CHILD FATALITIES IN TENNESSEE 2006

Tennessee Department of Health
Bureau of Health Services
Maternal and Child Health Section

Phil Bredesen
Governor

Susan R. Cooper MSN, RN
Commissioner

Acknowledgements

The Tennessee Department of Health, Maternal and Child Health Section (MCH) dedicate this report in memory of the children and their families who are sadly represented in the content of these pages. Each child death represents a tragic loss for the family as well as the community.

This report is made possible due to the partnership and the professional assistance of The University of Tennessee Extension (UT) and the Tennessee Department of Health, Division of Health Statistics.

Analysis and evaluation of data prepared by:

The UT Extension Staff
Martha Keel, PhD
Courtney Niemann, MS
Phillip Woodard
Dallas Sacca
Joanne McGowan

The MCH Staff
Dr. Theodora Pinnock
Judith Baker, BSBM / EM
Rebecca Walls, RN, CCM
Kwame Bawuah, Epidemiologist
Barbara West, Administrative Secretary

This report is also made possible by the support and dedication of community professionals and leaders who serve on the local Child Fatality Review Teams (CFRT) throughout the State of Tennessee. They have committed themselves to gaining a better understanding of how and why children die. Their work is driven by a passion to promote, protect and improve the lives of children in Tennessee. We thank them for having the courage to use their professional expertise to work toward preventing future child deaths.

We extend our thanks to the State Child Fatality Prevention Team members. Their input and support has led to continued program improvements and prevention initiatives.

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The collaborative efforts of all of these individuals and their organizations ensure Tennessee children can look forward to a safer, healthier future.

For additional copies or questions concerning this report, contact:

Judith Baker
Child Fatality Review Program Director
Tennessee Department of Health
Maternal and Child Health
425 5th Avenue North
5th Floor Cordell Hull Building
Nashville, TN 37243
(615) 741-0368
Judith.Baker@state.tn.us

This report is also available on the Internet:
http://health.state.tn.us/MCH/CFR.htm

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Executive Summary

2006 Tennessee Child Fatality Review

This report includes information from the reviews of deaths that occurred in 2006. The local Child Fatality Review Teams (CFRT) reviewed children's deaths by Manner of Death and Cause of Death. During 2006, a total of 1,096 child deaths were reported from Tennessee Vital Statistics. Of these, 1,088 reviews were completed. This represents 99.27 percent of all 1,096 child deaths for 2006. Deaths that were not reviewed include cases still under investigation. CFRTs are active in all judicial districts, covering every county and metropolitan area in the State of Tennessee. Department of Health team leaders provided administration and coordination of the teams.

Key Findings

- African American children and boys died at disproportionately higher rates than white children and girls for most causes of death, especially in infants.
- Sixty-five percent (709) of the deaths reviewed were to infants less than 1 year of age. Of these deaths reviewed, four hundred and eighty-four (484) were premature infant deaths.
- Three percent (40) of the total deaths reviewed were from Sudden Infant Death Syndrome (SIDS). While the number of reviews for SIDS has decreased, the number of sleep-related deaths has increased. Sleep-related deaths accounted for 81 deaths (not including SIDS deaths) to infants less than 1 year old.
- In 2006, Memphis had the highest infant mortality rate in the state and nation. The 2006 rate in Memphis is 16.1, more than double the national rate of 6.3.
- Of the deaths reviewed, one hundred twenty-six (126) children died in a motor vehicle accident.

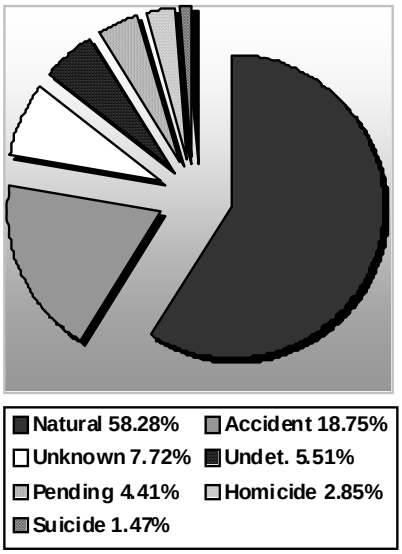
Table 1 - Counties with 15 or More Fatalities

County	Total
Shelby	271
Davidson	130
Hamilton	60
Knox	48
Montgomery	42
Rutherford	29
Washington	25
Sumner	22
Blount	19
Dickson	18
Madison	17
Maury	17
Sullivan	16
Bradley	16
Total	**730**

Table 2 - Manner of Death Summary

	Natural	Accident	Suicide	Homicide	Undetermined	Unknown	Pending	Missing	Total
Age									
<1	515	36	0	5	40	46	43	24	**709**
1-4	52	36	0	7	4	1	9	1	**110**
5-9	25	22	0	2	0	2	0	2	**53**
10-14	23	32	1	3	1	3	2	1	**66**
15-17	30	78	15	14	3	4	6	0	**150**
Race									
White	346	153	14	11	28	44	49	22	**667**
African American	286	46	2	20	20	11	10	7	**402**
Asian	9	3	0	0	0	1	0	1	**14**
Other	3	1	0	0	0	0	0	0	**4**
Unknown	1	0	0	0	0	0	1	0	**2**
Gender									
Male	342	119	16	22	28	37	35	15	**614**
Female	299	84	0	9	20	18	25	12	**467**
Unknown/Missing	4	1	0	0	0	1	0	1	**7**

Figure 1 - Manner of Death Summary



Manner of Death

Manner of Death is a classification of deaths based on the circumstances surrounding a cause of death and how the death occurred. The manner of death categories are natural, accident, homicide, suicide, pending, undetermined and unknown. For deaths being reviewed, the CFRTs reported the manner of death as indicated on the death certificates.

The overall rate of child fatalities as reviewed by the CFRTs was 75.42 per 100,000 in the population of children less than 17 years of age. Fatality rates identified in this report are based on population counts from the *Kids Count* report supplied by the Tennessee Department of Health Office of Policy Planning and Assessment, Division of Health Statistics (http://www.kidscount.org/cgi-bin/clicks.cgi.) For a Manner of Death summary, refer to Table 2 above.

Cause of Death

The CFR case report tool and data classifies causes of death by medical causes and external causes. Medical causes are further specified by particular disease entities. External causes are further specified by the nature of the injury. Of the 1,088 deaths reviewed by the CFRT in 2006:

- Fifty-nine percent (645) of the deaths reviewed were due to medical causes.
- Twenty-seven percent (299) of the deaths reviewed were due to external causes.
- Fourteen percent (144) cases were pending or unknown and could not be determined as a medical cause or external cause.

Table 3 - Cause of Death Summary

	Natural	Accident	Suicide	Homicide	Total
Age					
<1	621	63	0	5	**689**
1-4	57	43	0	7	**107**
5-9	27	23	0	2	**52**
10-14	30	33	1	3	**67**
15-17	34	86	15	14	**149**
Unknown	4	3	0	1	**8**
Race					
White	346	152	14	11	**523**
African American	286	44	2	20	**352**
Asian	9	3	0	0	**12**
Other	3	2	0	0	**5**
Unknown	2	0	0	1	**3**
Gender					
Male	419	117	16	22	**574**
Female	344	83	0	9	**436**
Unknown	4	0	0	1	**5**

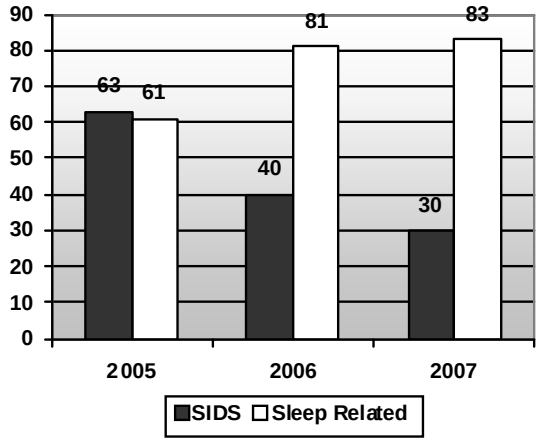
2008 State Child Fatality Prevention Team Recommendations

I. HIGH PRIORITIES

a. Infant Safe Sleeping - Develop and implement a statewide initiative surrounding safe sleep for infants. This initiative should include educational components on keeping cribs free of objects such as stuffed animals or toys, unsafe bedding, unsafe sleeping habits such as co-sleeping and close supervision of infants when placed in swings as follows:[1, 2,] For more information please refer to the "Infant Mortality" Section starting on Page 10

- A major, community based, public health campaign involving the media and public health service announcements.
- More education for parents thru the health departments' WIC program or thru advertisements.
- Education for daycare facilities and providers.
- Health education should be provided following delivery, prior to discharge from the hospital, and should include a discussion of proper sleeping arrangements for newborns.[3]
- Provide bassinets or cribs for families that cannot afford one. Enlist volunteer organizations and schedule a "Crib Day" to solicit old/used cribs to recycle and give to those in need of them.
- Increased effort to provide home visitations provided by HUGS and CHAD personnel.

Figure 2 - SIDS and Infant Sleep Related Deaths



b. Infant Mortality Prevention

- Encourage coordinated current and future state efforts in preventative substance abuse programs that mirror evidence based practices regarding families, pregnancies and children. Include a public educational awareness campaign that provides emphasis on tobacco, drug and alcohol use during pregnancy.
- Develop public awareness/educational campaign and encourage medical practitioners to conduct pre-conceptual counseling and promote pre-natal vitamin use to those of reproductive age.
- Increase efforts to reduce premature deliveries.
- Legislate and support funding for statewide evidence-based home visiting program for all mothers and babies discharged home from the hospital. Begin with a pilot program in Memphis.[4]

[1] 25 of the 31 Judicial Districts recommended action on initiatives to prevent sleep-related infant deaths
[2] Most sleep-related infant deaths occurred at 0-3 months of age
[3] According to TN Vital statistics, 42.7% of the infants that died in 2006 were a first-time birth to a first-time mom
[4] Shelby County had 163 infant deaths in 2005 and 199 in 2006. The city of Memphis has the highest infant mortality in the State and the country.

- Court-mandated Safe Haven Law and ongoing campaign to prevent child abuse.

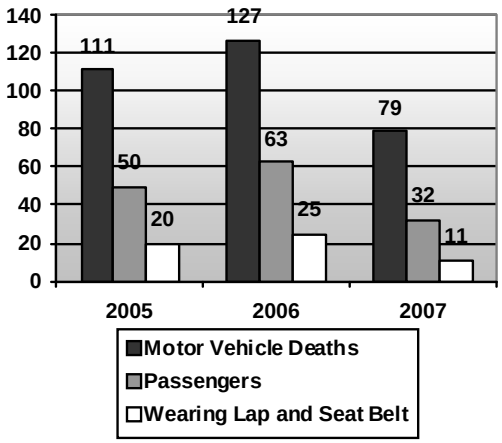
c. All Terrain Vehicles (ATV)[5] - Mandate a minimum age of operation for ATV use and mandate safety education at time of ATV purchase.

d. Motor Vehicles - **Graduated Drivers License -** Develop a media campaign to include public service announcements and parent educational material to increase the compliance with the State's Graduated Driver's License requirements.

e. Motor Vehicles – Seat Belts (see page 27)

- Increase awareness to prevent deaths from the lack of seat belt use.
- Promote public education of law requiring all vehicle occupants to use appropriate restraints and seating arrangements, including car seats for children.
- Make drivers responsible for passengers, bringing liability back to the original driver.

Figure 3 - Motor Vehicle Deaths



f. Motor Vehicles – Cell Phones and Electronic Devices[6] - Ban the use of cell phones, text messaging and the use of electronic devices for all drivers. Create a public awareness campaign and make this is primary infraction. Include an exemption for emergency and law enforcement vehicles.

g. Traffic Safety Awareness

- Health Departments distribute brochures concerning traffic safety to parents so that they may be better educated on traffic safety for their children. Include a media awareness campaign that targets affected parents.
- More attention should be put on vehicular homicide. Judicial District 1 reports 50% speed and/or alcohol use (50%) are contributing factors in the motor vehicle accidents.

h. Motorcycle Safety and Accident Prevention[7]

- Require mandatory safety classes prior to license issuance for motorcycles
- Increase the legal age requirement to operate a motorcycle.

i. Child Safety and Booster Seats

- Education should be provided to parents/public regarding the use of older car seats due to safety issues or manufacturers' recalls that may not be readily known/available on older models.
- Include booster seats for car seat programs at health departments across the state.

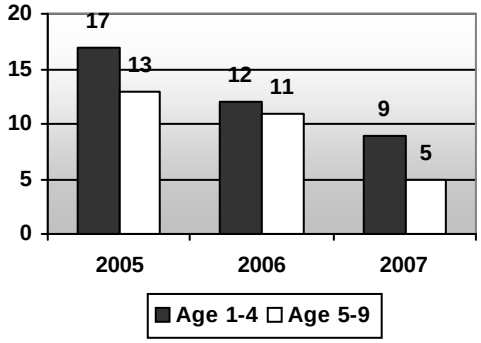
[5] ATV Deaths: 2005- 4; 2006– 8; 2007 - 5
[6] See Appendix F – Cell Phone Law Summary - "Cell Phone Law's in Other States"
[7] Motorcycle Deaths: 2005 – 3 drivers, 1 passenger; 2006 – 1 passenger; 2007 – 2 drivers

- Implement a public awareness campaign to include these recommendations from the American Academy of Pediatrics - **www.aap.org/advocacy/ncpsw.htm** as follows:

  - ✓ Children who have outgrown their car safety seats but are too small to wear seat belts properly should ride in booster seats.

  - ✓ Seat belts fit properly when they can be worn with the lap portion of the belt low and snug across the thighs, and the shoulder portion across the chest and shoulder without cutting across the face and neck while sitting against the vehicle seat back with feet comfortably hanging down.

