STATE of NEVADA
Division of Child and Family Services

Children's Justice Task Force
The Child Death Review Subcommittee

A REPORT ON CHILD DEATH
FOR THE YEARS 1999 THROUGH 2001

The Division of Child and Family Services
Family Programs Office

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Nevada Children's Justice Act Task Force
Statewide Child Death Review Subcommittee

Background

The Nevada Children's Justice Act Task Force (CJATF) was established in 1994 by the Nevada Division of Child and family and Services to accomplish the objectives outlined in the Federal Child Abuse Prevention and Treatment Act, 42 U.S.C., Sec. 107, to review and evaluate: State investigative, administrative and both civil and criminal judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, as well as cases involving suspected child maltreatment related fatalities and cases involving a potential combination of jurisdictions, such as interstate, Federal-State, and State-Tribal, with a view to making recommendations for policy change and training. The task force formed the Child Death Review Subcommittee to coordinate the statewide activities of child welfare agencies involved in the review of child maltreatment related fatalities and to evaluate service delivery systems, policy development, interagency protocol, data collection, and training. A "child" is defined in the Nevada Revised Statutes (NRS) 432B.040 as "a person under the age of eighteen (18) years."

The Statewide Child Death Review Subcommittee is a partnership of professionals, organizations, and agencies, with the main goal of reviewing cases of child fatalities to gain a better understanding of the cause of death and the identification of patterns of maltreatment that may respond to intervention. A secondary goal is the prevention of future child maltreatment and deaths in Nevada through recommendations for policy and practice change, training, and public education. A third goal is the collection of accurate data that will indicate trends that may be addressed through policy, training, and public education. A final goal is the preparation of an annual report about the activities of the child death review teams, their data findings, and recommendations.

The Statewide Child Death Review Subcommittee assisted in the development of the five county/regional Child Death Review Teams: Carson City, Clark County, Elko, Fallon, and Washoe County. These teams review child deaths throughout the state.

Clark County was the first county to establish a Child Death Review Team in 1992. Because of the number of child deaths in this region due to reasons other than child maltreatment (drowning, car accidents), they originally reviewed only cases involving children age five (5) years and younger. The county began to review fatalities of all children up to age eighteen (18) in the year 2000. Clark County has a medical examiner/coroner that conducts autopsies for the southern Nevada region. The coroner is also a member of the Clark County Child Death Review Team.

Washoe County was the second county to create a Child Death Review Team and is second in population to Clark County. Washoe County has a medical examiner/coroner that conducts autopsies for northern Nevada with some exceptions in areas near the Utah State border. Washoe County also conducts autopsies for some California counties near the Nevada-California border.

The coroner is a member of the Washoe County Child Death Review Team. The Washoe County Child Death Review Team distributes official autopsy reports to the Rural Regional Child Death Review Teams.

In 1995, the Rural Child Death Review Teams began and they are part of the local multi-disciplinary teams. These teams conduct child death reviews when they receive an official report from the medical examiner/coroner. The number of children who die in the rural counties is less than the number reported in the more densely populated counties of Clark and Washoe. There are three rural regional teams: Carson City Child Death Review Team covers Carson City, Douglas, Lyon, and Storey Counties; Elko Child Death Review Team covers Elko, Eureka, Humboldt, Lander, Lincoln, Pershing, and White Pine Counties; Fallon Child Death Review Team reviews child deaths in Churchill, Esmeralda, Mineral and Nye counties.

Child Death Review Legislation; State Assembly Bill 381

The child death review process was improved with the passage of landmark legislation during the 2003 Legislative Session. Assemblywoman, Sheila Leslie, sponsored State Assembly Bill 381 that was passed by the Nevada State Legislature and became effective July 1, 2003. This legislation creates a clear purpose for teams to review child death to make recommendations and improvements to laws, policies and practice, and to support the safety of children and prevent future deaths. Other provisions of the law include protection of privileged information from disclosure and from subpoena or discovery or introduction into evidence in any civil or criminal proceeding. The law also creates two statewide oversight committees for child death review. The legislation provides funding from an additional one dollar fee on death certificates to be used by the various committees for conducting statewide public education and awareness efforts concerning preventable deaths.

Child Death Review Process 2003

The Nevada Division of Child and Family Services, Clark County Department of Family Services and Washoe County Department of Social Services may form child death review multidisciplinary teams in accordance with NRS 432B.405. The members of the team may be determined by the child welfare agency and may include representatives from law enforcement, medical personnel, district attorney's office, school, coroner's office, and any other identified representative of an agency or organization.

The intention of the review is not to establish wrongful death, but to determine what actions may have prevented the death of a child and to make appropriate recommendations that may improve protocol, policy, training or public knowledge (NRS 432B.403). Autopsy reports are sent to the appropriate area team for review. The team discusses the report with a variety of disciplines and may even "petition the district court for the issuance of, and the district court may issue, a subpoena to compel the production of any books, records or papers relevant to the cause of any death being investigated by the team," (NRS 432B.407(3)). The information shared and discussed is not subject to subpoena, discovery, or introduction into evidence in any criminal or civil proceeding (NRS 432B.407).

There are two committees created by the law. The first committee is the Executive Committee to Review the Death of Children and members will transition from the Children's Justice Act Child Death Review Subcommittee to this committee. Members of the Executive Committee include the

local multidisciplinary team representatives, vital statistics, law enforcement, public health, and the Office of the Attorney General. The Administrator of the Nevada Division of Child and Family Services establishes the Executive Committee.

The Administrative Team is the second committee and consists of administrators of agencies, which provide child welfare services, vital statistics, public health, mental health, and public safety. This team responds to recommendations from the Executive Committee within ninety (90) days with regard to administrative action that may change policy, protocol, and regulations or make recommendations to change laws.

These two committees will work together to improve the outcomes for children in the State of Nevada through policy development, training, and public education about preventable deaths.

Statewide Activities – Report 1999 through 2001

Research estimates vary due to the difficulty in the identification of all child deaths that resulted from maltreatment. Identifying and documenting child death due to maltreatment is often difficult because the largest percentage of child deaths occur in the younger pre-verbal age groups where public visibility of the child is limited. Such deaths may be considered accidental or may be diagnosed as Sudden Infant Death Syndrome (SIDS). This nationwide trend is reflected in children under the age of one (1) year who accounted for 41% of maltreatment fatalities, while 85% of all fatalities nationwide were children under the age of six (6) years. In Nevada, less than fifteen percent (15%) of the total number of child fatalities reviewed by the teams was a victim of child maltreatment.

Child Death Review teams attempt to define the criteria for each type or manner of death to minimize inconsistencies in identification and reporting. In 2000, the Statewide Team developed common terminology and definitions for Review Teams and prepared a standardized data collection instrument with input from coroners and the Bureau of Health Planning and Statistics.[1] This effort has assisted with consistent data collection and identification of typologies of the manner of death. Data is collected and maintained by the statewide subcommittee. Local teams published individual annual reports until 1998 when the first statewide statistical report was published for calendar years 1997 through 1998. An annual statewide written report on the activities, findings, and recommendations from the teams will continue to be published.

National Efforts

The nationwide development of multidisciplinary Child Death Review Teams promises new understanding in the underlying nature and causes of child maltreatment that lead to fatalities. The review of such cases provides information that identify safety hazards, determine prevention efforts and ultimately, will improve the child protection system.

The Nevada Statewide subcommittee has been participating in national efforts with Dr. Michael Durfee and several states to standardize data definitions and collection. T

[1] NV Child and Service Plan, 1999-2004

Manner of Death

Prior to Child Death Review Teams analysis or involvement in a child fatality, the coroner or private attending physician identifies the mode or manner of death. The coroner then forwards the information to the Child Death Review Team Coordinator. The coroner lists one of the five modes of death on the death certificate:

- **Accidental**
These cases are deaths where there was not any intent to cause harm to another person and include drowning, vehicle accidents, asphyxia due to fire, and hyperthermia.

- **Homicide**
A homicide is the killing of one human by another.

- **Natural**
These are deaths of natural disease mechanisms and include Sudden Infant Death Syndrome (SIDS) cases.

- **Suicide**
A suicide is the taking of one's own life voluntarily and intentionally.

- **Undetermined**
Cases that do not have a clear indicator of what caused the death

The following charts tracks Nevada child fatalities for the years 1999 through 2001, and include all categories of death (Figure 1), child fatalities by sex (Figure 2), and ethnicity (Figure 3).

