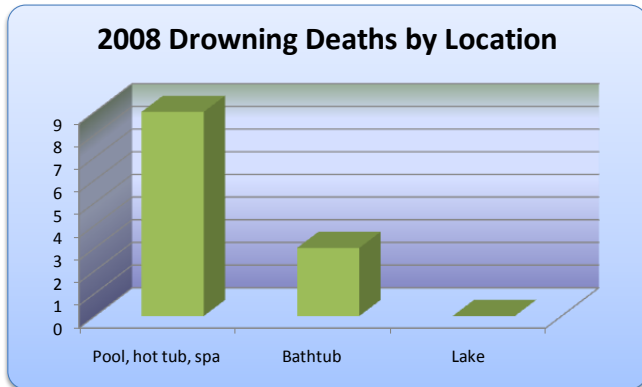
Gender	Total
Male	6
Female	6
Unknown	0
Not entered	0



## Findings:

- All drownings in 2008 occurred equally among males and females. Data from prior years shows that males are more likely to die by drowning than females.

## Location of Drowning



Location	Total
Pool or spa	9
Bathtub	3
Lake	0

## Findings:

- Most drownings occur in man-made swimming locations such as a pool, spa, or bathtub. This is consistent with data from prior years and again underscores the importance of public awareness efforts regarding pool and water safety for parents and other caregivers with young children.

## Contributing Factors

### Safety Factors

Factor	Total
Child <u>was</u> able to swim	0
Child <u>was not</u> able to swim	9
Child's swimming ability was <u>unknown</u>	0
Child's swimming ability was not entered	3
Child had a personal flotation device	0
No barriers to swimming area	1
Fence around swimming area	0
Gate to swimming area	1
Door to swimming area	6
Alarm for swimming area	0
Cover for swimming pool, hot tub, or spa	2

## Safety Breaches

Breach	Total
No barrier breached	3
Gate left open	0
Gate unlocked	0
Gate latch failed	0
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	1
Door unlocked	2
Door broken	0
Door screen torn	0
Door closer failed	0
Window left open	0
Alarm not working	0
Alarm not answered	0
Cover left off	1
Cover not locked	1
Unsecured dog door	2

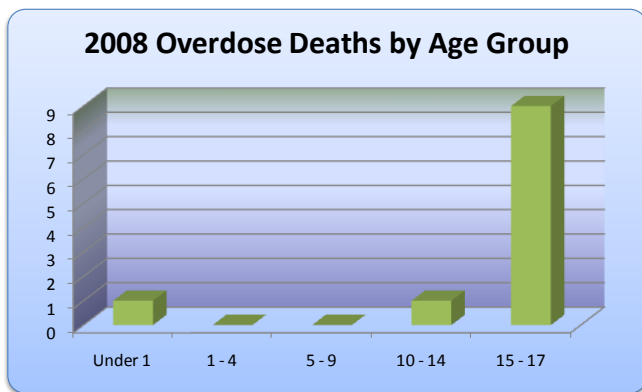
### Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee funded the production of 10,000 refrigerator magnets intended to educate parents and caregivers about water and pool safety as part of drowning prevention efforts. These were distributed along with brochures printed courtesy of the Southern Nevada Health District (SNHD). In the southern region, about 6,000 magnets were distributed through the Association of Pool and Spa Professionals (APSP) to businesses who are members of the group. These businesses were then able to distribute the magnets to pool and spa consumers. In the northern region, about 4,000 magnets were distributed as part of the Reno River Festival, a 3-day event held at the Truckee River in Downtown Reno. Additionally, the magnets were included in a direct mail to 800 child care facilities statewide, done in partnership with the Children's Trust Fund (CTF). The prevention message printed on the magnets focused on the ABCDs of Drowning Prevention campaign developed by SNHD: [www.gethealthyclarkcounty.org/be-safe/drowning-prevention-abcd.php](http://www.gethealthyclarkcounty.org/be-safe/drowning-prevention-abcd.php)

## Review: Accidents Involving Drug Overdose

Reviewed by Team		County of Residence	
Carson	0	Clark	10
Clark	10	Washoe	1
Elko	0	Out-of-state	0
Fallon	0		
Pahrump	0		
Washoe	1		
<b>TOTAL:</b>	<b>11</b>	<b>TOTAL:</b>	<b>11</b>

### Basic Demographics

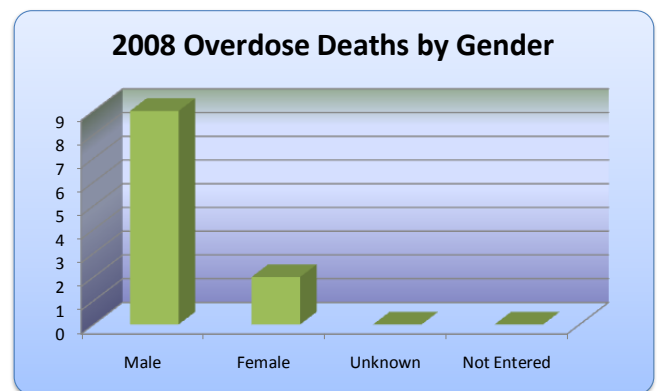


Age Group	Total
Under 1	1
1 - 4	0
5 - 9	0
10 - 14	1
15 - 17	9

### Findings:

- Nearly 82% (9 of 11) of all overdose deaths in 2008 occurred among teens 15 to 17 years of age. This underscores the high risk posed to teens through excessive use of alcohol and other drugs.

Gender	Total
Male	9
Female	2
Unknown	0
Not entered	0



## Findings:

- Nearly 82% (9 of 11) of all overdose deaths in 2008 occurred among males.

## Contributing Factors

### Mental Health and Disability

Factor	Total
Child had a prior disability or chronic illness	1
Prior disability was physical	1
Prior disability was mental	0
Prior disability was sensory	0
Prior disability was unknown	0
Child received prior mental health services	5
Child was receiving current mental health services	4
Child was on medications for mental illness	2
Issues prevented child from receiving mental health services	0

### Alcohol and Drug Use

Factor	Total
Child had a history of substance abuse	7
Alcohol	2
Cocaine	1
Marijuana	3
Methamphetamines	1
Opiates	2
Prescription drugs	5
Over-the-counter drugs	0
Other drugs – Methadone	1

### Prior Abuse or Neglect

Factor	Case Total
Child had a history of physical maltreatment	2
Child had a history of neglect	2
Child had a history of sexual maltreatment	0
Child had a history of emotional maltreatment	0
Unknown	0
Not entered	0

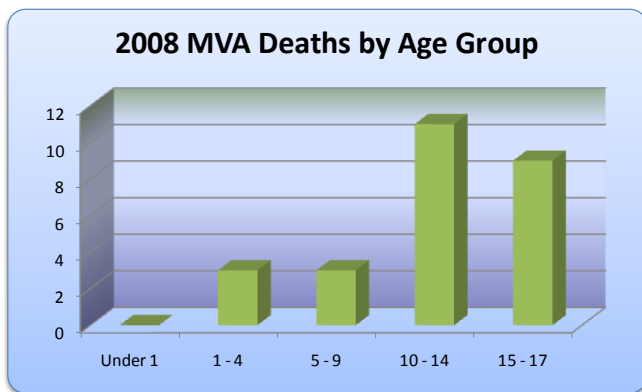
## Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee contributed funding to a collaboration between CAN Prevent and Join Together Northern Nevada (JTNN) to produce 10,000 magnets focused on the *I Am One of Many* campaign. JTNN sponsored a prescription drug roundup event during 2010 that resulted in the return of over 95,000 un-used prescription pills. Additionally, CAN Prevent and JTNN partnered to broadcast movie theater and radio public service announcements (PSAs) about the risks of drug overdose. A total of approximately 160,000 message impressions were made through the movie theater ads, and approximately 260,000 impressions through radio PSAs. The *I Am One of Many* campaign materials can be viewed at: [www.canpreventnv.org](http://www.canpreventnv.org)