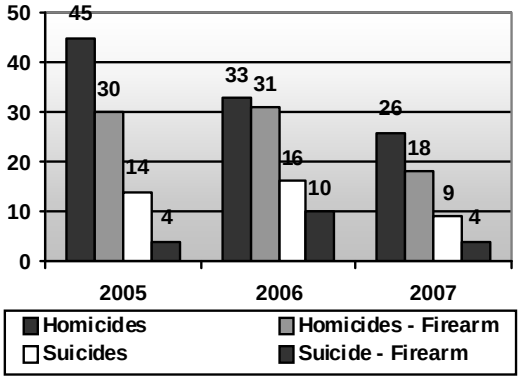
Figure 4 - Vehicle Deaths in Children Ages 1-9



j. Violence Prevention (see pages 19 and 27)

- Integrate violence prevention into the bullying legislation and include in middle and high school curriculum.
- Encourage continued efforts of state and local law enforcement agencies to have gun safety training for gun owners.
- Incorporate an awareness training program into existing school resources, focusing on of how to recognize guns and report guns. Initiate a toll-free number for anonymous reporting in schools.

Figure 5 - Violence and Suicides



k. Suicides (see page 20)

- Suicides have increased by 14.3%.
- Identify resources to increase suicide prevention programs.
- Continue to promote and support the Tennessee Suicide Prevention Network as they implement the youth training initiative "Tennessee Lives Count."
- Identify resources to provide counseling for children of recently divorced parents and include in parenting plans.

l. Fire Safety and Prevention (see page 28) – Develop a campaign to stress the importance of education regarding proper use and maintenance of smoke detectors. Raise awareness during the fall and winter months. Target a specific audience that uses wood stoves, space heaters and kerosene heaters. Include initiatives for volunteer fire departments in rural areas.

II. LOW PRIORITIES

a. Childhood Obesity - Continue to find and support efforts to prevent morbid obesity as a factor in childhood deaths.[8]

b. Bicycle Helmets - Increase the publics' awareness of the bicycle helmet law.

c. Birth Certificate Accuracy - Research current practice of how hospital personnel look into a mother's medical history and consult with the OB/GYN to gather accurate information for birth certificates. Birth certificates are not being completed accurately without this information.

III. OTHER

a. Traffic Safety - The local child review teams wish to commend the Department of Transportation as it is currently initiating the State of Tennessee Strategic Highway Safety Plan. http://www.tdot.state.tn.us/incident/TNStrategicHwyplan07.pdf The main objective is to "reduce the fatality rate by 10 percent by the end of CY 2008, based on CY 2002 data. It is projected this will result in saving 127 lives in CY 2008" by defining "a system, organization, and process for managing the attributes of the road, the driver, and the vehicle to achieve the highest level of highway safety by integrating the work of disciplines and agencies involved;" and "improve intersection safety." The teams would like to recommend that funding continue for this initiative.

The Local Child Fatality Review Teams wish to:

- Thank the legislature for their previous efforts toward safer ATV use.
- Recommend continued education of first responders and law enforcement officials regarding the performance of death scene investigations on all unexplained child fatalities. Recommend that investigators take pictures at death scene.

Note: All 2007 Child Death Review cases **have not** been entered into the National Child Death Case Reporting Database therefore, the data disclosed for 2007 is a preliminary count of what has been entered as of Sep 08 and is not a complete representation of the 2007 review year.

[8] 43% of TN children are overweight or at risk (*Kids Count*); U.S Childhood obesity tripled in the last 30 years; 70% of overweight adolescents will become obese adults; increased incidence of adult diseases occurring in children and adolescents

Tennessee Child Fatality Review Process

Child deaths are often regarded as indicators of the health of a community. While mortality data provide us with an overall picture of child deaths by number and cause, it is from a careful study of each and every child's death that we can learn how best to respond to a death and how best to prevent future deaths.

Mission

The mission of the Child Fatality Review (CFR) Program is to review deaths in order to:

- Promote understanding of the causes of childhood deaths.
- Identify deficiencies in the delivery of services to children and families by public agencies.
- Make and carry out recommendations that will prevent future childhood deaths.

State Child Fatality Prevention Team

The State Child Fatality Prevention Team (see Appendix A) is composed of elected officials, commissioners, and other policy makers in the State of Tennessee as described in T.C.A. 68-142-103 (see Appendix C). This team reviews the reports from the local teams, analyzes statistics of the incidence and causes of child deaths, and makes recommendations to the Governor and General Assembly to promote the safety and well being of children. Tennessee is part of a national movement to identify why children are dying and what preventive measures can be taken. Members of the state team include:

- Department of Health Commissioner, team chairperson
- Attorney General
- Department of Children's Services Commissioner
- Tennessee Bureau of Investigation Director
- Physician (nominated by Tennessee Medical Association)
- Physician credentialed in forensic pathology
- Department of Mental Health and Mental Retardation Commissioner
- Judiciary member nominated by the Supreme Court Chief Justice
- Tennessee Commission on Children and Youth chairperson
- Two members of the Senate
- Two members of the House of Representatives

Local Child Fatality Review Teams

The Child Fatality Review and Prevention Act of 1995 (T.C.A. 68-142-101-109 – see Appendix C) established a statewide network of child fatality review teams in the Judicial Districts of Tennessee (see Appendix B). The judicial districts cover all 95 counties of the State. Fourteen team leaders provide the administration and coordination of the teams. These mutli-discipline, multi-agency local teams have been established in each Judicial District. Team leaders are from Regional and Metropolitan Health offices across the State. The teams review all deaths of children seventeen years of age or younger and make recommendations to the Child Fatality Prevention Team (State team) for reduction and prevention of child deaths statewide. Their careful review process results in a thorough description of the factors related to child deaths. Members of the local teams include:

- Department of Health Regional Health Officer
- Department of Children's Services Social Services Supervisor
- Medical examiner
- Prosecuting attorney appointed by the District Attorney General
- Local law enforcement officer
- Mental health professional
- Pediatrician or family practice physician
- Emergency medical services provider or firefighter
- Juvenile court representative
- Representatives of other community agencies serving children:

Case Reporting Database

Tennessee uses a new case reporting tool and data system developed by the National Center for Child Death Review (CDR). The new tool captures more information about the factors related to the death. This report is based on data entirely from the CDR system. The comprehensive nature of the new case report tool and the functionality of the data system have allowed a more complete analysis of all childhood deaths.

The CFR Process

The State-level Prevention Team reviews the recommendations from the local CFRT's. These findings are ranked in the order of High, Medium, and Low and are incorporated into the Annual Child Fatalities in Tennessee report. The Annual Child Fatalities in Tennessee report is then presented to the Legislature for their consideration to make recommendations in law, policy and practice to prevent child deaths in Tennessee; and to make improvements in protocols and procedures (see Figure 6 on page 9).

The CFR data included in this report represent thoughtful inquiry and discussion by a multi-disciplinary group of community leaders who consider all the circumstances surrounding the death of each child. They bring to the review table information from a variety of agencies, documents and areas of expertise. Their careful review process results in a thorough description of the factors related to child deaths.

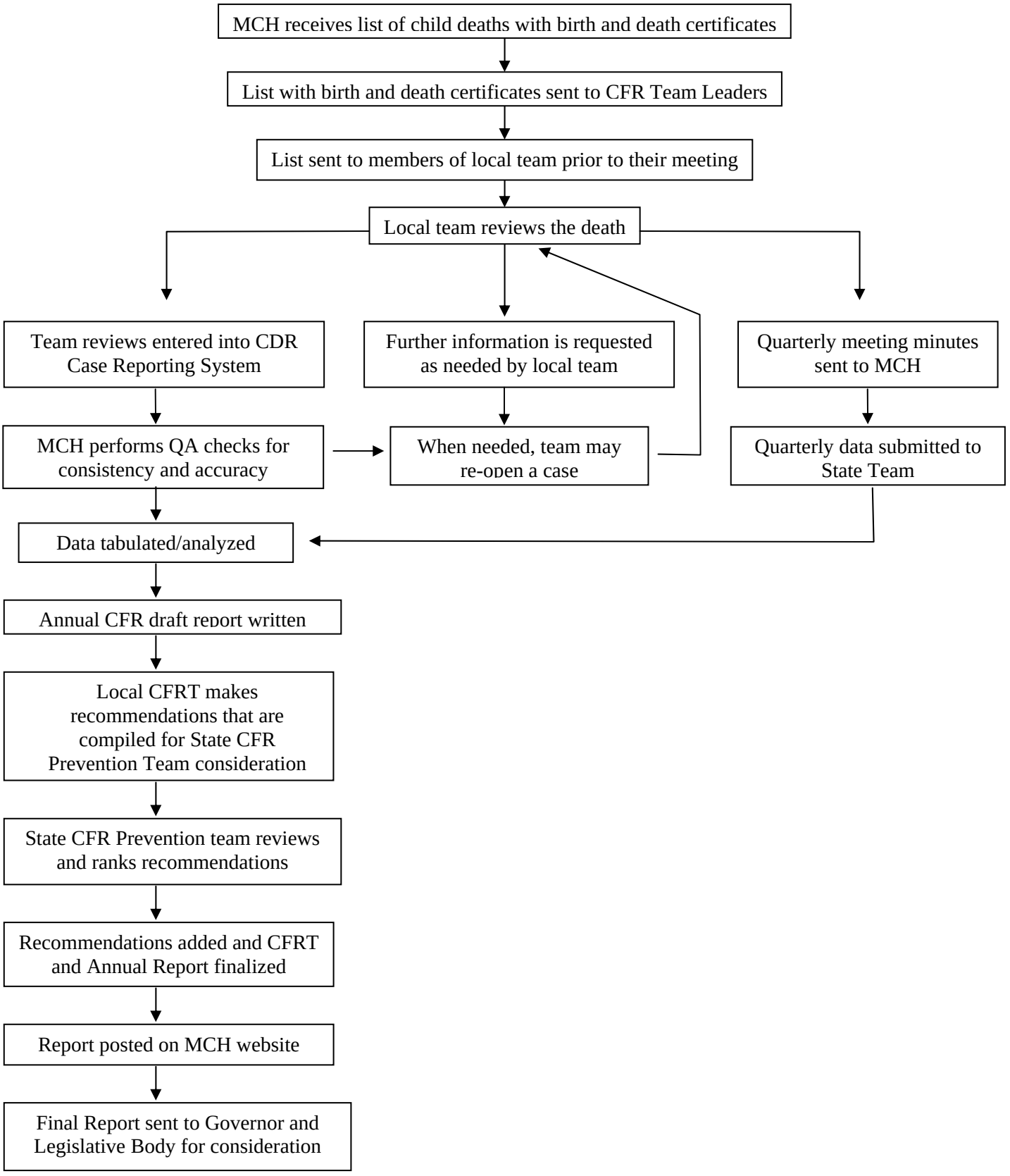
In spite of their best efforts, CFRTs are not able to review every child death. Some reviews must be delayed until all legal investigations, autopsies or prosecutions are completed. Some deaths occur outside the county of residence, resulting in long delays in notification for the CFRT. Because of these variables, it is usually impossible to find an exact number-for-number match between CFR data and data from other sources such as vital statistics. The unique role of CFR data is to provide a comprehensive depth of understanding to augment other, more one-dimensional data sources.

Conclusion

The CFR process has raised the collective awareness of all participants and has led to a clearer understanding of agency responsibilities and possibilities for collaboration on all efforts addressing child health and safety. It is only through continued collaborative work that we can hope to protect the health and lives of our children.

CFR Process Flow Chart

Figure 6 - CFR Process Flow Chart



Analysis of Prevention

Since the establishment of a Child Fatality Review Program, numerous recommendations have been made for prevention of future deaths. The CFRTs' conclusions regarding the preventability are included in Table 4. A child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death. Of the 2006 deaths the CFRTs reviewed, the determination for preventability is:

- 641 - Deaths were determined that they probably could not have been prevented
- 246 - Deaths were determined that they probably could have been prevented
- 95 - Preventability could not be determined
- 114 - Preventability is unknown

Table 4 - Preventability

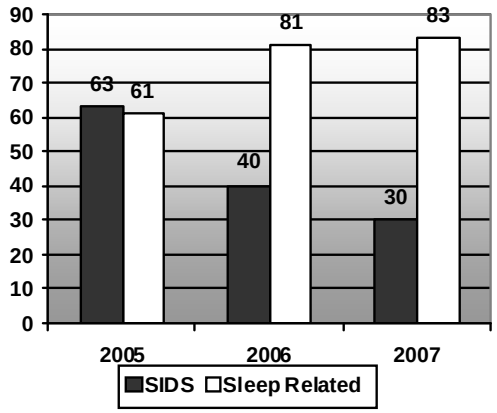
	No, Probably	Yes, Probably	Could Not Determine	Unknown	Total
Natural	558	10	34	51	**653**
Accident	11	156	7	33	**207**
Suicide	0	10	4	2	**16**
Homicide	0	29	0	4	**33**
Undetermined	7	11	26	5	**49**
Pending	10	28	14	8	**60**
Unknown	55	2	10	11	**78**
Total	**641**	**246**	**95**	**114**	**1096**

Infant Mortality

Sudden Infant Death Syndrome (SIDS)

In 2006, there were 40 deaths that were reported as Sudden Infant Death Syndrome (SIDS) and an additional 81 infant deaths from an unsafe sleep environment (see Figure 7).