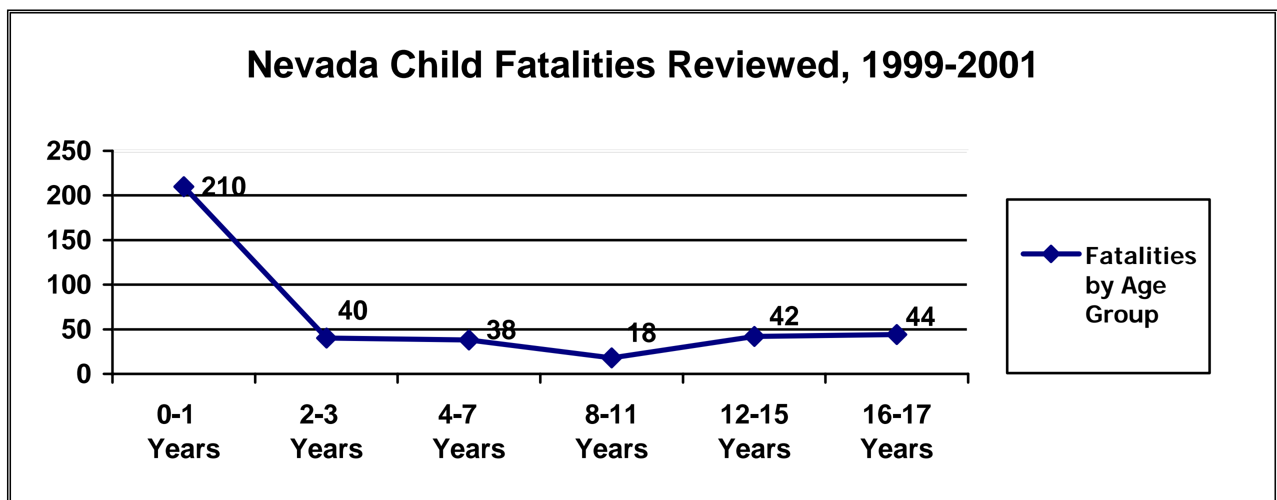

Figure 1

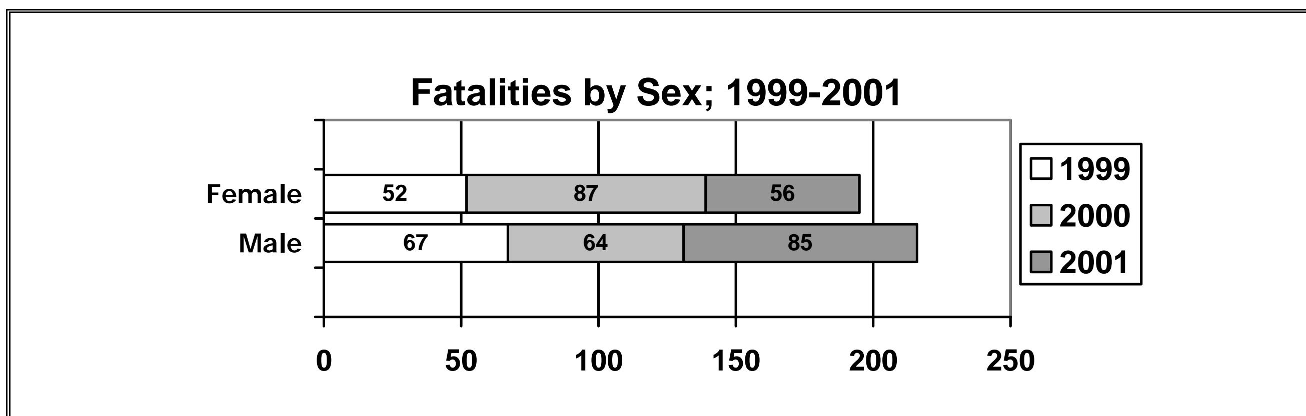

Figure 2

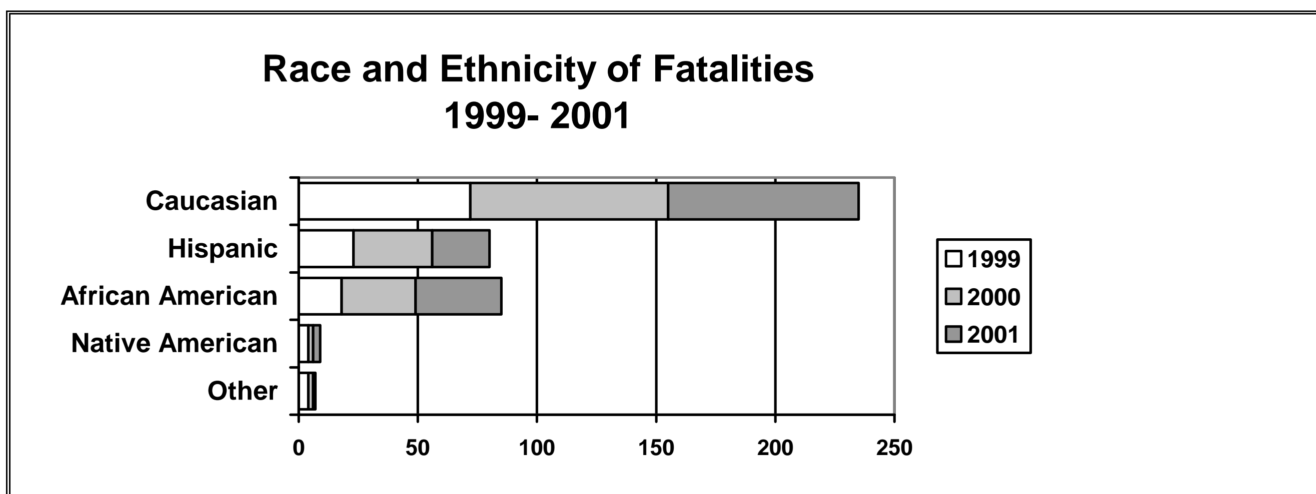

Figure 3

The review of the child fatality may be cursory or in-depth, depending on the nature of the death and the presence of several risk factors. Risk factors may include: undetermined cause of death, homicide, gunshot wounds, neglect, and abuse.

The largest percentage of child fatalities are children under one (1) year of age and children between the ages of one (1) and six (6) years. These children are the most vulnerable for maltreatment as they are often pre-verbal, unable to protect themselves, and they are often not seen publicly on a regular basis for anyone to report concerns of maltreatment. Older children and teen fatalities are often due to vehicle accidents or gang related homicides.

Child Maltreatment Related Fatalities

Child maltreatment occurs in all socio-economic groups, educational levels, ethnic and cultural backgrounds and family compositions. Child maltreatment covers many types of abuse and neglect of children under the age of eighteen, with the most tragic being child death. In a report released by the United Nations Children's Fund (September 2003), researchers found that of industrialized nations, the United States had one of the highest death rates of children due to abuse.

Approximately 903,000 children are the victims of abuse and neglect in the United States and an estimated 1,300 children die from abuse and neglect every year; that is approximately 1.81 children per 100,000 children in the population.[2] Moreover, the child abuse reporting rate has increased 46%, since 1986.[3]

An attempt to understand different types of neglect and abuse deaths is assisted by the analysis of data from Child Death Review Teams. Nationwide data collected by Child Death Review Teams demonstrate that abuse and neglect fatalities fall into separate categories that require different strategies for prevention. Many different acts are identifiable to specific maltreatment fatalities. Children die from head and/or body trauma, drowning, suffocation, Shaken Baby Syndrome, and other acts.

Death from neglect, due to lack of supervision, occurs when a caretaker is absent and a critical danger arises, such as leaving a child unattended during bathing. Chronic neglect includes deaths from a pattern of behavior by the caregiver, such as malnourishment of a child or lack of medical attention. According to data collected by the U.S. Department of Health and Human Services for the years up to 2001, maltreatment deaths due to neglect are higher nationally, than other types of abuse. The national trend is to include motor vehicle accident fatalities where a child is not in proper child restraints, such as a car seat or booster seat, under child neglect fatalities.

Nationwide, the age of victims for all maltreatment related deaths tends to be very young children. Children under the age of one year accounted for 41% of maltreatment fatalities, while 85% of all fatalities nationwide, were children under the age of six years.

At the national level, the age of most maltreatment fatalities are children under the age of five (5). More children are victims of neglect, including medical neglect, than from physical abuse. In many instances of child fatality, the children were victims of more than one type of maltreatment. They may have been victims of neglect as well as other types of abuse. Nationwide, more than thirty-five percent (35%) of child maltreatment deaths were due to neglect only, while 26% were reported as physical abuse only deaths.[4]

The following chart (Figure 4) is per year child fatalities from abuse that occurred in Nevada statewide for years 1999-2000, (see Figure 2). In Nevada, less than fifteen percent of the total number of child fatalities reviewed during 1999-2001 by the Child Death Review Teams was identified as a victim of child maltreatment. This is less than the national average.

This chart includes those children who died in Nevada because of maltreatment, but they may have been residents of other states and may have been in the State temporarily. This chart also reflects only those cases that come within the purview of the child protective services system. A single child with no siblings who died as a result of abuse would be handled by law enforcement as a homicide without the intervention of child protective services because there are no other children in the household to protect (NRS 432B.260).

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[2] Statistics from 1997 through 2001. U.S. Department of Health and Human Services, *Child Maltreatment 2001* (Washington DC: U.S. Govt. Printing Office, 2003).
[3] Child Abuse.com; *Prevention of Child Abuse and Neglect Fatalities Study # 9*, 2001
[4] Statistics from 1997 through 2001. U.S. Department of Health and Human Services, *Child Maltreatment 2001* (Washington DC: U.S. Govt. Printing Office, 2003).

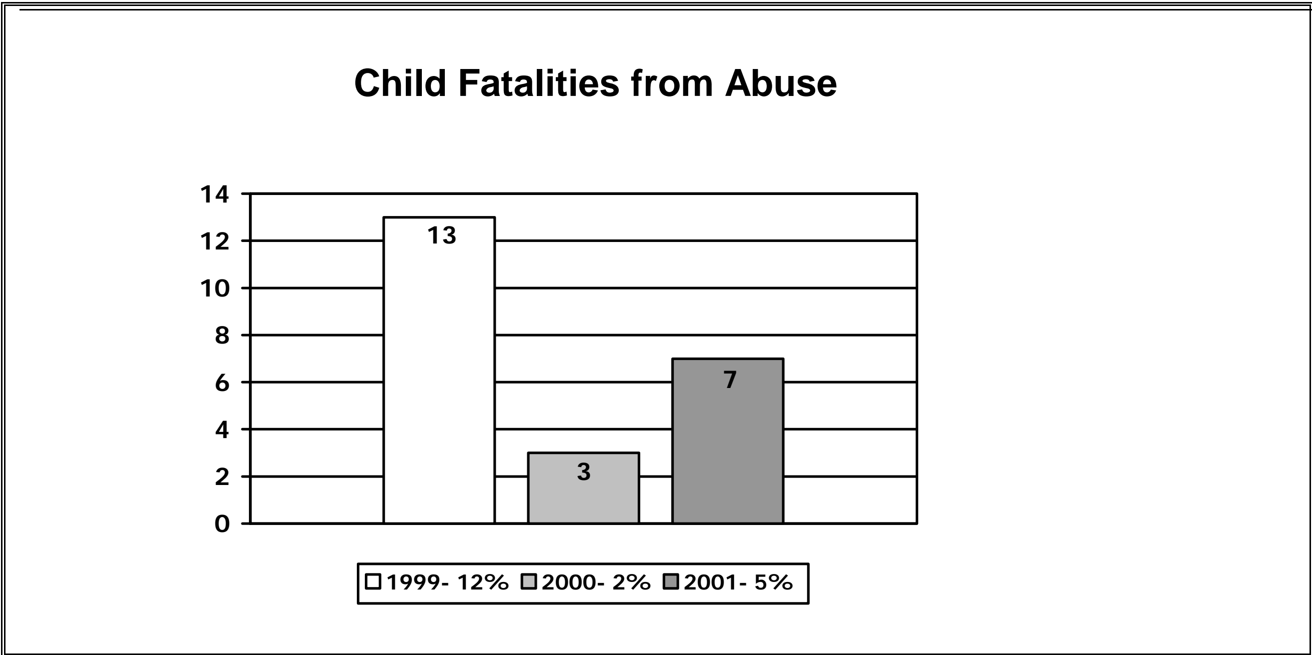

Figure 4

Included in child neglect fatalities are those children involved in vehicle accidents and who were not wearing child restraints. A child drowning is included in neglect deaths when there are extenuating circumstances, such as a caretaker leaving a child unsupervised in the pool or bathtub (Figure 5).