## Review: Motor Vehicle Accidents (MVA)

Reviewed by Team		County of Residence	
Carson	0	Clark	16
Clark	19	Churchill	1
Elko	4	Elko	3
Fallon	1	Lander	1
Pahrump	0	Washoe	2
Washoe	2	Out-of-state	3
TOTAL:	26	TOTAL:	26

## Basic Demographics



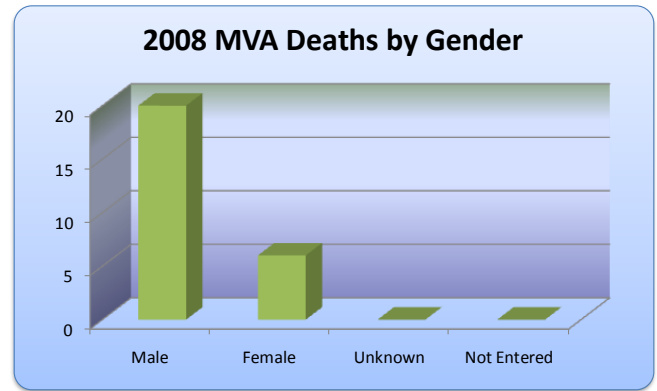
Age Group	Total
Under 1	0
1 - 4	3
5 - 9	3
10 - 14	11
15 - 17	9

### Findings:

- Consistent with national data, the risk of death from MVA generally increases with age for children in Nevada.<sup>28</sup>
- Teens are at the greatest risk of MVA deaths.

<sup>28</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>.

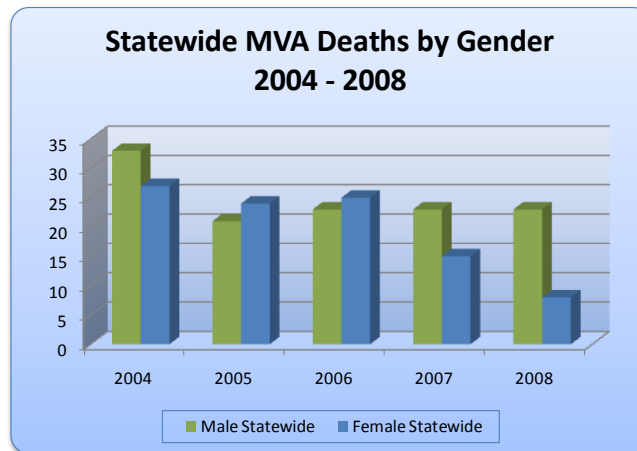
Gender	Total
Male	20
Female	6
Unknown	0
Not entered	0



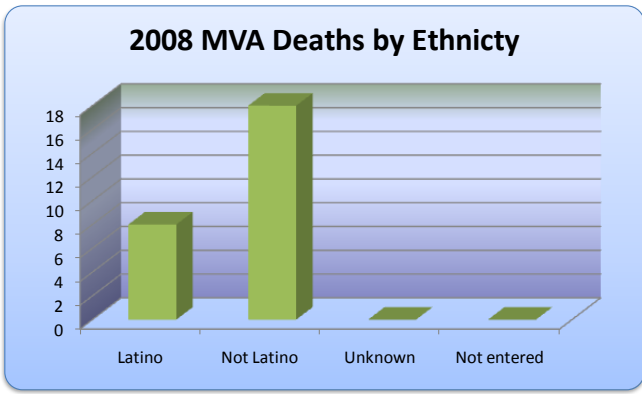
**Findings:**

- In 2008 cases reviewed, male deaths from MVA are much higher than that of females. This is the first time in several years that this gender data has been consistent with national data, which shows that males typically die at more than twice the rate of females in motor vehicle accidents across the lifespan (21.4 per 100,000 versus 8.8 per 100,000).<sup>29</sup>

The opposite trend was consistent over the past four years for both statewide deaths and cases reviewed, with male and female MVA deaths rates much closer. In both 2005 and 2006, female MVA deaths statewide exceeded male MVA deaths statewide:



<sup>29</sup> National Center for Health Statistics. (2010). *Health, United States, 2009, With Special Feature on Medical Technology*. Hyattsville, MD: National Center for Health Statistics.



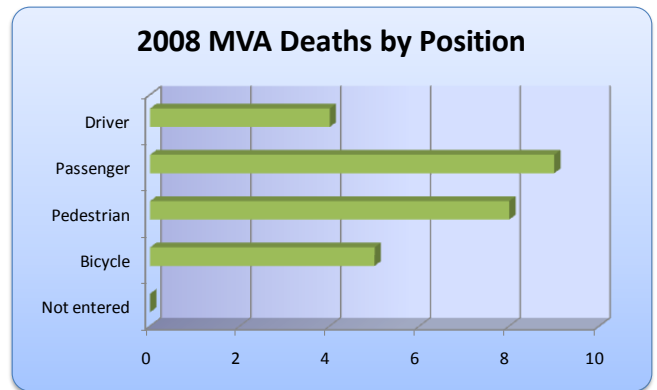
Ethnicity	Total
Latino	8
Not Latino	18
Unknown	0
Not entered	0

**Findings:**

- Approximately 44% (8 of 18) of child deaths by MVA in 2008 occurred among Hispanics and Latinos. This is disproportionately higher than the statewide population distribution for Hispanic and Latino children and adolescents at 36.8%.

**Position of Child in Accident**

Position	Total
Driver	4
Passenger	9
Pedestrian	8
Bicycle	5
Not entered	0



**Findings:**

- Just over one-third (9 of 26) of children who died in motor vehicle accidents were passengers in vehicles.
- Nearly one-third (8 of 26) of children who died in motor vehicle accidents were pedestrians. Although overall MVA deaths decreased, pedestrian deaths increased in comparison with 2007 data.
- Of the 9 passengers, 3 were in cars, 3 were in trucks, 1 was in a sport utility vehicle, 1 was on jet ski, and 1 was in a golf cart.
- Of the 4 drivers, 1 was driving a car, 1 was driving a van, and 2 were driving sport utility vehicles.

## Position of Child by Age Group

Age Group	Driver	Passenger	Pedestrian	On Bicycle	Unknown	Not Entered	Total
Less than 1	0	0	0	0	0	0	0
1 – 4	0	1	2	0	0	0	3
5 – 9	0	2	0	1	0	0	3
10 – 14	1	4	3	3	0	0	11
15 – 17	3	2	3	1	0	0	9
TOTAL:	4	9	8	5	0	0	26

### Findings:

- Almost half of passenger deaths (4 of 9) in 2008 occurred in the 10 – 14 age group.
- 75% of pedestrian deaths (6 of 8) in 2008 occurred among teens in the 10 – 14 and 15 – 17 age groups.

## Causes of Accidents for All Cases

More than one cause may apply to more than one case, therefore total causes exceed the total of cases reviewed.

