CHILD FATALITIES IN TENNESSEE 2004

Tennessee Department of Health

Bureau of Health Services
Maternal and Child Health Section

Phil Bredesen
Governor

Kenneth S. Robinson, M.D.
Commissioner

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Acknowledgements

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Analysis and evaluation of data prepared by:

The University of Tennessee Safety Center Staff
Gregory C. Petty, PhD
Susan M. Smith, Ed.D, MSPH
June Gorski, DrPH

The Division of Maternal and Child Health Staff
Jacqueline Johnson, M.P.A.
Kwame A. Bawuah, M.P.H.
Pinky Noble-Britton, R.N.

Special thanks to the child fatality review teams for their efforts in child death review and prevention.

For additional copies or questions concerning the report, contact:

Child Fatality Review Director
Tennessee Department of Health
Maternal and Child Health
425 5th Avenue North
5th Floor Cordell Hull Building
Nashville, TN 37243
(615) 741-0368

This report is also available on the Internet:

http://www2.state.tn.us/health/MCH/CFR.htm

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Executive Summary

2004 Tennessee Child Fatality Review

Child Fatality Review Teams (CFRT) are active in all judicial districts in the state. During 2004, the teams completed review of 1,042 (95.2%) of the 1095 fatalities of Tennessee resident children. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed children's deaths by Manner of Death and what caused the deaths (Cause of Death).

MANNER OF DEATH

The manner of death for 1,042 child fatalities reported in 2004, was determined by the CFRT to be natural causes for 68.71% (N=716); unintentional injury (accidental) causes for 21.88% (N=228); homicide for 2.98% (N=31); suicide for 1.73% (N=18); could not be determined 3.55% (N=37); and undetermined due to suspicious circumstances 1.15% (N=12) (see Table 1 entitled Manner of Death).

Table 1: Manner of Death (N=1,042)

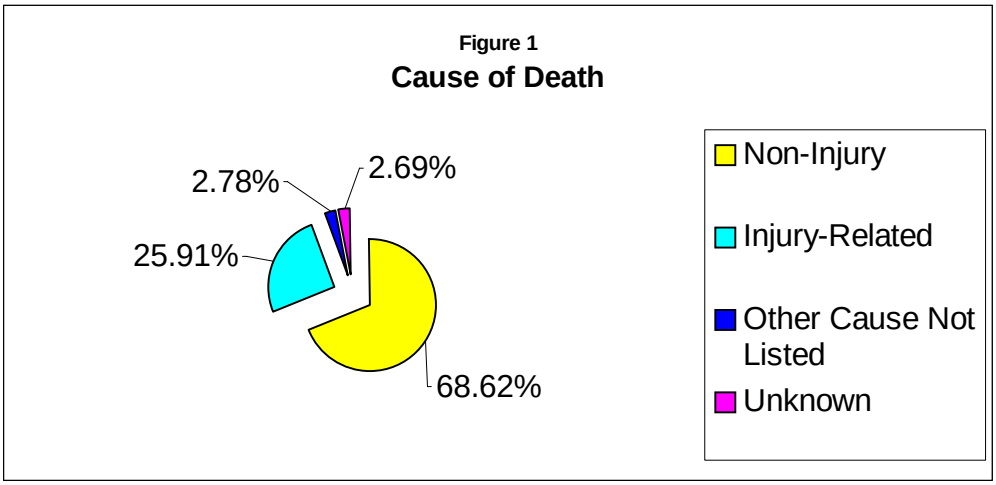
Manner of Death	Number	Percent**	Rate*
Homicide	31	2.98%	2.22
Accidental	228	21.88%	16.30
Natural	716	68.71%	51.20
Suicide	18	1.73%	1.29
Could Not Be Determined	37	3.55%	2.65
Undetermined due to suspicious circumstances	12	1.15%	0.86
All Manner	**1042**	**100.00%**	**74.51**

***Rates per 100,000 in the population**
****Percentage rounded for reporting purposes**

CAUSE OF DEATH

The 1,042 child fatalities were divided into the following categories by cause of death: Non-injury 68.62% (N=715); Injury-related 25.91% (N=270); Other cause not listed 2.78% (N=29); Unknown 2.69% (N=28).

Figure 1



Overall, the cause of death was reported in thirteen categories. The 715 deaths recorded as non-injury were reported in the categories of SIDS, Lack of Adequate Care, Prematurity, and Illness/Other Natural Cause. Injury related deaths (N=270) were reported in the categories of Drowning, Suffocation/Strangulation, Vehicular, Firearm, Inflicted Injury, Poison/Overdose, and Fire/Burn. Other Cause Not Listed (N=29) and Unknown Cause (N=28) were reported separately (see Table 2 entitled Overall Cause of Death).

Table 2: Overall Cause of Death (N=1,042)

Cause of Death	Number	Percent	Rate*
Sudden Infant Death Syndrome	68	6.53	4.86
Lack of adequate care	1	0.10	0.07
Prematurity	311	29.85	22.24
Illness or other natural cause	335	32.15	23.95
Drowning	24	2.30	1.72
Suffocation/strangulation	37	3.55	2.65
Vehicular	135	12.96	9.65
Firearm	27	2.59	1.93
Inflicted Injury	20	1.92	1.43
Poisoning/overdose	10	0.96	0.72
Fire/burn	17	1.63	1.22
Other cause not listed above	29	2.78	2.07
Unknown cause	28	2.69	2.00
Total	**1042**	**100.00**	**74.51**

***Rates per 100,000 in the population**
****Percentage rounded for reporting purposes**

Deaths Due to Non-injury Causes

There were 715 deaths due to non-injury causes among Tennessee children in 2004, representing 68.62% of all child fatalities including those that were not determined. Of these, the greatest number of deaths due to non-injury resulted from illness (N=335) followed by prematurity (N=311).

Of the deaths where gestational age was reported, 121 involved extremely premature infants (i.e., less than 23 weeks gestation), 151 involved gestations of 23 to 37 weeks and 3 involved more than 37 weeks gestation.

Deaths Due To Injury

In 2004 there were 270 deaths (25.91% of all childhood fatalities) due to injury among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (135) or 50% of all injury-related fatalities). Suffocation/strangulation fatalities were the next most common cause of injury-related death resulting in 37 fatalities (13.70% of all injury-related fatalities) and Firearm fatalities (27 or 10%). Overall, childhood fatalities due to injuries in 2004 occurred at a rate of 19.31 per 100,000.

Recommendations from the State Child Fatality Prevention Team

The State Child Fatality Prevention Team discussed the recommendation submitted by the child fatality review team leaders (see attached) and concluded that they were all important. The state prevention team decided the main items that should be brought before the legislature were recommendations to:

1. Establish guidelines for child death review teams in order to define the minimum age for review by the local teams. Currently, deaths of infants less than 22 weeks of completed gestation, or less than 500 grams in weight are not required to be reported as a fetal death. Therefore, the local teams should not review these deaths.

2. Amend T.C.A. §68-142-103 to include the commissioner of the Department of Education, or their designee to serve as a statutory member of the state team. Also, amend T.C.A. §68-142-106 to include a local district school employee as a statutory member of the local child fatality review team.

3. Establish a law requiring drivers to check the van for children at the end of a day care related trip. Sensors should be placed in the day care vans that would alert drivers that child remains in seat.

4. Encourage coordinated current and future state efforts in preventative substance abuse programs that mirror evidence based practices regarding families, pregnancies and children. (Impact of methamphetamine and methadone use of mothers/ parents on infant and children)

5. Promote and collaborate public awareness of child abuse and neglect and the need for making reports of such incidents, also supporting the need for additional training to staff of the Department of Children's Services in investigating abuse and neglect of children, particularly in sex abuse allegations/cases.

6. Develop public awareness/educational campaign that provide emphasis on pre-conceptual and prenatal care.

7. Develop statewide media campaign surrounding safe sleep practices for infants, including safe bedding, provide information to day care providers regarding safe sleep practices. Resurrect the co-sleeping campaign and unsafe sleeping habits for infants

8. Continue to promote and support the Tennessee Suicide Prevention Network as they implement the youth training initiative -"Tennessee Lives Count."

9. Support the Governor's initiative to create a Fetal Infant Mortality Review (FIMR) Team with the purpose of taking a more comprehensive look at fetal and infant deaths that are considered natural. Davidson County has a high infant mortality rate. The primary cause of this high rate is pre-maturity. Following the development of the Davidson County team, FIMR should be conducted statewide.

10. Encourage continued efforts of state and local law enforcement agencies to have gun safety training for gun owners.

11. Create and launch a public awareness campaign regarding the dangers of hood surfing (riding on the hood of an automobile standing or dancing while car is in motion), and also riding in the back of a pick-up trucks. Law should be enacted that would suspend or revoke the driver's license of students involved in hood surfing.

12. Driver's education requirements should be established. Those requirements should include advanced driver education assertive driver's training. Establish campaign for first time drivers to provide brochures and additional safety classes, etc., to educate new teen drivers. Ensure that all graduated drivers' license rules are included in driver's education handbook and licensure examinations.

13. Develop or promote legislation to regulate all terrain vehicles (ATV) usage. Establish a minimum age requirement, safety gear, parental requirements, seller requirements and pre-training prior to driving.

14. Copies of all autopsy reports should be automatically sent to each CDR team leaders to help with case investigation including the check list and autopsy notes. Decrease the response time for receiving toxicology and complete autopsy reports so they are received in a timely manner.

15. Promote public awareness on the impact of environmental toxins on children i.e., pesticides, lead, etc.

16. First responders should be trained on the new data forms so that their reports can capture some of the items requested on the data collection form by the review team.

Child Fatality Review State Prevention Team, 2006

Karen Alexander, Assistant Special Agent in Charge, Tennessee Bureau of Investigation
Bonnie Beneke, Tennessee Professional Society on Abuse of Children
Andy Bennett, Chief Deputy Attorney General
Shalonda Cawthon, Executive Director, Child Safety
Senator Diane Black, Member, General Welfare, Health and Human Resources Committee
Dr. Howard Burley, Mental Health and Developmental Disabilities
Senator Charlotte Burks, Tennessee State Senate
Representative Dennis Ferguson, Member, House Health and Human Resources Committee
Judge Betty Adams Green, Juvenile Court
Senator Roy Herron, Chair, Select Committee on Children and Youth
Jacqueline Johnson, M.P.A., Program Director, Child Fatality Review Program
Bruce Levy, M.D., State Medical Examiner
Representative Joe McCord, Tennessee House of Representatives
Linda O'Neal, Tennessee Commission on Children and Youth
Cindy Perry, Select Committee, Children and Youth
Theodora Pinnock, M.D., Director Maternal and Child Health
Scott Ridgeway, Tennessee Suicide Prevention Network
Kenneth S. Robinson, M.D., Commissioner of the Department of Health
Kim Rush, Program Director for Children and Youth Services
Vacant, M.D., Director, Davidson County Health Department

Recommendations from the Local Child Fatality Review Teams
August 2006

After review of the year's progress and concerns, the child fatality review teams (CFRT) submitted recommendations that were discussed and summarized by the CFRT team leaders. Recommendations to the state child fatality prevention team follow:

Highest Priority

1. The State should establish a law or criteria, or adopt the CDC's recommended guidelines that would allow child fatality review teams to reach a consensus for the age at which deaths should be reviewed by the CFRT; deaths of infants less than 22 weeks should not be considered live births, should be considered miscarriages or fetal demise not pre-maturity and should not be reviewed by the team.

2. Communication between the Child Death Review Team and other child serving agencies should be strengthened and/or a link established to provide coordination among Child Protective Services, Department of Education and other key child service entities.

3. Legislators should pass a law requiring drivers to check the van for children at the end of a day care related trip. Sensors should be placed in the day care vans that would alert drivers that child remains in seat.