The second leading cause of child neglect death is from maternal drug usage that results in the child being stillborn. Listed in the child neglect category are children who commit suicide even after their parents have been made aware of their attempts.

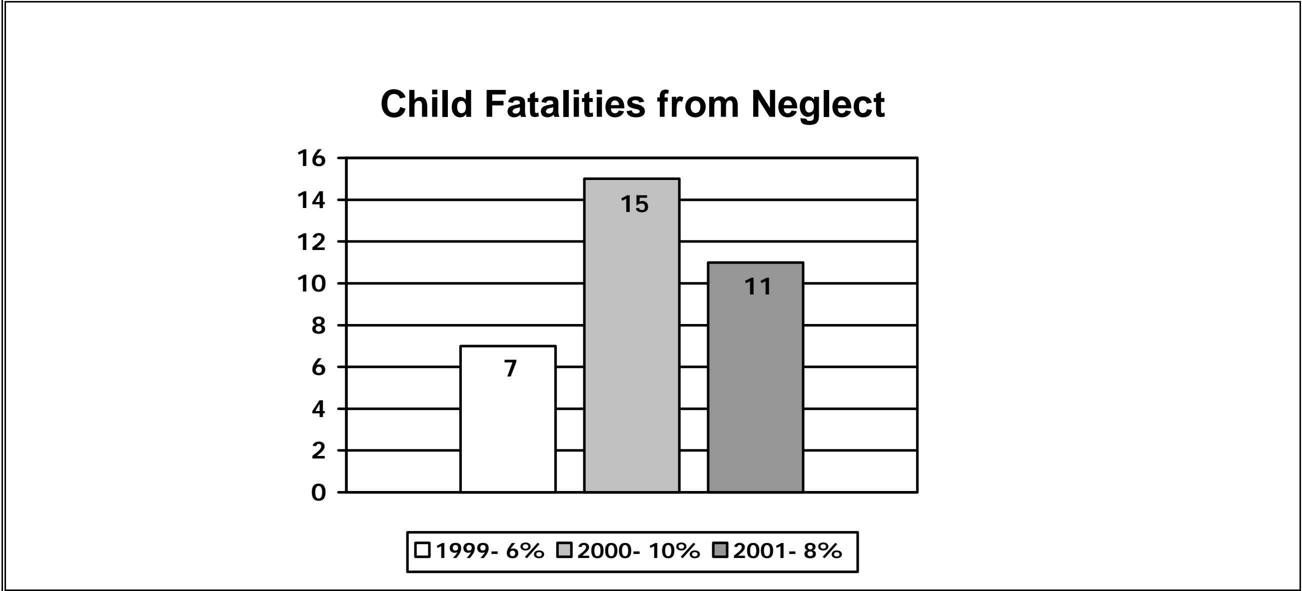

Figure 5

Child Fatalities in Foster Care

In 2001, nationwide there were eighteen (18) child fatalities of children while under custody of a child welfare agency. Less than 2% of all fatalities occurred in an out-of-home setting.[5] Nevada had three (3) fatalities of children in foster care in 1999. Two died due to complications stemming from the initial injury that placed them in foster care and one child was the victim of abuse inflicted by the foster parent and this resulted in her death. Nevada had no child victims who died from maltreatment in foster care during 2000 and 2001, although there was one child placed in a medically fragile foster home whose death was unpreventable due to multiple medical issues.

Categories of Fatalities Reviewed

The Teams reviewed the total of112 child fatalities for the year 1999, 151 fatalities in 2000, and 144 fatalities in 2001.

Although death from natural causes is usually the highest category of deaths, during 2000 and 2001 there were more deaths that were determined accidental. Many of these deaths were due to motor vehicle accidents.

The following chart shows the modes of death, as determined by the coroner, that the Teams reviewed for the three years, 1999 through 2001 (Figure 6). Clark County did not review children six years and older until the year 2000.

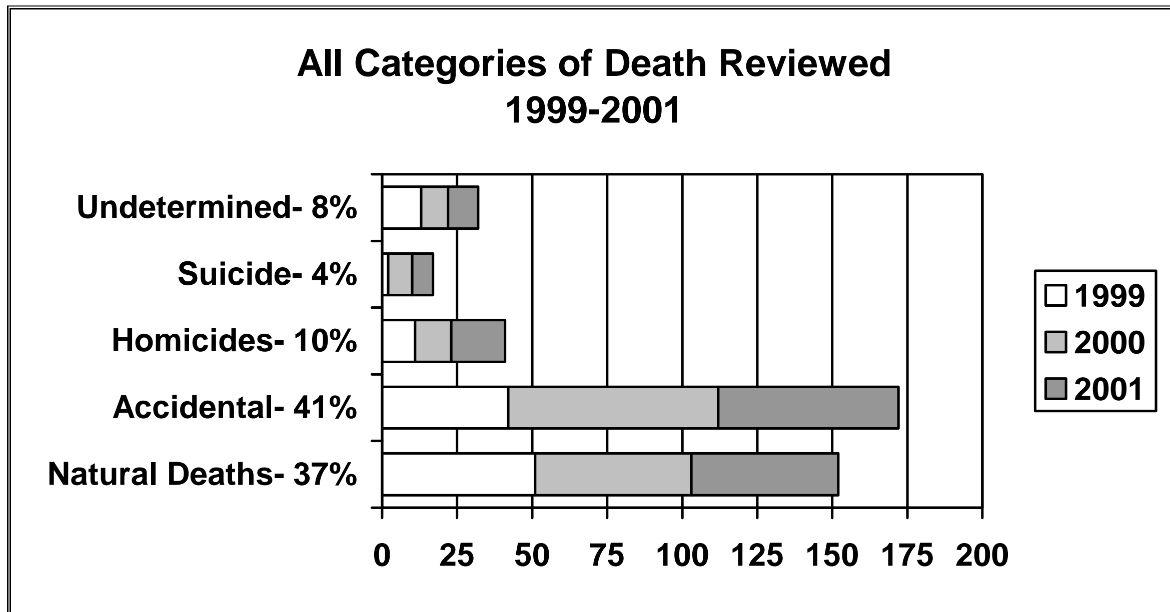

Figure 6

[5] Statistics from 1997 through 2001. U.S. Department of Health and Human Services, *Child Maltreatment 2001* (Washington DC: U.S. Govt. Printing Office, 2003).

Natural Deaths

At the nationwide level, the highest numbers of children die from natural death. These are cases where the child dies of natural disease mechanisms, which include Sudden Infant Death Syndrome (SIDS). In Nevada, during 1999, the category of Natural Death accounted for forty-three percent (43%) of all deaths reviewed, dropping to thirty-four percent (34%) for the years 2000 and 2001. Nationally, SIDS fatalities account for almost 2,500 infant deaths per year.[6] The number of diagnosed SIDS deaths in Nevada was sixteen (16) cases for 1999 and 2000, and in 2001, the number increased to eighteen (18) SIDS deaths.

The following charts (Figures 7-9) show the fatalities by sex, age and race statewide and by county. The most vulnerable age group appears to be in the newborn to eleven month grouping.