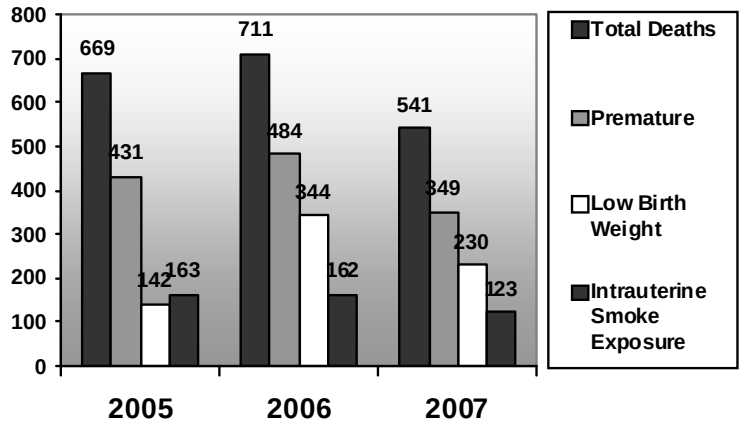
Figure 7 - SIDS and Infant Sleep Related Deaths



- The 40 SIDS deaths represent 5.20% of deaths due to medical conditions and 3.68% of all childhood deaths in 2006.
- Of all fatalities due to SIDS, 28 (70.00%) occurred from birth through 4 months of age, yet the most frequently occurring age of death was 2 to 3 months.
- SIDS deaths decreased 36.51% from 2005
- Non-SIDS infant deaths occurring in the sleep environment have increased 32.78% from 2005 to 2006.
- Preliminary 2007 data of non-SIDS infant deaths occurring in the sleep environment have already exceeded both 2005 and 2006 with a total of 83 infant deaths (2.46% increase).
- There were 26 infant deaths in the sleep environment from asphyxia (see page 27).

Summary of Infant Deaths and SIDS

Figure 8 - Summary of Infant Deaths Reviewed



SIDS is defined as sudden death of an infant less than one year old, which remains unexplained after a thorough investigation, complete autopsy, examination of the death scene, and review of medical history (excluding suffocation-related).

In October 2005 the American Academy of Pediatrics recognized nationwide inconsistencies in the diagnosis of sudden, unexpected infant deaths. Deaths with similar circumstances have been diagnosed as SIDS, accidental suffocation, positional asphyxia or as undetermined deaths.

Because SIDS is a diagnosis of exclusion, all other probable causes of death mus
t be eliminated through autopsy, death scene investigation and health history. Incomplete investigations, ambiguous findings and the presence of known risk factors for other causes of deaths result in many sudden infant deaths being diagnosed as “undetermined cause” rather than SIDS.

Infant Manner of Death

Table 5 - Infant Manner of Death Information							
	Natural	Accident	Homicide	Undetermined	Pending	Unknown	Total[9]
Deaths Reviewed	515	36	5	40	43	4	**709**
Premature (<37 weeks)	394	12	2	8	11	57	**484**
Low birth weight (<2500 grams)	289	8	1	8	5	33	**344**
Intrauterine Smoke Exposure	99	12	2	14	21	14	**162**
Intrauterine Alcohol Eposure	2	0	0	0	0	0	**2**
Intrauterine Drug Exposure	13	1	0	3	4	2	**23**
Late (>6 wks) or No Penatal Care	43	3	1	0	1	5	**53**

Infant Primary Cause of Death

Table 6 - Sleep Related Deaths by Death Certificate Primary Cause[10]						
	SIDS	Asphyxia	Medical Condition[11]	Undetermined[12]	All Other Cases	Total
0-1 Month	6	11	6	5	6	**34**
2-3 Months	11	12	5	7	3	**38**
4-5 Months	5	5	4	2	2	**18**
6-7 Months	1	3	0	0	0	**4**
8-11 Months	1	0	5	0	2	**8**
1-4 Years	0	1	3	2	2	**8**
5 Years & up	0	0	0	0	0	**0**
Unknown	0	0	0	0	0	**0**
Total	**24**	**32**	**23**	**16**	**15**	**110**

[9] Columns do not add up to total deaths because the factors are not mutually exclusive
[10] Columns do not add up to total deaths because the factors are not mutually exclusive
[11] Medical condition included unknown medical causes
[12] Undetermined included undetermined deaths from both medical and injury causes. All other causes include deaths from other unknown causes

Circumstances in Infant Sleep Environment Deaths

Table 7 - Contributing factors in Infant Sleep Environment Deaths	2005	2006	2007
Infant not in a crib or bassinette	54	69	67
Infant sleeping with other people	45	60	49
Infant not sleeping on back	30	38	38
Unsafe bedding or toys in sleep area with infant	13	18	14
Obese adult sleeping with infant	3	9	6
Adult drug impaired sleeping with infant	0	2	2
Adult alcohol impaired sleeping with infant	1	2	1
Adult fell asleep bottle feeding	0	0	2
Adult fell asleep breast feeding	0	0	1

Table 8 - Circumstances of Sleep-Related Deaths[13]						
Age in Months	**0-1**	**2-3**	**4-5**	**6-7**	**8-11**	**Total**
Infant unobstructed by person or object	6	7	2	1	0	**16**
Infant on top of person	0	0	0	0	0	**0**
Infant on top of object	0	0	0	0	0	**0**
Infant under person	1	1	0	0	0	**2**
Infant under object	2	0	0	0	0	**2**
Infant between person[14]	5	1	0	0	0	**6**
Infant between object	0	0	1	0	0	**2**
Infant wedged	2	2	0	0	0	**4**
Infant pressed	2	3	0	0	0	**5**
Infant fell or rolled onto object	0	1	1	2	0	**4**
Infant tangled in object	1	0	0	0	0	**2**
Other	3	1	3	1	1	**9**
Unknown	14	23	11	0	7	**55**
Total	**36**	**39**	**18**	**4**	**8**	**107**

[13] Columns do not add up to total deaths because the factors are not mutually exclusive
[14] Under and between objects includes animals

Infant Deaths by Month and Infant Sleep Environment Risk Factors

Although the cause and mechanism of SIDS remains unknown, several risk factors appear to put an infant at a higher risk for SIDS.

Figure 9 - Infant Deaths By Month

Month	2005	2006
January	64	52
February	58	47
March	66	70
April	61	51
May	55	47
June	54	67
July	63	55
August	52	58
September	53	53
October	43	67
November	58	60
December	72	83
TOTAL	**699**	**710**

- Infants who sleep on their stomachs are more likely to die of SIDS than those who sleep on their backs
- Infants whose mothers smoked during pregnancy and who are exposed to passive smoking after birth
- Soft sleep surfaces, waterbeds, sofas, armchairs excessive loose bedding and bed sharing increase the risk of sleep-related deaths
- Bed sharing is more common in African-American mothers
- Multiple bed sharers increase the risk
- The National Infant Sleep Position study reported that teenage African-American mothers are 4 times more likely to routinely bed-share than white mothers
- African-American infants who die from SIDS or sudden unexpected infant death are more likely to have shared a sleep surface
- Infants that are exposed to tobacco smoke from one or both parents
- When the bed-sharer has consumed alcohol
- When the bed-sharer is overly tired
- When there are items in the sleep area that the infant can sink into or may fall on the infant such as stuffed animals, toys, bumper pads and heavy blankets
- Where there is a pet in the sleep environment with the infant

Infants need a safe sleep area. Prevention tips on how to create one include:

- Infants should sleep on a firm mattress covered with only a tight-fitting crib sheet
- Using a wearable blanket or other type sleeper instead of blankets increases an infants safety during sleep
- Soft or pillow-like bumpers, wedges and positioners should never be used in an infant's sleep area.
- Always place infants on their back for sleep
- Make sure an infant has a safe place to sleep when visiting or traveling

Table 9 - Infant Deaths by County					
County	**2005**	**2006**	**County**	**2005**	**2006**
Anderson	5	10	**Knox**	36	**34**
Bedford	12	2	**Lewis**	2	**0**
Benton	3	2	**Lincoln**	0	**3**
Bledsoe	0	2	**Loudon**	3	**3**
Blount	3	8	**Macon**	3	**2**
Bradley	7	10	**Madison**	24	**13**
Campbell	5	2	**Marion**	5	**3**
Cannon	2	0	**Marshall**	1	**9**
Carroll	4	6	**Maury**	4	**11**
Carter	8	3	**McMinn**	6	**1**
Cheatham	5	3	**McNairy**	1	**2**
Chester	2	1	**Meigs**	2	**0**
Claiborne	2	3	**Monroe**	6	**5**
Clay	1	0	**Montgomery**	17	**28**
Cocke	4	3	**Moore**	0	**0**
Coffee	10	4	**Morgan**	2	**1**
Crockett	2	0	**Obion**	3	**4**
Cumberland	6	2	**Overton**	1	**3**
Davidson	73	91	**Perry**	0	**0**
Decatur	2	1	**Pickett**	1	**0**
DeKalb	0	0	**Polk**	2	**0**
Dickson	6	8	**Putnam**	9	**3**
Dyer	4	7	**Rhea**	6	**4**
Fayette	2	1	**Roane**	0	**3**
Fentress	3	1	**Robertson**	6	**4**
Franklin	3	2	**Rutherford**	22	**19**
Gibson	2	5	**Scott**	2	**6**
Giles	2	1	**Sequatchie**	3	**1**
Grainger	1	1	**Sevier**	8	**4**
Greene	7	4	**Shelby**	163	**199**
Grundy	1	1	**Smith**	2	**3**
Hamblen	4	6	**Stewart**	3	**0**
Hamilton	36	47	**Sullivan**	20	**9**
Hancock	1	0	**Sumner**	10	**15**
Hardeman	7	2	**Tipton**	7	**4**
Hardin	1	4	**Trousdale**	1	**0**
Hawkins	2	4	**Unicoi**	1	**2**
Haywood	6	1	**Union**	1	**0**
Henderson	1	3	**VanBuren**	0	**1**
Henry	4	3	**Warren**	4	**6**
Hickman	2	5	**Washington**	12	**12**
Houston	1	0	**Wayne**	1	**1**
Humphreys	1	0	**Weakley**	0	**3**
Jackson	0	0	**White**	4	**0**
Jefferson	3	5	**Williamson**	7	**6**
Johnson	3	1	**Wilson**	12	**7**
Missing	**5**	**0**	**TOTAL**	**699**	**710**

Manner of Death

Manner of Death is a classification of deaths based on the circumstances surrounding a cause of death and how the death occurred. The five manner of death categories used in this report are natural, accident, homicide, suicide, pending, undetermined and unknown. For deaths being reviewed the CFRT report the manner of death as indicated on the death certificate. The Cause of death is discussed on page 23.

The manner of death for 1088 child fatalities in 2006, determined by the CFRT to be natural causes for 59.28% (645); accidental causes for 18.75% (204); homicide for 2.85% (31); suicide for 1.47% (16); undetermined for 4.41% (48); and pending/unknown causes for 13.24% (144) (Table 10).

Table 10 - Manner of Death

Manner of Death	Number	Percent	Rate[15]
Natural	645	59.28	44.71
Accident	204	18.75	14.14
Suicide	16	1.47	1.11
Homicide	31	2.85	2.15
Pending	60	4.41	3.33
Undetermined	48	5.51	4.16
Unknown	84	7.72	5.82
Total	**1088**	**100.00**	**75.42**

The overall rate of child fatalities as reviewed by the CFRT was 75.42 per 100,000 in the population of children less than 18 years of age. Fatality rates identified in this report are based on population counts from the *Kids Count* report supplied by the Tennessee Department of Health Office of Policy Planning and Assessment, Division of Health Statistics (http://www.kidscount.org/cgi-bin/clicks.cgi).

Manner of Death and Age

Across all groups the most fatalities in 2006 occurred during the first year of life with 709 (65.17%) deaths. The second highest fatality rate occurred in youth aged 15-17 with 150 deaths (13.79%) and the third highest was in the 1-4 years of age with 110 (10.10%), (Table 11).

Table 11 - Number of Fatalities by Manner of Death and Age

Age	Natural	Accident	Homicide	Suicide	Undet.	Unknown	Pending	Missing	Total	Percent[16]
<1	515	36	5	0	40	46	43	24	709	65.17
1-4	52	36	7	0	4	1	9	1	110	10.10
5-9	25	22	2	0	0	2	0	2	53	4.87
10-14	23	32	3	1	1	3	2	1	66	6.07
15-17	30	78	14	15	3	4	6	0	150	13.79
Total	**645**	**204**	**31**	**16**	**48**	**56**	**60**	**28**	**1088**	**100**

[15] Rates based on TN population per 100,000 less than 18 years of age
[16] Percent of all 2006 reviewed child deaths

Manner of Death and Sex

In 2006, 42.92% of child fatalities were female and 56.43% were male, a figure that corresponded to rates of 66.28 for females and 83.20 for males. The largest number of deaths for both sexes was by natural manner (Table 12).

Table 12 - Manner of Death and Sex[17]

Manner	Female			Male			Missing			Unknown		
	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate
Natural	299	27.48	42.44	342	31.43	46.34	3	0.28	0.21	1	0.09	**0.07**
Accidental	84	7.72	11.92	119	10.94	16.12	1	0.09	0.07	0	0	**0**
Homicide	9	0.83	1.28	22	2.02	2.98	0	0	0	0	0	**0**
Suicide	0	0	0	16	1.47	2.17	0	0	0	0	0	**0**
Undetermined	20	1.84	2.84	28	2.57	3.79	0	0	0	0	0	**0**
Unknown	18	1.65	2.55	37	3.40	5.01	1	0.09	0.07	0	0	**0**
Pending	25	2.30	3.55	35	3.22	4.74	0	0	0	0	0	**0**
Missing	12	1.10	1.70	15	1.38	2.03	1	0.09	0.07	0	0	**0**
Total	**467**	**42.92**	**66.28**	**614**	**56.43**	**83.20**	**6**	**0.55**	**0.42**	**1**	**0.09**	**0.07**

Manner of Death and Race

Natural was the highest category of death for all races (645 or 59.17%). The total number of natural fatalities for White children was 346 (32.08%), for African-American children 286 (26.29%), for Asian children 9 (.83%) and 3 (0.28%) natural deaths attributed to Other. One natural death (0.09%) was categorized as Unknown (Table 13).