Cause	Total	Cause	Total
Speeding over limit	6	Medical event	0
Unsafe speed for conditions	3	Back over	3
Recklessness	7	Rollover	2
Ran stop sign/red light	3	Poor sightline	2
Driver distraction	3	Car changing lanes	0
Inexperienced driver	3	Road hazard	0
Mechanical failure	0	Animal in road	0
Poor tires	3	Cell phone use while driving	0
Poor weather	1	Racing	1
Poor visibility	1	Other driver error	1
Drug or alcohol use	5	Other cause	2
Fatigue/sleeping	3	Unknown	0

## Causes of Accidents When Child Was Responsible for Accident

Cause	Total
Child responsible for causing accident	5
Child was alcohol or drug impaired	1
Child had no license	0
Child had a learners permit	0
Child had a graduated license	0
Child had full license, not graduated	2
Child had a full license, restricted	0

Cause	Total
Child had suspended license	0
If recreational vehicle, child had driver safety certificate	0
Child was violating graduated license rules	0

#### Causes of Accidents When Child's Driver Was Responsible for Accident

Cause	Total
Child's driver responsible for accident	7
Child's driver was alcohol or drug impaired	4
Child's driver had no license	0
Child's driver had a learners permit	0
Child's driver had a graduated license	1
Child's driver had full license, not graduated	3
Child's driver had full license, restricted	0
Child's driver had suspended license	0
If recreational vehicle, child's driver had driver safety certificate	0
Child's driver was violating graduated license rules	0

#### Causes of Accidents When Another Driver Was Responsible for Accident

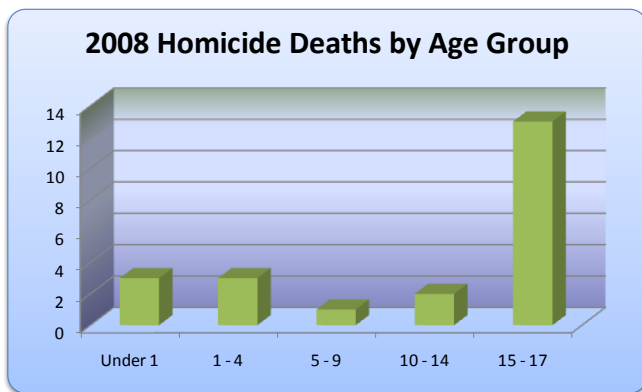
Cause	Total
Another driver responsible for accident	7
Another driver was alcohol or drug impaired	1
Another driver had no license	0
Another driver had a learners permit	0
Another driver had a graduated license	0
Another driver had a full license, not graduated	5
Another driver had full license, restricted	0
Another driver had suspended license	0
If recreational vehicle, child's driver had driver safety certificate	0
Another driver was violating graduated license rules	0

DATA NOTES: Detail for causes of accidents is limited in many cases, which may represent lack of information collection or determination during investigations, difficulty in obtaining investigation information, and/or increase need for data entry on the part of the regional CDR teams.

## Review: Homicides

Reviewed by Team		County of Residence	
Carson	0	Clark	16
Clark	21	Washoe	2
Elko	0	Out-of-state	3
Fallon	0	Unknown	2
Pahrump	0		
Washoe	2		
<b>TOTAL:</b>	<b>23</b>	<b>TOTAL:</b>	<b>23</b>

## Basic Demographics

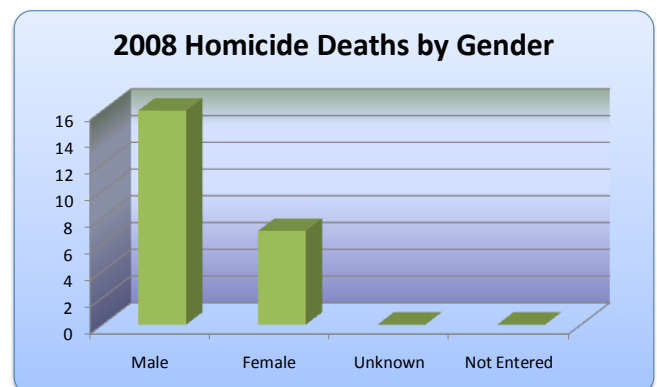


Age Group	Total
Under 1	3
1 - 4	3
5 - 9	1
10 - 14	2
15 - 17	13
Unknown	1

### Findings:

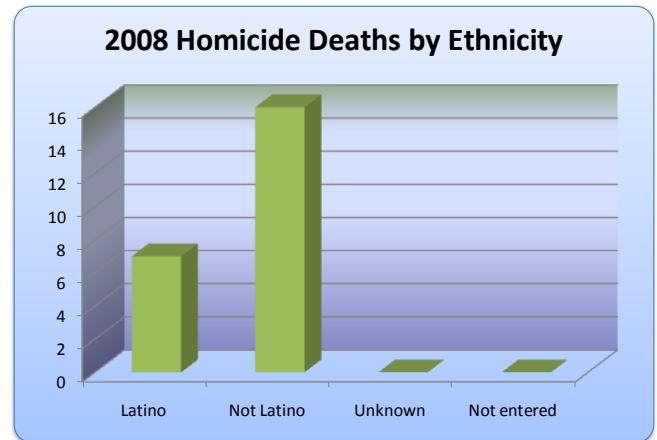
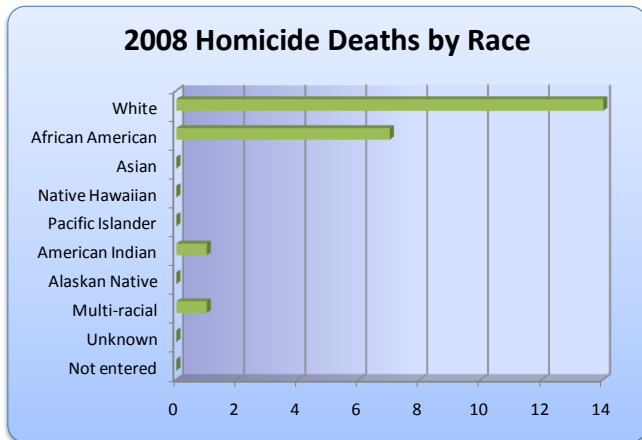
- 56% (13 of 23) of homicide deaths in 2008 occurred among adolescents ages 15 to 17.
- About 13% (3 of 23) of homicide deaths in 2008 occurred among infants less than one year of age. These are all deaths caused by child abuse, which are reviewed in more detail below.

Gender	Total
Male	16
Female	7
Unknown	0
Not Entered	0



**Findings:**

- Approximately 70% (16 of 23) of homicide deaths in 2008 occurred among males. This is roughly consistent with national data that shows male homicide death rates are nearly four times that of females across the lifespan (2.5 per 100,000 versus 9.7 per 100,000).<sup>30</sup>



Race Group	Total	Race Group	Total
White	14	American Indian	1
African American	7	Alaskan Native	0
Asian	0	Multi-racial	1
Native Hawaiian	0	Unknown	0
Pacific Islander	0	Not entered	0

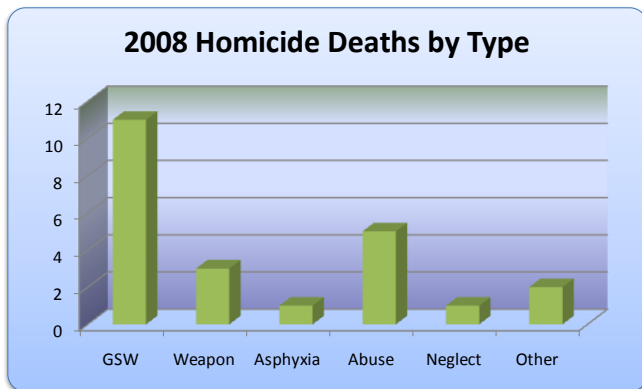
Ethnicity	Total	Ethnicity	Total
Latino	7	Unknown	0
Not Latino	16	Not entered	0

**Findings:**

- Approximately 30% (7 of 23) of homicide deaths in 2008 occurred among Hispanics and Latinos. This is slightly lower than the statewide population distribution for Hispanics and Latinos at 36.8%.
- Approximately 30% (7 of 23) of homicide deaths in 2008 occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.3%.