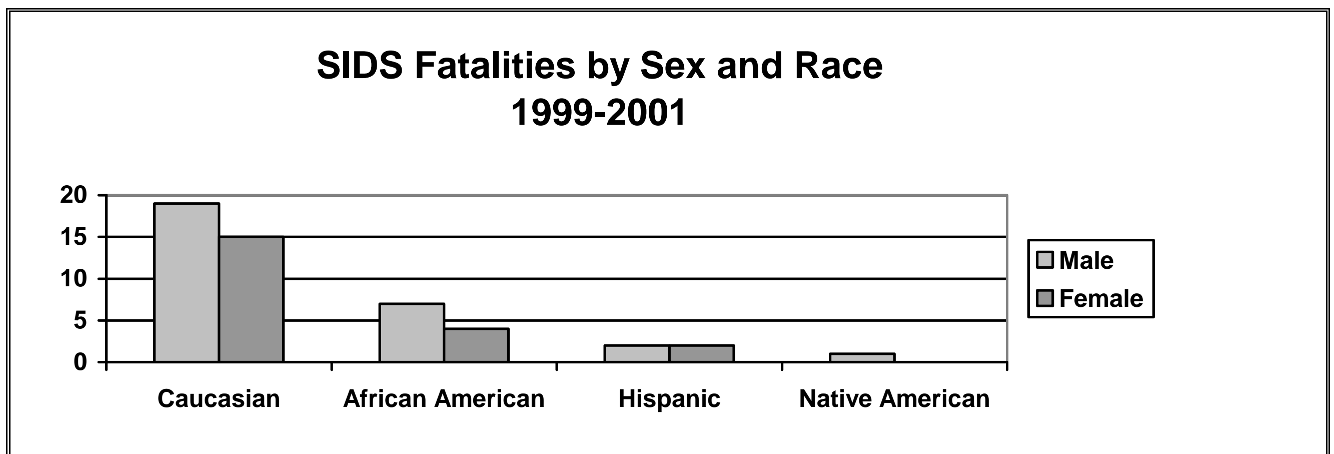

Figure 7

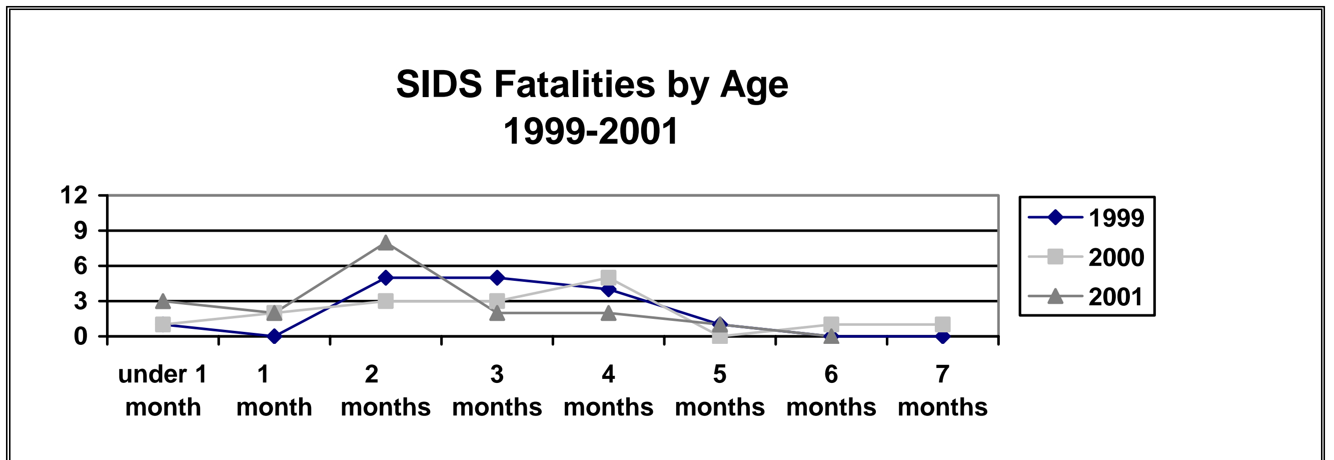

Figure 8

[6] Sudden Infant Death Syndrome Alliance, Webpage: info@sidsalliance,org

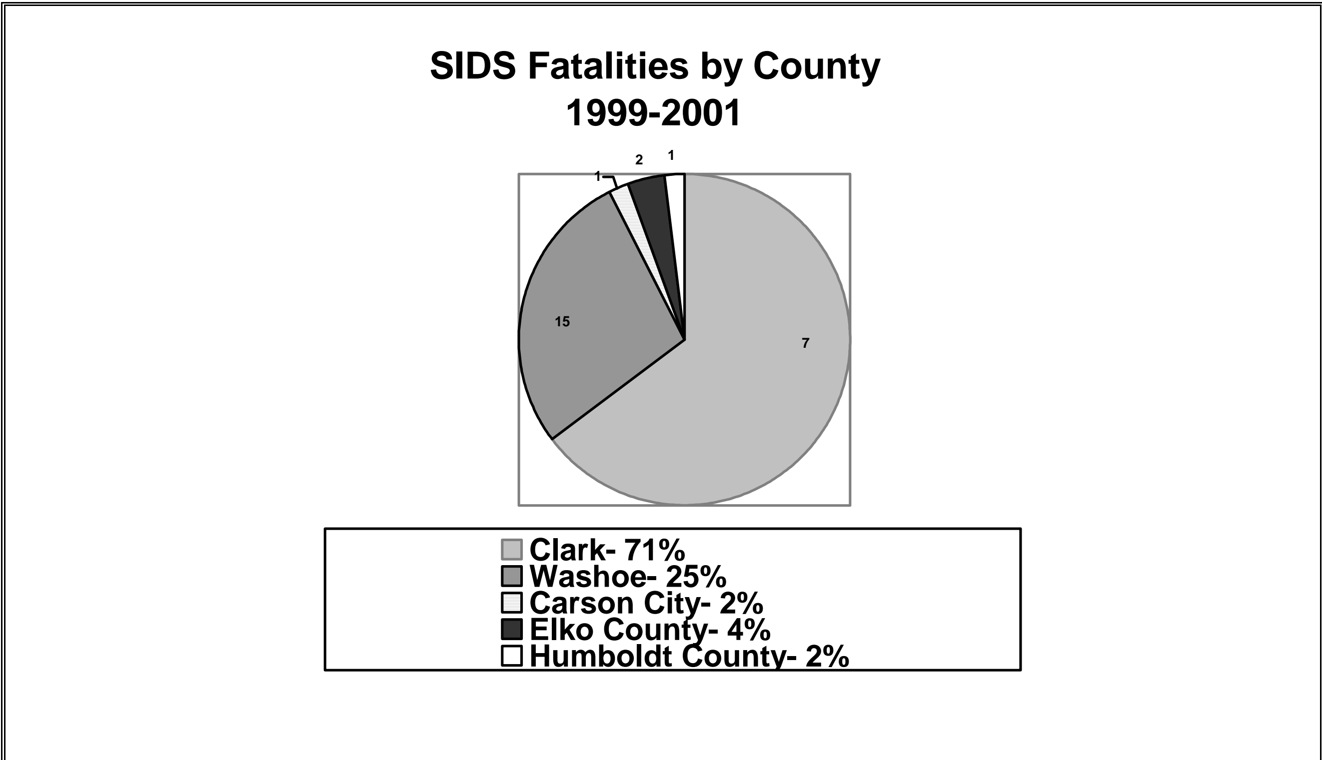

Figure 9

After the announcement of the "Back to Sleep" advisory (placing infants on their back for sleep) in 1992, the national rate of SIDS deaths has dropped nearly fifty percent (50%).

Accidental Deaths

Accidental child death raises concerns and questions about whether the death was preventable and whether any precautions were taken to avoid the death. Deaths in this category include drowning, motor vehicle accidents, deaths by asphyxia and other accidental means. Many accidental deaths may be preventable. For example, a small child drowning in a swimming pool - was there appropriate supervision at the time? How did the accident occur? Was the pool uncovered? Was there a gate around the pool? Questions like these are considered during the investigation and review of the child death.

In 1999, there were twenty-nine (29) accidental deaths reported in Clark County, six (6) in Washoe County, three (3) in Carson City, two (2) in Lyon County, one (1) in Douglas and Elko Counties for a total of forty-two (42) deaths. These types of deaths included drowning, motor vehicle accidents, death by asphyxia and by other accidental means. During 2000, there were thirty-nine (39) accidental deaths in Clark County, seven (7) in Washoe County, two (2) in Lyon County and one (1) each in Carson, Churchill, and two (2) in outlying counties, for a total of fifty (52) deaths. In 2001, this number was thirty-one (31) in Clark County, thirteen (13) in Washoe County, two (2) in Carson City, two (2) in Elko County, and one (1) in Douglas County, for a total of forty-nine (49) deaths.

These total numbers are represented in the following chart of accidental deaths for Nevada counties for the period of 1999-2001 (Figure 10).

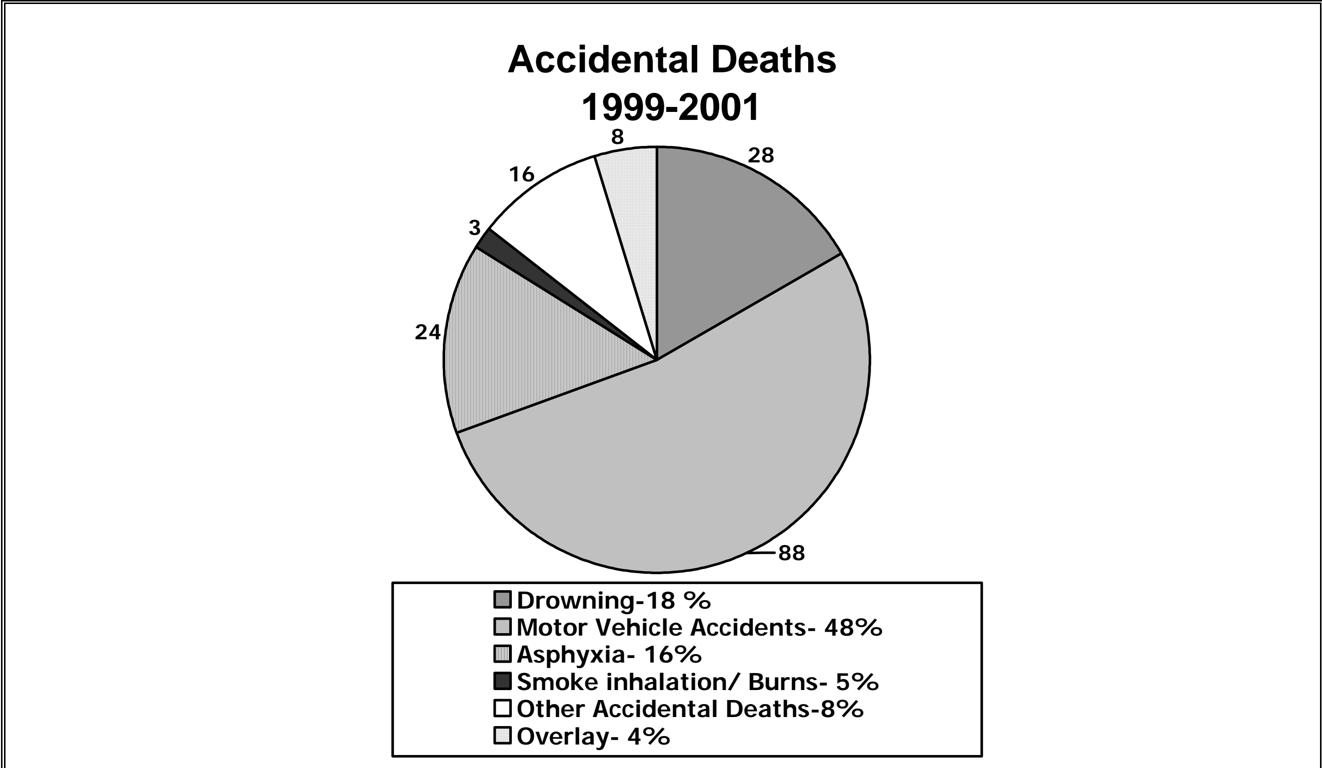

Figure 10

Historically, drowning has been the main cause of accidental deaths, but drowning deaths have dropped in frequency, with motor vehicle accidents responsible for the majority of accidental deaths. In the year 2000, out of seventy (70) accidental deaths reviewed, forty-seven (47) were due to motor vehicle accidents, either as passengers or as pedestrians. Figure 11 illustrates the breakdown of accidental deaths by category of accidental deaths. Many of these deaths are determined to be preventable.