Other Concerns by Category

Infant Mortality/Pre-Conceptual Issues

1. Develop public awareness/educational campaign that provide emphasis on pre-conceptual and prenatal care.

2. Develop state-wide media campaign surrounding safe sleep practices for infants, including safe bedding, provide information to day care providers regarding safe sleep practices. Resurrect the co-sleeping campaign and unsafe sleeping habits with infants.

3. Support the Governor's initiative to create a Fetal Infant Mortality Review (FIMR) Team in Davidson County with the purpose of taking a more comprehensive look at fetal and infant deaths which are considered natural. Davidson County has a high infant mortality rate. The primary cause of this high rate is pre-maturity. Following the development of the Davidson County team, FIMR should be conducted statewide.

Education

1. The Department of Health should create an educational campaign that will emphasize the importance of Gun Safety training for gun owners.

2. Create and launch a public awareness campaign regarding the dangers of hood surfing (riding on the hood of an automobile standing or dancing while care is in motion), and also riding in the back of a pick-up trucks. Law should be enacted that would suspend or revoke the driver's license of students involved in hood surfing.

3. Education campaign should be launched regarding the effects of prescribed medication on driving.

Law

1. Driver's education requirements should be established. Those requirements should include advanced driver education assertive driver's training. Establish campaign for first time drivers to provide brochures and additional safety classes, etc., to educate new teen drivers. Ensure that all graduated drivers' license rules are included in driver's education handbook and licensure examinations.

2. Develop or promote legislation to regulate all terrain vehicles (ATV) usage. Establish a minimum age requirement, safety gear, parental requirements, seller requirements and pre-training prior to driving.

Data Issues

1. Copies of all autopsy reports should be automatically sent to each CDR team leaders to help with case investigation including the check list and autopsy notes. Increase the response time for receiving toxicology and complete autopsy reports in timely manner.

2. First responders should be trained on the new data forms so that their reports can capture some of the items requested on the data collection form by the review team.

These recommendations were identified by the team leaders as having the highest concern for 2006. However, the recommendations from 2005 continue to be of vital concern to the team leaders.

Health Department Regions, Judicial Districts, and CFR Team Leaders

Region	CFR Team Leader, Judicial District (JD) and Counties
Northeast	Dr. Lawrence Moffatt/Pat Rash JD 1: Carter, Johnson, Unicoi, and Washington Dr. Barbara Skelton/Pat Rash JD 3: Greene, Hamblen, Hancock, and Hawkins
Sullivan	Dr. Stephen May/Dana Osborne JD 2: Sullivan
East	Dr. Paul Erwin/Frank Bristow JD 4: Cocke, Grainger, Jefferson, and Sevier JD 5: Blount JD 7: Anderson JD 8: Campbell, Claiborne, Fentress, Scott, and Union JD 9: Loudon, Meigs, Morgan, and Roane
Knox	Dr. Kelly Boggan JD 6: Knox
Southeast	Dr. Jan Beville JD 10: Bradley, McMinn, Monroe, and Polk JD 12: Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie
Hamilton	Kaye Greer JD 11: Hamilton
Upper Cumberland	Dr. Don Tansil JD 13: Clay, Cumberland, DeKalb, Overton, Pickett, Putnam, and White JD 15: Jackson, Macon, Smith, Trousdale, and Wilson JD 31: Van Buren and Warren
South Central	Dr. Langdon Smith JD 14: Coffee JD 17: Bedford, Lincoln, Marshall, and Moore JD 2101: Hickman, Lewis, and Perry JD 2201: Giles, Lawrence, and Wayne JD 2202: Maury
Davidson	Dr. Kimberly Wyche-Etheridge/Brook McKelvey JD 20: Davidson
Mid Cumberland	Dr. Alison Asaro/ Sharon A. Woodard JD 16: Cannon, and Rutherford JD 18: Sumner JD 1901: Montgomery JD 1902: Robertson JD 2102: Williamson JD 23: Cheatham, Dickson, Houston, Humphreys, and Stewart

Region	CFR Team Leader, Judicial District (JD) and Counties
West	Dr. Shavetta Conner JD 24: Benton, Carroll, Decatur, Hardin, and Henry JD 25: Fayette, Hardeman, Lauderdale, McNairy, and Tipton JD 27: Obion and Weakley JD 28: Crockett, Gibson, and Haywood JD 29: Dyer and Lake
Madison	Dr. Tony Emison JD 26: Chester, Henderson, and Madison
Shelby	Flo Patton JD 30: Shelby

2004 Tennessee Child Fatality Review

Tennessee Child Fatality Review 2004

MANNER OF DEATH

The manner of death for 1,042 child fatalities in 2004, was determined by the CFRT to be natural causes for 68.71% (N=716); unintentional injury (accidental) causes for 21.88% (N=228); homicide for 2.98% (N=31); suicide for 1.73% (N=18); could not be determined 3.55% (N=37); and undetermined due to suspicious circumstances 1.15% (N=12) (Table 1).

The overall rate of child fatalities for 2004 computed from the cases reviewed by the CFRT was 74.51 per 100,000. Fatality rates identified in this report were computed based on census data for Tennessee in 2000 and reported as the number of cases per 100,000 in the population of children less than 18 years of age.

Table 1: Manner of Death (N=1,042)

Manner of Death	Number	Percent	Rate*
Homicide	31	2.98%	2.22
Accidental	228	21.88%	16.30
Natural	716	68.71%	51.20
Suicide	18	1.73%	1.29
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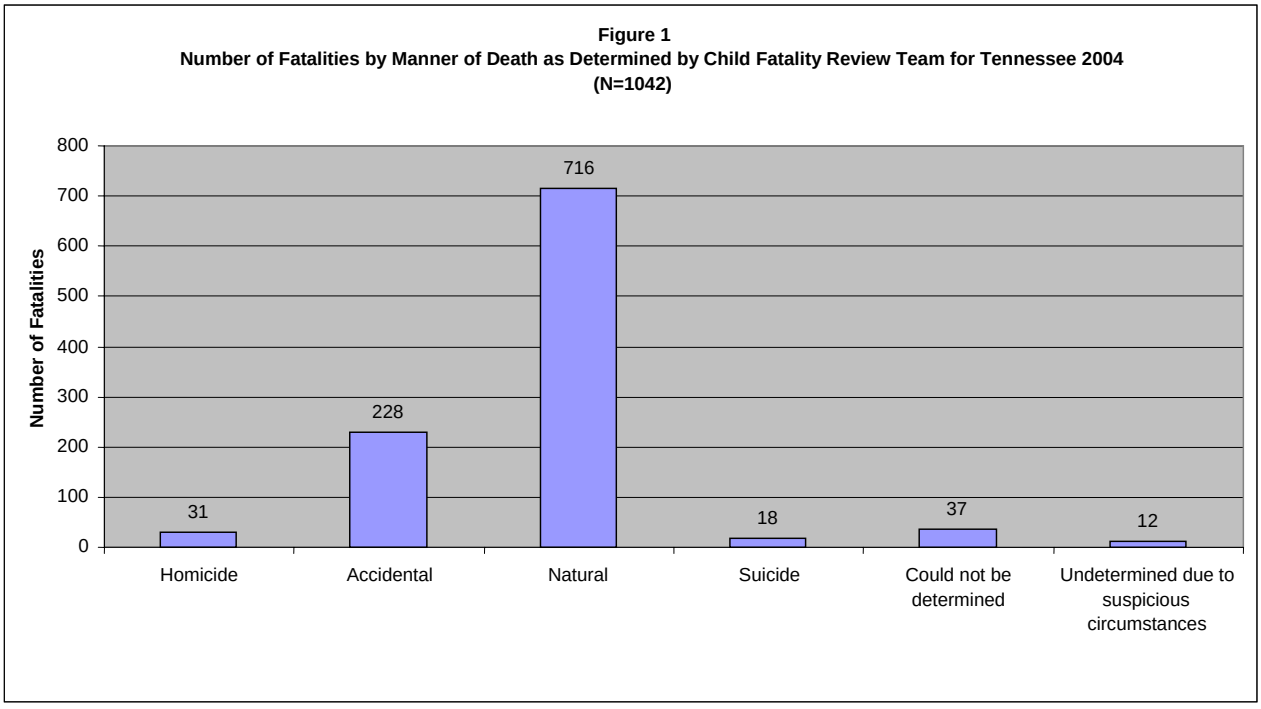
All Manner	**1042**	**100.00%**	**74.51**

***Rates per 100,000 in the population**
****Percentage rounded for reporting purposes**

Figure 1
Number of Fatalities by Manner of Death as Determined by Child Fatality Review Team for Tennessee 2004 (N=1042)



Manner of Death as Determined by CFRT

The CFRT on average, agreed with the manner of death indicated on the death certificate in 67.47% (N=703) of the cases (Table 2). The CFRT concluded 31 of the cases were homicides (versus 24 on death certificate); 228 were accidental (versus 199 on death certificate); 716 were natural deaths (versus 567 on death certificates); 18 suicides (versus 20 on death certificate); 36 could not be determined (versus 20 on death certificate). Twelve deaths were undetermined by the CFRT versus 78 deaths that listed pending investigation. All of the CFRT reports were marked except for one death that occurred out of state, versus 128 death certificates that were blank or not listed. The CFRT noted differences with the death certificate in 32.53% (N=339) of cases.

Table 2:
Differences in Death Certificate and CFRT Determination

CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT
Age	**Homicide**		**Accidental**		**Natural**		**Suicide**		**Could Not Be Determined**		**Blank/Unmarked**		**Pending Investigation/ Undetermined**	
<1	7	10	22	36	461	581	0	0	16	28	93	0	56	4
1-2	4	6	16	19	27	35	0	0	0	3	12	0	4	0
3-5	1	2	17	16	14	16	0	0	1	0	2	0	3	4
6-8	2	2	10	10	14	20	0	0	1	1	5	0	2	2
9-11	0	0	19	21	10	12	0	0	0	0	2	0	2	0
12-14	1	2	33	35	12	18	2	2	1	0	7	0	2	1
15-17	9	9	82	91	29	34	18	16	1	4	7	0	9	1
Total	24	31	199	228	567	716	20	18	20	36	128	1	78	12
%Agree		**77.42**		**87.28**		**79.19**		**90.0**		**55.56**				**15.38**
Average Agreement			**67.47%**											

Manner of Death and Age

Across all groups the highest rate of fatalities in 2004 was during the first year of life (877.18 per 100,000). The second highest rate of fatalities occurred in youth aged 15-17 (66.62 per 100,000) (Table 3).