Table 13 - Manner of Death and Race

Manner	White		African American		Asian		Other		Unknown		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Natural	346	32.08	286	26.29	9	0.83	3	0.28	1	0.09	645	**59.17**
Accident	153	14.06	46	4.23	3	0.28	1	0.09	0	0	204	**18.72**
Homicide	11	1.01	20	1.84	0	0	0	0	0	0	31	**2.84**
Suicide	14	1.29	2	0.18	0	0	0	0	0	0	16	**1.47**
Undetermined	28	2.57	20	1.84	0	0	0	0	0	0	48	**4.40**
Unknown	44	4.04	11	1.01	1	0.09	0	0	0	0	56	**5.14**
Pending	49	4.50	10	0.92	0	0	0	0	1	0.09	60	**5.51**
Missing	22	2.02	7	0.64	1	0.09	0	0	0	0	30	**2.75**
Total	670	61.57	402	36.95	14	1.29	4	0.37	2	0.18	1090[18]	100.00

[17] Rates based on TN population specific (males/females) per 100,000 less than 18 years of age.
[18] Totals exceed total deaths due to multi-racial reporting

Manner of Death and Ethnicity

Natural was the highest category of death for all ethnicities (645). The total number of natural fatalities for Hispanic children was 40, for Non-Hispanic children 574. Seven (7) natural deaths were categorized as Unknown (Table 14). There were 24 cases with missing ethnicity data.

Table 14 - Manner of Death and Ethnicity

Manner	Ethnicity				Total[19]
	Hispanic	Non-Hispanic	Unknown	Missing	
Natural	40	574	7	24	645
Accident	13	184	0	7	204
Suicide	0	16	0	0	16
Homicide	3	27	0	1	31
Undetermined	4	43	0	1	48
Pending	5	53	1	1	60
Unknown	3	51	1	1	56
Missing	1	27	0	0	28
Total	**69**	**975**	**9**	**35**	**1088**

Manner of Death by Age, Sex and Race

In 2006, the highest rate of fatalities occurred to those in the first year of life with a fatality rate of 890.74. Males suffered a higher rate of mortalities (83.20) than their female counterparts. African-Americans were at a significantly higher risk than other racial groups, with a fatality rate at 129.92. Asians had the third highest fatality rate at 66.18 (Table 15).

Table 15 - Child Deaths by Age, Sex and Race[20]

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	709	890.74	Female	467	66.28	White	663	64.97
1-4	110	34.61	Male	614	83.20	African-American	397	129.92
5-9	53	13.64	Unknown	7	5.15	Native Hawaiian	0	0
10-14	66	16.43				Pacific Islander	3	509.34
15-17	150	59.01				Asian	13	66.18
						American Indian	0	0
						Native Alaskan	0	0
						Multi-Racial	7	26.49
						Unknown	5	0.35
Total	**1088**	**75.42**	**Total**	**1088**	**75.42**	**Total**	**1088**	**75.42**

[19] Rates based on TN population per 100,000 less than 18 years of age
[20] Rates based on TN specific populations per 100,000 less than 18 years of age

Manner of Death Violence Related

In 2006, there were 47 child fatalities due to violence-related injuries. These injuries were the result of either homicide (31, Table 17) or suicide (16, Table 18). This represents 4.32% of all child fatalities.

Children in the 15-17 years age group had the highest rate of violence-related fatalities (11.41 per 100,000), followed by children one to four years of age (2.20 per 100,000). Males (5.15 per 100,000) were more likely than females (1.28 per 100,000) to die from violence-related injuries. African-American children had a higher rate of violence-related deaths at 7.20 per 100,000 and White children had the rate of 2.45 per 100,000 (Table 16).

Table 16 - Violence-Related Fatalities by Age, Sex and Race[21]

Age			Sex			Race		
	Number	**Rate**		**Number**	**Rate**		**Number**	**Rate**
<1	5	6.22	Female	9	1.28	White	25	2.45
1-4	7	2.20	Male	38	5.15	African-American	22	7.20
5-9	2	0.51				Asian	0	0
10-14	4	1.00				Other	0	0
15-17	29	11.41				Unknown	0	0
Total	**47**	**3.26**	**Total**	**47**	**3.26**	**Total**	**47**	**3.26**

Manner of Death Violence Related Homicide

In 2006, there were 31 child fatalities due to homicide. This represents 65.96% of all violence-related deaths and 2.85% of all child fatalities. It is a decrease of 62.36% from 2005[22]. Males (22; 2.98 per 100,000) were more likely than females (9; 1.28 per 100,000) to die from homicides. African-American children (20; 6.55 per 100,000) died at a higher number than other races followed by White children (11; 1.08 per 100,000). Children ages 15-17 (14; 5.51 per 100,000) and one to four years of age (7; 2.20 per 100,000) had a higher rate of death by homicide (Table 17).

Table 17 - Homicide Fatalities by Age, Sex and Race[23]

Age			**Sex**			**Race**		
	Number	**Rate**		**Number**	**Rate**		**Number**	**Rate**
<1	5	6.22	Female	9	1.28	White	11	1.08
1-4	7	2.20	Male	22	2.98	African-American	20	6.55
5-9	2	0.51				Asian	0	0
10-14	3	0.75				Other	0	0
15-17	14	5.51				Unknown	0	0
Total	**31**	**2.15**	**Total**	**31**	**2.15**	**Total**	**31**	**2.15**

[21] Rates based on TN specific populations per 100,000 less than 18 years of age
[22] Note: There were 42 homicides in 2005
[23] Rates based on TN specific population per 100,000 less than 18 years of age

Manner of Death Violence Related Suicide

During 2006, 16 young people committed suicide. This was an increase in the numbers of suicides by 14.3%[24] from 2005. Most of these deaths were by children in the 15-17 age group (15; 5.9 per 100,000) and/or Male (16; 2.98 per 100,000). Fourteen White children (1.37 per 100,000) and two African-American children (0.65 per 100,000) died as a result of suicide (Table 18).

Table 18 - Suicide Fatalities by Age, Sex and Race[25]

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	0	0	Female	0	0	White	14	1.37
1-4	0	0	Male	16	2.98	African-American	2	.65
5-9	0	0				Asian	0	0
10-14	1	0.25				Other	0	0
15-17	15	5.9				Unknown	0	0
Total	**16**	**1.11**	**Total**	**16**	**1.11**	**Total**	**16**	**1.11**

Manner of Death by County with 15 or More Fatalities
Of the 1088 deaths in Tennessee:

- 730 (67.10%) of all child fatalities occurred in 14 counties with 15 or more deaths each (Table 19).
- Shelby County had the highest percentage of all childhood fatalities (271; 24.91%), followed by Davidson (130; 11.95%), Hamilton (60; 5.51%) and Knox (48; 3.86%) Dickson County had the highest rate of death at 147.52.
- The highly populated counties of Shelby and Davidson reported a total of 401 fatalities and accounted for 36.86% of all child fatalities.
- For a list containing the data of all 95 counties, please refer to Table 20.

Table 19 - Ranking of Counties with 15 or More Fatalities

County	Total	Percent	Rate[26]	Rank
Shelby	271	24.91	105.37	1
Davidson	130	11.95	100.43	2
Hamilton	60	5.51	85.83	4
Knox	48	4.41	54.26	3
Montgomery	42	3.86	103.15	7
Rutherford	29	2.67	53.67	5
Washington	25	2.30	104.29	13
Sumner	22	2.02	59.24	8
Blount	19	1.75	74.96	11
Dickson	18	1.65	147.52	27
Madison	17	1.56	69.46	12
Maury	17	1.56	89.33	15
Sullivan	16	1.47	47.70	9
Bradley	16	1.47	71.99	14
Total	**730**	**67.10**	**50.60**	

[24] There were 14 suicides in 2005
[25] Rates based on TN population per 100,000 less than 18 years of age
[26] Rates based on TN specific population per 100,000 less than 18 years of age.

Manner of Death by All Counties

Table 20 - Manner of Death for All Counties										
County	Natural	Accident	Homicide	Suicide	Pending	Undet.	Unknown	Missing	Total	Rate[27]
Anderson	9	3	0	0	0	1	0	0	13	79.24
Bedford	2	2	0	1	0	1	0	0	6	53.79
Benton	0	1	0	0	1	0	1	0	3	82.55
Bledsoe	1	0	0	0	0	0	1	0	2	66.07
Blount	**7**	**9**	**1**	**0**	**0**	**2**	**0**	**0**	**19**	**74.96**
Bradley	**10**	**1**	**0**	**0**	**2**	**0**	**3**	**0**	**16**	**71.99**
Campbell	2	3	0	0	0	0	0	0	5	55.06
Cannon	0	0	0	0	0	0	0	0	0	0
Carroll	2	2	0	0	0	2	2	0	8	116.87
Carter	4	1	0	0	2	0	0	0	7	56.83
Cheatham	2	2	0	0	1	0	0	0	5	46.69
Chester	1	0	0	0	0	0	0	0	1	23.75
Claiborne	4	1	0	0	0	0	0	0	5	71.65
Clay	0	0	0	0	0	0	0	0	0	0
Cocke	3	1	0	0	1	0	0	0	5	63.62
Coffee	5	3	0	1	0	0	0	1	10	80.76
Crockett	1	0	0	0	0	0	1	0	2	51.56
Cumberland	1	2	1	0	1	1	0	1	7	67.35
Davidson	**93**	**16**	**5**	**1**	**0**	**10**	**5**	**0**	**130**	**99.69**
Decatur	2	2	0	0	0	0	0	0	4	93.59
Dekalb	0	0	0	0	0	0	1	0	1	39.34
Dickson	**8**	**5**	**0**	**0**	**4**	**0**	**0**	**1**	**18**	**147.52**
Dyer	2	2	0	0	1	1	3	1	10	102.48
Fayette	1	1	0	0	0	0	0	0	2	26.49
Fentress	1	1	0	0	0	0	0	0	2	49.35
Franklin	0	0	0	0	0	1	2	0	3	31.87
Gibson	3	2	0	0	0	0	1	1	7	58.35
Giles	2	0	0	0	1	0	0	1	4	55.59
Grainger	1	1	0	0	0	0	0	0	2	39.57
Greene	1	2	0	0	2	0	1	0	6	40.94
Grundy	1	0	0	0	0	0	1	0	2	54.04
Hamblen	4	1	0	0	2	0	2	1	10	70.51
Hamilton	**40**	**5**	**2**	**0**	**0**	**5**	**8**	**0**	**60**	**85.83**
Hancock	0	1	0	0	0	0	0	0	1	66.45
Hardeman	3	0	0	0	0	0	0	0	3	42.38
Hardin	3	1	0	0	0	0	1	0	5	81.70
Hawkins	4	2	0	0	3	0	0	1	10	76.13
Haywood	1	0	0	0	0	0	0	1	2	36.91
Henderson	6	0	0	0	0	0	0	0	6	93.05
Henry	1	1	0	0	0	1	1	0	4	57.86
Hickman	2	0	0	0	1	3	0	0	6	98.17
Houston	0	0	0	0	0	0	0	0	0	0
Humphreys	0	0	0	0	0	0	0	0	0	0
Jackson	0	0	0	0	0	0	0	0	0	0
Jefferson	3	3	0	0	0	1	0	0	7	60.74
Johnson	1	0	0	0	0	0	1	0	2	56.47

[27] Rates based on TN specific population per 100,000 less than 18 years of age

Table 20 - Manner of Death for All Counties										
County	Natural	Accident	Homicide	Suicide	Pending	Undet.	Unknown	Missing	Total	Rate[27]
Knox	**33**	**12**	**2**	**0**	**0**	**0**	**1**	**0**	**48**	**54.26**
Lake	0	0	0	0	0	0	1	0	1	69.54
Lauderdale	4	1	0	0	0	1	3	0	9	127.86
Lawrence	3	2	0	0	1	0	0	0	6	56.47
Lewis	2	0	0	0	0	0	0	0	2	65.04
Lincoln	1	1	0	0	1	0	0	1	4	51.81
Loudon	4	3	0	0	0	0	0	0	7	79.27
Macon	2	3	0	0	0	0	0	0	5	87.92
Madison	**12**	**3**	**0**	**0**	**0**	**2**	**0**	**0**	**17**	**69.46**
Marion	2	1	0	0	3	0	0	0	6	93.23
Marshall	4	0	0	0	0	0	0	5	9	83.57
Maury	**9**	**4**	**1**	**0**	**2**	**0**	**0**	**1**	**17**	**42.33**
McMinn	0	0	0	1	0	1	2	0	4	96.11
McNairy	1	2	0	0	0	0	1	0	4	50.28
Meigs	1	1	0	0	0	0	0	0	2	65.83
Monroe	3	3	0	0	3	0	1	0	10	97.26
Montgomery	**16**	**10**	**1**	**0**	**11**	**0**	**0**	**4**	**42**	**59.23**
Moore	0	0	0	0	0	0	0	0	0	142.96
Morgan	1	2	0	0	0	0	0	0	3	84.73
Obion	2	1	0	0	0	0	2	0	5	37.69
Overton	2	1	1	0	1	0	0	0	5	103.67
Perry	1	1	0	0	0	0	0	0	2	107.07
Pickett	0	1	0	0	0	0	0	0	1	94.34
Polk	0	1	0	0	0	0	0	0	1	78.55
Putnam	2	0	0	0	0	0	0	1	3	61.94
Rhea	2	7	0	0	2	0	0	0	11	104.70
Roane	4	2	0	0	0	0	0	0	6	49.83
Robertson	1	2	0	0	0	1	0	1	5	45.70
Rutherford	**11**	**5**	**1**	**4**	**5**	**3**	**0**	**0**	**29**	**56.39**
Scott	3	4	0	0	0	0	0	0	7	70.11
Sequatchie	1	2	0	0	0	0	0	0	3	98.46
Sevier	2	2	0	1	0	1	0	0	6	81.24
Shelby	**212**	**27**	**15**	**4**	**0**	**8**	**1**	**4**	**271**	**89.98**
Smith	3	3	0	0	1	0	1	0	8	20.93
Stewart	0	0	0	0	0	0	0	0	0	124.46
Sullivan	**11**	**4**	**0**	**0**	**0**	**0**	**0**	**1**	**16**	**83.41**
Sumner	**15**	**5**	**0**	**0**	**1**	**1**	**0**	**0**	**22**	**60.03**
Tipton	5	3	0	0	0	0	0	0	8	50.60
Trousdale	0	3	0	0	0	0	0	0	3	164.29
Unicoi	1	0	0	0	0	0	1	0	2	54.48
Union	2	0	0	0	0	0	0	0	2	38.89
Van Buren	1	0	0	0	0	0	0	0	1	73.10
Warren	5	0	0	0	0	0	1	0	6	61.79
Washington	**10**	**3**	**1**	**1**	**4**	**1**	**5**	**0**	**25**	**104.29**
Wayne	0	1	0	0	0	0	0	1	2	54.54
Weakley	3	0	0	0	0	0	0	0	3	36.82
White	0	1	0	0	0	0	0	0	1	17.88
Williamson	5	0	0	0	0	0	1	0	6	14.01
Wilson	6	0	0	2	3	0	0	0	11	42.71
Total	**645**	**204**	**31**	**16**	**60**	**48**	**56**	**28**	**1088**	75.42