<sup>30</sup> National Center for Health Statistics. (2010). *Health, United States, 2009, With Special Feature on Medical Technology*. Hyattsville, MD: National Center for Health Statistics.

## Homicides by Type



Type	Total
Gunshot wounds	11
Other Weapon	3
Asphyxia	1
Abuse	5
Neglect	1
Other	2

### Findings:

- Almost half (11 of 23) of homicide deaths in 2008 were caused by gunshot wounds (GSW). Additional information on GSW deaths is provided below.
- Over one-fourth (6 of 23) of homicide deaths in 2008 were caused by abuse and neglect. Abuse and neglect deaths are reviewed in the next section of this report.

## Homicides by Gunshot Wound (GSW)

All homicide deaths by gunshot wound in 2008 occurred among the 10 – 14 and 15 – 17 age groups. This is consistent with national data, which shows that deaths from firearm-related injuries increase considerably in the 15 – 19 age group.<sup>31</sup> [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]

### GSW Deaths: Incident Detail

Detail	Total
Person handling fatal weapon was a relative	1
Person handling fatal weapon was a acquaintance	2
Person handling fatal weapon was a rival gang member	4
Person handling fatal weapon was a stranger	1

<sup>31</sup> National Center for Health Statistics. (2010). *Health, United States, 2009, With Special Feature on Medical Technology*. Hyattsville, MD: National Center for Health Statistics.

## GSW Deaths: Criminal Activity Detail

Detail	Total
Use of fatal weapon involved random violence	1
Use of fatal weapon involved an argument	3
Use of fatal weapon involved playing with weapon	1
Use of fatal weapon involved gang-related activity	4
Use of fatal weapon involved an unknown activity	1

### Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee funded the placement of gunshot wound prevention information on eight billboards statewide: 1 in Elko, 1 in Ely, 2 in Reno, and 4 in Las Vegas. The prevention message was based on the *Bullets Leave Holes* campaign formerly developed in Illinois. The billboard messages were contracted for a minimum of 30 days, which resulted in approximately 70,000 exposures per day in Las Vegas, and approximately 40,000 exposures per day in Reno. The Bullets Leave Holes prevention message can be viewed at: [www.canpreventnv.org](http://www.canpreventnv.org)

## Review: Deaths Caused by Abuse, Neglect, and Other Negligence

Reviewed by Team		County of Residence		Cause	
Carson	0	Clark	4	Abuse	5
Clark	7	Elko	1	Neglect	3
Elko	2	Lander	1	Other negligence	1
Fallon	0	Out-of-state	1		
Pahrump	0	Unknown	2		
Washoe	0				
TOTAL:	9	TOTAL:	9	TOTAL:	9

### Basic Demographics

Ref	Cause	Age Group	Gender	Race	Ethnicity
1	Homicide – abuse	Under 1	Female	African-American	Not Latino
2	Accident – Asphyxia	Under 1	Male	African-American	Not Latino
3	Homicide – abuse	Under 1	Male	White	Not Latino
4	Homicide – abuse	1 – 4	Male	White	Not Latino
5	Homicide – abuse	1 – 4	Male	African-American	Not Latino
6	MVA – Passenger	5 – 9	Male	White	Not Latino
7	Homicide – abuse	5 – 9	Male	White	Latino
8	MVA – Driver	15 – 17	Male	White	Not Latino
9	Homicide – neglect	Unknown	Male	White	Not Latino

For deaths cause by abuse and neglect that were not determined to be homicides, additional detail is provided to understand the abuse and neglect determinations made by the regional CDR teams:

Ref	Case Details
2	Child was co-sleeping with an adult on an adult bed; overlay death.
6	Driver and child’s parent were in violation of graduated driver’s license laws.
8	Driver was distracted.

### Contributing Factors

These contributing factors apply only to cases of direct abuse and neglect, not other negligence.

#### Type of Abuse or Neglect

Type of Abuse	Case Total
Abusive head trauma	5
Chronic battered child syndrome	0
Beating/kicking	0
Scalding/burning	0
Munchausen syndrome by proxy	0

Type of Abuse	Case Total
Other physical abuse	0
Unknown physical abuse	0

### Triggering Events

Trigger	Case Total
Crying	0
Toilet training problem	0
Disobedience	0
Feeding problems	0
Domestic argument	0
Failure to protect child from hazards	2
Failure to provide child necessities	1
Failure to provide child necessities – food	1
Failure to provide child necessities – shelter	1
Failure to provide child necessities – supervision	1
Other negligence	1
None	0
Other event	0
Unknown event	5
Not entered	0

### Term of Abuse or Neglect

Term	Case Total
Chronic with child	0
Pattern in family or with perpetrator	1
Isolated incident	1
Unknown	7
Not entered	0

### Prior Abuse or Neglect

Factor	Case Total
Child had a history of physical maltreatment	2
Child had a history of neglect	1
Child had a history of sexual maltreatment	0
Child had a history of emotional maltreatment	0
Unknown	0
Not entered	0

## Drug or Alcohol Exposure

Factor	Case Total
Toxicology screen completed	3
Toxicology screen outcome: positive	0
Toxicology screen outcome: negative	3

## CPS Involvement

Factor	Case Total
CPS record check conducted	8
Evidence of prior abuse	2
CPS action taken as a result of the death	3
Open CPS case on child at time of death	2
Was the child ever placed in foster care?	1

## Abusive Head Trauma

In 2008, all 5 homicide cases where children died from abuse included the discovery of abusive head injuries, and 3 of these cases were reported to involve shaking. These deaths highlight the importance of public awareness campaigns and other prevention activities related to Shaken Baby Syndrome (SBS).

Factor	Case Total
For abusive head trauma, were there retinal hemorrhages?	4
For abusive head trauma, was the child shaken?	3
If the child was shaken, was there impact?	1

## Review: Abuse and Neglect Related Deaths

In addition to homicide deaths where abuse and neglect were the primary cause, there are other deaths where abuse and neglect contributed to the cause of death. It is useful to examine these deaths to understand the impact that abuse and neglect has on child fatalities.

### Related Deaths – Child Abuse

Manner	Cause	Case Total
Accident	Drug exposed	1

### Related Deaths – Child Neglect

Manner	Cause	Case Total
Accident	Asphyxia – co-sleeping	5
Accident	Asphyxia – bedding	5
Accident	Drowning	1
Accident	Overdose	1
Undetermined	Asphyxia – co-sleeping	10
Undetermined	Asphyxia – bedding	1
Natural	SIDS	2

### Related Deaths – Other Negligence

Manner	Cause	Case Total
Accident	Asphyxia – co-sleeping	1
Homicide	Gunshot wound	1

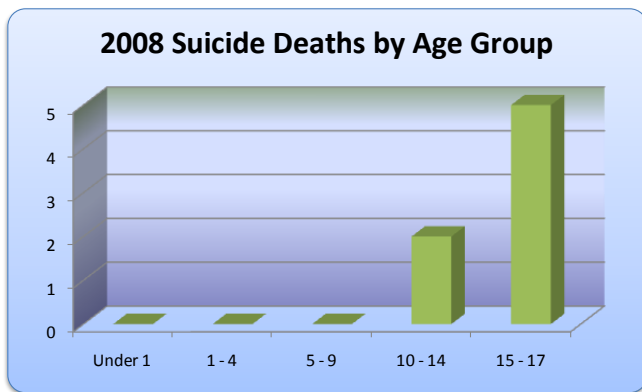
### Related Deaths – Poor or Absent Supervision

Manner	Cause	Case Total
Accident	Asphyxia	2
Accident	Drowning	6
Homicide	Heat exposure	1
Undetermined	Low blood glucose level	1