Table 3: Number and Rates of Fatalities by Manner of Death and Age (N=1,042)

		Homicide	Accidental	Natural	Suicide	Could Not Determined	Undetermined/ Suspicious	Not Marked	Total	Rate*
Age	<1	10	36	581	0	28	4	0	659	877.18
	1-2	6	19	35	0	3	0	0	63	42.08
	3-5	2	16	16	0	0	4	0	38	16.76
	6-8	2	10	20	0	1	2	0	35	14.81
	9-11	0	21	12	0	0	0	0	33	13.49
	12-14	2	35	18	2	0	1	0	58	24.86
	15-17	9	91	34	16	4	1	0	155	66.62
Total		**31**	**228**	**716**	**18**	**36**	**12**	**1**	**1042**	**74.51**
Percent		**2.98%**	**21.90%**	**68.78%**	**1.73%**	**3.46%**	**1.15%**	**100.00%**	**2.98%**	
Rate		**2.22**	**16.30**	**51.20**	**1.29**	**2.57**	**0.86**	**74.51**	**2.22**	

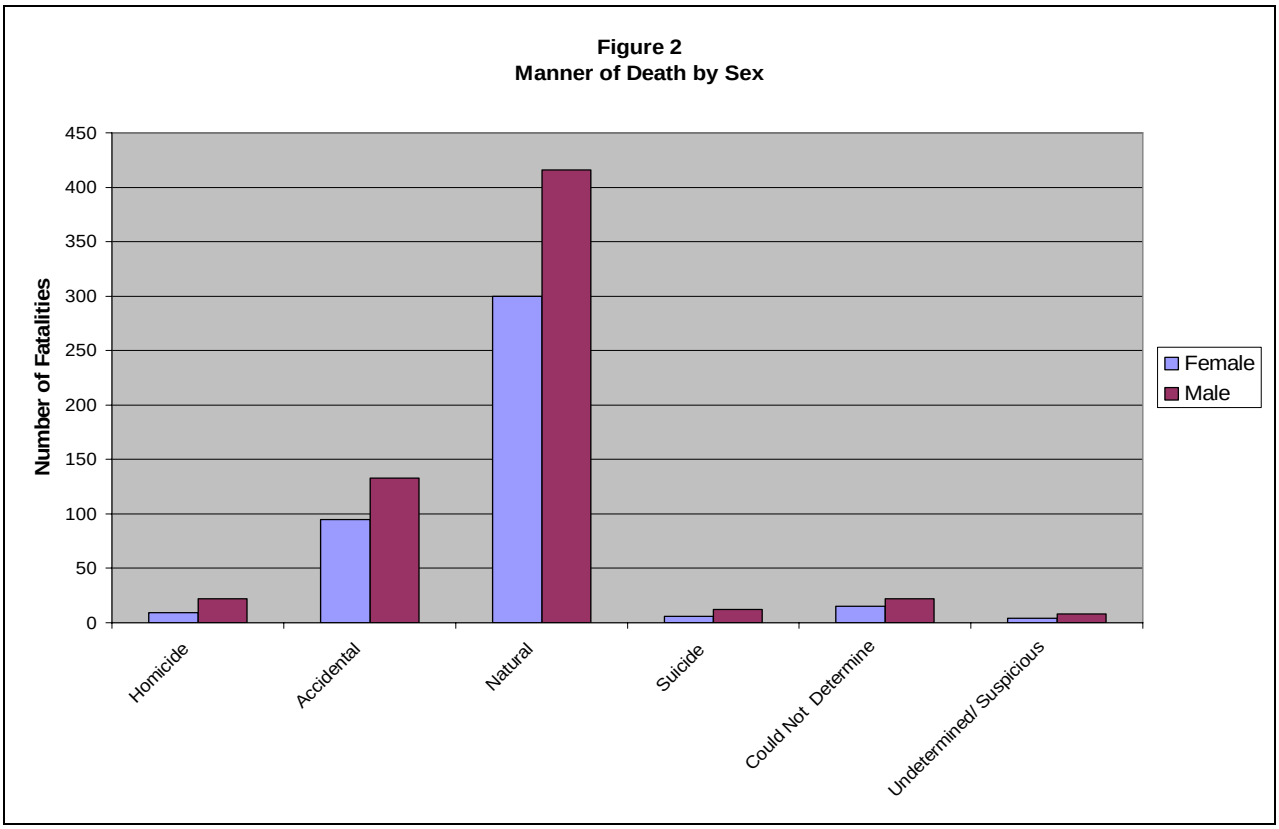
***Rates per 100,000 in the population**
Note: No data reported on one death that occurred out of state

Manner of Death and Sex

Fifty nine percent of child fatalities were males (N=613) and 41% were females (N=429), which corresponded to rates of 85.31 per 100,000 for males and 63.09 per 100,000 for female children in Tennessee. The largest number of fatalities for both sexes occurred by natural manner (Table 4 and Figure 2).

Table 4: Manner of Death and Sex (N=1,042)

		Homicide	Accidental	Natural	Suicide	Could Not Determine	Undetermined/ Suspicious	Not Marked	Total
Sex	Female	9	95	300	6	15	4	0	429
	Male	22	133	416	12	22	8	0	613
	Not Marked	0	0	0	0	0	0	0	0
Total		**31**	**228**	**716**	**18**	**37**	**12**	**0**	**1042**



Manner of Death and Race

Natural was the highest category of manner of death for all races (N=716). The total number of natural fatalities for White children was 396 (55.3%), for African-American children 283 (39.5%), and for Other 33 (4.6%). Four of the natural fatalities were classified as Asian (Table 5).

Table 5: Manner of Death and Race (N=1,042)

		Homicide	Accidental	Natural	Suicide	Could Not Determine	Undetermined Suspicious	Not Marked	Total
RACE	African-American	12	37	283	3	10	4	0	349
	White	17	180	396	15	25	8	0	641
	Other	2	11	33	0	1	0	0	47
	Asian	0	0	4	0	0	0		4
	Missing	0	0	0	0	0	0	1	1
Total		**31**	**228**	**716**	**18**	**36**	**12**	**1**	**1042**

Manner of Death by Age, Sex, and Race

Of the 1,042 child fatalities, one death occurred out of state and no CFR data were recorded, 641 (61.5%) were reported as White, 349 (33.5%) were reported as African-American, and 47 (4.5%) were reported as Other race. Four deaths were reported in 2004 as Asian, however census data

were not available to calculate death rate. The rate of all fatalities for African-American children was 117.70 per 100,000 or nearly twice the rate for White children of 61.71 per 100,000. The rate for Other race was 74.37 per 100,000.

Across all races, the highest rate of fatalities was during the first year of life. African-Americans had the second highest fatality rate of 117.70 (N=349). Males had the next highest fatality rate of 85.31 (N=613). (Table 6).

Table 6: Overall Manner of Death Fatality Rates by Age, Sex and Race, (N=1,042)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	659	877.18	Female	429	63.09	African-American	349	117.70
1-2	63	42.08	Male	613	85.31	White	641	61.71
3-5	38	16.76				Other	47	74.37
6-8	35	14.81				Asian	4	
9-11	33	13.49				Not Marked	1	
12-14	58	24.86						
15-17	155	66.62						
Total	**1041**	**74.51**		**1042**	**74.51**		**1042**	**74.51**

***Rates per 100,000 in the population**
Note: One death occurred out of state and no age was recorded

Manner of Death: Violence-related

In 2004, there were 49 child fatalities due to violence-related injuries. These injuries were the result of either homicide (N=31) or suicide N=18). This represents 4.7% of all child fatalities (Table 7, Figure 3).

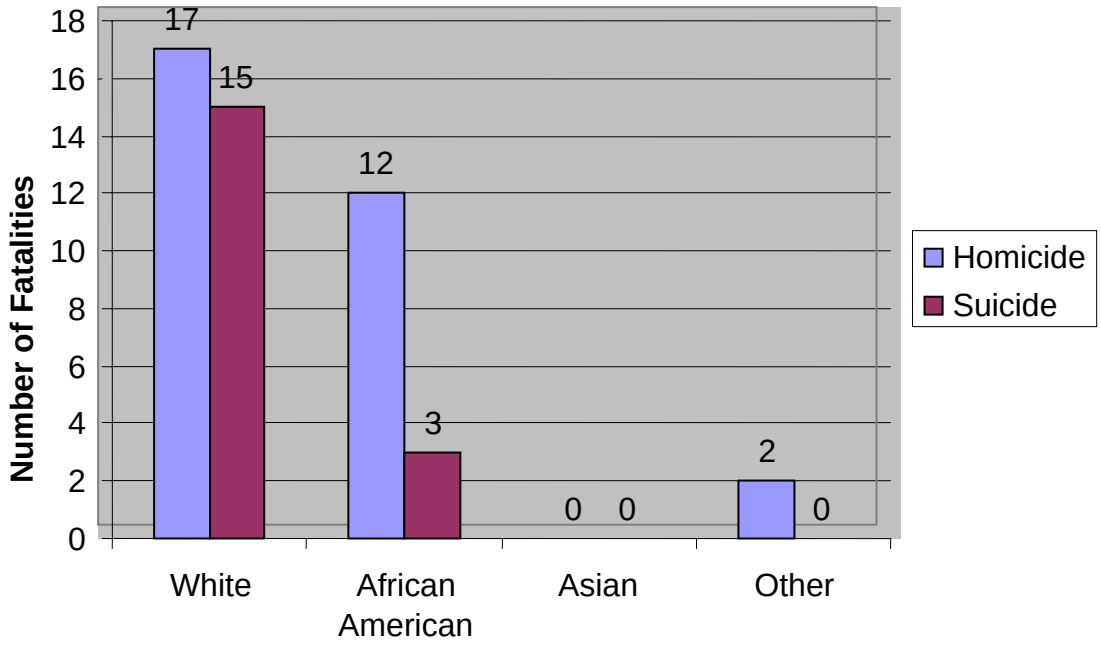
Males (N=34; 4.73 per 100,000) were more likely than females (N=15; 2.21 per 100,000) to die from violence-related injuries. African-American children (N=15; 5.06 per 100,000) were more likely to die of violence-related injuries as White children (N= 32; 3.08 per 100,000) followed by children in the "Other" racial category (N=2; 3.16 per 100,000). Children in the 15-17 years age group had the highest rate of violence-related fatalities (N= 25; 10.74 per 100,000), followed by children less than one year (N=10; 13.31 per 100,000).

Table 7: Violence-related Fatalities by Age, Sex, and Race (N=49)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	10	13.31	Female	15	2.21	African-American	15	5.06
1-2	6	4.01	Male	34	4.73	White	32	3.08
3-5	2	0.88				Other	2	3.16
6-8	2	0.85				Asian	0	
9-11	0	0.00						
12-14	4	1.71						
15-17	25	10.74						
Total	**49**	**3.50**		**49**	**3.50**		**49**	**3.50**

***Rates per 100,000 in the population**

Figure 3
Violence-related Child Fatalities by Manner and Race (N=49)



Homicide

In 2004, there were 31 child fatalities due to homicides. This represents 63% of all violence-related deaths and 2.98% of all child fatalities (Table 8).

Males (N=22; 3.06 per 100,000) were more likely than females (N=9; 1.32 per 100,000) to die from homicides. African-American children (N=12; 4.05 per 100,000) died at a higher rate than that of other children (N=2; 3.16 per 100,000) followed by white children (N=17; 1.64 per 100,000).

Table 8: Homicide Fatalities by Age, Sex, and Race (N=31)

Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	10	13.31	Female	9	1.32	African-American	12	4.05
1-2	6	4.01	Male	22	3.06	White	17	1.64
3-5	2	0.88				Other	2	3.16
6-8	2	0.85				Asian	0	**
9-11	0	0.00						
12-14	2	0.86						
15-17	9	3.87						
Total	**31**	**2.22**		**31**	**2.22**		**31**	**2.22**

***Rates per 100,000 in the population**
****Rates not available**

Suicide

During 2004, 18 young people committed suicide. Most of these deaths were by children in the 15 to 17 years age group (N=16; 6.88 per 100,000). Two children committed suicide in the 12-14 age group (N=2; 0.86 per 100,000). Males (N=12; 1.67 per 100,000) were more likely than females (N=6; 0.88 per 100,000) to die from suicide. Three African-American children committed suicide in 2004 (1.01 per 100,000) while 15 White children (1.44 per 100,000) died as a result of suicide (Table 9).