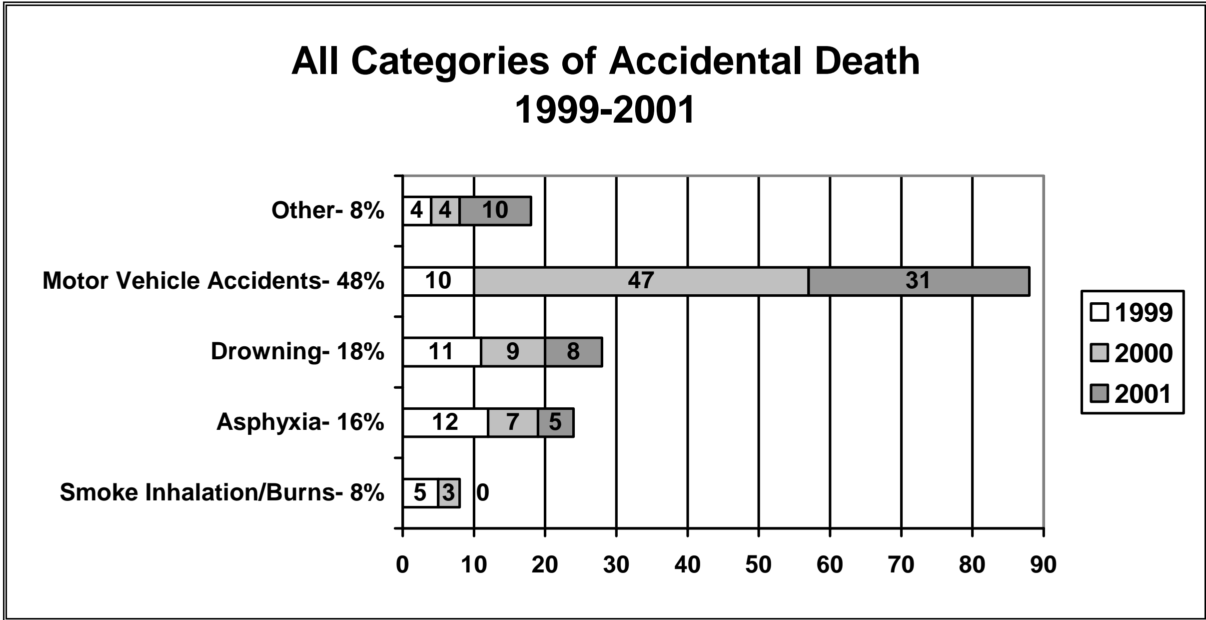

Figure 11

Homicides

A homicide occurs with the killing of one human by another. Most of the homicides reviewed during 1999 were due to Shaken Baby Syndrome or Battered Child Syndrome. During the year 2000, there were twelve (12) homicide deaths reviewed and seven (7) of these were gunshot wounds. The incidents surrounding these deaths were gang related and occurred in Clark County. There were eighteen (18) homicides reviewed by the Teams during 2001, seven (7) of these were due to maltreatment. Five (5) deaths were due to gang shootings, four (4) were shooting victims by unknown assailants, and the police shot one (1) child and a friend shot another.

Following is a chart (figure 12) of the number of homicides by Nevada counties.

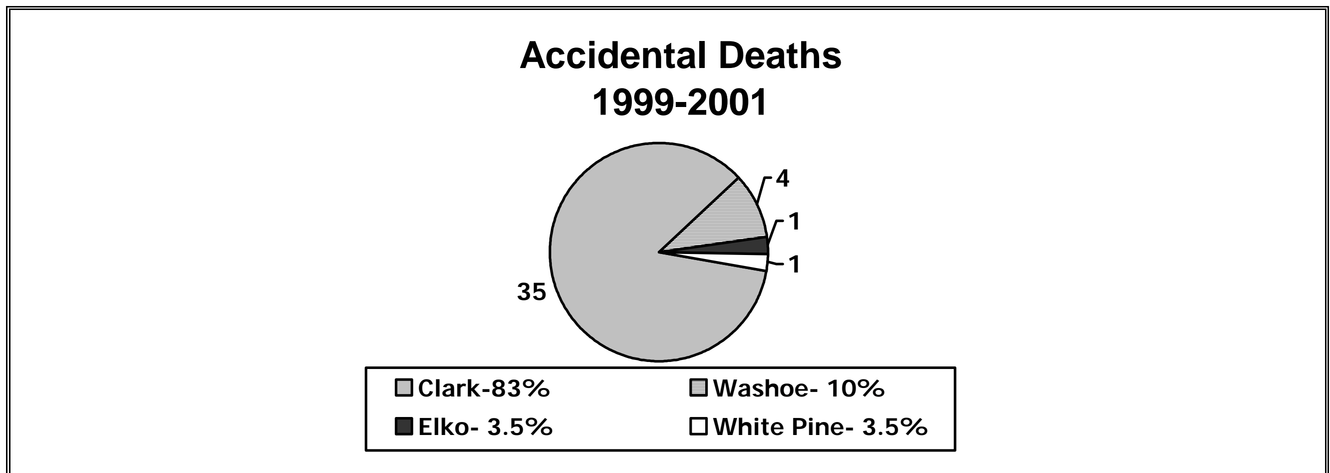

Figure 12

Suicides

A suicide is the act or an instance of taking one's own life voluntarily and intentionally. It is debated as to whether or not suicides are preventable deaths. Mental Health professionals believe that these types of death are preventable, because the right intervention may help.

During 1999, one suicide in Douglas County was reported. Eight (8) suicides were reviewed in the year 2000; seven of those were from Clark County.

The following chart shows Suicides by County (Figure 13).

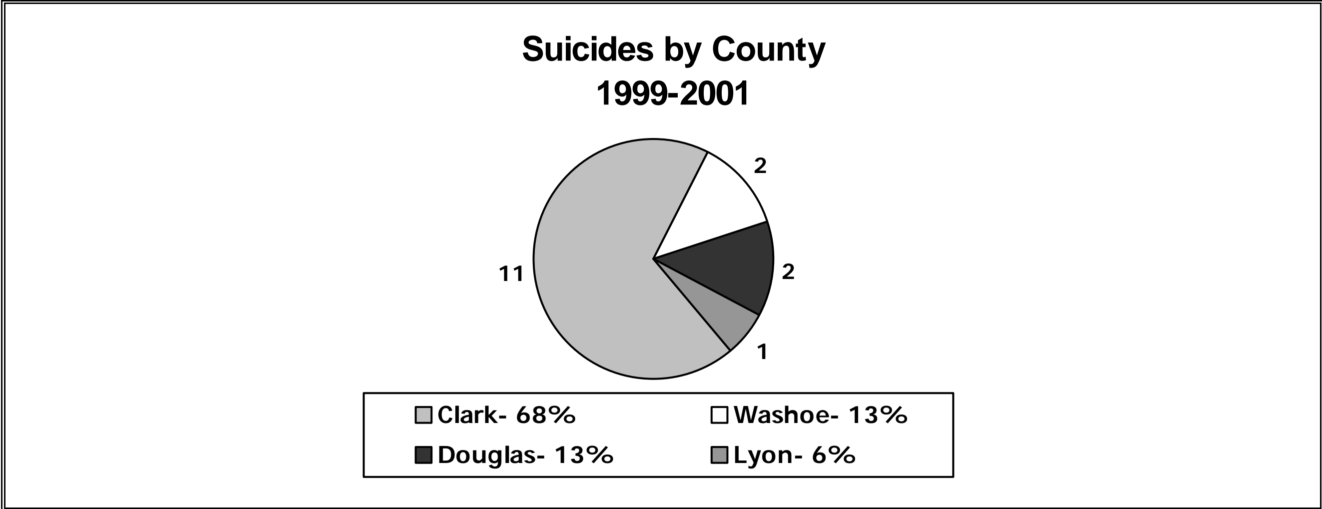

Figure 13

Undetermined

Undermined deaths are cases that involve deaths where the coroner is unable to determine a manner of death. There is not a clear indicator how the death was caused. These deaths are always reviewed by a Team.

Figure 14 shows Undetermined Deaths by county.

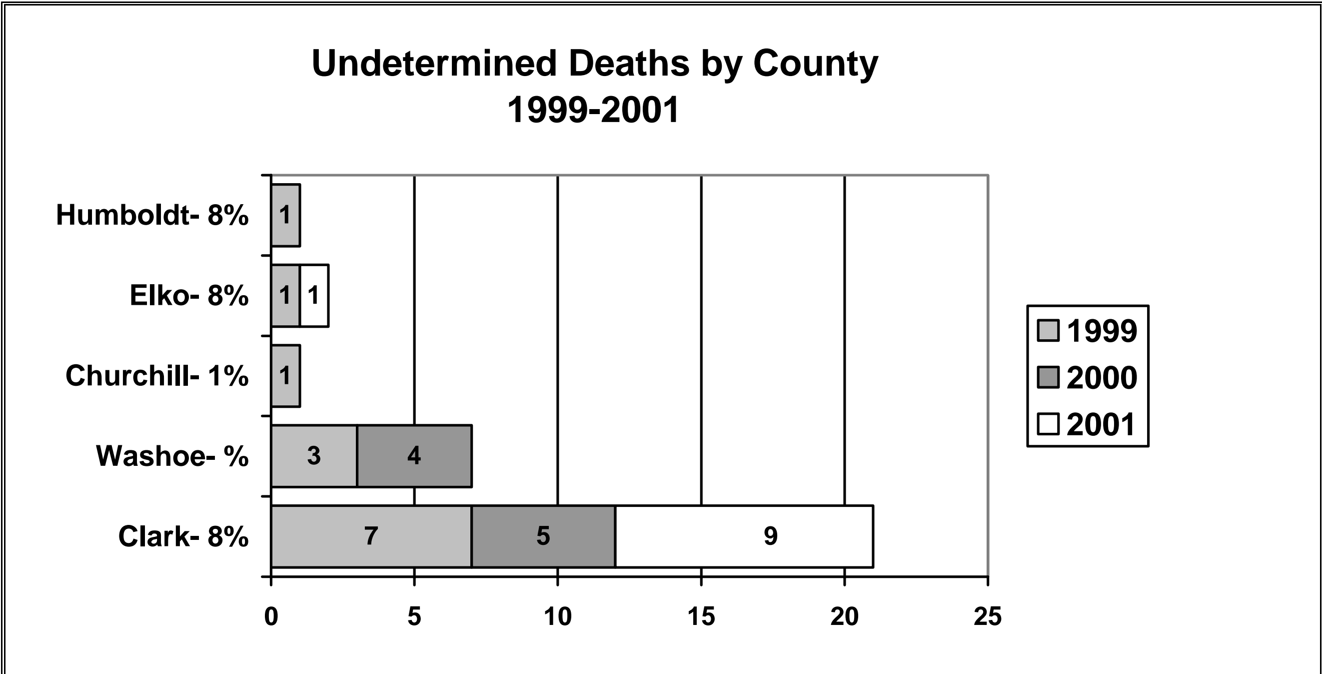

Figure 14

Preventability

The teams attempt to establish as a component of their review, whether the child fatality was preventable. The definition of preventable can be a philosophical issue and is a nationwide debate. However, in 2003, Nevada adopted the standard definition developed by the State of Colorado. Since the statistical information is used to prevent future child deaths, it is important to have a uniform standard for preventability criteria.