## Review: Suicides

Reviewed by Team		County of Residence	
Carson	2	Carson City	1
Clark	4	Clark	4
Elko	1	Lyon	1
Fallon	0	Out-of-state	1
Pahrump	0		
Washoe	0		
<b>TOTAL:</b>	<b>7</b>	<b>TOTAL:</b>	<b>7</b>

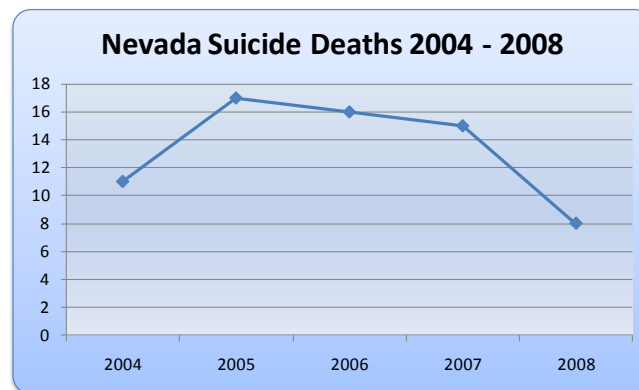
## Basic Demographics



Age Group	Total
Under 1	0
1 - 4	0
5 - 9	0
10 - 14	2
15 - 17	5

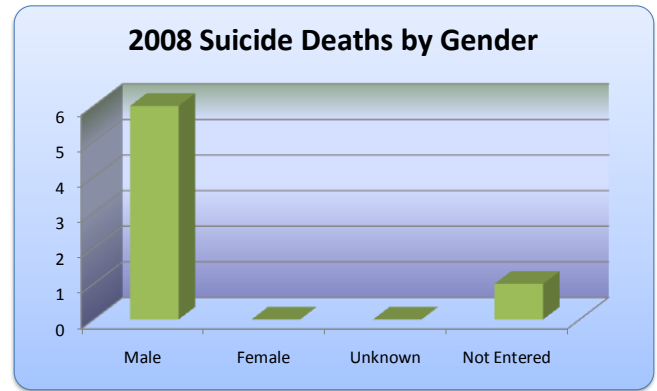
## Findings:

- Suicide deaths occurred exclusively in the 10 – 14 and 15 – 17 age groups. This is consistent with national data, which shows that deaths from suicide increase considerably in the pre-teen and teen years.<sup>32</sup>
- Suicide deaths dropped considerably in 2008 as compared data from prior years:



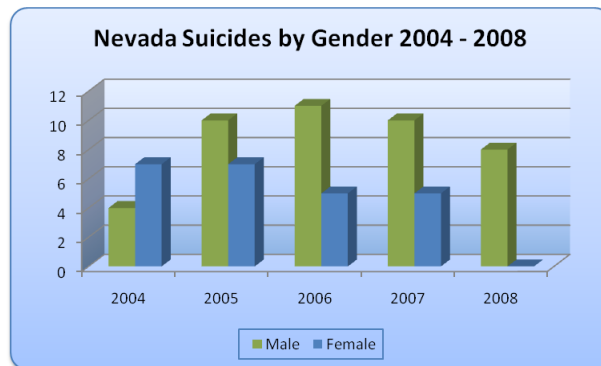
<sup>32</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>

Gender	Total
Male	6
Female	0
Unknown	0
Not Entered	1



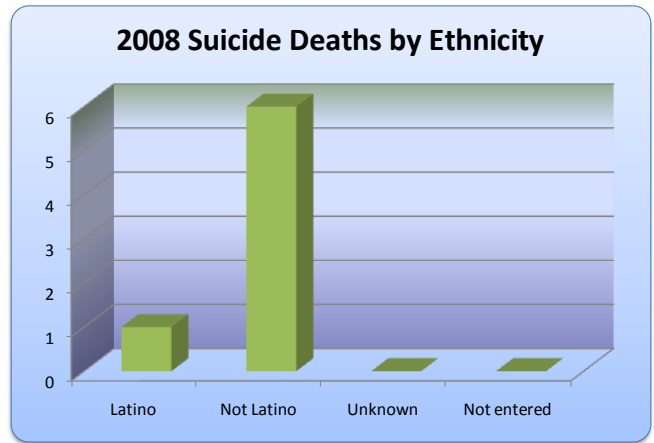
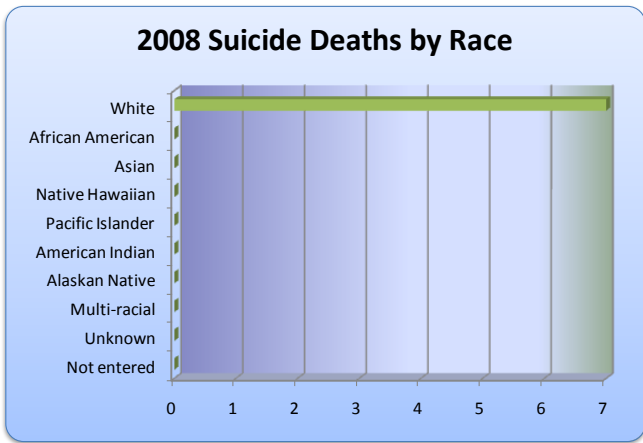
**Findings:**

- As noted in Section 1, for the first time since this report has been published by the Executive Committee, no females died by suicide in 2008. This is unusual because across the past five years, females in Nevada died by suicide at a rate much closer to that of males in Nevada. Based on this trend, prior years' data has been inconsistent with national data, which shows the rate of male deaths by suicide in the 15 – 19 age group at four times that of females (11.5 per 100,000 population for male suicides compared with 2.8 per 100,000 for female suicides).<sup>33</sup> Other national research shows that adolescent males are much more likely to complete suicide, while adolescent females are much more likely to attempt suicide.<sup>34</sup> [Please note that national comparison data utilizes different age groupings and is only available through age 19, not age 17.]



<sup>33</sup> National Center for Health Statistics. (2010). *Health, United States, 2009, With Special Feature on Medical Technology*. Hyattsville, MD: National Center for Health Statistics.

<sup>34</sup> National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.



Race Group	Total	Race Group	Total
White	7	American Indian	0
African American	0	Alaskan Native	0
Asian	0	More than one race	0
Native Hawaiian	0	Unknown	0
Pacific Islander	0	Not entered	0

Ethnicity	Total	Ethnicity	Total
Latino	1	Unknown	0
Not Latino	6	Not entered	0

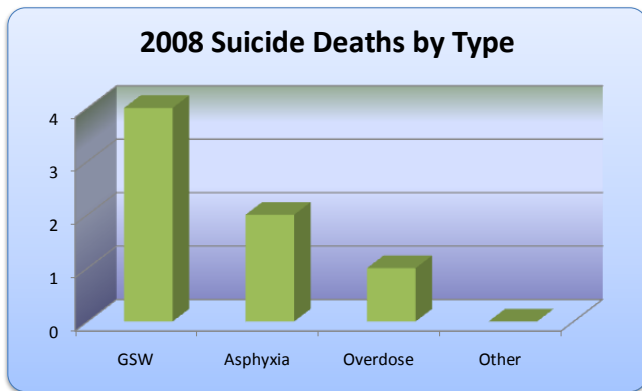
**Findings:**

- Suicide occurs most frequently among whites. This is generally consistent with national data, which shows that whites account for the second highest suicide rate within race categories.<sup>35</sup>
- National data shows that the highest suicide rates for both males and females are among American Indians.<sup>36</sup> Given Nevada’s indigenous American Indian population, the fact that there were no reported suicides among American Indians in 2007 may suggest that some suicides are incorrectly classified by either race or cause, or they are under-reported. As noted in *Section 1*, because of the ongoing lack of child death data for American Indians, the Executive Committee has recently undertaken an effort to establish formal communication with Nevada’s tribes regarding American Indian child deaths. This should result in better data under this section of the report in future years.