Table 9: Suicide Fatalities by Age, Sex, and Race (N=18)***

Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	0	0.00	Female	6	0.88	African-American	3	1.01
1-2	0	0.00	Male	12	1.67	White	15	1.44
3-5	0	0.00				Other	0	0.00
6-8	0	0.00				Asian	0	**
9-11	0	0.00						
12-14	2	0.86						
15-17	16	6.88						
Total	**18**	**1.29**		**18**	**1.29**		**18**	**1.29**

Rates per 100,000 in the population
****Rates not available**
*****Note: There were 19 suicides in 2003**

Manner of Death by County

Six hundred and thirty three (60.7%) of all child fatalities occurred in thirteen counties with 15 or more deaths each (Table 10). In 2004, the highly populated counties of Shelby and Davidson reported a total of 342 fatalities and accounted for 33% of all child fatalities. Shelby County had the highest percentage of all childhood fatalities (N=255; 24.5%) followed by Davidson (N=87; 8.4%), Hamilton (N=52; 5%). Knox (N=35; 3.3%), and of the 13 counties reporting the most child fatalities, all ranked in the top 18 counties with the highest population age 0-17 years. (Table 10).

Table 10: Fatalities from Counties with15 or More Fatalities (N=633)

County	Fatalities	Rank in Population Ages 0-17
SHELBY	255	1
DAVIDSON	87	2
HAMILTON	52	4
KNOX	35	3
MONTGOMERY	31	6
RUTHERFORD	25	5
BRADLEY	24	14
MADISON	24	11
WASHINGTON	24	13
SULLIVAN	22	9
TIPTON	21	18
SUMNER	18	8
BLOUNT	15	10
TOTAL	**633**	

Table 11: Fatalities from All Counties (N=1042)

COUNTY	Accidental	Natural	Homicide/ Suicide	Could not be determined	Undetermined due to suspicious circumstances	Total	*Rate
ANDERSON	5	4	1	0	0	10	60.48
BEDFORD	1	8	0	0	0	9	92.91
BENTON	2	1	0	0	0	3	82.39
BLEDSOE	1	1	0	0	0	2	70.08
BLOUNT	5	7	0	3	0	15	62.16
BRADLEY	3	21	0	0	0	24	115.21
CAMPBELL	1	4	0	0	0	5	54.78
CANNON	3	1	0	1	0	5	153.42
CARROLL	1	1	2	1	0	5	73.10
CARTER	2	7	0	3	0	12	99.02
CHEATHAM	0	6	0	1	0	7	70.49
CHESTER			0				0.00
CLAIBORNE	0	1	0	0	0	1	14.20
CLAY	0	1	0	0	0	1	58.34
COCKE	2	1	0	0	1	4	52.21
COFFEE	2	7	1	0	0	10	83.02
CROCKETT	0	1	0	0	0	1	27.37
CUMBERLAND	2	4	2	0	0	8	79.91
DAVIDSON	15	62	5	4	1	87	68.80
DECATUR			0				0.00
DEKALB	0	3	0	0	0	3	74.04
DICKSON	3	5	2	0	0	10	87.06
DYER	3	3	0	0	0	6	62.52
FAYETTE	2	5	0	0	0	7	94.48
FENTRESS	2	1	1	0	0	4	99.43
FRANKLIN	0	4	0	0	0	4	44.23
GIBSON	0	5	0	0	0	5	43.34
GILES	2	4	0	1	0	7	96.95
GRAINGER	2	6	0	0	0	8	169.06
GREENE	5	9	0	0	0	14	100.06
GRUNDY	4	4	1	0	0	9	249.93
HAMBLEN	0	6	0	0	0	6	44.35
HAMILTON	8	40	2	1	1	52	72.79
HANCOCK	0	1	0	0	0	1	63.69
HARDEMAN	1	6	0	0	0	7	104.14
HARDIN	0	1	0	0	0	1	16.96
HAWKINS	2	7	0	0	1	10	80.13
HAYWOOD	2	3	0	0	0	5	92.94
HENDERSON	3	5	0	0	0	8	128.78
HENRY	1	2	1	0	0	4	57.86
HICKMAN	0	1	0	0	0	1	18.17
HOUSTON	0	1	0	0	0	1	50.76
HUMPHREYS	3	0	0	0	0	3	70.06
JACKSON	1	0	0	0	0	1	40.88
JEFFERSON	5	3	0	1	0	9	88.76
JOHNSON	1	3	0	0	0	4	115.98
KNOX	10	20	0	5	0	35	41.13

LAKE			0				0.00
LAUDERDALE	1	5	0	0	0	6	89.30
LAWRENCE	2	3	0	1	0	6	57.40
LEWIS			0				0.00
LINCOLN	1	3	1	0	0	5	66.86
LOUDON	0	3	1	0	0	4	46.73
MCMINN	1	4	1	1	0	7	59.69
MCNAIRY	1	1	0	1	0	3	51.50
MACON	1	2	0	0	1	4	75.27
MADISON	3	18	2	1	0	24	101.19
MARION	1	4	0	0	0	5	75.83
MARSHALL	4	3	0	0	0	7	102.28
MAURY	6	4	0	0	0	10	54.84
MEIGS			0				0.00
MONROE	1	4	2	0	0	7	72.62
MONTGOMERY	9	16	2	2	2	31	80.88
MOORE			0				0.00
MORGAN	1	4	0	0	0	5	109.10
OBION	0	6	0	0	0	6	78.89
OVERTON	0	3	1	0	0	4	86.39
PERRY	1	2	0	0	0	3	161.12
PICKETT	0	1	0	0	0	1	94.61
POLK	0	1	0	0	0	1	27.57
PUTNAM	1	10	0	0	0	11	79.26
RHEA	2	5	0	0	0	7	103.84
ROANE	2	2	0	0	0	4	34.50
ROBERTSON	3	7	0	0	0	10	68.58
RUTHERFORD	5	16	2	1	1	25	51.96
SCOTT	2	3	0	1	0	6	108.97
SEQUATCHIE	4	1	0	0	0	5	179.08
SEVIER	1	1	0	1	0	3	18.32
SHELBY	33	209	12	1	0	255	100.68
SMITH	1	1	2	1	0	5	110.60
STEWART	2	4	0	0	0	6	202.70
SULLIVAN	7	13	1	0	1	22	65.85
SUMNER	5	11	0	1	1	18	52.42
TIPTON	3	17	1	0	0	21	139.77
TROUSDALE			0				0.00
UNICOI	0	1	2	0	0	3	82.76
UNION	1	2	0	0	0	3	65.56
VAN BUREN			0				0.00
WARREN	2	1	1	1	0	5	53.88
WASHINGTON	7	15	0	2	0	24	105.09
WAYNE	0	1	0	0	0	1	27.79
WEAKLEY	0	1	0	0	1	2	26.49
WHITE	1	4	0	0	0	5	91.93
WILLIAMSON	3	10	0	0	1	14	37.48
WILSON	5	8	0	0	0	13	55.78
Total	228	716	49	36	12	**1042	74.51

***Rates per 100,000 in the population**

****One death occurred out of state and county was not reported**

Note: Counties with no reviewed deaths: Chester, Decatur, Lake, Lewis, Meigs, Moore, Trousdale, and Van Buren

CAUSE OF DEATH

The 1,042 child fatalities were divided into the following categories by cause of death:

- Non-injury 715 (68.62%)
- Injury-related 270 (25.91%)
- Other cause not listed 29 (2.78%)
- Unknown 28 (2.69%)

Overall, the cause of death was reported in thirteen categories. The 715 deaths recorded as non-injury were reported in the categories of SIDS, Lack of Adequate Care, Prematurity, and Illness/Other Natural Cause. Injury related deaths (N=270) were reported in the categories of Drowning, Suffocation/Strangulation, Vehicular, Firearm, Inflicted Injury, Poison/Overdose, and Fire/Burn. Other Cause Not Listed (N=29) and Unknown Cause (N=28) were reported separately (Table 12).

Table 12: Overall Cause of Death (N=1,042)

Cause of Death	Number	Percent	Rate*
Sudden Infant Death Syndrome	68	6.53%	4.86
Lack of adequate care	1	0.10%	0.07
Prematurity	311	29.85%	22.24
Illness or other natural cause	335	32.15%	23.95
Drowning	24	2.30%	1.72
Suffocation/strangulation	37	3.55%	2.65
Vehicular	135	12.96%	9.65
Firearm	27	2.59%	1.93
Inflicted Injury	20	1.92%	1.43
Poisoning/overdose	10	0.96%	0.72
Fire/burn	17	1.63%	1.22
Other cause not listed above	29	2.78%	2.07
Unknown cause	27	2.59%	1.93
Out of State Death	1	.10%	
Total	**1042**	**100**	**74.51**

***Rates per 100,000 in the population**

A summary of cause of death by age, sex and race are reported in Tables 13, 14, and 15.

Table 13: Cause of Death by Age (N=1,042)*								
	<1	**1-2**	**3-5**	**6-8**	**9-11**	**12-14**	**15-17**	**Total**
SIDS	68	0	0	0	0	0	0	68
Lack of adequate care	1	0	0	0	0	0	0	1
Prematurity	308	3	0	0	0	0	0	311
Illness or other natural cause	203	34	16	20	11	18	33	335
Drowning	4	5	5	4	2	3	1	24
Suffocation/strangulation	22	3	0	0	3	2	7	37
Vehicular	6	6	5	3	9	28	78	135
Firearm	1	0	1	3	0	3	19	27
Inflicted Injury	8	4	2	1	0	1	4	20
Poisoning/overdose	1	0	1	0	0	0	8	10
Fire/burn	1	2	6	0	5	3	0	17
Other cause not listed above	13	4	2	2	3	0	5	29
Unknown cause	23	2	0	2	0	0	0	27
Out of State Death								1
All Causes	**659**	**63**	**38**	**35**	**33**	**58**	**155**	**1042**

***Cause for one death that occurred out of state was not reported**

Table 14: Cause of Death by Sex (N=1,042)			
	Female	**Male**	**Total**
SIDS	24	44	68
Lack of adequate care	1	0	1
Prematurity	133	178	311
Illness or other natural cause	141	194	335
Drowning	4	20	24
Suffocation/strangulation	13	24	37
Vehicular	57	78	135
Firearm	7	20	27
Inflicted Injury	7	13	20
Poisoning/overdose	8	2	10
Fire/burn	7	10	17
Other cause not listed above	12	17	29
Unknown cause	15	13	28
TOTAL	**429**	**613**	**1042**

Table 15: Cause of Death by Race (N=1,042)*						
	African American	**White**	**Asian**	**Other**	**Not Marked**	**Total**
SIDS	29	38	0	1	0	68
Lack of adequate care	1	0	0	0	0	1
Prematurity	151	145	2	13	0	311
Illness or other natural cause	103	210	1	21	0	335
Drowning	5	18	0	1	0	24
Suffocation/strangulation	13	24	0	0	0	37
Vehicular	12	119	0	4	0	135
Firearm	10	17	0	0	0	27
Inflicted Injury	4	14	0	2	0	20
Poisoning/overdose	2	7	0	1	0	10
Fire/burn	7	6	0	4	0	17
Other cause not listed above	3	25	1	0	0	29
Unknown cause	9	18	0	0	1	28
All Causes	**349**	**641**	**4**	**47**	**1**	**1042**

***Race for one death that occurred out of state was not reported**

Deaths Due to Non-injury Causes

There were 715 deaths due to non-injury causes among Tennessee children in 2004, representing 68.62% of all child fatalities including those that were not determined. Of these, the greatest number of deaths due to non-injury resulted from illness (N=335) followed by prematurity (N=311).

Of the 311 deaths due to prematurity where gestational age was reported, 121 involved extremely premature infants (i.e., less than 23 weeks gestation) and 151 involved gestations of 23 to 37 weeks. Three infants with gestational age of more than 37 weeks were reported as having died due to prematurity in 2004. This information is discussed in more detail further in the report.

Deaths Due to Illness or Other Conditions

In 2004, 335 children died due to illness or other conditions. This represents 46.85% of all non-injury deaths and 32.15% of all child fatalities for 2004. More than half (N=203) of all fatalities due to illness involved children of less than one year of age (Table 16).

