

2011

Summary of Findings from the 2011 Child Death Review Annual Report

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Summary of Findings from the 2011 Child Death Review Annual Report

The 2011 Annual Report of Child Deaths in Clark County, Nevada provides data regarding all infant, child, and fetal (over 20 weeks gestation) deaths occurring in Clark County in 2011. This represents the fourth year that the Child Death Review Team in Clark County reviewed 100% of the child deaths referred to the team by the Clark County Office of the Coroner/Medical Examiner; this includes all natural deaths, as well as all accidents, homicides, suicides, and undetermined cases. The team also reviewed all fetal deaths over 20 weeks gestation.

Overall 2011 Child Death Statistics

Manners of Death in 2011

- 237 cases reviewed in 2011 (23.8% decrease since 2008)
- 155 Natural (decrease of 7.7 % from 168 in 2010)
- 37 Accidents (decrease of 19.6% from 46 cases in 2010)
- 16 Suicide (128.6% increase from 2010 – more incidents in 2011 than 2008-2010 combined)
- 19 Homicide (one more case than in 2010)
- 10 Undetermined (same number as in 2010, but a 44.4% decrease from 2009 (n=18))

Causes of Death in 2011

- Increase in motor vehicle incidents from 8 in 2010 to 10 in 2011
- SIDS stayed the same at 1 cases in 2011
- Increase in deaths caused by weapons from 22 in 2010 to 30 in 2011
- Decrease in suffocation/strangulation deaths from 18 in 2010 to 15 in 2011.
- Drowning down by two cases from 10 in 2010 to 8 in 2011.
- Poisoning/Overdose cases showed an increase from 5 in 2010 to 9 in 2011.

2011 Child Deaths by Manner of Death – Additional Details and Recommendations for Prevention

Natural – There were 155 natural deaths reviewed in 2011. 39.4% of these deaths were due to complications of prematurity, followed by congenital defect (36.8%) and chronic illness (15.4%). 72.9% of natural deaths were children less than one year of age. We continued to see a decrease in the number of SIDS deaths in 2011 from 2 in 2009 to 1 in 2010, and 1 in 2011.

Recommendations:

- Continue to improve data collection and research on child deaths related to prematurity.
- Improve access and outreach for adequate prenatal care, particularly for young women.
- Improve parent education about proper management of common chronic illnesses in children.

Accident- Accidental deaths accounted for 15.6% (37 cases) of child deaths in 2011. The leading causes of accidental death included suffocation at 29.7% followed by motor vehicle accidents (MVA) at 27%, poisoning at 21.6%, and drowning at 18.9%. For the second time in six years the leading cause of accidental deaths were suffocations. In 2011 nearly all accidental suffocations (n=11) were children less than one year of age and nearly all of those cases (n=10) occurred in a sleeping environment. Motor vehicle accidents increased from 17.45 % in 2010 to 27% in 2011 with half of the decedents (50%) between the ages of 15-17. Poisoning also showed an increase from 8.7% in 2010 to 21.6% in 2011. Similar to 2010, in 2011, nearly all (n=5) of the drowning victims in Clark County were between the ages of one and four years and 71.4 % of all victims drowned in a pool or spa. In 2011, we also see the lowest number of child drowning incidents since data collection in 2006.

Recommendations:

- Focus on changing regulations to bring older pools up to current standards for barriers to accessing the pool including, fences, gates, alarms, etc.
- Improve/expand culturally sensitive outreach and education efforts regarding safe sleep environments for infants.
- Support initiatives related to preventing substance abuse in children and youth, especially those related to limiting access to prescription drugs.

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Homicide- In 2011, 8% (19 cases) of child deaths were categorized as homicides. This is an increase from 17 deaths in 2009 but a decrease from 20 deaths in 2010. In 2011 children ages 1-4 years and youth 15-17 years were the most frequent age groups both at 36.8% respectively. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2011 there were more non-firearm homicides (n=12) than firearm homicides (n=7). For firearm homicides (n=7) the data show that 71.4 % of the victims had a prior juvenile justice history, and in 3 of these incidents gang affiliation was known or suspected. For non-firearm homicides (n=12), 83.3% were a result of child abuse or neglect (n=10). In three of those cases the perpetrator was the mother’s boyfriend and in the remaining cases the perpetrator was a relative or family friend. One third (n=4) of the decedents’ families had a history of involvement with the child welfare system.

Recommendations:

- Firearm Homicides: Focus on addressing the needs of minority youth through community based outreach and gang prevention activities.
- Non-Firearm Homicides: Develop and promote networks of services to help families most at risk to prevent incidents before they start. Parenting/stress management training should also be targeted toward adults living in the home with children who are not their biological parents, but are responsible for care giving.