<sup>35</sup> National Adolescent Health Information Center. (2006). *2006 Fact Sheet on Suicide: Adolescents & Young Adults*. San Francisco, CA: University of California, San Francisco.

<sup>36</sup> Ibid.

## Suicides by Type



Type	Total
Gunshot wound (GSW)	4
Asphyxia	2
Overdose	1
Other	0

### Findings:

- Gunshot wounds were the most common method of death by suicide based on regional CDR team data, accounting for 4 of 6 deaths reviewed. Asphyxia accounted for 2 deaths by suicide, and the remaining death resulted from a drug overdose. This is consistent with national trends, which indicate that suicide by gunshot wound is the most common method, accounting for almost half of all deaths by suicide.<sup>37</sup>
- National data also shows that females typically attempt suicide by ingesting pills, while males typically complete suicide by gunshot wound.<sup>38</sup> This is consistent with Nevada data, which shows all 4 deaths by suicide resulting from gunshot wounds were among males.

## Contributing Factors

More than one factor may apply to more than one case, therefore total factors exceed the total of cases reviewed.

### Child History

Factor	Total
• History of homelessness	0
• History of mental illness	0
• History of substance abuse	4
• History of child abuse – physical	0
• History of child abuse – neglect	2
• History of child abuse – sexual	0
• History of child abuse – emotional	0
• History of child abuse – unknown	0
• History of delinquent or criminal behavior	2
• Child spent time in juvenile detention	2
• Child was gay, lesbian, bisexual, or questioning orientation	0

<sup>37</sup> American Association of Suicidology. (2006). *Youth Suicide Fact Sheet*. Washington, DC: American Association of Suicidology.

<sup>38</sup> Ibid.

## Circumstances Surrounding Event

Factor	Total
• Child left a note	1
• Child talked about suicide	0
• Prior suicide threats were made	0
• Prior suicide attempts were made	0
• Suicide was completely unexpected	1
• Child had a history of running away	0
• Child had a history of self-mutilation	0
• History of suicides in family	0
• Suicide was part of a murder-suicide	0
• Suicide was part of a suicide pact	0
• Suicide was part of a suicide cluster	0

## Recent History of Personal Crisis

Factor	Number
• Family discord	1
• Parents divorced or separated	0
• Argument with parents or caregivers	1
• Argument with boyfriend or girlfriend	1
• Breakup with boyfriend or girlfriend	0
• Argument with other friends	0
• Rumor mongering	0
• Suicide by friend or relative	0
• Other death of friend or relative	0
• Victim of bullying	0
• Perpetrator of bullying	0
• School failure	0
• Child entered new school	0
• Other serious school problems	0
• Pregnancy	0
• Physical abuse or assault	0
• Rape or sexual abuse	0
• Problems with law enforcement	0
• Problems with drugs or alcohol	0
• Sexual orientation issues	0
• Religious or cultural issues	0
• Employment problems	0
• Financial problems	0
• Gambling problems	0
• Involvement in cult activities	0
• Involvement in computer or video gaming	0
• Involvement with the Internet	0

Factor	Number
• Other crisis	0
• Unknown crisis	0

### CPS Involvement

Factor	Total
• Open CPS case on child at time of death	2
• Was the child ever placed in foster care?	1

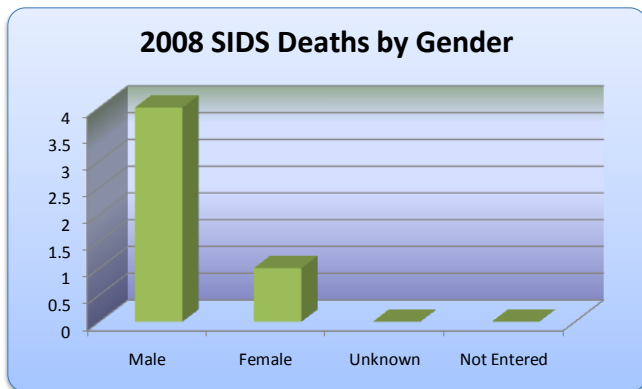
## Review: Sudden Infant Death Syndrome (SIDS)

SIDS deaths are required to be reviewed by regional CDR teams per NRS 432B.405, and so data gathered by the regional CDR teams for this cause of death should be representative of statewide data. The totals match correctly for calendar year 2008, with five SIDS deaths reported by the Nevada State Health Division, and five SIDS deaths reviewed by the regional CDR teams. There is no known cause for SIDS, although it is associated with several risk factors, discussed below under *Contributing Factors*.

Reviewed by Team		County of Residence	
Carson	0	Clark	3
Clark	3	Nye	1
Elko	0	Washoe	1
Fallon	0		
Pahrump	1		
Washoe	1		
<b>TOTAL:</b>	<b>5</b>	<b>TOTAL:</b>	<b>5</b>

## Basic Demographics

By definition, all SIDS deaths occur in infants less than one year of age.<sup>39</sup>



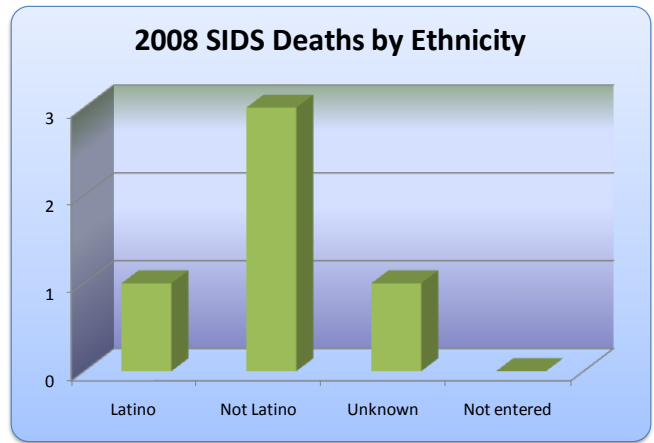
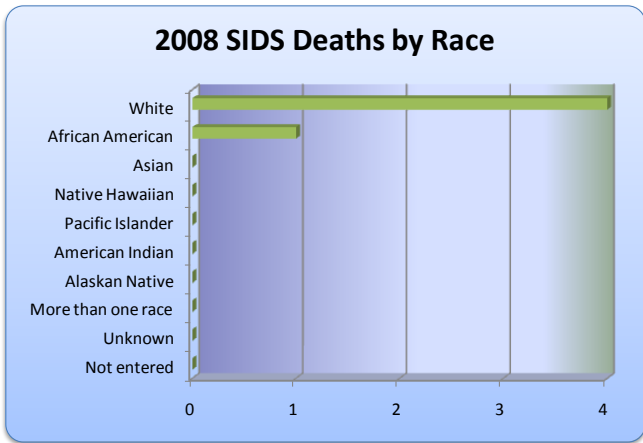
Gender	Total
Male	4
Female	1
Unknown	0
Not entered	0

## Findings:

- 80% (4 of 5) of SIDS deaths in 2007 occurred among males. This is consistent with national data, which shows that males die from SIDS at a higher rate than females.<sup>40</sup>

<sup>39</sup> Centers for Disease Control and Prevention. (2010). *Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID): Home*. Retrieved November 3, 2010, from <http://www.cdc.gov/SIDS/index.htm>.

<sup>40</sup> National Center for Injury Prevention and Control. (2010). *Web-based Injury Statistics Query and Reporting System: 10 Leading Causes of Death, United States, 2007* [custom data query]. Retrieved September 1, 2010, from <http://www.cdc.gov/injury/wisqars/index.html>.