Table 16: Fatalities Due To Illness or Other Natural Causes by Age, Sex and Race (N=335)								
Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	203	270.21	Female	141	20.74	African-American	103	34.74
1-2	34	22.71	Male	194	27.00	White	210	20.22
3-5	16	7.06				Other	21	33.29
6-8	20	8.46				Asian	1	**
9-11	11	4.50				Missing	0	0
12-14	18	7.72						
15-17	33	14.18						
Total	**335**	**23.95**		**335**	**23.95**		**335**	**23.95**

***Rates per 100,000 in the population**
****Rates not available**

Prematurity

A total of 311 deaths were from complications due to prematurity in 2004. Gestational age was recorded for 275 children. Of these, 121 (44%) deaths in 2004 occurred in infants with a gestational age of less than 23 weeks. For infants who died with a gestational age of 23 to 37 weeks, 151 deaths (54.9%) were recorded. Prematurity was the cause of death of 3 children (1.1%) who were reported with a gestational age of more than 37 weeks. Overall, prematurity was the manner of death for 43.5% of deaths due to non-injury and 29.85% of all childhood deaths (Table 17).

Of the 121 fatalities due to prematurity with less than 23 weeks of gestational age:
- One hundred four (85.95%) died within 24 hours of birth
- Eight (6.61%) died between 1 and 6 days of birth
- Five (4.13%) died between 7 and 28 days
- Three (2.48%) died between 29-364 days of birth
- Age at death was not reported for one child

Of the 151 fatalities due to prematurity with 23-37 weeks of gestational age:
- Sixty four (42.38%) died within 24 hours
- Thirty nine (25.83%) died between 1 and 6 days of age
- Twenty four (15.89%) died between 7 and 28 days
- Twenty two (14.57%) died between 29 and 364 days of age
- Age at death was not reported for two children

Of the 3 fatalities due to prematurity with greater than 37 weeks of gestational age:
- All three died within 24 hours

Table 17: Fatalities Due To Prematurity by Age, Sex, Race and Gestational Age (N=275)

Gestational Age Less than 23 Weeks (N=121)								
Age	Number	%	**Sex**	Number	%	**Race**	Number	%
<1 day	104	85.95%	Female	47	38.84%	African-American	68	56.20%
1-6 days	8	6.61%	Male	74	61.16%	White	50	41.32%
7-28 days	5	4.13%				Other	1	0.83%
29-364 days	3	2.48%				Asian	2	1.65%
Not Reported	1	0.83%		0	0		0	0
Total	**121**	**100%**		**121**	**100%**		**121**	**100%**

Gestational Age 23-37 Weeks (N=151)								
Age	Number	%	**Sex**	Number	%	**Race**	Number	%
<1 day	64	42.38%	Female	69	45.70%	African-American	59	39.07%
1-6 days	39	25.83%	Male	82	54.30%	White	82	54.30%
7-28 days	24	15.89%				Other	10	6.62%
29-364 days	22	14.57%				Asian	0	0.00%
Not Reported	2	1.3%						
Total	**151**	**100%**		**151**	**100%**		**151**	**100%**

Gestational Age More than 37 Weeks (N=3)								
Age	Number	%	**Sex**	Number	%	**Race**	Number	%
<1 day	3	100%	Female	2	66.66%	African-American	0	0
1-6 days	0		Male	1	33.33%	White	3	100%
7-28 days	0					Other	0	0
29-364 days	0					Asian	0	0
Total	**3**	**100%**		**3**	**100%**		**3**	**100%**

Mother's age and gestational age was reported for 266 of the 311 children who died due to prematurity. Of these 266, childhood fatalities among infants born at less than 23 weeks gestation were most frequent among women between 22 to 25 years of age (N=34). Childhood fatalities among infants born between 23 and 37 weeks of gestation were most frequent among mother's who were 31 to 40 years of age (N=48) (Table 18).

Table 18: Fatalities Due To Prematurity by Mother's Age and Gestational Age (N=266)								
Less than 23 weeks			**23-37 weeks**			**More than 37 weeks**		
Mother's Age	Number	Percent	Mother's Age	Number	Percent	Mother's Age	Number	Percent
14-17	7	5.93%	14-17	11	7.53%	14-17	0	0
18-21	22	18.64%	18-21	29	19.86%	18-21	0	0
22-25	34	28.81%	22-25	23	15.75%	22-25	2	100%
26-30	21	17.80%	26-30	35	23.97%	26-30	0	0
31-40	33	27.97%	31-40	48	32.88%	31-40	0	0
41-45	1	0.85%	41-45	0	0.00%	41-45	0	0
Total	**118**	**100.00%**	**Total**	**146**	**100.00%**	**Total**	**2**	**100%**

Sudden Infant Death Syndrome (SIDS)

In 2004, 68 deaths were reported as sudden infant death syndrome (SIDS). This represents 9.5% of deaths due to non-injury and 6.5% of all childhood deaths in 2004. The most frequently occurring age of death was 5 to 8 weeks (N=32). Of all fatalities due to SIDS, 44 (64.7%) occurred between 5 and 12 weeks of age (Figure 4).

Of the 68 reported SIDS deaths, sleeping position was known for 28 children. Of these 28, 19 (73%) were on their stomachs with face down, 2 (7.1%) were on his/her stomach with face to the side, 1 (3.6%) was on his/her side, and 6 (21.4%) were on their back. Of the 48 known responses to sleeping with another person, 22 (45.8%) were sleeping with another person, 26 (54.2%) were not sleeping with another person. The other 20 were either not reported or were unknown. Regarding Smoker in the household, of the 31 total reported as known, 23 (74.2%) reported yes and 8 (25.8%) reported no.

Deaths Due To SIDS

In 2004 there were 68 deaths that reported Cause of Death as Sudden Infant Death Syndrome (see Figure 5 below). This was a 15.5% increase from 2003 when there were 58 Deaths due to SIDS.

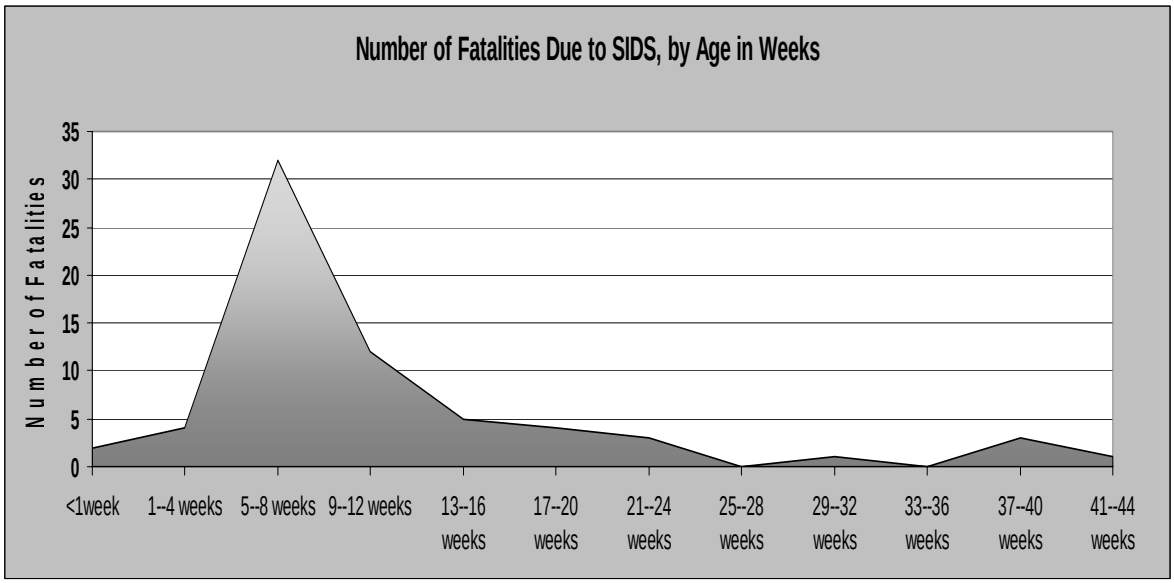


Figure 5: Sudden Infant Death Syndrome (SIDS) (N=68)

Deaths Due To Lack of Medical Care

In 2004, one fatality was attributed to delayed, inadequate, or lack of medical care (Table 19).

Table 19: Fatalities Due To Lack of Care by Age, Sex and Race (N=1)

Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	1	1.33	Female	1	0.150	African-American	1	6.55
1-2	0	0	Male	0	0	White	0	0
3-5	0	0				Other	0	0
6-8	0	0						
9-11	0	0						
12-14	0	0						
15-17	0	0						
Total	**1**	**0.07**						

***Rates per 100,000 in the population**

Deaths Due To Injury

In 2004, there were 270 deaths (25.9% of all childhood fatalities) due to injury among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (135) or 50% of all injury-related fatalities). Suffocation/strangulation fatalities were the next most common cause of injury-related death resulting in 37 fatalities (13.7% of all injury-related fatalities) (Figure 6). Death rates for African-American children were nearly as likely to be involved in an injury-related fatality as White children (Tables 20-21). Overall, childhood fatalities due to unintentional injuries in 2004 occurred at a rate of 19.31 per 100,000.

Table 20: Fatalities Due To Injury by Age, Sex and Race (N=270)								
Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	43	57.24	Female	103	15.15	African-American	53	17.87
1-2	20	13.36	Male	167	23.24	White	205	19.73
3-5	20	8.82				Other	12	18.99
6-8	11	4.65				Asian	0	**
9-11	19	7.77				Missing	0	**
12-14	40	17.15						
15-17	117	50.29						
Total	**270**	**19.31**		**270**	**19.31**		**270**	**19.31**

***Rates per 100,000 in the population**
**** Rates not available**

Childhood fatalities to injuries were more prevalent among males (N= 167; 23.24 per 100,000) than females (N= 103; 15.15 per 100,000). Children ages 15 to 17 had the highest incidence of unintentional injury deaths (N=117; 50.29 per 100,000). Infants less than one year of age had the next highest number of deaths at 43 but were the highest injury-related death rate at 58.24 per 100,000.

Fatalities due to injuries among African-American children (N=53; 17.87 per 100,000) but were less than the rate of White children 205 (19.73 per 100,000) and 12 (18.99 per 100,000) children died with race selected as other.

