

2010

Summary of Findings from the 2010 Child Death Review Annual Report

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Summary of Findings from the 2010 Child Death Review Annual Report

The 2010 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 2010. This represents the third 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 2010 Child Death Statistics

Manners of Death in 2010

- 251 cases reviewed in 2010 (11.3 % decrease from 283 cases in 2009, a 19.3% decrease since 2008)
- 168 Natural (decrease of 9.2 % from 185 in 2009)
- 46 Accidents (decrease of 19.3 % from 57 cases in 2009, still lower than 66 cases in 2007)
- 7 Suicide (an increase from 4 in 2009 and 2008, but down from 12 in 2007)
- 20 Homicide (an increase of 17.6 % from 17 in 2009)
- 10 Undetermined (44.4% decrease from 2009 (n=18), 2006 (n=18) and 2008(n=18))

Causes of Death in 2010

- Decrease in motor vehicle incidents from 16 in 2009 to 8 in 2010
- SIDS decreased from 2 cases in 2009 to 1 cases in 2010
- Increase in deaths caused by weapons from 14 in 2009 to 22 in 2010
- Increase in suffocation/strangulation deaths from 13 in 2009 to 18 in 2010.
- Drowning down by one case (11 in 2009, 10 in 2010)
- Poisoning/Overdose cases decreased from 12 in 2008 and 16 in 2009, to only 5 in 2010

2010 Child Deaths by Manner of Death – Additional Details and Recommendations for Prevention

Natural – There were 168 natural deaths reviewed in 2010. 39.3% of these deaths were due to complications of prematurity, followed by congenital defect (32.1%) and chronic illness (15.5%). 70.2% of natural deaths were children less than one year of age. We continued to see a decrease in the number of SIDS deaths in 2010 from 3 in 2008 down to 2 in 2009, then 1 in 2010.

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 like asthma and diabetes.

Accident- Accidental deaths accounted for 18.3% (46 cases) of child deaths in 2010. The leading causes of accidental death included suffocation at 28.3%, followed by drowning at 21.7% and motor vehicle accidents (MVA) at 17.4 %. For the first time in five years the leading cause of accidental deaths were suffocations. In 2010 nearly all accidental suffocations (n=13) were children less than one year of age and nearly all of those cases (n= 12) occurred in a sleeping environment. Similar to 2009, in 2010, nearly all (70 %) of the drowning victims in Clark County were between the ages of one and four years and 80 % of all victims drowned in a pool or spa. Motor vehicle accidents decreased 47% from 15 in 2009 to 8 in 2010. This significant decline reflects national trends showing a reduction in motor vehicle related fatalities for all ages.

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.
- Continue to support efforts related to the elimination of recreational drug use and expand efforts to prevent drug use among youth and especially women of child bearing age.

Homicide- In 2010 12% (20 cases) of child deaths were categorized as homicides. This is a increase from 17 deaths in 2009 but a decrease from 21 deaths in 2008. In 2010 children ages 1-4 years and youth 15-17 years were the most frequent age groups at 30% and 40% respectively. Homicides are categorized as either “firearm” homicides or “non-firearm” homicides, and in 2010 there were more non-firearm homicides (n=12) than firearm homicides (n=8). For firearm homicides (n=8) the data show that 62.5 % 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), 58.3% were a result of child abuse (n=7) and in almost half of those cases (n=4) the perpetrator was the mother’s boyfriend. Half (n=6) of the decedents’ families had a history of involvement with the child welfare system.

The full report is available at the NICRP website <http://nic.unlv.edu>



Recommendations:

- Firearm Homicides: Focus on addressing the needs of minority youth through community based outreach and gang prevention activities, especially African American and Hispanic populations. These groups continue to be over represented among youth homicides in 2010.
- Non Firearm Homicides: Prevention efforts should focus on developing a network of services within our community to reach out to families at risk. Additionally, providing parenting/stress management training to adult caregivers in the home other than biological parents could also help reduce the risk of abuse.

Suicide –Suicide was the cause of 4.2 % (7 cases) of child deaths in Clark County which represents an increase from 2008 and 2009 when there were 4 suicide deaths. 86 % (6 cases) of the decedents attended school regularly, one decedent talked about suicide prior to their death, and in two cases the decedent had made a previous attempt.

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 messages about preventing 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 the 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. 8 of these 10 cases (80%) were infants less than 1 year of age. 2010 showed a slight increase in undetermined deaths for African American children rising to 30 % of all undetermined deaths from 27.8 % in 2009. Among children less than 1 year of age (n=8), 6 died in a sleeping environment and in 3 of the 6 cases the child was sleeping with another person (parent, sibling or both).

Summary of Child Welfare History for all 2010 Child Deaths

The team records whether a child or their family has ever had any involvement with the Department of Family Services (DFS).

- 57 of the 251 cases reviewed had some family history of involvement with DFS – a decrease from 2009 (n=63).
- In 7 cases the child/family had an open case with DFS at the time of the child’s death.
- In 1 case the child was in foster/shelter care at the time of their death (the same as in 2009).
- In 2010 there were 12 substantiated death allegations of abuse or neglect.
- Of the 12 substantiated allegations (4.8 % of all child deaths in Clark County), 3 were ruled accidents, while 8 were ruled homicides. In half (n=6) of these cases the child, sibling, or parent as a child victim had prior history with CPS.

2010 CDR Team Prevention Activities

- In 2010 one of the team’s pediatricians, Dr. Sandra Cetl was invited to present at the November 2010 CAN Prevent Annual Conference in Reno, Nevada to discuss issues related to substance abuse among teens, specifically the recreational use of prescription and over the counter medications.
- This year the team drafted a letter informing physicians and nurse about best practices for asthma management as well as education for parents of children with asthma. This information was distributed statewide to licensing boards and professional organization. It was also featured in the state’s medical board newsletter.
- Members on the Clark County Child Death Review Team (CDRT) continue to be committed to drowning prevention in our community. Recently the Southern Nevada Drowning Prevention Coalition has been re-energized to coordinate efforts related to water safety and drowning prevention. There are three members of the Clark County CDRT that serve on this coalition to foster community collaboration and work to prevent fatal drowning incidents in Clark County.
- In December of 2010 the Las Vegas Review Journal published an article on the importance of safe sleep practices. The article featured comments from several members of the team and also statistics compiled for this report regarding the number of fatalities related to unsafe sleep environments. Additionally, NICRP and the Southern Nevada Health District applied for federal funding to start a safe sleep hospital education program in Clark County and are currently awaiting the final funding decision.
- The NICRP developed a “Child Safety Booklet” for parents in Clark County. This booklet is organized by age group and provides prevention information and statistics for parents to keep their children safe from accidental injuries. The booklet was distributed by the Southern Nevada Maternal Child Health Coalition and also to several child care facilities in Clark County.

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