Primary Cause of Death

The primary cause of death is defined as the effect or condition that brought about the cessation of life. The causes are broken down into two categories: medical causes and external causes. Many of the medical causes are not believed to be preventable. External causes are specified by injury and are discussed on page 26. The 1088 child fatalities were divided into the following Cause of Death categories:

- Natural 645 (59.28%)
- Accident 204 (18.75%)
- Suicide 16 (1.47%)
- Homicide 31 (2.85%)
- Undetermined 48 (4.41%)
- Pending 60 (5.51%)
- Unknown 84 (7.72%)

Medical Causes of Deaths

A natural death can result from one of many serious health issues: from inherent conditions, existing conditions, congenital anomalies, prematurity, disease, other medical causes, SIDS, genetic disorders, cancers, heart and cerebral problems. Serious infections and respiratory disorders such as asthma can be fatal to children. With infant deaths it is important to note that when SIDS and/or a Sudden Unexplained Infant Death is identified on a death certificate, it is classified under Manner of death as "Natural" or "Undetermined." There are 645 (59.28%) natural deaths reviewed by the CFRTs in 2006, broken down by all deaths, age, sex, and race in Table 21.

Table 21 - Cause of Death – Natural Medical Causes

Cause of Death	All Deaths			Age					Sex		Race				Ethnic
	Total	Percent	Rate	<1	1-4	5-9	10-14	15-17	Female	Male	White	African-American	Asian	Other	Hispanic
Asthma	9	0.83	0.62	0	1	3	3	2	2	7	3	6	0	0	0
Cancer	29	2.67	2.01	0	9	9	8	7	17	15	20	8	1	0	1
Cardiovascular	31	2.85	2.15	25	5	3	2	5	20	19	24	5	2	0	0
Congenital anomaly	114	10.48	7.90	109	14	1	1	1	62	63	65	48	0	1	18
HIV/AIDS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Influenza	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Low birth weight	1	0.09	0.07	1	0	0	0	0	0	1	0	1	0	0	0
Malnutrition/ dehydration	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0
Neurological/ Seizure disorder	23	2.11	1.59	4	8	5	5	3	13	12	13	9	0	1	3
Pneumonia	19	1.75	1.30	13	3	0	2	4	5	17	10	9	0	0	1
Prematurity	290	26.65	20.10	328	2	0	0	0	143	185	129	158	2	1	10
SIDS	21	1.93	1.46	40	0	0	0	0	14	26	14	7	0	0	1
Other infection	37	3.40	2.56	30	2	4	3	3	19	23	20	15	2	0	3
Other perinatal condition	15	1.38	1.04	18	0	0	0	0	10	8	8	6	1	0	0
Other medical condition	52	4.78	3.60	36	10	2	4	9	32	28	38	13	1	0	3
Undetermined medical cause	1	0.09	0.07	14	2	0	1	0	6	11	1	0	0	0	0
Unknown	3	0.28	0.21	2	1	0	1	0	1	3	1	1	0	0	0
Total	**645**	**59.28**	**44.71**	**621**	**57**	**27**	**30**	**34**	**344**	**419**	**347**	**286**	**9**	**3**	**40**

Non-Medical Causes of Deaths

Non-medical deaths are categorized as: accident (a manner of death indicating non-intentional trauma); suicide (death from a self-caused event); and homicide (death at the hands of another). In 2006 the CFRTs reviewed 204 accidents (18.75%), 16 suicides (1.47%), 31 homicides (2.85%) and 48 undetermined (4.41%). There were 60 (5.51%) pending cases and 84 (7.72%) unknown. Table 22 presents the non-medical causes, Table 23 provides a summary of non-medical causes by ages, Table 24 provides a summary of non-medical causes by sex, and Table 25 presents a summary of non-medical causes by race.

Table 22 - Non-Medical Cause of Death Categories[28]

Cause of Death	Accident			Suicide			Homicide			Undetermined		
	#	%	R	#	%	R	#	%	R	#	%	R
Any medical cause	2	0.18	0.14	0	0	0	0	0	0	20	1.84	1.39
Motor vehicle	120	11.03	8.32	0	0	0	0	0	0	0	0	0
Fire, Burn, or Electrocution	12	1.10	0.83	0	0	0	0	0	0	0	0	0
Drowning	15	1.38	1.03	0	0	0	1	0.09	0.07	0	0	0
Asphyxia	31	2.85	2.15	5	0.46	0.35	0	0	0	0	0	0
Weapon	2	0.18	0.14	10	0.92	0.69	24	2.21	1.66	0	0	0
Animal bite or attack	0	0	0	0	0	0	0	0	0	0	0	0
Fall or crush	8	0.74	0.55	0	0	0	0	0	0	0	0	0
Poisoning, Overdose, acute intoxication	5	0.46	0.35	1	0.09	0.07	1	0.09	0.07	1	0.09	0.07
Exposure	1	0.09	0.07	0	0	0	0	0	0	0	0	0
Other injury	8	0.74	0.55	0	0	0	4	0.37	0.28	1	0.09	0.07
Undetermined injury	0	0	0	0	0	0	0	0	0	12	1.10	0.83
Unknown	0	0	0	0	0	0	1	0.09	0.07	14	1.29	0.97
Total	**204**	**18.75**	**14.14**	**16**	**1.47**	**1.11**	**31**	**2.85**	**2.15**	**48**	**4.41**	**3.33**

Non-Medical Cause of Death by Age

Table 23 – Non-Medical Cause of Death by Age

Cause	Accident					Suicide					Homicide				
Age	<1	1-4	5-9	10-14	15-17	<1	1-4	5-9	10-14	15-17	<1	1-4	5-9	10-14	15-17
Motor vehicle	5	17	12	25	67	0	0	0	0	0	0	0	0	0	0
Fire, Burn, or Electrocution	3	6	3	2	2	0	0	0	0	0	0	0	0	0	0
Drowning	0	8	2	1	5	0	0	0	0	0	0	1	0	0	0
Asphyxia	35	3	2	2	0	0	0	0	1	4	0	0	0	0	0
Weapon	0	0	0	1	2	0	0	0	0	10	1	4	2	3	14
Animal bite or attack	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fall or crush	1	2	1	1	3	0	0	0	0	0	0	0	0	0	0
Poisoning, overdose or acute intoxication	0	1	0	0	5	0	0	0	0	1	1	0	0	0	0
Exposure	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Other injury	5	2	3	1	2	0	0	0	0	0	3	1	0	0	0
Undetermined injury	13	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown	1	2	0	0	0	0	0	0	0	0	0	1	0	0	0
Total	**63**	**43**	**23**	**33**	**86**	**0**	**0**	**0**	**1**	**15**	**5**	**7**	**2**	**3**	**14**

[28] R = Rate, Rates based on TN population per 100,000 less than 18 years of age

Non-Medical Cause of Death by Sex

Table 24 - Non-Medical Cause of Death by Sex						
Cause	**Accident**		**Suicide**		**Homicide**	
Sex	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Motor vehicle	54	66	0	0	0	0
Fire, Burn, or Electrocution	7	5	0	0	0	0
Drowning	4	11	0	0	1	0
Asphyxia	15	16	0	5	0	0
Weapon	0	2	0	10	5	19
Fall or crush	0	8	0	0	0	0
Poisoning, overdose or acute intoxication	2	3	0	1	0	1
Other injury	1	6	0	0	3	1
Unknown	0	0	0	0	0	1
Total	**83**	**117**	**0**	**16**	**9**	**22**

Non- Medical Cause of Death by Race

Table 25 - Non-Medical Cause of Death by Race															
Cause	**Accident**					**Suicide**					**Homicide**				
Race or Ethnicity	**White**	**African-American**	**Asian**	**Other**	**Hispanic**	**White**	**African-American**	**Asian**	**Other**	**Hispanic**	**White**	**African-American**	**Asian**	**Other**	**Hispanic**
Motor vehicle	94	23	3	0	5	0	0	0	0	0	0	0	0	0	0
Fire, Burn, or Electrocution	7	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Drowning	10	5	0	0	0	0	0	0	0	0	0	1	0	0	0
Asphyxia	22	7	0	2	5	4	1	0	0	0	0	0	0	0	0
Weapon	0	2	0	0	0	9	1	0	0	0	5	19	0	0	1
Fall or crush	7	1	0	0	2	0	0	0	0	0	0	0	0	0	0
Poisoning, overdose or acute intoxication	4	1	0	1	0	0	0	0	0	0	1	0	0	0	0
Other injury	8	0	0	0	0	0	0	0	0	0	4	0	0	0	2
Unknown	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Total	**152**	**44**	**3**	**2**	**10**	**14**	**2**	**0**	**0**	**0**	**11**	**20**	**0**	**0**	**3**

External Causes of Deaths

As discussed on page 23, the cause of death is defined as the effect or condition that brought about the cessation of life. The causes are broken down into medical causes and external causes. External causes are specified by injury and are believed to be preventable. The 1088 child fatalities were divided into the following injury related external causes of deaths:

- Motor Vehicle 42.71% (126)
- Asphyxia 15.93% (47)
- Weapons 12.54% (37)
- Drowning 5.76 % (17)
- Other Injuries 5.76% (17)
- Undetermined 4.75% (14)
- Fire 5.42% (16)
- Falls 2.71% (8)
- Poisoning/OD[29] 2.71% (8)
- Unknown 1.36% (4)

Deaths Due to Injury

Table 26 -Fatalities Due to Injury by Race

Cause	White	Black	Asian	Other	Total
Motor Vehicle	100	23	3	0	126
Asphyxia	35	10	0	1	47
Weapons	15	22	0	0	37
Drowning	11	6	0	0	17
Fire, burn, electrocution	11	5	0	0	16
Fall or crush	7	1	0	0	8
Poisoning/OD	7	1	0	0	8
Exposure	1	0	0	0	1
Other Injury	17	0	0	1	17
Unknown	2	2	0	0	4
Undetermined	9	5	0	0	14
Animal bite	0	0	0	0	0
Total	**215**	**75**	**3**	**2**	**295**
Rate[30]	**21.07**	**24.54**	**15.27**	**0.14**	**20.45**

- In 2006, there were 295 deaths (23.07% of all childhood fatalities) due to injury related causes among children.
- There were 126 (42.71%) fatalities from vehicular incidents. This represents the greatest number of all injury-related fatalities.
- The highest rate of child death fatalities due to injuries occurred in the 15 to 17 years of age category 115 (45.24 per 100,000).
- The highest numbers of deaths were white 215 (74.38%).
- Childhood fatalities due to injury-related causes occurred at a rate of 20.45 per 100,000. (Table 27)

Fatalities Due to Injury-Related Causes

Table 27 - Fatalities Due to Injury-related Causes[31]

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	69	85.84	Female	110	2.41	White	215	21.07
1-4	49	15.42	Male	184	2.44	African-American	75	24.54
5-9	25	4.58	Missing	1		Asian	3	15.27
10-14	37	15.16				Other	0	0
15-17	115	45.24				Unknown	2	0.14
Total	**295**	**20.45**	**Total**	**295**	**20.45**	**Total**	**295**	**20.45**

[29] OD = Overdose
[30] Rates based on TN population per 100,000 less than 18 years of age
[31] Rates based on TN specific populations per 100,000 less than 18 years of age

Motor Vehicle Related Deaths

In 2006, 126 children died in vehicle-related incidents. This represents 42.71% of all injury-related deaths and 11.58% of all child fatalities for 2006. Children ages 15-17 were most likely to die as a result of a vehicle-related injury (67; 26.36 per 100,000) and children 10-14 (25; 10.25 per 100,000) were the second most likely to die in vehicular-related incident. Females (57; 9.35 per 100,000) were only slightly less likely to die in a vehicle-related death than were males (69; 8.09 per 100,000). Whites (100; 9.80 per 100,000) had a higher rate of death by vehicle than African-Americans (23; 7.53 per 100,000) (Table 28).

Table 28 - Fatalities Due to Motor Vehicle and Other Transport[32]

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	5	6.22	Female	57	9.35	White	100	9.80
1-4	17	5.35	Male	69	8.09	African-American	23	7.53
5-9	12	2.20				Asian	3	15.27
10-14	25	10.25				Other	0	0
15-17	67	26.36				Unknown	0	0
Total	**126**	**8.73**	**Total**	**126**	**8.73**	**Total**	**126**	**8.73**

Asphyxia Deaths

In 2006, there were 35 asphyxia deaths due to suffocation or strangulation. This represents 15.93% of all injury-related deaths and 3.22% of all child fatalities for 2006. Among these deaths, 33 (94.28%) involved a child less than one year old and 26 (74.29) of all asphyxia deaths were sleep related (Table 29). When an infant dies from asphyxiation and or suffocation it is classified under Manner of Death as an Injury event (see Infant Mortality section on page 11).