Statistical information collected on what cases are determined to be preventable can be used to educate the public and professional agencies. The data also identifies what are the risk factors that may cause a child's death along with recommendations for preventative measures.

The prevention of child maltreatment is very important in the prevention of other types of violence, such as child deaths due to neglect. Identifying children who are victims of maltreatment is a step toward prevention of possible child fatalities. Although child maltreatment is a reportable crime, the reported cases are only a small portion of the actual number. With statistical risks identified by the Teams, social programs and other forms of intervention may be put into place to prevent child maltreatment fatalities.

For the year 2000, it was determined that forty-eight percent (48%) of deaths reviewed were preventable, with another ten percent (10%) probably preventable. In following year (2001), fifty-five percent (55%) of the cases were deemed preventable, and another six percent (6%) were probably preventable.

The following chart is the Preventability of Child Deaths for the years 1999-2001, (Figure 15).

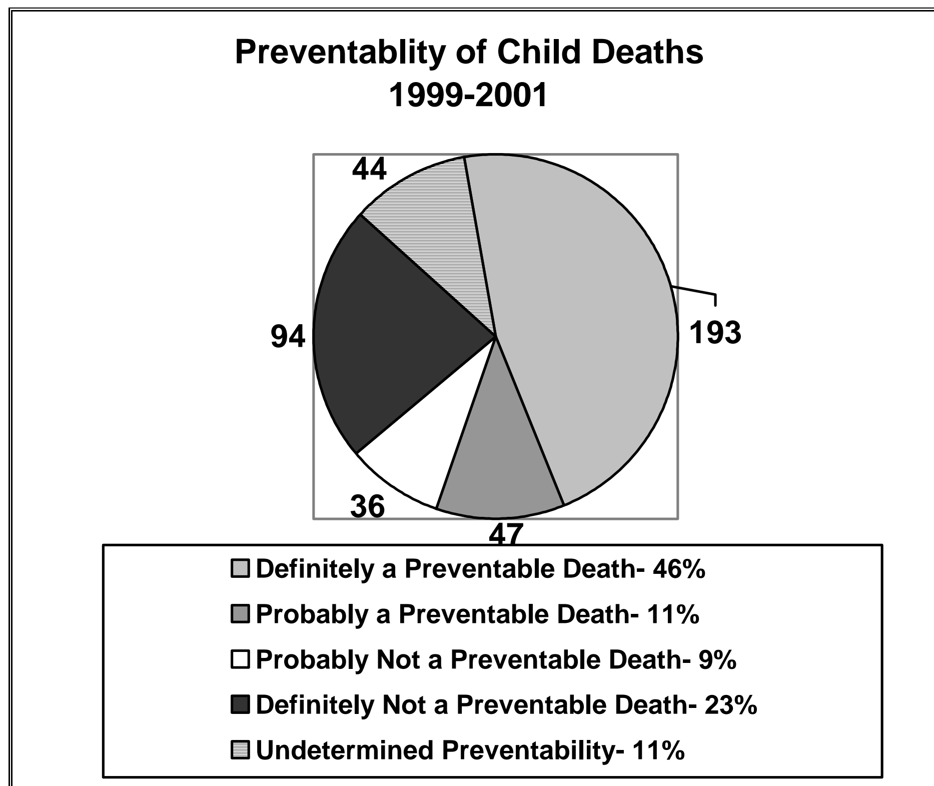

Figure 15

Recommendations

Listed are the recommendations that the State Child Death Review Subcommittee will attempt to address in the year 2002.

1. That the State Child Death Review Subcommittee makes recommendations for new laws relating to Child Death Reviews. The main goal of these new laws will be to mandate team participation and the availability of records. This will strengthen the review process and help eliminate a cursory paper review of child deaths that currently exists.

2. That a new improved data collection tool be implemented. This will ensure that all the local teams collect the same data that can be used to educate local agencies involved in the protection of children.

3. That a policies and procedure manual be written and distributed to the local teams.

4. That the State Child Death Review Subcommittee will submit a proposal to access grant funding through the University of Nevada, Las Vegas to initiate a Child Death Review research Project to develop a Uniform Child Death Review Curriculum.

5. That a training manual with a glossary of terms be created for the distribution to all local team members.

Case Reviews

To illustrate the cases reviewed by the teams, the following are actual case reviews from the combined years 1999-2001. Included are the cause of death, the category and some categories of preventability.

Natural Death

Actual Case Review:

Parents enter a hospital waiting room with a deceased two-year-old child and neither parent asks for help. Upon examining the child, staff found the child's body to be in an emancipated and dehydrated state. The family reports that she was vomiting and had diarrhea two days before and had been taken to a medical clinic. Upon investigation of the child's death, two siblings were removed from the home, due to the condition found in the home.

Cause of Death: Dehydration, electrolyte imbalance, pulmonary edema
Manner of Death: Natural

Actual Case Review:

A two-month-old infant was taken to the hospital and diagnosed with severe respiratory deficiency. The pregnancy was normal, and the infant had been born healthy. The parents learn to administer CPR and how to use an apnea-monitor on the infant. Several weeks after medical treatment, the child was put down for sleep. The infant was discovered on her stomach and was unresponsive. The mother had stopped using the monitor five days before the death. The autopsy was negative for trauma or any other diagnoses.

Cause of Death: Dehydration, electrolyte imbalance, pulmonary edema
Manner of Death: Natural
Preventability: Probably not Preventable

Actual Case Review:
A six month old infant is put to bed on his stomach and when checked later was unresponsive. The autopsy was negative

Cause of Death: SIDS
Manner of Death: Natural
Preventability: Probably Not Preventable

Accidental

Actual Case Review:

A family of five live in a trailer that catches on fire and the father awakens to the sound of a smoke detector. He grabs the baby and yells for his other three children (ages three, four and five) to get out of the trailer. The three children did not follow and the trailer was too hot to go back inside the trailer.

Cause of Death: Smoke Inhalation
Manner of Death: Accidental

Actual Case Review:

A two-year-old boy, while climbing on a rock formation, receives multiple traumatic injuries when the rocks slide and land on him. The main injuries occurred to his head and resulted in the child's death.

Cause of Death: Multiple Traumatic Injuries
Manner of Death: Accidental

Actual Case Review:

A 17-year-old male was at the lake with friends, drinking alcohol and using drugs. He attempted to swim to an island and became exhausted before reaching it.

Cause of Death: Drowned while swimming
Manner of Death: Accidental
Preventability: Preventable

Homicide

Actual Case Review:

A woman arrives at the hospital with vaginal bleeding and the hospital staff determines she has recently given birth. The maternal grandmother found the deceased infant in the daughter's home, in a bag within a box. The infant suffocated in the bag over a long period. The parents denied knowledge of the pregnancy, although the mother appeared to have delivered the infant while the father was sleeping.

Cause of Death: Asphyxiation
Manner of Death: Homicide

Actual Case Review:
A man shot and killed his wife and two daughters, ages one and three, then committed suicide during a police standoff.

Cause of Death: Gunshot wound to the head
Manner of Death: Homicide

Actual Case Review:

A father puts his 10-month-old daughter in a bathtub, turns the water on, and falls asleep. The mother arrives home several hours later and discovers the child still in the tub with the water on, and the father still asleep. The father tested positive for cocaine.

Cause of Death: Drowning
Manner of Death: Homicide
Preventability: Preventable

Suicide

Actual Case Review:

A sixteen-year-old girl shot herself under the chin with a rifle. She had been depressed since moving, three years earlier, to her present residence. The girl left a suicide note in her diary.

Cause of Death: Gunshot Wound to the Head
Manner of Death: Undetermined

Undetermined

Actual Case Review:

A 14-year-old girl was living with her grandmother due to conflicts with her mother. While arguing with her mother, she got her grandmother's gun and put the gun to her head. She thought the gun was unloaded and was it was concluded that she was attempting to scare her mother.

Cause of Death: Gunshot Wound to the Head
Manner of Death: Undetermined

Significant Findings

Co-Sleeping

These Nevada statistics (figure 16) show how many children were sleeping with someone at the time of their deaths. Only a small number of these deaths are attributed to the co-sleeping. A number of these deaths are ruled as SIDS deaths or Undetermined deaths. Most of these children are infants four-months old or younger, although there was a case of a six-month old child.