Table 21: Fatalities Due to Injury by Race (N=270)					
	African-American	White	Other	Asian	Total
Drowning	5	18	1	0	24
Suffocation/Strangulation	13	24	0	0	37
Vehicular	12	119	4	0	135
Firearm	10	17	0	0	27
Inflicted Injury	4	14	2	0	20
Poison/Overdose	2	7	1	0	10
Fire/Burn	7	6	4	0	17
TOTAL	53	205	12	0	270
Rate*	**17.87**	**19.73**	**18.99**	**	**19.31**

***Rates per 100,000 in the population**
**** Rates not available**

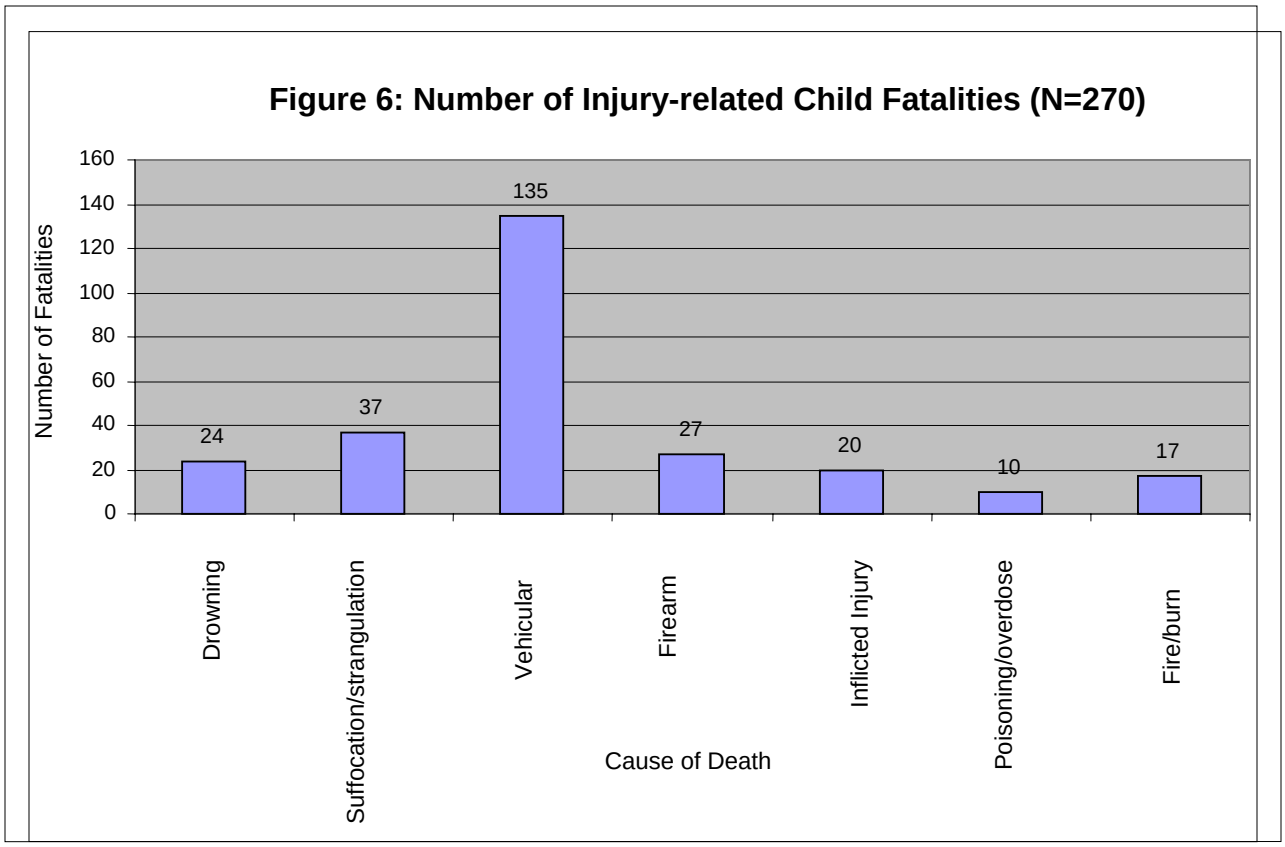


Figure 6: Number of Injury-related Child Fatalities (N=270)
Number of Fatalities
160
140
120
100
80
60
40
20
0
24
37
135
27
20
10
17
Drowning
Suffocation/strangulation
Vehicular
Firearm
Inflicted Injury
Poisoning/overdose
Fire/burn
Cause of Death

Vehicle-Related Deaths

In 2004, 135 children died in vehicle-related incidents. This represents 50% of all injury-related deaths and 13% of all child fatalities for 2004. Children aged 15 to 17 were most likely to die as a result of a vehicle related injury N=78; 33.52 per 100,000) and children aged 12 to 14 (N=28; 12.00 per 100,000 in the population) were the second most likely to die in a vehicle related incident. Males (10.86 per 100,000 in the population) were only slightly more likely to die in a vehicle related death as females (8.38 per 100,000 in the population). Whites had a slightly higher rate of vehicle related incidents than African-Americans (11.46 versus 4.05 respectively) (Table 22).

Table 22: Fatalities Due To Vehicular by Age, Sex and Race (N=135)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	6	7.99	Female	57	8.38	African-American	12	4.05
1-2	6	4.01	Male	78	10.86	White	119	11.46
3-5	5	2.21				Other	4	6.33
6-8	3	1.27				Asian	0	**
9-11	9	3.68				Missing	0	**
12-14	28	12.00						
15-17	78	33.52						
Total	**135**	**9.65**		**135**	**9.65**		**135**	**9.65**

***Rates per 100,000 in the population**
****Rates not available**

Vehicular

There were 135 vehicular deaths in 2004. These deaths occurred in a car (N=99; 73.33%) or truck/rv (N=23; 17%), all terrain vehicles were involved in seven deaths (5.2%), motorcycles in two deaths (1.5%), bicycles in one death (0.7%), farm tractors one (0.7%) and other (N=2; 1.5%). The decedent was driver of the vehicle in 54 incidents (40%) and passenger in 57 (42.2%). Thirteen (9.6%) were pedestrians and eleven (8.15%) were other or unknown.

Safety belts were present in vehicle but not used in 53 (39%) of deaths and speed/recklessness was indicated in 37 (27.4%) of deaths (Table 23).

Table 23: Fatalities Due To Vehicular (N=135)								
Safety Belt Use?	Number	Percent	Helmet?	Number	Percent	VEHICLE IN WHICH DECEDANT WAS OCCUPANT	Number	Percent
Present in vehicle, but not used	53	39.0	Yes	3	14.3	Operator driving impaired	9	6.67
None in vehicle	3	2.2	No	18	85.7	Speed/recklessness indicated	37	27.4
Restraint used	24	17.8				Other violation by operator	5	3.7
Unknown	19	14.1				Other	9	6.67
NA	30	22.2				Unknown	13	9.6
Not Marked	6	4.4				NA	23	17.0
						Not Marked	39	28.9
Total	**135**	**100**				**Total**	**135**	**100**

Note: Percentages rounded to nearest whole percent for illustration purposes

Suffocation or Strangulation

In 2004, there were 37 child fatalities due to suffocation or strangulation. This represents 13.7% of all injuries and 3.55% of all child fatalities in 2004. Among these deaths, 59.5% (N=22) involved a child less than one year old (Table 24).

Table 24: Fatalities Due To Suffocation or Strangulation by Age, Sex and Race (N=37)								
Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1 day	0		Female	13	1.91	African-American	13	4.38
1-6 days	0		Male	24	3.34	White	24	2.31
7-28 days	4					Other	0	0
29-364 days	18							
< 1 year	22	29.28						
1-2 years	3	2.00						
3-5 years	0	0.00				Asian	0	**
6-8 years	0	0.00						
9-11 years	3	1.23						
12-14 years	2	0.86						
15-17 years	7	3.01						
Total	**37**	**2.65**		**37**	**2.65**		**37**	**2.65**

***Rates per 100,000 in the population**
****Rates not available**

Firearms

In 2004, 27 children died due to firearm injuries. This represents 10% of all injury deaths and 3% of all childhood fatalities (Table 25). Males (N=20; 2.78 per 100,000) were significantly more likely to die due to firearm injuries than females (N=7; 1.03 per 100,000). Seventy (N=19) percent of all firearm deaths occurred in age groups of 15-17 years old.

Table 25: Fatalities Due To Firearm by Age, Sex and Race (N=27)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	1	1.33	Female	7	1.03	African-American	10	3.37
1-2	0	0.00	Male	20	2.78	White	17	1.64
3-5	1	0.44				Other	0	0
6-8	3	1.27				Asian	0	**
9-11	0	0.00						
12-14	3	1.29						
15-17	19	8.17						
Total	**27**	**1.93**		**27**	**1.93**		**27**	**1.93**

***Rates per 100,000 in the population**
****Rates not available**

Drowning

In 2004, 24 children died from accidental drowning. This represents 8.89% of all injury-related deaths and 2.3% of all child fatalities in 2004. There was little difference by race for the rate of death by drowning. (African-American children (N=5; 1.69 per 100,000 in the population; white children, N=18; 1.73 per 100,000 in the population; and Other races, N=1; 1.58 per 100,000 in the population) (Table 26).

Table 26: Fatalities Due To Drowning by Age, Sex and Race (N=24)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	4	5.32	Female	4	0.59	African-American	5	1.69
1-2	5	3.34	Male	20	2.78	White	18	1.73
3-5	5	2.21				Other	1	1.58
6-8	4	1.69				Asian	0	**
9-11	2	0.82						
12-14	3	1.29						
15-17	1	0.43						
Total	**24**	**1.72**		**24**	**1.72**		**24**	**1.72**

***Rates per 100,000 in the population**
*****Rates not available***

Inflicted Injury

In 2004, there were 20 child fatalities due to inflicted injuries. This represents 7.4% of all injury-related fatalities and 7.4% of all child fatalities in 2004.

Children under one year of age were the most likely to die from inflicted injuries (N=8; 10.65 per 100,000 in the population) and males N=13; 1.81 per 100,000 in the population). African-American children (N=4; 1.35 per 100,000 in the population) were as likely to die from inflicted injuries as White children (N=14; 1.35 per 100,000 in the population) (Table 27).

Table 27: Fatalities Due To Inflicted Injury by Age, Sex and Race (N= 20)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	8	10.65	Female	7	1.03	African-American	4	1.35
1-2	4	2.67	Male	13	1.81	White	14	1.35
3-5	2	0.88				Other	2	3.16
6-8	1	0.42				Asian	0	**
9-11	0	0.00						
12-14	1	0.43						
15-17	4	1.72						
Total	**20**	**1.43**		**20**	**1.43**		**20**	**1.43**

***Rates per 100,000 in the population**
****Rates not available**

Inflicted Injury

Most injuries were inflicted by a person (Other) who was not a parent or relative (N=14; 70%) and most of the injured were reported as male (9 males versus 4 females). When race was reported or known seven were white and four were African American (Table 28).

Table 28: Relationship, Gender, and Race of Person Inflicting Injury (N=20)

Who Inflicted Injury?	Number	Percent	**Gender of Person Inflicting Injury**	Number	Percent	**Race of Person Inflicting Injury**	Number	Percent
Parent	4	20.0	Male	9	45.0	White	7	35.0
Relative	1	5.0	Female	4	20.0	African American	4	20.0
Other	14	70.0	Not Marked	2	10.0	Unknown	9	45.0
Self Inflicted	1	5.0						
Total	**20**	**100**	**Total**	**20**	**100**	**Total**	**20**	**100**

Manner and Location of Inflicted Injury

Most inflicted injury deaths occurred when a child was shaken (N=7; 35.0%) and hands/feet were used to inflict the injury (N=8; 40%). The child's residence was the location of most inflicted injury deaths (N=13; 65%) (Table 29).

Table 29: Manner and Location where Injury was Inflicted (N=20)

Manner in which Injury was Inflicted	Number	Percent	**Injury Inflicted With?**	Number	Percent	**Where did Injury Occur?**	Number	Percent
Shaken	7	35.0	Sharp object	1	5.0	Child's residence	13	65.0
Struck	6	30.0	Blunt object	2	10.0	Relative/ friend's home	2	10.0
Thrown	1	5.0	Hands/feet	8	40.0	School	1	5.0
Cut/stabbed	1	5.0				Other	2	10.0
Other	4	20.0	Other	6	30.0	Unknown	2	10.0
Unknown	1	5.0	Unknown	3	15.0			
Total	**20**	**100**	**Total**	**20**	**100**	**Total**	**20**	**100**

Fire/Burns

In 2004, there were 17 child fatalities due to fire or burn injuries. This represents 6.3% of all injury fatalities and 1.63% of all child fatalities in 2004 (Table 30).