Table 29 - Fatalities Due to Suffocation or Strangulation

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	33	41.05	Female	17	2.41	White	26	2.55
1-4	1	0.31	Male	18	2.44	African-American	8	2.62
5-9	0	0				Asian	0	0
10-14	1	0.41				Other	0	0
15-17	0	0				Unknown	1	0.07
Total	**35**	**2.43**	**Total**	**35**	**2.43**	**Total**	**35**	**2.43**

Deaths Due to Weapons

In 2006, 37 children died due to weapons injuries. This represents 12.54% of all injury-related deaths and 3.40% of all childhood fatalities. Males (32; 4.34 per 100,000) were significantly more likely to die due to weapon injuries than females (5; 0.71 per 100,000). Over 70% (26) of all weapon deaths occurred in age groups of 15-17 years old (Table 30).

[32] Rates based on TN population per 100,000 less than 18 years of age.

Table 30 - Fatalities Due to Weapons								
Age			**Sex**			**Race**		
	Number	**Rate**		**Number**	**Rate**		**Number**	**Rate**
<1	1	1.24	Female	5	0.71	White	15	1.47
1-4	4	1.26	Male	32	4.34	African-American	22	7.20
5-9	2	0.37				Asian	0	0
10-14	4	1.64				Other	0	0
15-17	26	10.23				Unknown	0	0
Total	**37**	**2.56**	**Total**	**37**	**2.43**	**Total**	**37**	**2.43**

Deaths Due to Drowning

In 2006, 17 children died from accidental drowning. This represents 5.76% of all injury-related deaths and 1.56% of all child fatalities for 2006. The highest rate occurred in the age group of 1-4 years of age (8; 2.52 per 100,000). More White children died by drowning (11; 1.08 per 100,000 (Table 31).

Table 31 - Fatalities Due to Drowning								
Age			**Sex**			**Race**		
	Number	**Rate**		**Number**	**Rate**		**Number**	**Rate**
<1	1	1.24	Female	6	0.85	White	11	1.08
1-4	8	2.52	Male	11	1.49	African-American	6	1.96
5-9	2	0.37				Asian	0	0
10-14	1	0.41				Other	0	0
15-17	5	1.97				Unknown	0	0
Total	**17**	**1.18**	**Total**	**17**	**1.18**	**Total**	**17**	**1.18**

Deaths Due to Fire/Burns

In 2006, there were 16 child fatalities due to fire and/or burns. This represents 5.42% of all injury-related deaths and 1.47% of all child fatalities for 2006 (Table 32).

Table 32 - Fatalities Due to Fire/Burns								
Age			**Sex**			**Race**		
	Number	**Rate**		**Number**	**Rate**		**Number**	**Rate**
<1	3	3.73	Female	9	1.28	White	11	1.08
1-4	6	1.89	Male	7	0.95	African American	5	1.64
5-9	3	0.55				Asian	0	0
10-14	2	0.82				Other	0	0
15-17	2	0.79				Unknown	0	0
Total	**16**	**1.11**	**Total**	**16**	**1.11**	**Total**	**16**	**1.11**

Deaths Due to Falls

In 2006, there were eight (8) child fatalities due to falls. This represents 2.71% of all injury-related deaths and 0.74% of all child fatalities for 2006 (Table 33).

Table 33 - Fatalities Due to Falls

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	1	1.24	Female	2	0.28	White	7	0.69
1-4	1	0.31	Male	6	0.81	African-American	1	0.33
5-9	0	0				Asian	0	0
10-14	0	0				Other	0	0
15-17	6	2.36				Unknown	0	0
Total	**8**	**0.55**	**Total**	**8**	**0.55**	**Total**	**8**	**0.55**

Deaths Due to Poisoning

In 2006, there were eight (8) child fatalities due to poisoning. This represents 2.71% of all injury-related deaths and 0.74% of all child fatalities for 2006. Most deaths occurred in the 15-17 age category (8; 2.36 per 100,000) (Table 58).

Table 34 - Fatalities Due to Falls

Age			Sex			Race		
	Number	Rate*		Number	Rate*		Number	Rate*
<1	1	1.24	Female	2	0.28	White	7	0.69
1-4	1	0.31	Male	6	0.81	African-American	1	0.33
5-9	0	0				Asian	0	0
10-14	0	0				Other	0	0
15-17	6	2.36				Unknown	0	0
Total	**8**	**0.55**	**Total**	**8**	**0.55**	**Total**	**8**	**0.55**

Deaths Due to Exposure

In 2006, one (1) child died of exposure. This represents 0.34% of all injury-related deaths and 0.09% of all child fatalities for 2006 (Table 35).

Table 35 - Fatalities Due to Exposure

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	1	1.24	Female	0	0	White	1	0.10
1-4	0		Male	1	0.14	African-American	0	0
5-9	0					Asian	0	0
10-14	0					Other	0	0
15-17	0					Unknown	0	0
Total	**1**	**0.07**	**Total**	**1**	**0.07**	**Total**	**1**	**0.07**

Deaths Due to Other Injury

In 2006, there were 17 child fatalities determined to be other injury. This represents 5.76% of all injury-related deaths and 1.56% of all child fatalities for 2006 (Table 36).

Table 36 - Fatalities Due to Other Injury

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	8	9.95	Female	5	0.71	White	17	0.10
1-4	3	0.94	Male	11	1.49	African-American	0	0
5-9	3	0.55				Asian	0	0
10-14	1	0.41				Other	0	0
15-17	2	0.79				Unknown	0	0
Total	**17**	**1.18**	**Total**	**17**	**1.18**	**Total**	**17**	**1.18**

Undetermined and Unknown Deaths

In 2006, there were a total of 15 fatalities that were categorized as "Undetermined." This represents 4.75 % of all child fatalities for 2006 (Table 37). There were four (4) "Unknown" injury-related deaths, which represents 1.36 of all injury-related deaths.

Table 37 - Fatalities Due to Undetermined Causes

Age			Sex			Race		
	Number	Rate		Number	Rate		Number	Rate
<1	12	14.93	Female	8	1.14	White	8	0.78
1-4	3	0.94	Male	7	0.95	African-American	7	2.29
5-9	0	0				Asian	0	
10-14	0	0				Other	0	
15-17	0	0				Unknown	0	
Total	**15**	**1.04**	**Total**	**15**	**1.04**	**Total**	**15**	**1.04**

Medical Conditions that Contributed to Cause of Death

Table 38 - Medical Contributors		
Non-injury	**Total**	**Percent**
Asthma	9	1.17%
Cancer	33	4.29%
Cardio	40	5.20%
Congenital	126	16.38%
Low birth weight	1	0.13%
Malnutrition	1	0.13%
Neurological	25	3.25%
Pneumonia	22	2.86%
Prematurity	330	42.92%
SIDS	40	5.20%
Other infection	42	5.46%
Other perinatal	18	2.34%
Other medical	61	7.93%
Undetermined	17	2.21%
Unknown	4	0.53%
Total	**769**	**100%**

This information differs from the official Medical Cause of Death in Table 21, in that it provides a more in-depth analysis of the medical conditions and the factors that contributed to the Cause of Death. It is possible for duplicate information to be presented in this section since the official Medical Condition that contributed to the Cause of Death may also show up in Table 21. For example, the 21 SIDS deaths in Table 21 are included in this table. There were 21 death certificates that listed SIDS as the primary cause of death but there are 40 SIDS deaths that the CFRTs identified SIDS as Medical Condition from their case reviews. It is important to analyze this detailed information by cause of death to determine the impact of these conditions and prevention initiatives.

There were 769 deaths due to medical illness conditions among Tennessee children in 2006, representing 70.68% of all child fatalities. Of these, the greatest number of deaths due to medical conditions resulted from illness (378) followed by prematurity (330), and SIDS (40).

APPENDIX

Appendix A – 2008 State Child Fatality Prevention Team

Tennessee Department of Health

Susan R. Cooper, MSN, RN
Commissioner, Tennessee Department of Health
425 5th Avenue North
Cordell Hull Building, 3rd Floor, Nashville, TN 37243, (615) 741-3111
Serves by virtue of position as the Commissioner of the Tennessee Department of Health

Cathy R. Taylor, DrPH, MSN, RN
Bureau of Health Services Administration, (615) 532-9223

Dr. Theodora Pinnock, Chair
Director of Maternal and Child Health
425 5th Avenue North, Cordell Hull Building, 5th Floor, Nashville, TN 37243, (615) 741-0322
Serves by request of the Commissioner of the Tennessee Department of Health

Judith Baker, BSBM/EM
Director, Child Fatality Review Program
425 5th Avenue North, Cordell Hull Building, 5th Floor, Nashville, TN 37243, (615) 741-0361
Serves as team coordinator

Kwame A. Bawuah, MPH
Epidemiologist, (615) 741-4447

Rebecca Walls, RN
Nurse Consultant, (615) 532-3249

Carla Aaron
Executive Director, Child Safety
436 Sixth Avenue North,
Cordell Hull Building, 8th Fl.
Nashville, TN 37243-1290, (615) 741-8278
Serves as designee for the Commissioner of the Department of Children's Services

Dr. Thomas Jaselskis
Medical Services Director, (615) 532-2431

Tom Sharp
TDOH Legislative Liaison, **(**615) 741-5233

Dr. Howard Burley
Mental Health & Developmental Disabilities
425 5th Avenue North
Cordell Hull Building, 5th Floor
Nashville, TN 37243-6564, (615) 532-6564
Serves as designee for the Department of Mental Health & Developmental Disabilities

Tennessee Elected Senators and Representatives

Senator Charlotte Burks
Legislative Plaza, Room 9
Nashville, TN 37243, (615) 741-3978
Serves by virtue of position as a member of the Tennessee Senate

Senator Raymond Finney
War Memorial Building, Suite 320
Nashville, TN 37243, (615) 741-2427
Appointed by: Tennessee Speaker of the Senate
Serves by virtue of position as a member of the Tennessee Senate and as a member of the Senate General Welfare, Health, and Human Resources Committee

Representative Sherry Jones
26 Legislative Plaza
Nashville, TN 37243, (615) 741-2035
Serves by virtue of position as the Chair of the Select Committee on Children and Youth

Representative Dennis Ferguson
34 Legislative Plaza
Nashville, TN 37243, (615) 741-7658
Appointed by: Tennessee Speaker of the House Serves by virtue of position as a member of the Tennessee House of Representatives and a member of the House Health and Human Resources Committee

Representative Joe McCord
214 War Memorial Building,
Nashville, TN 37243, Phone (615) 741-5481
Appointed by: Tennessee Speaker of the House
Serves by virtue of position as a member of the Tennessee House of Representatives

American Medical Association

Dr. Lisa Piercey
11 Raleigh Place
Jackson, TN 38305
(731) 664-7118
Serves as a physician selected from nominations submitted by the State chapter of the American Medical Association

Attorney General

Lucy Haynes
500 5th Ave North
John Sevier Building, Room 114
Nashville, TN 37243
(615) 532-2580
Serves by virtue of position as designee for the Attorney General and Reporter for Tennessee

Center for Forensic Medicine

Bruce Levy, M.D.
TN State Medical Examiner
850 R.S. Gass Blvd.
Nashville TN 37216
(615) 743-1800 x 0
blevy@forensicmed.com
Serves as a physician who has credentials in forensic pathology, preferably with experience in pediatric forensic pathology

Department of Education

Mr. Mike Herrmann
Tennessee Department of Education
5th Floor Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
(615) 741-8468
Serves as designee for the Commissioner of the Department of Education

TN Bureau of Investigation

Karen Alexander
Assistant Special Agent in Charge
901 R.S. Gass Boulevard
Nashville, TN 37215-2639
(615) 744-4216; 24 hour: 744-4000; fax 744-4513
Serves by virtue of position as designee for the Tennessee Bureau of Investigation

TN Commission on Children and Youth

Linda O'Neal
9th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243-0800
(615) 741-2633
Serves by virtue of position as the Executive Director of the Tennessee Commission on Children and Youth

TN Professional Society on Abuse of Children

Bonnie Beneke
5819 Old Harding Road, Suite 204
Nashville, TN 37205
(615) 352-4439

State Supreme Court Judiciary

Vacant
Appointed by: Commissioner of Health Serves by virtue of position as member of the judiciary selected from a list submitted by the Chief Justice of the State Supreme Court

Exofficio/Non-Voting Participants

Cindy Perry
Select Committee, Children & Youth
James K Polk Building, 3rd Fl.
Nashville, TN 37243-0061
(615) 741-6239

Kim Rush
Program Director for Children and Youth Services
Middle Tennessee Mental Health Institute
3411 Belmont Boulevard
Nashville, TN 37215
(615) 741-3290

Scott Ridgeway
Tennessee Suicide Prevention Network
PO Box 40752
Nashville, TN 37204
(615) -297-1077