Race Group	Total	Race Group	Total
White	4	American Indian	0
African American	1	Alaskan Native	0
Asian	0	More than one race	0
Native Hawaiian	0	Unknown	0
Pacific Islander	0	Not entered	0

Ethnicity	Total	Ethnicity	Total
Latino	1	Unknown	1
Not Latino	3	Not entered	0

**Findings:**

- Data from prior years has shown disproportionately higher SIDS deaths among African-Americans and Hispanics and Latinos. Data for 2008 does not demonstrate any trends. Race and ethnicity comparisons may be skewed because of the small number of cases reviewed.

**Manner of Death**

In prior years, some cases have been identified with an undetermined manner of death, but had many characteristics of SIDS, and were determined to be the likely cause of death by the regional CDR teams. All SIDS cases in 2008 were concluded to be natural deaths.

**Contributing Factors**

Factor	Total
Child exposed to second-hand smoke	1
Child was overheated	0
Child had a history of seizures	0
Child had a history of apnea	0

**SIDS Death Sleeping Locations**

Location	Total
Bassinette	2
Crib	0
Mattress/Adult Bed	2
Chair	0
Couch	0
Baby swing	0
Unknown	1
Not entered	0

### SIDS Death Sleeping Positions

Factor	Total
Child put to sleep on stomach	1
Child put to sleep on side	1
Child put to sleep on back	1
Sleep position unknown	2
Sleep position not entered	0

### SIDS Death Unsafe Sleeping Risks

Factor	Total
Child found co-sleeping with another adult	0
Child found sleeping on mattress/adult bed	2
Child found sleeping on couch	0
Child found with blanket	0
Child found with pillow	0
Child found with comforter	0
Child found with toy(s)	0
Child found with baby bottle, pacifier, and/or other items	0

### Related Public Awareness Efforts by the Executive Committee

During SFY 2010, the Executive Committee contributed funding to 2 trainings provided by First Candle, a national organization focused on safe pregnancies and infant safety. The trainings centered on SIDS prevention and safe sleeping, with two each held in Las Vegas and Reno. The Las Vegas trainings were held at the University of Nevada, Las Vegas (UNLV) School of Social Work, and the Clark County Government Center. The Reno trainings were held at the Washoe County Department of Social Services (WCDSS) and the Washoe County Commission Chambers. Both trainings included specific outreach to pharmacists, because research shows that pharmacists are highly trusted advice-givers to consumers. Training was free to attendees and included the option for continuing education credits.

## Review: Maternal Drug Use and Drug Exposed Infants

Statewide Health Division data showed no child deaths by drug exposure resulting from maternal drug use in 2008. This is likely because drug-related deaths are often difficult to identify and/or coroners and medical examiners do not have substantial evidence to support this as a cause of death. Regional CDR team data showed a total of 10 cases involving maternal drug use in 2008. This is a decrease from a total of 14 in 2007. For 3 of these child deaths, infants tested positive for drug exposure after birth.

Ref	Manner	Age Group	Gender	Race	Ethnicity	Drug Exposed?
1	Accident	Under 1	Female	African-American	Not Latino	No
2	Natural	Under 1	Female	White	Not Latino	No
3	Accident	Under 1	Male	African-American	Not Latino	Yes
4	Accident	Under 1	Male	African-American	Not Latino	No
5	Undetermined	Under 1	Male	White	Not Latino	No
6	Undetermined	Under 1	Male	White	Not Latino	No
7	Natural	Under 1	Male	African-American	Not Latino	No
8	Natural	Under 1	Female	African-American	Not Latino	Yes
9	Accident	Under 1	Female	African-American	Not Latino	Yes
10	Homicide	Under 1	Male	White	Not Latino	No

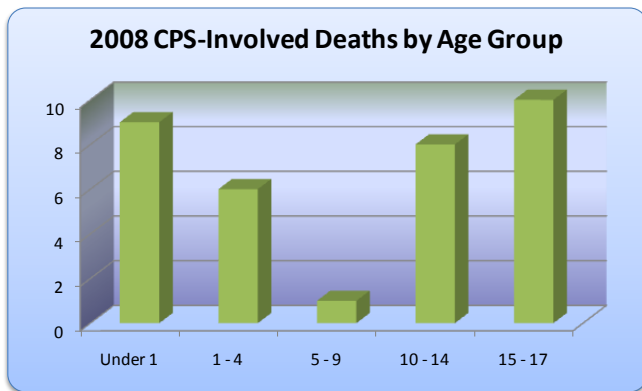
## Contributing Factors

Factor	Total
During pregnancy did mother smoke tobacco?	3
During pregnancy did mother use illicit drugs?	10
Infant born drug exposed	3
During pregnancy did mother misuse over-the-counter or prescription drugs?	0
During pregnancy did mother have heavy alcohol use?	0
Infant born with fetal alcohol effects or syndrome	0
Primary caregiver has a history of substance abuse	9
Secondary caregiver has a history of substance abuse	4
Primary caregiver has a history of child maltreatment as a victim	1
Primary caregiver has a history of child maltreatment as a perpetrator	3
Caregiver has prior child deaths	0
Toxicology screen completed on child	5
Was a CPS record check conducted?	8
Did investigation find evidence of prior abuse?	0

## Review: Children Involved in the Child Protective Services (CPS) System

During 2008, 34 out of 363 cases reviewed included children with a current or prior child protective services (CPS) history. Of these 34 cases, 16 had an open CPS case at the time of death, and 8 were living in a foster care setting.

### Basic Demographics

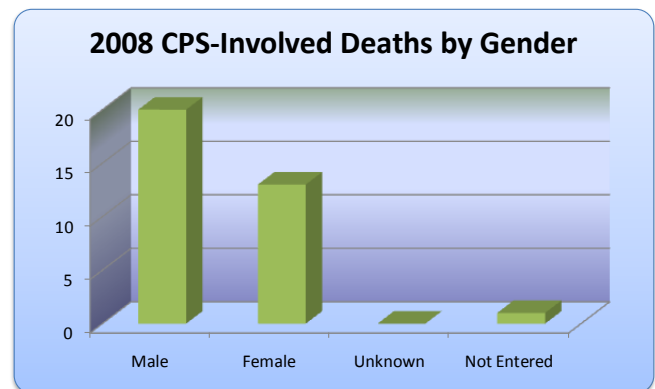


Age Group	Total
Under 1	9
1 - 4	6
5 - 9	1
10 - 14	8
15 - 17	10

### Findings:

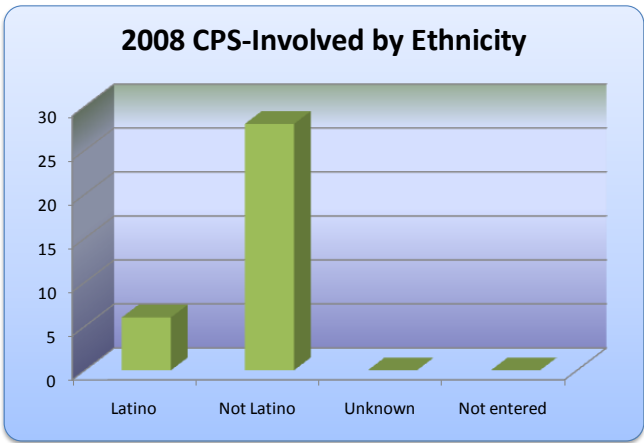
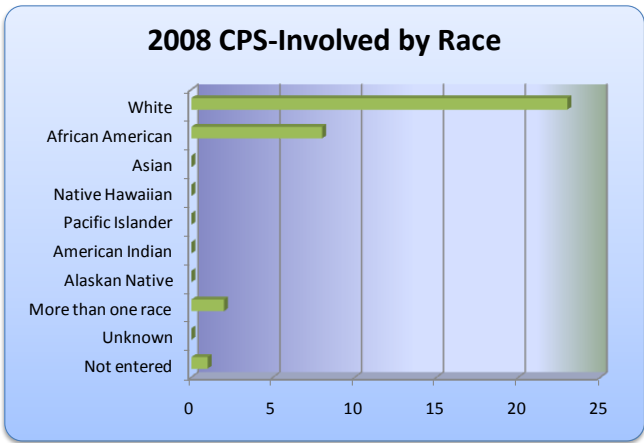
- For children involved in the CPS system, the distribution by age group is similar to the u-shaped distribution of statewide child deaths reviewed in *Section 1*.