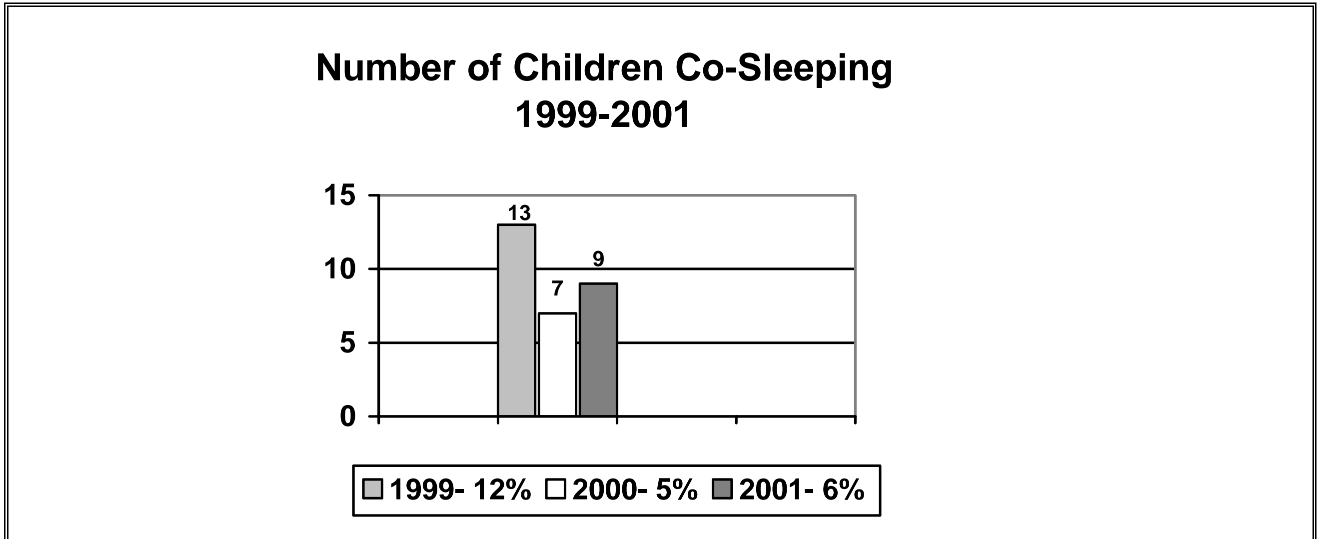

Figure 16

Gang Related Deaths

Clark County only reviewed children five years and younger in 1995. There are no statistics pertaining to gang related deaths for that year. Percentages are out of total deaths reviewed for the two years, 2000 and 2001 (figure 17).

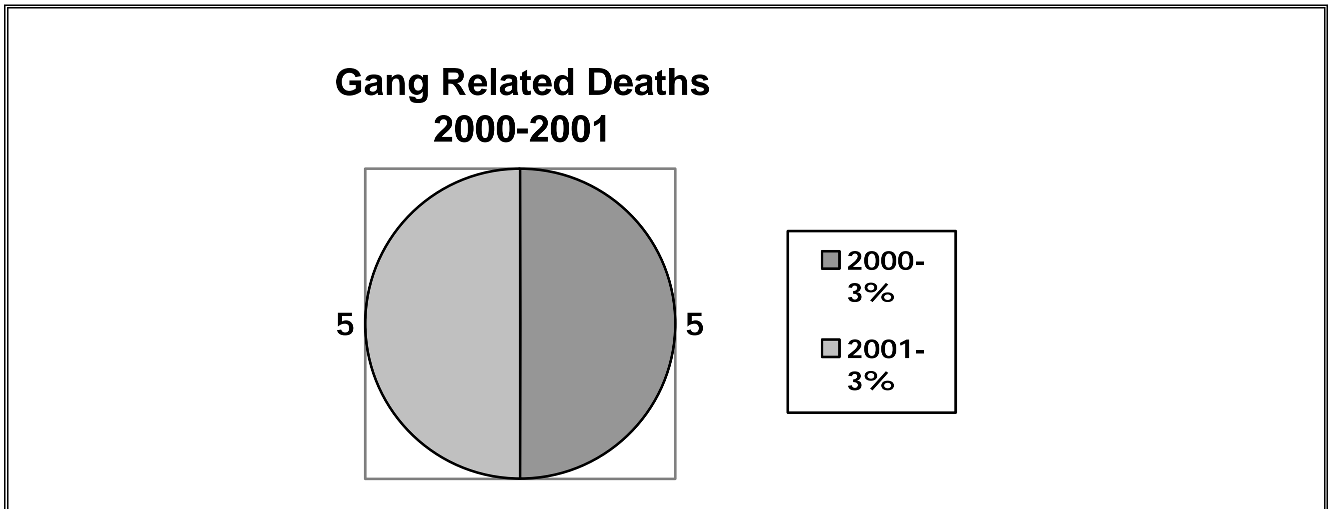

Figure 17

Unrestrained Teenage Drivers/Passengers

Clark County only reviewed children five years and younger in 1995. There are no statistics pertaining to unrestrained teenage drivers/passengers related deaths for that year. Percentages are out of total deaths reviewed for the two years, 2000 and 2001 (figure 18).

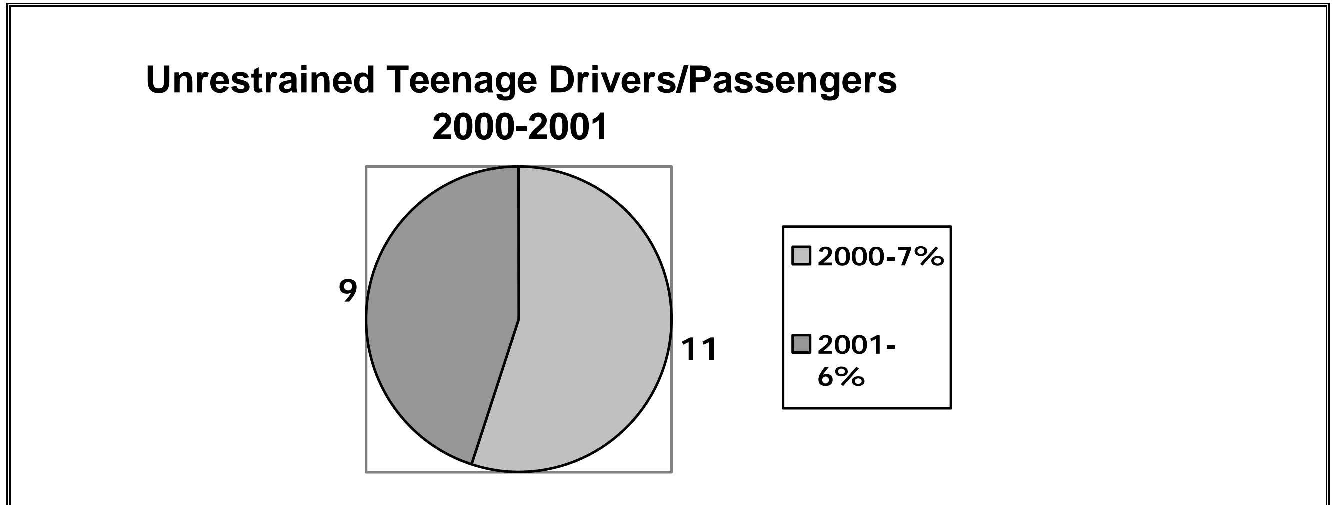

Figure 18

Nevada Statistical Information

The following tables (tables 1-3) give State of Nevada statistical information. Included is population by county, race estimates by county, and poverty estimates by county. All information is from the U.S. Census Bureau.

Additional Information

Tables 3-6: Review natural deaths as to cause for the years 1999-2001.

State of Nevada

Population by County

Years 1999, 2000, 2001

There are seventeen counties in the State of Nevada. Clark County is the largest populated county with approximately 69% of the total population. Washoe County follows with 17% of the State's population. The remaining 14% is distributed among the other fifteen counties, which are mostly rural.