Appendix B – 2008 Local Child Fatality Review Teams

Local CFRT Team Leaders

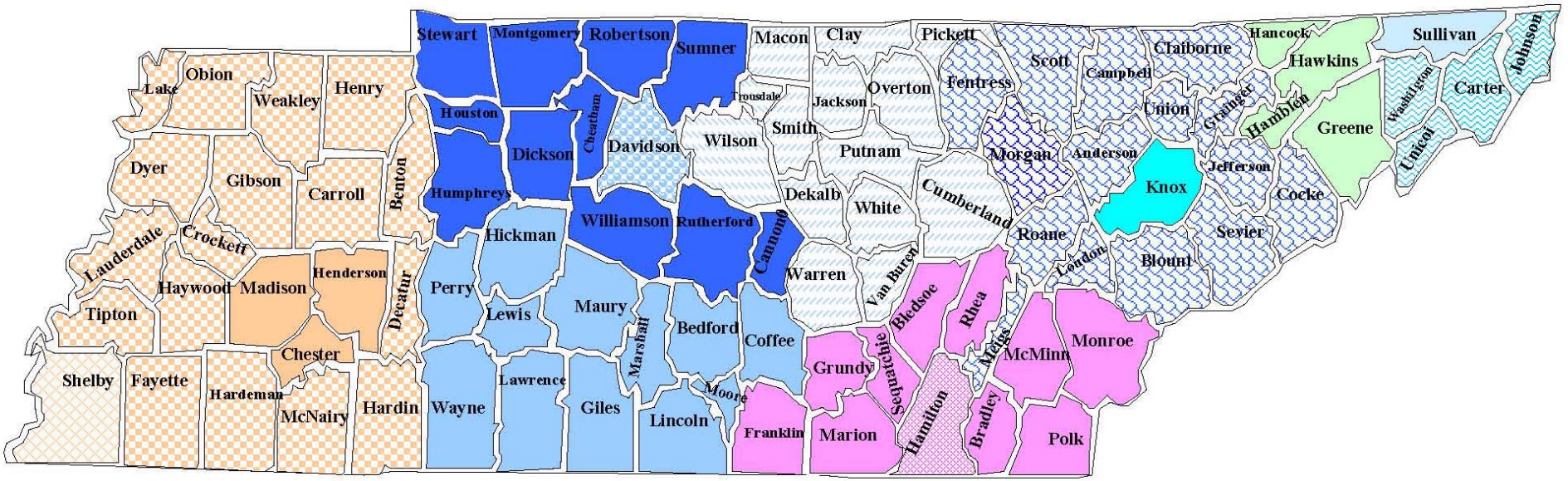
Judicial Districts (JD) and Counties	CFRT Leader	Phone
JD 1: Carter, Johnson, Unicoi, and Washington Counties	**Dr. Lawrence Moffatt/Pat Rash** Child Fatality Review Team Coordinator Northeast TN Regional Health Office 1233 Southwest Ave. Ext. Johnson City, TN 37604	Phone: (423) 979-4625 Fax: (423) 979-3677
JD 2: Sullivan County	**Dr. Stephen May** Janice Miller Sullivan Co. Health Dept. PO Box 630, (154 Blountville Bypass) Blountville, TN 37617	Phone: (423) 279-2794 Fax: (423) 279 2797
JD 3: Greene, Hamblen, Hancock, and Hawkins Counties (Sandy J. Malone, Admin.)	**Dr. Barbara Skelton/Pat Rash** Child Fatality Review Team Coordinator Northeast TN Regional Health Office 1233 Southwest Ave. Ext. Johnson City, TN 37604	Phone: 423) 979-4625 Fax: (423) 979-3267
JD 4 – Dr. Ken Marmon Cocke, Grainger, Jefferson, and Sevier Counties **JD 5 –** Dr. Ken Marmon: Blount County **JD 7 –** Patti Campbell: Anderson County **JD 8 –** Kerri Byrd-Hamby: Campbell, Claiborne, Fentress, Scott, and Union Counties **JD 9 –** Dr. Bud Guider: Loudon, Meigs, Morgan, and Roane Counties	**Paul Haug** East TN Regional Health Office PO Box 59019 1522 Cherokee Trail Knoxville, TN 37950-9019 Note: Frank Bristow has retired	Phone: (865) 549-5301 Fax: (865) 594 5738
JD 6: Knox County	**Dr. Kathy Brown Phd.** **Alicia Mastronardi** Knox County Health Dept. 140 Dameron Ave. Knoxville, TN 37917	Phone: (865) 215-5170 Mary Campbell Linda Weber (ASA) 865-215-5272
JD 10: Bradley, McMinn, Monroe, and Polk Counties **JD 12**: Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie Counties	**Dr. Jan BeVille** Southeast Regional Health Office State Office Building 540 McCallie Avenue Chattanooga, TN 37402	Phone: (423) 634-5887

Judicial Districts (JD) and Counties	CFRT Leader	Phone
JD 11: Hamilton County	**Dr. Valerie Boaz/Nadine Bynum** Chattanooga/Hamilton Co. Health Dept. 921 East Third Street Chattanooga, TN 37403 Note: Kaye Greer has retired	Phone: (423) 209-8155 Debbie McKeehan (423) 209-8002
JD 13: Clay, Cumberland, DeKalb, Overton, Pickett, Putnam, and White Counties **JD 15**: Jackson, Macon, Smith, Trousdale, and Wilson Counties **JD 31**: Van Buren and Warren Counties	**Dr. Fred Vossel**/ Jean Coffee Upper Cumberland Reg. Health Office 200 West 10th Street Cookeville, TN 38501-6067 Note: Dr. Tansil has retired	Phone: (931) 520-4215 Infirmary (931) 372-3320 Jean Coffee 931-646-7533
JD 14: Coffee County **JD 17**: Bedford, Lincoln, Marshall, and Moore Counties **JD 2101**: Hickman, Lewis, and Perry Counties **JD 2201**: Giles, Lawrence, and Wayne Counties **JD 2202**: Maury County	**Dr. Langdon Smith/David Brumley** South Central Regional Health Office 1216 Trotwood Avenue Columbia, TN 38401-4809	Phone: (931) 490-8388 Jan Winters (931) 490-8343 David Brumley 931-490-8373 Fax: (931) 380-3364
JD 16: Cannon and Rutherford Counties **JD 18**: Sumner County **JD 1901**: Montgomery County **JD 1902**: Robertson County **JD 2102**: Williamson County **JD 23**: Cheatham, Dickson, Houston, Humphreys, and Stewart Counties	**Dr. Alison Asaro/Sharon A. Woodard** Mid Cumberland Reg. Health Office 710 Hart Lane Nashville, TN 37247-0801	Phone: (615) 650-7015 Fax: (615) 253-3178
JD 20: Davidson County	**Dr. Kimberly Wyche-Etheridge/Brook McKelvey** Metro/Davidson Co. Health Dept. 311 23rd Ave. North Nashville, TN 37203	Phone: (615) 340-0474
JD 24: Benton, Carroll, Decatur, Hardin, and Henry Counties **JD 25**: Fayette, Hardeman, Lauderdale, McNairy, and Tipton Counties **JD 27**: Obion and Weakley Counties **JD 28**: Crockett, Gibson, and Haywood Counties **JD 29**: Dyer and Lake Counties	**Dr. Shaveta Conner** West TN Regional Health Office 295 Summar Street Jackson, TN 38301	Phone: (731) 423-6600 Carolyn West Regional Health Office PO Box 190 Union City, TN 38281

Judicial Districts (JD) and Counties	CFRT Leader	Phone
JD 26: Chester, Henderson, and Madison Counties	**Dr. Tony Emison** Jackson/Madison Co. Health Dept. 804 North Parkway Jackson, TN 38305	Phone: (731) 423-3020
JD 30: Shelby County	**Dr. Helen Morrow/Flo Patton** Shelby County Health Department 814 Jefferson Avenue Memphis, TN 38105-5099	Phone: (901) 544-7380 (901) 544-7564
	Dr. Bruce Levy State Medical Examiner 850 R.S. Gass Blvd. Nashville TN 37216	Phone: (615) 743-1800 Lisa Robison Phone: (615) 743-1801

Tennessee Child Fatality Local Judicial District Map

Figure 10 - TN Local Judicial Districts



Northeast 1
JD 1
Carter
Johnson
Unicoi
Washington

East
JD 4
Cocke
Grainger
Jefferson
Sevier

JD 5
Blount

JD 7
Anderson

JD 8
Campbell
Claiborne
Fentress
Scott
Union

JD 9
Loudon
Meigs
Morgan
Roane

Upper Cumberland
JD 13
Clay
Cumberland
Dekalb
Overton
Pickett
Putnam
White

JD 15
Jackson
Macon
Smith
Trousdale
Wilson

JD 31
Van Buren
Warren

Northeast 3
JD 3
Green
Hamblen
Hancock
Hawkins

Southeast
JD 10
Bradley
McMinn
Monroe
Polk

JD 12
Bledsoe
Franklin
Grundy
Marion
Rhea
Sequatchie

South Central
JD 14
Coffee

JD 17
Bedford
Lincoln
Marshall
Moore

JD 2101
Hickman
Lewis
Perry

JD 2201
Giles
Lawrence
Wayne

JD 2202
Maury

Mid Cumberland
JD 16
Cannon
Rutherford

JD 18
Sumner

JD 1901
Montgomery

JD 1902
Robertson

JD 2102
Williamson

JD 23- Cheatham, Dickson, Houston, Humphreys, Stewart

West
JD 24
Benton
Carroll
Decatur
Hardin
Henry

JD 25
Fayette
Hardeman
Lauderdale
McNairy
Tipton

JD 27
Obion
Weakley

JD 28
Crockett
Gibson
Haywood

JD 29
Dyer
Lake

Sullivan JD 2

Knox JD 6

Hamilton JD 11

Davidson JD 20

Madison JD 26- Chester, Henderson, Madison

Shelby JD 30

Appendix C – Child Fatality Review and Prevention Act

Section

68-142-101. Short title

This part shall be known as and may be cited as the "Child Fatality Review and Prevention Act of 1995."
[Acts 1995, ch. 511, § 1; 2007, ch. 588, § 2.]

68-142-102. Child fatality prevention team.

There is created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.
[Acts 1995, ch. 511, § 1.]

68-142-103. Composition

The state team shall be composed as provided in this section. Any ex officio member, other than the commissioner of health, may designate an agency representative to serve in such person's place. Members of the state team shall be as follows:

(1) The commissioner of health, who shall chair the state team;
(2) The attorney general and reporter;
(3) The commissioner of children's services;
(4) The director of the Tennessee bureau of investigation;
(5) A physician nominated by the state chapter of the American Medical Association;
(6) A physician to be appointed by the commissioner of health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;
(7) The commissioner of mental health and developmental disabilities;
(8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee supreme court;
(9) The executive director of the commission on children and youth;
(10) The president of the state professional society on the abuse of children;
(11) A team coordinator, to be appointed by the commissioner of health;
(12) The chair of the select committee on children and youth;
(13) Two (2) members of the house of representatives to be appointed by the speaker of the house of representatives, at least one (1) of whom shall be a member of the health and human resources committee;
(14) Two (2) senators to be appointed by the speaker of the senate, at least one (1) of whom shall be a member of the general welfare, health and human resources committee; and
(15) The commissioner of education or the commissioner's designee.

[Acts 1995, ch. 511, § 1; 1996, ch. 1079, § 152; 2007, ch. 588, § 3.]

68-142-104. Voting members - Vacancies

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.
[Acts 1995, ch. 511, § 1.]

68-142-105. Duties of state team

The state team shall:

(1) Review reports from the local child fatality review teams;
(2) Report to the governor and the general assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
(3) Undertake annual statistical studies of the incidence and causes of child fatalities in this state. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;
(4) Provide training and written materials to the local teams established by this part to assist them in carrying out their duties. Such written materials may include model protocols for the operation of local teams;
(5) Develop a protocol for the collection of data regarding child deaths;
(6) Upon request of a local team, provide technical assistance to such team, including the authorization of another medical or legal opinion on a particular death; and
(7) Periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed.

[Acts 1995, ch. 511, § 2; 2007, ch. 588, § 4.]

68-142-106. Local teams - Composition - Vacancy - Chair - Meetings

(a) There shall be a minimum of one (1) local team in each judicial district.
(b) Each local team shall include the following statutory members or their designees:
(1) A supervisor of social services in the department of children's services within the area served by the team;
(2) The regional health officer in the department of health in the area served by the team, who shall serve as interim chair pending the election by the local team;
(3) A medical examiner who provides services in the area served by the team;
(4) A prosecuting attorney appointed by the district attorney general;
(5) An employee of the local education agency, to be appointed by the director of schools; and
(6) The interim chair of the local team shall appoint the following members to the local team:
(A) A local law enforcement officer;
(B) A mental health professional;
(C) A pediatrician or family practice physician;
(D) An emergency medical service provider or firefighter; and
(E) A representative from a juvenile court.
(c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families.
(d) The local team may include non-statutory members to assist them in carrying out their duties. Vacancies on a local team shall be filled by the original appointing authority.
(e) A local team shall elect a member to serve as chair.
(f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

[Acts 1995, ch. 511, § 3; 1996, ch. 1079, § 152; 2007, ch. 588, § 5.]

68-142-107. Duties of local teams

(a) The local child fatality review teams shall:
(1) Be established to cover each judicial district in the state;
(2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger;
(3) Collect data according to the protocol developed by the state team;
(4) Submit data on child deaths quarterly to the state team;
(5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and
(6) Participate in training provided by the state team.
(b) Nothing in this part shall preclude a local team from providing consultation to any team member conducting an investigation.

(c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.
[Acts 1995, ch. 511, § 4; 2007, ch. 588, § 6.]

68-142-108. Powers of local team - Limitations - Confidentiality of state and local team records

(a) The department of health, state team and local teams are public health authorities conducting public health activities pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA), compiled in 42 U.S.C. § 1320d et seq.. Notwithstanding §§ 63-2-101(b) and 68-11-1502, and regardless of any express or implied contracts, agreements or covenants of confidentiality based upon those sections, the records of all health care facilities and providers shall be made available to the local team for inspection and copying as necessary to complete the review of a specific fatality and effectuate the intent of this part. The local team is authorized to inspect and copy any other records from any source as necessary to complete the review of a specific fatality and effectuate the intent of this part, including, but not limited to, police investigations data, medical examiner investigative data, vital records cause of death information, and social services records, including records of the department of children's services.

(b) The local team shall not, as part of the review authorized under this part, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.

(c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality; such persons may include the person or persons who first responded to a report concerning the child.

(d) Meetings of the state team and each local team shall not be subject to the provisions of title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection. However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.