Gender	Total
Male	20
Female	13
Unknown	0
Not entered	1



### Findings:

- Approximately 59% (20 of 34) of 2008 deaths of children with a current or prior CPS history occurred among males.



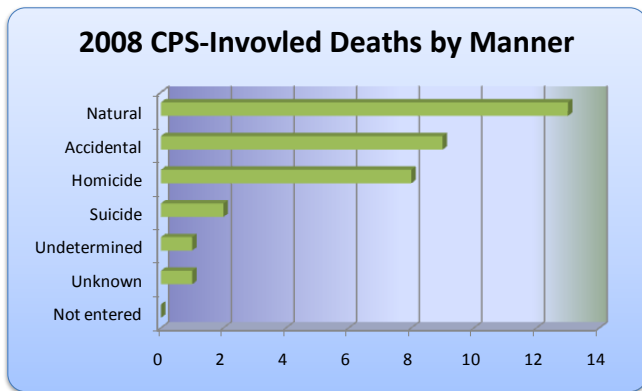
Race Group	Total	Race Group	Total
White	23	American Indian	0
African American	8	Alaskan Native	0
Asian	0	More than one race	2
Native Hawaiian	0	Unknown	0
Pacific Islander	0	Not entered	1

Ethnicity	Total	Ethnicity	Total
Latino	6	Unknown	0
Not Latino	28	Not entered	0

**Findings:**

- Approximately 24% (8 of 34) of 2008 deaths of children with a current or prior CPS history occurred among African Americans. This is disproportionately higher than the statewide population distribution for African Americans at 8.3%.
- Approximately 18% (6 of 34) of 2008 deaths of children with a current or prior CPS history occurred among Hispanics and Latinos. This is disproportionately lower than the statewide population distribution for Hispanics and Latinos at 36.8%.

## Manner of Death



Manner	Total
Natural	13
Accidental	9
Homicide	8
Suicide	2
Undetermined	1
Unknown	1
Not entered	0

### Findings:

- Approximately 24% (8 of 34) of 2008 deaths of children with a current or prior CPS history were homicides. This is disproportionately higher than the statewide percentage of homicides in 2008 at 6.2%.

# Appendix A

## Background on Child Death Review in Nevada

The State of Nevada Division of Child and Family Services (DCFS) established the Children's Justice Act (CJA) Task Force in 1994, based on a federal mandate through the Child Abuse Prevention and Treatment Act (CAPTA). The Statewide Child Death Review (CDR) Subcommittee, operating as part of the CJA Task Force, was formed as a partnership of professionals, organizations, and agencies to coordinate the statewide activities of child welfare agencies involved in the review of child deaths. Prior to 2003, the Statewide CDR Subcommittee engaged in several core activities:

- Reviewing cases of child fatalities to gain a better understanding of the causes of child death
- Identifying patterns of abuse, neglect, and other causal factors of child death that may respond to intervention
- Collecting data and completing trends analysis surrounding child death
- Reviewing laws, policies, and practices
- Addressing statewide staff training needs
- Addressing public awareness and education needs

The primary goal of the Statewide CDR Subcommittee was to prevent future child maltreatment and deaths in Nevada by making recommendations for law, policy, and practice changes; staff training; and public education based on data from child death reviews.

During 2002, the Statewide CDR Subcommittee developed recommendations for new laws relating to child death review. A primary goal was to give the regional CDR teams a mechanism to channel recommendations to appropriate agencies and maximize community resources so that future child deaths can be prevented.

These efforts resulted in a bill draft request supported by State Assemblywoman Sheila Leslie, who sponsored Assembly Bill (AB) 381 during the 2003 Nevada State Legislature. This landmark legislation was passed by the Legislature and allows for the implementation of significant changes in the child death review process. This legislation creates a clear purpose for the regional CDR teams to review child death and make recommendations for the improvement of laws, policies, and practices; support the safety of children; and prevent future deaths. Other provisions of the legislation establish the confidentiality of information obtained and reviewed by the regional teams, including protection from disclosure, subpoena, discovery, and introduction into evidence for civil or criminal proceedings.

Additionally, this bill established two statewide oversight committees: 1) the Administrative Team and 2) the Executive Committee to review the death of children. The Administrative Team reviews reports and recommendations from the regional CDR teams and makes decisions regarding the recommendations for improvements to laws, policies, and practices. The Administrative Team also makes recommendations about funding for improvements, initiatives, and public education requiring expenditures.

The Executive Committee, in turn, makes decisions about funding initiatives to prevent child maltreatment and death, which may be based on recommendations from the Administrative Team. Additionally, per NRS, the Executive Committee adopts statewide protocols for the review of the death of children; designates the

members of the Administrative Team; oversees training and development for the regional CDR teams; and compiles and distributes a statewide annual report. Funding for the work of the Committee was also established as a result of AB 381, and is derived from a \$1 fee collected from death certificates issued by the State. The funds are intended to be used for prevention efforts and training of the regional CDR teams.

In essence, the Administrative Team and the Executive Committee have taken over the functions of the original Statewide CDR Team, and now work together to prevent future child deaths in Nevada.

Currently, seven regional CDR teams review local child deaths throughout the State of Nevada as follows:

1. **Clark Team:** Reviews deaths in Clark County.
2. **Southern Nevada Child Fatality Task Force:** Works in Clark County to improve the investigation of child deaths by stakeholders in the CDR process.
3. **Washoe Team:** Reviews deaths in Washoe County.
4. **Elko Team (District 1 – North):** Reviews deaths in Elko, Eureka, Humboldt, Lander, Lincoln, and White Pine Counties.
5. **Carson Team (District 2 – West):** Reviews deaths in Carson City, Douglas, and Storey Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Carson Team covers Stagecoach and Dayton.
6. **Fallon Team (District 3 – East):** Reviews deaths in Churchill, Mineral, and Pershing Counties. Areas of Lyon County are split between the Carson and Fallon Teams, and within Lyon County the Fallon Team covers Fernley, Silver Springs, and Yerington.
7. **Pahrump Team (District 4 – South):** Reviews deaths in Esmeralda and Nye Counties.

The purpose, organization, and functions of the regional CDR teams are mandated by Nevada Revised Statutes (NRS) Chapter 432B, sections 403 through 4095. Each of the seven regional CDR teams reviews all coroner-referred child deaths within their region with two exceptions: 1) The Clark Team reviews all coroner-referred child deaths with the exception of some natural death cases. Clark County accounts for approximately 72% of the state's population, and it is not feasible for the Clark Team to review all child deaths in the region because of the high caseload. 2) The Southern Nevada Child Fatality Task Force reviews only select cases in its work to improve the investigation of child deaths by stakeholders in the CDR process.

State-mandated reviews include the following:

- Reviews requested from 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 die from Sudden Infant Death Syndrome (SIDS).

In Clark County, the team meets monthly because of its high caseload. The Southern Nevada Child Fatality Task Force meets every other month. 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 may meet less frequently if no child fatalities are reported in a given quarter.