Table 30: Fatalities Due To Fire or Burn by Age, Sex and Race (N=17)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	1	1.33	Female	7	1.32	African-American	7	1.69
1-2	7	4.68	Male	10	1.53	White	6	1.35
3-5	78	34.41				Other	4	1.58
6-8	19	8.04				Asian	0	**
9-11	4	1.63						
12-14	8	3.43						
15-17	0	0.00						
Total	**17**	**1.22**		**17**	**1.22**		**17**	**1.22**

***Rates per 100,000 in the population**
****Rates not available**

Poisoning or Overdose

In 2004, there were ten child fatalities due to poisoning or overdose. This represents 3.7% of all injury deaths and 1% of all child fatalities in 2004. The highest rate of deaths occurred with the 15-17 age group (N=8; 3.44 per 100,000 in the population). Females (N=8; 1.18 per 100,000 in

the population) were more likely than males (N=2; 0.28 per 100,000 in the population) to die from poisonings or overdose (Table 31).

Table 31: Fatalities Due To Poisoning or Overdose by Age, Sex and Race (N=10)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race***	Number	Rate*
<1	1	1.33	Female	8	1.18	African-American	2	0.67
1-2	0	0.00	Male	2	0.28	White	7	0.67
3-5	1	0.44				Other	1	1.58
6-8	0	0.00				Asian	0	**
9-11	0	0.00						
12-14	0	0.00						
15-17	8	3.44						
Total	**10**	**0.72**		**10**	**0.72**		**10**	**0.72**

***Rates per 100,000 in the population**
****Rates not available**

Other or Undetermined Cause of Death

In 2004, there were 57 total fatalities where Other Cause (N=29) or Unknown Cause (N=28) was selected for Cause and Circumstances of death. This represented 5.5% of all child fatalities in 2004.

Table 32: Fatalities Due To Other Cause Not Listed by Age, Sex and Race (N=29)

Age	Number	Rate	**Sex**	Number	Rate	**Race***	Number	Rate
<1	13	17.30	Female	12	1.76	African-American	3	1.01
1-2	4	2.67	Male	17	2.37	White	25	2.41
3-5	2	0.88				Other	0	0.00
6-8	2	0.85				Asian	1	**
9-11	3	1.23						
12-14	0	0.00						
15-17	5	2.15						
Total	**29**	**2.07**		**29**	**2.07**		**29**	**2.07**

***Rates per 100,000 in the population.**
****Rates not available**

Table 33: Fatalities Due To Unknown Causes by Age, Sex and Race (N=28)								
Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1 year	23	30.61	Female	15	2.21	African-American	9	3.04
1-2 years	2	1.34	Male	13	1.80	White	18	1.73
3-5 years	0	0.00				Other	0	**
6-8 years	2	0.85				Asian	0	**
9-11 years	0	0.00						
12-14 years	0	0.00						
15-17 years	0	0.00						
Age Unknown	1	0				Race Unknown	1	0
Total	**28**	**2.00**		**28**	**2.00**		**28**	**2.00**

Note: One death that occurred out of state only reported sex of victim
***Rates per 100,000 in the population**
****Rates not available**

Place of Death

When asked to mark the place of death, the CFR team indicated most deaths occurred as hospital inpatients (N=608; 58%) with deaths in the hospital emergency room (N=149; 14.3%). One hundred forty deaths (13.44%) occurred at the child's residence and 86 (8.25%) at the scene of incident. Four deaths occurred in an institutional setting and four in a child care facility (Table 34).

Table 34: Fatalities and Place of Death		
Place of Death	**Number**	**Percent**
Hospital Inpatient	608	58.35
Hospital Emergency Room	149	14.30
In Transit	26	2.50
Institutional Setting	4	0.38
At Scene of Incident	86	8.25
Child's Residence	140	13.44
Relative's/Friend's Home	5	0.48
Child Care	4	0.38
Not Listed	7	0.67
Not Marked, Blank or Other	13	1.25
Total	**1042**	**100.0**

APPENDIX

Child Fatality Review and Prevention Act

Section

68-142-101. Short title

The chapter shall be known as and may be cited as the "Child Fatality Review and Prevention Act of 1995."

[Acts 1995, ch.511,§ 1.]

68-142-102. Child fatality prevention team

There is hereby 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 herein. 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 mental retardation;
(8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee Supreme Court;
(10) The executive director of the commission of children and youth;
(11) The president of the state professional society on the abuse of children
(12) A team coordinator, to be appointed by the commissioner of health;

(13) The chair of the select committee on children and youth;
(14) Two members of the house of representatives to be appointed by the speaker of the house, at least one of whom shall be a member of the house health and human resources committee; and
(15) Two senators to be appointed by the speaker of the senate at least one of whom shall be a member of the senate general welfare, health and human resources committee.

[Acts 1995, ch. 511, § 152.]

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 chapter 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.]

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

(a) There shall be a minimum of one 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 or such officer's designee, 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) 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.]

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 chapter 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.]

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

(a) The local team shall have access to and subpoena power to obtain all medical records and records maintained by any state, county or local agency, Including, but not limited to, police investigations data, medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality.

(b) The local team shall not, as part of the review authorized under this chapter, 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.

(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 in evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams. 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 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.]

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.

Sudden, Unexplained Child Death

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.
(b) 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.
(c) 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.

(d) 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.

(e) 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.

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

(g) 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.

(h) 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.

(i) 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.

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

(k) 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.

(l) 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.

(m) 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.]

State Child Fatality Prevention Team Members (2005)

Dr. Theodora Pinnock, Chair
Director of Maternal and Child Health
425 5th Avenue North
Cordell Hull Building, 5th Floor
Nashville, TN 37247
615-741-0322
Serves by request of the Commissioner of the Tennessee Department of Health

Commissioner Kenneth S. Robinson, M.D.
425 5th Avenue North
Cordell Hull Building, 3rd Floor
Nashville, TN 37247
615-741-3111
Serves by virtue of position as the Commissioner of the Tennessee Department of Health

Jacqueline Johnson, M.P.A.
Director, Child Fatality Review Program
425 5th Avenue North
Cordell Hull Building, 5th Floor
Nashville, TN 37247
615-741-0368
Serves as team coordinator

Voting Members

Shalonda Cawthon
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

Vacant
Serves as a physician selected from nominations submitted by the State chapter of the American Medical Association

Bruce Levy, M.D.
Center for Forensic Medicine
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

Bonnie Beneke
TN Professional Society on Abuse of Children
5819 Old Harding Road, Suite 204
Nashville, TN 37205
615-352-4439

Serves by virtue of position as the President of the TN. Professional Society on the Abuse of Children

Senator Charlotte Burks
Legislative Plaza, Room 9
Nashville, TN 37243
615-741-3978

Appointed by: Tennessee Speaker of the Senate
Serves by virtue of position as a member of the Tennessee Senate

Senator Diane Black
War Memorial Building, Room 305
Nashville, TN 37243
615-741-1999

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

Senator Roy Herron
10A Legislative Plaza
Nashville, TN 37243
(615) 741-4576

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

Linda O'Neal
Tennessee Commission on Children and Youth
9th Floor, Andrew Johnson Tower
Nashville, TN 37243-0800
615-741-2633

Serves by virtue of position as the Executive Director of the Tennessee Commission on Children and Youth

Andy Bennett
Deputy Chief Attorney General
John Sevier Building, Suite 114
Nashville, TN 37243
615-741-3491

Serves by virtue of position as designee for the Attorney General and Reporter for Tennessee

Karen Alexander
Assistant Special Agent in Charge
Tennessee Bureau of Investigation
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

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

Judge Betty Adams Green
Juvenile Court
100 Woodland St.
Nashville, TN 37213
615-862-8054 elainefrey@jis.nashville.org

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

TDH Central Office
Maternal and Child Health
425 5th Avenue North
Cordell Hull Building, 5th Floor
Nashville, TN 37247-4701

Kwame A. Bawuah, M.P.H.
Epidemiologist
615-741-4447

Pinky Noble-Britton, R.N.
Nurse Consultant
615-741-0355

Theresa Lindsey, Assistant Commissioner
Bureau of Health Services Administration
(615) 532-9223

Dr. Ruth Hagstrom, Medical Services Director
(615) 532-2431

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

TENNESSEE CHILD FATALITY REVIEW TEAM LEADERS

CFRT Leader	Phone	Judicial Districts (JD) and Counties
Dr. Lawrence Moffatt/Pat Rash Washington County Health Dept. 415 State of Franklin Johnson City, TN 37604	Phone: (423) 975-2200 Kathy Carver Region (423) 979-4627	**JD 1**: Carter, Johnson, Unicoi, and Washington Counties
Dr. Stephen May Dana Osborne Sullivan Co. Health Dept. PO Box 630 (154 Blountville Bypass) Blountville, TN 37617	Phone: (423) 279-2794 Fax: (423) 279 2797	**JD 2**: Sullivan County
Dr. Barbara Johnston Skelton/Pat Rash Hawkins Co. Health Dept. PO Box 209 247 Silver Lake Road Church Hill, TN 37642	Phone: Rogersville (Base): (423) 272-7641 x 129 Churchill 423-357-5341	**JD 3**: Greene, Hamblen, Hancock, and Hawkins Counties (Sandy J. Malone, Admin.)
Dr. Kelly Boggan Knox County Health Dept. 140 Dameron Ave. Knoxville, TN 37917	Phone: (865) 544-4259 (865) 215-5437 Mary Campbell Linda Weber (ASA) 865-215-5272	**JD 6**: Knox County
Dr. Paul Erwin/Frank Bristow East TN Regional Health Office P.O. Box 59019 1522 Cherokee Trail Knoxville, TN 37950-9019	Phone: SH: (865) 549-5252 Office: (865) 549-5253 Fax: (865) 594-5738	**JD4 –** Priscilla Garner: 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
Dr. Jan BeVille Southeast Regional Health Office State Office Building 540 McCallie Avenue Chattanooga, TN 37402	Phone: (423) 634-3124 Eloise Waters 423-476-0568 x 105	**JD 10**: Brad;eu, MCMinn, Monroe and Polk Counties **JD12**: Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie Counties

Kaye Greer Chattanooga/Hamilton Co. Health Dept. 921 East Third Street Chattanooga, TN 37403	Phone: (423) 209-8155	**JD 11**: Hamilton County
Dr. Langdon Smith South Central Regional Health Office 1216 Trotwood Avenue Columbia, TN 38401-4809	Phone: (931) 380-2532 x 146 Brandy Fox, Sec. Peggy Michonski x 123	**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. Alison Asaro/ Sharon A. Woodard Mid Cumberland Reg. Health Office 710 Hart Lane Nashville, TN 37247-0801	Phone: (615) 650-7015 Fax 262-6139 Melissa Crook 650-4008	**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. Kimberly Wyche-Etheridge /Brook McKelvey Metro/Davidson Co. Health Dept. 311 23rd Ave. North Nashville, TN 37203	Phone: (615) 340-0474	**JD 20**: Davidson County
Dr. Shavetta Conner Regional Health Officer 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	**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. Tony Emison Jackson/Madison Co. Health Dept. 544 Rowland Ave. Jackson, TN 38301	Phone: (731) 423-3020	**JD 26**: Chester, Henderson, and Madison Counties

Flo Patton Shelby County Health Department 814 Jefferson Avenue Memphis, TN 38105-5099	Phone: (901) 544-7380	**JD 30**: Shelby County
Dr. Bruce Levy State Medical Examiner	Phone: (615) 743-1800	
Lisa Robison	Phone: (615) 743-1801	

Child's Name: _____
Last First Middle

Date of Death: ____/____/____ Date of Birth: ____/____/____ Age at Death: _____ Sex: ☐ Male ☐ Female

Address: _____ Zip Code: _____
Street City

Race: ☐ White ☐ African American ☐ Asian ☐ Other:_____ Ethnicity: Hispanic origin? ☐ Yes ☐ No

Mother's Name: _____/_____/_____/_____
Last Maiden First Middle

Mother's Date of Birth: _____/_____/_____ Mother's Marital Status (at time of Child's birth): ☐ S ☐ M ☐ D ☐ W
Month Day Year

Census Tract: _____ County of Residence _____

Birth Weight: _____/_____ _____/_____ Clinical Estimate of Gestation (weeks): _____
kg gm lb oz

Abnormal Conditions: _____ Congenital Anomalies: _____

Prenatal Care Questions:

Specify Month Prenatal Care Began _____ ☐ No Prenatal Care ☐ Unknown

Number of Prenatal Visits _____ ☐ No Visits ☐ Unknown

Risk Factors: Tobacco Use: ☐ Yes ☐ No No. of cigarettes per day _____

Alcohol Use: ☐ Yes ☐ No No. of drinks per week _____

Chemical Substance Abuse: ☐ Yes ☐ No Specify _____

To the best of the team's knowledge, is the Birth Certificate information correct/complete: ☐ Yes ☐ No

Death Certificate Number _____ Is the Death Certificate adequate/complete? ☐ Yes ☐ No

Manner of death on Death Certificate: ☐ Homicide ☐ Suicide ☐ Accidental ☐ Natural
☐ Pending Investigation ☐ Could not be determined ☐ Blank

Place of Death: ☐ Hospital Inpatient ☐ At Scene of Incident
☐ Hospital Emergency Room ☐ Child's Residence
☐ In Transit ☐ Relative's/Friend's Home
☐ Institutional Setting ☐ Child Care

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

If Yes, location: ☐ Medical Examiner _____ ☐ Hospital _____ ☐ Other _____

Review team comments/recommendations and prevention issues (for local team use):

_____
_____
_____
_____
_____

Recommended for additional review? ☐ Yes ☐ No

Which reports/records were requested for full review?