(e) (1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams and for the purposes of the Sudden, Unexplained Child Death Act, pursuant to title 68, chapter 1, part 11.

(2) In addition, all otherwise confidential information and records created by a local team in the exercise of its duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams and for the purposes of the Sudden, Unexplained Child Death Act, pursuant to title 68, chapter 1, part 11. Release to the public or the news media of information discussed at official meetings is strictly prohibited. No member of the state team, a local team nor any person who attends an official meeting of the state team or a local team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meeting.

(3) This subsection (e) shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.

(f) Each statutory member of a local child fatality review team and each non-statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.
[Acts 1995, ch. 511, § 5; 2001, ch. 321, §§ 5, 6; 2007, ch. 588, §§ 7, 8.]

68-142-109. Staff and consultants
To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.
[Acts 1995, ch. 511, § 6.]

68-142-110. Immunity from civil and criminal liability
Any person or facility acting in good faith in compliance with this part shall be immune from civil and criminal liability arising from such action.
[Acts 2007, ch. 588, § 9.]

68-142-111. Child death investigations and reviews
Nothing in this part shall preclude any child death investigations or reviews to the extent authorized by other laws.
[Acts 2007, ch. 588, § 10.]

Appendix D – Sudden, Unexplained Child Death Act

Section

68-1-1101. Short title - Legislative findings - Definitions

(a) This part shall be known and may be cited as the "Sudden, Unexplained Child Death Act."

(b) The legislature hereby finds and declares that:
   (1) Protection of the health and welfare of the children of this state is a goal of its people and the unexpected death of a child is an important public health concern that requires legislative action;
   (2) The parents, guardians, and other persons legally responsible for the care of a child who dies unexpectedly have a need to know the cause of death;
   (3) Collecting accurate data on the cause and manner of unexpected deaths will better enable the state to protect children from preventable deaths, and thus will help reduce the incidence of such deaths; and
   (4) Identifying persons responsible for abuse or neglect resulting in unexpected death will better enable the state to protect other children who may be under the care of the same persons, and thus will help reduce the incidence of such deaths.

(c) As used in this part and in § 68-3-502 and unless the context otherwise requires:
   (1) "Sudden infant death syndrome" means the sudden death of an infant under one (1) year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history;
   (2) "Certified child death pathologist" means a pathologist who is board certified or board eligible in forensic pathology and who has received training in, and agrees to follow, the autopsy protocol, policies and guidelines for child death investigation, as prescribed by the chief medical examiner for the state of Tennessee; and
   (3) "Chief medical examiner" means the individual appointed pursuant to title 38, chapter 7, part 1. [Acts 2001, ch. 321, § 1.]

68-1-1102. Purpose - Training - Notice and Investigation - Autopsy

(a) The purpose of this part is to help reduce the incidence of injury and death to infants by accurately identifying the cause and manner of death of infants under one (1) year of age. This shall be accomplished by requiring that a death investigation be performed in all cases of all sudden, unexplained deaths of infants under one (1) year of age.

(a) The chief medical examiner shall develop and implement a program for training of child death pathologists. The protocol and policies shall be based on nationally recognized standards.

(b) All emergency medical technicians and professional firefighters shall receive training on the handling of cases of sudden, unexplained child death as a part of their basic and continuing training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members.

(c) All law enforcement officers shall receive training on the investigation and handling of cases of sudden, unexplained child death as part of their basic training requirements. The training, which shall be developed jointly by the departments of health and children's services, shall include the importance of being sensitive to the grief of family members and shall be consistent with the death scene investigation protocol approved by the chief medical examiner. Additionally, whenever changes occur in policies or procedures pertaining to sudden infant death syndrome investigations, the department of health shall promptly notify the various law enforcement associations within the state. Such changes shall then be communicated in a timely manner to the respective law enforcement agencies for dissemination to their enforcement personnel.

(d) In the case of every sudden, unexplained death of an infant under one (1) year of age, the attending physician or coroner shall notify the county medical examiner who shall coordinate the death investigation.

(e) The county medical examiner shall inform the parent or parents or legal guardian of the child, if an autopsy is authorized.

(f) The county medical examiner shall ensure that the body is sent for autopsy to a child death pathologist as defined in this part. Parents or legal guardians who refuse to allow an autopsy based

on the grounds of religious exemption shall personally file a petition for an emergency court hearing in the general sessions court for the county in which the death occurred.

(g) The county medical examiner shall contact the appropriate local law enforcement personnel to conduct a death scene investigation according to the protocol developed by the chief medical examiner. Such investigation shall be initiated within twenty-four (24) hours of the time the local law enforcement personnel are contacted by the county medical examiner.

(h) The county medical examiner shall send a copy of the death scene investigation and the medical history of the child to the pathologist conducting the autopsy.

(i) A copy of the completed autopsy, medical history, and death scene investigation shall be forwarded to the chief medical examiner.

(j) The cause of death, as determined by the certified child death pathologist, may be reported to the parents or legal guardians of the child. A copy of the autopsy results, when available, may be furnished to the parent or parents or legal guardian of the child, upon request, within forty-eight (48) hours of such request, except where the cause of death may reasonably be attributed to child abuse or neglect, in the judgment of the certified child death pathologist.

(k) Sudden infant death syndrome shall not be listed as the cause of death of a child, unless the death involves an infant under one (1) year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the child's clinical history.

(l) Any individual or entity providing information pertinent to the investigation and related autopsy in a suspected case of sudden, unexplained infant death syndrome shall not be civilly liable for breach of confidentiality concerning the release of such information.

[Acts 2001, ch. 321, § 2; 2002, ch. 591, §§ 1, 2.]

68-1-1103. Implementation

In order to implement the provisions of this part, the commissioner of health shall:

(1) Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, as may be necessary to obtain in proper form all information relating to the occurrence of a sudden unexplained child death which is relevant and appropriate for the establishment of a reliable statistical index of the incidence, distribution and characteristics of cases of sudden, unexplained child death;

(2) Promulgate rules and regulations in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, that establish minimum standards for conducting and completing an investigation, including an autopsy if deemed necessary, into the sudden, unexplained death of any child from birth to age seventeen (17). Initial rules promulgated pursuant to subdivision (2) are authorized to be promulgated as public necessity rules, pursuant to § 4-5-209. In promulgating such rules, the commissioner may rely, in whole or in part, on any nationally recognized standards regarding such investigations. Compliance with such rules shall make county governments eligible for reimbursement, to the extent authorized by those rules, of the costs of any autopsy deemed necessary;

(3) Collect such factual information from physicians, coroners, medical examiners, hospitals, and public health officials who have examined any child known or believed to have experienced sudden, unexplained death; provided that no information shall be collected or solicited that reasonably could be expected to reveal the identity of such child;

(4) Make such information available to physicians, coroners, medical examiners, hospitals, public health officials, and educational and institutional organizations conducting research as to the causes and incidence of sudden, unexplained child death;

(5) Cause appropriate counseling services to be established and maintained for families affected by the occurrence of sudden infant death syndrome; and

(6) Conduct educational programs to inform the general public of any research findings which may lead to the possible means of prevention, early identification, and treatment of sudden infant death syndrome.

[Acts 2001, ch. 321, § 3; 2005, ch. 356, § 1.]

Appendix E – Internet Resources

American Academy of Pediatrics SIDS Policy Statement	www.cjsids.com/art/AAP_policy_statement.pdf 2005
Anne E. Casey Foundation Kids Count	www.kidscount.org/cgi-bin/clicks.cgi
Bereavement Support Services in TN	www.mtsu.edu/learn/sids/support.shtml
CDC – SIDS	www.cdc.gov/SIDS/
CDC Infant Sleep Recommendations	www.cdc.gov/SIDS/sleepenvironment.htm
First Candle	www.firstcandle.org/bedtimebasics/
Governors Highway Safety Association	www.ghsa.org/html/stateinfo/laws/cellphone_laws.html
MTSU Death Scene Investigation Training	www.mtsu.edu/learn/sids/
National MCH Center for Child Death Review	www.childdeathreview.org/
National MCH Center for Child Death Review Case Reporting Form	www.childdeathreview.org/reports/CDRCaseReportForm02202008.pdf
NICHD Back to Sleep Brochures – FREE	www.nichd.nih.gov/publications/pubskey.cfm?from=sids
State of Tennessee Strategic Highway Safety Plan	www.tdot.state.tn.us/incident/TNStrategicHwyplan07.pdf
State of Tennessee, Department of Health Maternal and Child Health	health.state.tn.us/MCH/index.html
State of Tennessee, Tennessee Department of Health, Child Fatality Review Program (CFR)	health.state.tn.us/MCH/CFR.htm
State of Tennessee, Tennessee Department of Health, Help Us Grow Successfully (HUGS)	health.state.tn.us/MCH/hugs.htm
State of Tennessee, Tennessee Department of Health, Sudden Infant Death Syndrome Program (SIDS)	health.state.tn.us/MCH/SIDS/index.htm
State of Tennessee, Tennessee Department of Health, Vital Statistics	health.state.tn.us/statistics/vital.htm

Appendix F – Cell Phone Law Summary

Cell Phones Laws in Other States[33]

Current state cell phone driving law highlights include the following:

- **Handheld Cell Phone Bans:** 5 states (California, Connecticut, New Jersey, New York and Washington), the District of Columbia and the Virgin Islands have enacted cell phone laws prohibiting driving while talking on handheld cell phones.
    - With the exception of Washington State, these laws are all **primary enforcement**—an officer may ticket a driver for using a handheld cell phone while driving without any other traffic offense taking place.
- **Text Messaging:** 5 states (Alaska, Louisiana, Minnesota, New Jersey and Washington) have a text messaging ban for all drivers.
- **Novice Drivers:** 17 states and the District of Columbia restrict all cell phone use by novice drivers.
- **School Bus Drivers:** In 16 states and the District of Columbia, school bus drivers are prohibited from all cell phone use when passengers are present, except for in emergencies.
- **Preemption Laws:** Some cities, such as Phoenix and Detroit, have cell phone laws, but 9 states have preemption laws that prohibit local jurisdictions from enacting restrictions.
- Some states, such as Utah and New Hampshire, treat cell phone use as a larger distracted driving issue.
    - Utah considers speaking on a cellphone to be an offense *only* if a driver is also committing some other moving violation (other than speeding).

No state completely bans all types of cell phone use (handheld and hands-free) for all drivers.

State	Crash Data Collected	Pre-emption Law	Handheld Ban	Text Messaging Ban	All Cell Phone Ban		Enforcement
					School Bus Drivers	Novice Drivers	
Alabama							
Alaska	Yes			Yes (eff. 9/1/08)			
Arizona					Yes		Primary
Arkansas					Yes		Primary
California	Yes		Yes (commercial drivers exempted until 2011)		Yes	<18	Primary
Colorado	Yes					Learners Permit	Secondary
Connecticut	Yes		Yes (some professions exempted)		Yes	Learners Permit and <18	Primary
Delaware	Yes				Yes	GDL	Primary

[33]Information obtained from the Governors Highway Safety Association, American Automobile Association, Insurance Institute for Highway Safety and State Highway Safety Offices. Most recently reviewed October, 2008.
www.ghsa.org/html/stateinfo/laws/cellphone_laws.html

State	Crash Data Collected	Pre-emption Law	Handheld Ban	Text Messaging Ban	All Cell Phone Ban		Enforcement
					School Bus Drivers	Novice Drivers	
D.C.			Yes (applies to all drivers, regardless of residency; some professions exempted)		Yes	Learners Permit	Primary
Florida	Yes ("Driver Distraction" w/ cell phone in the narrative. <0.2% of 2006 reports cited cell phone use.)	Yes					
Georgia	Yes				Yes		Primary
Hawaii							
Idaho							
Illinois	Yes		By jurisdiction		Yes	<19 with Permit or GDL	Primary
Indiana	Yes						
Iowa	Yes						
Kansas							
Kentucky		Yes			Yes		Primary
Louisiana		Yes		Yes			
Maine						<18	Primary
Maryland	Yes					<18 w/ Learner or Provisional License	Secondary
Massachusetts	Yes		By jurisdiction		Yes		Primary
Michigan	Yes		By jurisdiction			See footnote	
Minnesota	Yes			Yes	Yes	Learner or Provisional License or until age 18	Primary
Mississippi		Yes					
Missouri							
Montana	Yes						
Nebraska	Yes					Teens w/ Learners or Provisional License	Secondary
Nevada	Yes	Yes					
New Hampshire							
New Jersey	Yes	Yes	Yes	Yes	Yes	<21 w/ GDL or Provisional License	Primary
New Mexico			By jurisdiction and in State vehicles				
New York	Yes		Yes				Primary
North Carolina	Yes				Yes	<18	Primary
North Dakota							
Ohio			By jurisdiction				
Oklahoma	Yes	Yes					
Oregon	Yes	Yes				>18 w/ Learner or Provisional License	Secondary
Pennsylvania	Yes		By jurisdiction				
Rhode Island					Yes	<18	Primary
South Carolina							
South Dakota	Yes						
Tennessee	Yes				Yes	Learners	Primary

State	Crash Data Collected	Pre-emption Law	Handheld Ban	Text Messaging Ban	All Cell Phone Ban		Enforcement
					School Bus Drivers	Novice Drivers	
						Permit or Intermediate License	
Texas	Yes				Yes, w/ passenger ≤17	<18 in Learner or Intermediate Stage	Primary
Utah 3	Yes	Yes					
Vermont							
Virgin Islands	Yes		Yes				No data
Virginia	Yes				Yes	Intermediate License	Secondary
Washington	Yes		Yes	Yes			Secondary
West Virginia						Learner or Intermediate Stage	Secondary
Wisconsin							
Wyoming							
Total	29 States + Virgin Islands	9 States	5 States + D.C., Virgin Islands	5 States	16 States + D.C.	17 States + D.C.	Varies

Appendix G – Index of Tables

Appendix H – Index of Figures