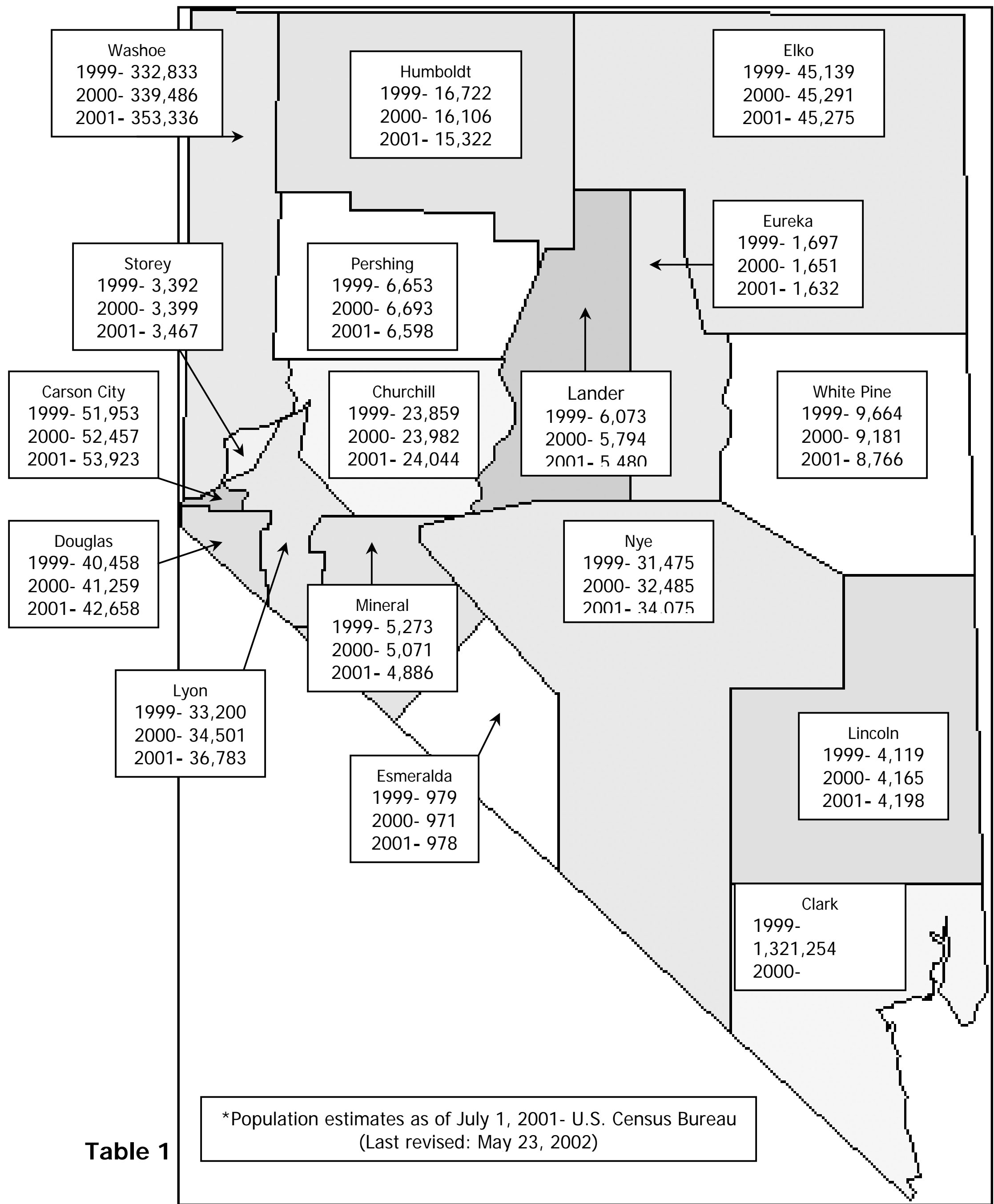

Table 1

Race Estimates Breakdown by County

State Breakdowns by Race Estimates 2000								
Geographic Area	Race							
County	White	Black/ African-American	Native American And Alaskan Native	Asian	Native Hawaiian and/or Pacific Islander	Other Race	Two or More Races	Hispanic or Latino any race
Churchill	20,192	383	1,146	649	54	73	785	2,076
Clark	984,796	124,885	10,895	72,547	6,412	118,465	57,765	302,143
Douglas	37,908	129	692	517	63	1,048	902	3,057
Elko	37,159	267	2,400	306	52	3,849	1,258	8,935
Esmeralda	796	1	50	0	2	74	48	99
Eureka	1,474	7	26	13	1	72	58	158
Humboldt	13,401	82	647	92	11	1,375	498	3,040
Lander	4,891	12	231	20	2	502	136	1,073
Lincoln	3,811	74	73	14	1	112	80	721
Lyon	30,576	225	844	210	47	1,585	1,014	3,784
Mineral	3,747	242	779	41	5	136	121	428
Nye	29,117	383	636	253	105	969	1,022	2,713
Pershing	5,200	358	229	42	15	628	221	1,294
Story	3,161	10	49	34	5	57	83	174
Washoe	272,985	7,093	6,162	14,526	1553	26,034	11,133	56,301
White Pine	7,928	380	302	72	22	284	193	1,008
Carson City	44,744	946	1,259	930	76	3,391	1,111	7,466

* Source: *U.S. Census Bureau, Census 2000 Redistricting Data Summary File*

Table 2

Natural Deaths

The following tables break down the causes of natural death for the years 1999-2001.

1999 Determined Causes of Natural Death	
Anoxic Encephalopathy	1
Cancer	1
Cerebral Palsy	2
Congenital Anomalies	1
Congenital Heart Defect	1
Congenital Malformation of the Brain	1
Congenital Myopathy	1
Dehydration- Electrolyte Imbalance	1
Intrauterine Asphyxia	2
Necrotizing Trachectis	1
Placental Hemorrhage	1
Pneumonia	4
Prematurity	2
Pulmonary Cerebral Edema	1
Rare Illness	1
Sepsis	5
Special Needs- Many Disabilities	1
Stillborn	2
Tycamin 4 q	1
Upper Respiratory Infection	2
Viral infection	3

2000 Determined Causes of Natural Death	
Anoxic Encephalopathy	1
Bronchopneumonia	4
Cardiac Arrhythmia	2
Dehydration and Electrolyte Imbalance	1
Hemorrhagic Pancreatitis- Diabetes	1
Heptocellular Carcenoma	1
Idioparthia Hypertrophic Cardiomyopathy	2
Intrauterine Asphyxia	2
Meningitis	3
Myocarditis	2
Pneumonia	4
Prematurity	5
Seizure Disorder	1
Septicemia	4
Unknown	1
Upper Respiratory Infection	1
Wolf-Hirsch Horn Syndrome	1

2001 Determined Causes of Natural Death	
Asthma	1
Astracytoma	1
Cerebral anoxia incident of asphyxia	1
Cerebral Palsey	1
Congenital Heart Defect	1
Dehydration	2
Escherichic coli meningoencephalitis	1
Hemothorax due to hemorrhage aorta	1
Hypoxic ischemic encephalopathy	1
Liver Disease	1
Lung Collapse	1
Other	4
Pneumonia	6
Prematurity	1
Ruptured Appendix /Peritonitis	1
Seizure Disorder	1
Sepsis	4
Sickle Cell	1
Stillborn	1

Table 3

APPENDIX

Child Death Review Team Members

Carson City Team

Abserasturi, Ruth
Carson City School District

Arndell, Sgt.
Lyon County Sheriff's Office

Bayer, Chris
CASA

Beseler, Ruth
Coroner's Office

Church, Pam
Carson City Sheriff's Office

Claassen, Sharon
Carson City District Attorney

Fabrizius, Vicki
Division of Child & Family Services

Hall, Rob
Lyon County Sheriff's Office

Molina, Kathy
Carson Tahoe Hospital

Numes, Norm
Carson City Coroner's Office

Pittsley, Alice
Division of Child & Family Services

Clark County Team

Anderson, Debbie
North Las Vegas Police

Campbell, Elena
Nellis Air Force Base

Cosgrove, Jeannie
Safe Kids Coalition

Courtney, Francis
Public Health

Cummings. Karen
Special Children's Clinic

Clark County Team – cont.

Eisen, Andrew M.D.
University of Nevada School of Medicine

Fanning, Maureen
Public Health

Flud, Ron
Coroner's Office

Hancock, Marion
Sunrise Hospital

Herndon, Doug
District Attorney's Office

Jones, Kari M.D.
Sunrise Hospital

Lipscomb, Diane M.D.
Sunrise Hospital

Magleby, Suzanne
Clark County Social Services

Martin, Jan
North Las Vegas Police

Monohan, Lt. Tom
LVMPD Homicide

New, Judy
Clark County Dept. of Family Services-CPS

Rader, Vicki
Clark County Dept. of Family Services - CPS

Sauchak, Cyndi
LVMPD Abuse/Neglect Unit

Schmidt, Edith M.D.
Sunrise Hospital

Scotello, Margaret M.D.
Sunrise Hospital

Sigdestad, Karin M.D.
Special Children's Clinic

Simms, Larry M.D.
Coroner's Office

Clark County Team – cont.

Worrell, Rexene
Coroner's Office

Zbiegien, Michael M.D.
Sunrise Hospital

Elko Team

Allison, Dave
Humboldt County District Attorney

Bauer, Bill
Carlin Police Department

Bowen, Jon
Division of Child & Family Services

Cavanaugh, Antionette
Elko County School District

Cline, Bill
Lander County Coroner

Dinwiddie, Kevin M.D.

Forgeron, Hy
Battle Mountain District Attorney

Griener, Gretchen

Harris, Neil
Elko County Sheriff

Hill, Gene
Humboldt County Sheriff's Office

Jonas, Ilene
Division of Child & Family Services

Morris, Clair
Elko Police Department

Power, Carrie
Public Health Nurse

Robb, Larry
Division of Child & Family Services

Elko Team – cont.

Schott-Bernius, Martha
HAPPY

Shirley, Jim
Pershing County District Attorney

Webb, Bill
Elko County Coroner

Woodbury, Gary
Elko District Attorney

Fallon Team

Churchill County:

Bowmer, Linda
Youth Parole Officer

Coke, Dolly
Fallon Mental Health

East, Ray
Fallon Paiute Law Enforcement

Ingram, Richard
Churchill County Sheriff's Office

Mallory, Art
District Attorney

McDonald, Arlene
Churchill Community Hospital

Phillips, Bob
Churchill School District

Richardson, James
Adult Parole & Probation

Richardson, Tami
Juvenile Probation

Shyne, Frank
Fallon Police Department

Smith, Russell
Churchill County District Attorney

Stadler, Shelly
Churchill Community Hospital

Fallon Team- cont.

Stuart, Jim
Churchill County Sheriff's Office

Syriac, Shelly
Churchill Community Hospital

Warner, Richard
Fallon Naval Criminal Investigative Services

Mineral County:

Baker, Clyde
Mineral High School

Bishop, Betty
Mineral County School District

Cook, Steve
Mineral County School Administrator

Emm, Cheri
Mineral County District Attorney

Farrall, Juanita
Mineral County Junior High School

Hagen, Steve
Juvenile Probation

Hoferer, Rob
Mineral County Sheriff's Department

Horton, Charlie
CAHS

Jackson, Joann
Family Resource center

Kollege, Jan
Mt. Grant General Hospital

Montoya, Julian
Mental Health Counselor

Munger, Richard
Mt. Grant General Hospital

Oberhansil, Sandy
Juvenile Probation Department

Richardson, James
Adult Parole & Probation

Schott, Susan
Family resource Center

Smith, Kristy
Mineral County High School

Torres, Connie
Public Health Nurse

Nye/Esmeralda County:

Cameron, Karen
WIC

Cobb, Debbie
UNCE

Ebeling, Corrie
Mental Health

Elgan, Kenneth
Esmeralda County Sheriff's Office

Ennis, Beth
Public Health Nurse

Floto, Barbar
Tonopah High School

Friel, John
Nye County District Attorney

Greber, Curly
Nye County Juvenile Probation

Howerton, Lynna
Silver Rim Elementary School

Jordan, Curtis
Esmeralda County School District

Kryder, Joy
Nye County Health & Human Services

McBride, Brent
Tonopah Middle and Elementary School

Phillips, Tony
Nye County Sheriff's Office

Scoccia, Vincent
Nye Regional Medical Center

Nye/Esmeralda County – cont.

Shaffer, William
Esmeralda County District Attorney

Walker, Kay
Nye County School District

Watts, Debbie
Round Mountain High School

Washoe County Team

Clark, Ellen M.D.
Washoe Medical Center

Druckman, Rebecca
Washoe County Deputy District Attorney

Evans, Doug
Reno Police Department

Frank, Barry
Washoe Medical Center

Fricke, Carolyn
Washoe County School District

Gavin, Art
Paramedic

Hayden, Kelly
Washoe County Sheriff's Office

Hunter, Candace
Washoe County Health Department

Kohls, Joanne
Washoe Medical Center

Lucier, Michelle
Washoe County Department of Social Services

March, Jeanne
Washoe County Department of Social Services

Mayeroff, Meredith
Washoe County Department of Social Services

McCarty, Vernon
Washoe County Coroner

McDonald, Bill
CASA

Miller, Tom
Sparks Police Department

Olsen, Alane
Washoe County Coroner's Office

Report written by Judy New, Coordinator
CJA Child Death Review Subcommittee

Edited by Kirsten Whitney and Marjorie Walker
Family Program's Office
Division of Child & Family Services