☐ Law enforcement ☐ Court ☐ DA report
☐ School ☐ DHS ☐ Health Dept.
☐ Med. Exam autopsy ☐ Hospital autopsy
☐ Attending physician ☐ Other: _____

☐ Sudden Infant Death Syndro
☐ Lack of adequate care
☐ Prematurity
☐ Illness or other natural cause
☐ Drowning
☐ Suffocation/strangulation
☐ Vehicular

2. Family has prior child protec
☐ Yes ☐ No ☐ Unknown

3. Other public/private agency i
☐ Yes ☐ No ☐ Unknown
If yes, name of agency:
Health Department: ☐ Imr
☐ Hor
DHS: ☐ FF ☐ Foc
☐ Counseling/Mental Healt
☐ TennCare
☐ Other: _____

4. Was there an apparent delay
☐ Yes ☐ No ☐ Unknown

5. Suspected child abuse/neglec
☐ Yes ☐ No ☐ Unknown

6. Overall was the investigation
If no, was the problem with:
☐ Autopsy
☐ Hospital review
☐ Interagency Cooperation
☐ Other _____

7. Manner of death as determin
☐ Homicide ☐ Accidental
☐ Could not be determined
☐ Undetermined due to susp

Additional information for Stat
_____
_____
_____
_____
_____

CAUSE AND CIRCUMSTANCES OF THE DEATH
Complete one of blocks 1-12 as applicable to indicate cause of death.

☐ **1. Sudden Infant Death Syndrome (SIDS)**
A. Position of infant on discovery?
1.☐ On stomach, face down
2.☐ On stomach, face to side
3.☐ On back 4.☐ On side 5.☐ Unknown
B. Sleeping with another person?
☐ Yes ☐ No ☐ Unknown
C. Smoker in household?
☐ Yes ☐ No ☐ Unknown

☐ **2. Lack of Adequate Care**
A. Apparent lack of supervision? ☐ Yes ☐ No
B. Apparent lack of medical care? ☐ Yes ☐ No
C. If yes: 1. ☐ Malnutrition or dehydration
2. ☐ Oral water intoxication
3. ☐ Delayed medical care
4. ☐ Inadequate medical attention
5. ☐ Out-of-hospital birth
6. ☐ Other:_____
7. ☐ Unknown

☐ **3. Prematurity** (less than 37 weeks gestation)
A. ☐ Known Condition _____

☐ **4. Illness or Other Natural Cause**
A. ☐ Known condition _____
_____
B. ☐ Unknown

☐ **5. Drowning**
A. Place of drowning?
1. ☐ Creek, river, pond or lake
Location prior to drowning?
a. ☐ Boat b. ☐ Waters edge
c. ☐ Other_____ d. ☐ Unknown
2. ☐ Well, cistern, or septic tank
3. ☐ Bathtub 4. ☐ Swimming pool
5. ☐ Bucket 6. ☐ Wading pool
7. ☐ Other:_____ 8. ☐ Unknown
B. Wearing flotation device?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown 4. ☐ NA
C. ☐ Circumstances Unknown

☐ **6. Suffocation/Strangulation**
A. Circumstances of the event?
1. ☐ Other person overlying or rolling over decedent?
2. ☐ Caused by other person, not overlying or rolling over
3. ☐ Self-inflicted by decedent
4. ☐ Not inflicted by any person
5. ☐ Other:_____ 6. ☐ Unknown
B. Object impeding breath?
1. ☐ Food 2. ☐ Other person's hand(s)
3. ☐ Small object or toy in mouth
4. ☐ Object (e.g., plastic bag) covering victim's mouth/nose
5. ☐ Object (e.g., rope) exerting pressure on victim's neck
6. ☐ Other:_____ 7. ☐ Unknown
C. Injury occurred in bed, crib, or other sleeping arrangement?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
D. If in bed/crib, due to:
1. ☐ Hazardous design of crib/bed
2. ☐ Malfunction/improper use of crib/bed
3. ☐ Placement on soft sleeping surface (e.g. waterbed)
4. ☐ Other:_____
5. ☐ Unknown 6. ☐ NA
E. Due to carbon monoxide inhalation?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
F. ☐ Circumstances unknown

☐ **7. Vehicular**
A. # and type of vehicles involved:
1. Cars____ 2. All-terrain vehicles____
3. Motorcycles____ 4. Riding mowers____
5. Bicycles____ 6. Farm tractors ____
7. Other farm vehicles____ 8. Truck/RV____
9. Other____ 10. Unknown ____
B. Position of decedent?
1. ☐ Driver 2. ☐ Pedestrian
3. ☐ Passenger 4. ☐ Back of truck
5. ☐ Other:_____ 6. ☐ Unknown
C. Type vehicle in which decedent was occupant?
1. ☐ Car 2. ☐ All-terrain vehicle
3. ☐ Motorcycle 4. ☐ Riding mower
5. ☐ Bicycle 6. ☐ Farm tractor
7. ☐ Other farm vehicle 8. ☐ Truck/RV
9. ☐ Other:_____ 10. ☐ Unknown
D. Deceased's safety belt use?
1. ☐ Present in vehicle, but not used
2. ☐ None in vehicle 3. ☐ Restraint used
4. ☐ Unknown 5. ☐ NA
E. Deceased's infant/toddler seat use?
1. ☐ Present in vehicle, but not used
2. ☐ None in vehicle
3. ☐ Seat used correctly
4. ☐ Seat used incorrectly
5. ☐ NA
F. Deceased was wearing a helmet?
1. ☐ Yes 2. ☐ No
3. ☐ Unknown 4. ☐ NA
G. Vehicle in which decedent was occupant?
1. Age of driver_____ ☐ Unknown
2. ☐ Operator driving impaired (alcohol/drug)
3. ☐ Speed/recklessness indicated
4. ☐ Other violation by operator
5. ☐ Mechanical failure
6. ☐ Other_____
7. ☐ Unknown 8. ☐ NA
H. Vehicle in which decedent was not occupant?
1. Age of driver_____ ☐ Unknown
2. ☐ Operator driving impaired (alcohol/drug)
3. ☐ Speed/recklessness indicated
4. ☐ Other violation by operator
5. ☐ Mechanical failure
6. ☐ Other_____
7. ☐ Unknown 8. ☐ NA
I. Condition of road?
1. ☐ Normal 2. ☐ Loose gravel
3. ☐ Wet 4. ☐ Ice or snow
5. ☐ Other:_____ 6. ☐ Unknown
7. ☐ NA
J. ☐ Circumstances unknown

☐ **8. Firearm**
A. Person handling the firearm?
1. ☐ Decedent 2. ☐ Parent
3. ☐ Other:_____ 4. ☐ Unknown
B. Type firearm involved?
1. ☐ Handgun 2. ☐ Rifle 3. ☐ Shotgun
4. ☐ Other:_____ 5. ☐ Unknown
C. Age of person handling firearm:
1. years_____ 2. ☐ Unknown
D. Use of firearm at time of injury?
1. ☐ Shooting at other person 2. ☐ Suicide
3. ☐ Hunting 4. ☐ Playing
5. ☐ Other:_____ 6. ☐ Unknown
E. Was decedent's home source of firearm?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
F. ☐ Circumstances unknown

☐ **9. Inflicted Injury** (NOT firearm or suffocation/strangulation)
A. Who inflicted the injury?
1. ☐ Self-inflicted 2. ☐ Parent
3. ☐ Relative:_____ 4. ☐ Other:_____
B. Person inflicting injury?
1. Age _____ ☐ Unknown
2. Gender: ☐ Male ☐ Female
3. Race: ☐ White ☐ African American
☐ Other:_____ ☐ Unknown
C. Manner in which injury was inflicted?
1. ☐ Shaken 2. ☐ Struck 3. ☐ Thrown
4. ☐ Cut/stabbed 5. ☐ Sexual Assault
6. ☐ Other:_____ 7. ☐ Unknown
D. Injury inflicted with?
1. ☐ Sharp object (e.g., knife, scissors)
2. ☐ Blunt object (e.g., hammer, bat)
3. ☐ Hot liquid or other substance
4. ☐ Hands/feet 5. ☐ Fire
6. ☐ Other:_____ 7. ☐ Unknown
E. Where did injury occur?
1. ☐ Child's residence 2. ☐ School
3. ☐ Relative/friend's home
4. ☐ Child care
5. ☐ Other:_____ 6. ☐ Unknown
F. ☐ Circumstances unknown

☐ **10. Poisoning/overdose**
A. Name of drug or chemical?
1. ☐ Name _____
2. ☐ Unknown
B. ☐ Circumstances unknown

☐ **11. Fire/burn**
A. If not a fire burn, its source?
1. ☐ Hot water, etc. 2. ☐ Appliance
3. ☐ Other:_____
4. ☐ Unknown 5. ☐ NA
B. If ignition/fire, what was source?
1. ☐ Oven/stove explosion
2. ☐ Cooking appliance used as heat source
3. ☐ Matches 4. ☐ Lit cigarette
5. ☐ Lighter 6. ☐ Space heater
7. ☐ Furnace 8. ☐ Explosives
9. ☐ Fireworks 10. ☐ Electrical wiring
11. ☐ Other:_____
12. ☐ Unknown 13. ☐ NA
C. Smoke alarm present at fire scene?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
D. If alarm present, did it sound?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
E. Was the fire started by a person?
1. ☐ Yes 2. ☐ No 3. ☐ Unknown
F. If started by a person, his/her age:_____years
1. ☐ Unknown 2. ☐ NA
G. If started by a person, his/her activity
1. ☐ Playing 2. ☐ Smoking
3. ☐ Cooking 4. ☐ Suspected arson
5. ☐ Other:_____
6. ☐ Unknown 7. ☐ NA
H. Type of construction of building burned:
1. ☐ Wood frame 2. ☐ Brick/stone
3. ☐ Trailer 4. ☐ Other:_____
5. ☐ Unknown 6. ☐ NA
I. Smoke inhalation death: 1. ☐ Yes 2. ☐ No
J. ☐ Circumstances unknown

☐ **12. Other Cause Not Listed Above:**
_____
_____

2004