Suicide – Suicide was the cause of 6.8% (16 cases) of child deaths in Clark County which represents a 128.6% increase from 2010 and represents more cases than 2008-2010 combined. All of the decedents attended school regularly, 25% of the decedents (n=4) made a previous attempt, and 18.8% of decedents had made prior threats of suicide.

Recommendations:

- Expand suicide prevention efforts in elementary schools and continue education to teachers, parents, and others about suicide prevention.
- Expand existing firearm safety campaigns to include specific messages about preventing access to lethal means for suicide, especially if children have a history of mental health issues or prior attempts.
- Expand and promote gatekeeper training for anyone working with youth to recognize signs of suicide as well as techniques for how to intervene if suicidal ideation is suspected.

Undetermined – 4% (10 cases) of child deaths were ruled undetermined, which is a decrease from 2008 (n=18). This ruling is used by the Office of the Coroner/Medical Examiner when information regarding the circumstances of the death makes it difficult for the medical examiner to make a distinct determination about the manner of the death. 5 of these 10 cases (50%) were infants less than 1 year of age. 2011 showed a slight increase in undetermined deaths for African American children rising to 50% of all undetermined deaths from 30% in 2010. Among children less than 1 year of age (n=5), all died in a sleeping environment and in 1 of the 5 cases the child was sleeping with another person (parent, sibling or both).

Summary of Child Welfare History for all 2011 Child Deaths

The team records whether a child or their family has ever had any involvement with the Department of Family Services (DFS). Prior history is recorded regardless of the cause of the child’s death and often the cause of the child’s death is unrelated to any previous history of involvement with DFS.

- 51 of the 237 cases reviewed had some family history of involvement with DFS prior to the child’s death – a decrease from 2010 (n=57).
- In 10 cases the child/family had an open case with DFS at the time of the child’s death
- In 3 cases the child was in foster/shelter care at the time of their death (an increase from 2010).
- In 2012 there were 9 substantiated death allegations of abuse or neglect.
- Of the 9 substantiated death allegations (3.4% of all child deaths in Clark County), 1 was ruled an accident, while 8 were ruled homicides. In more than 75% (n=7) of these cases the decedents’ and their family did not have any prior history with DFS.

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2011 CDR Team Prevention Activities

- In 2011 the team added members from the Clark County School District Police-Threat Assessment Team. Given the large spike in youth suicides in 2011, partnership with this team was crucial to understanding the circumstances of these fatalities. In addition, the team developed a new process for obtaining school records that allows for members from the school district to help facilitate the receipt of complete records for the purpose of the review.
- In 2011 the team continued to support efforts related to safe sleep by serving as the local point of contact for distribution of safe sleep brochures printed by the Nevada Executive Committee for the Review of Child Deaths. Dr. Sandra Cetl, one of the pediatricians on the team, organized a meeting with Sunrise Hospital Staff, local law enforcement, district attorneys, and the coroner's office to discuss common issues associated with child death investigations when a child dies at the hospital. In this meeting each agency used the time to explain their process and understand the motivations for other agency positions. The meeting was successful in helping to make simple changes to processes to ensure that all agency needs are met and expectations are clarified.
- In 2011 a collaboration of members from the Clark County Child Death Review Team worked together to generate a proposal to the Executive Committee for Child Death Review to receive funding to support a "Choose Your Partner Carefully Campaign." The collaboration was awarded funding and NICRP as Prevent Child Abuse Nevada worked to organize the group to create print materials (brochures and posters) as well as post bus stop signs throughout the Las Vegas area. The campaign also held a press conference during child abuse prevention month and several of the members of the collaboration were interviewed about the campaign on both television and radio. The group was able to print and distribute more than 25,000 brochures and there were 15 bus stop signs around the Las Vegas area with 5 stops displaying both English and Spanish versions of the poster.
- Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. The Southern Nevada Drowning Prevention Coalition continues to coordinate efforts, and ensure consistent prevention messaging related to water safety and drowning prevention. There are three members of the Clark County CDRT that continue to serve on the coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County. This year the collaboration celebrated April Pools Day with a joint press conference.
- Unsafe sleep practices continue to claim the lives of infants in our community. In an effort to address this problem, in 2011, NICRP and the Southern Nevada Health District were awarded funding from the Health Resource Support Administration (HRSA) Healthy Tomorrow's Program to support a hospital based safe sleep initiative in Clark County. This program will work with local birthing hospitals to ensure that there is a hospital policy on sleep positioning, that staff are trained in safe sleep practices, and that new parents watch a short informational video on how to safely place their baby to sleep. This program has grant support for five years, and during that period, we hope to implement the program in all birthing hospitals in the Las Vegas Valley.

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