CHILD FATALITIES IN TENNESSEE 2005

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

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Acknowledgements

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

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

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Executive Summary

2005 Tennessee Child Fatality Review

Child Fatality Review Teams (CFRT) are active in all judicial districts in the state. During 2005, the teams completed reviews of 1069 (98.3%) of the 1087 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 Cause of Death.

Manner of Death

The Manner of Death for 1069 child fatalities reported in 2005, was determined by the CFRT to be natural manner for 62.68% (670); accidental manner for 17.49% (187); homicide manner for 3.93% (42); suicide manner for 1.31% (14); undetermined for 5.89% (63); and the manner of death was unknown for 8.61% (92) (Table 1).

Table 1: Manner of Death

Manner of Death	Number	Percent	Rate [1]
Natural	670	62.68%	48.18
Accident	187	17.49%	13.45
Homicide	42	3.93%	3.02
Suicide	14	1.31%	1.01
Pending	1	0.09%	0.07
Undetermined	63	5.89%	4.53
Unknown	92	8.61%	6.62
Total[2]	1,069	100.0%	76.88

Cause of Death

The 1069 fatalities were divided into the following categories by cause of death: Non-injury 70.07% (749); Injury-related 22.64% (242); and Unknown/Undetermined 7.30% (78) (Figure 1).

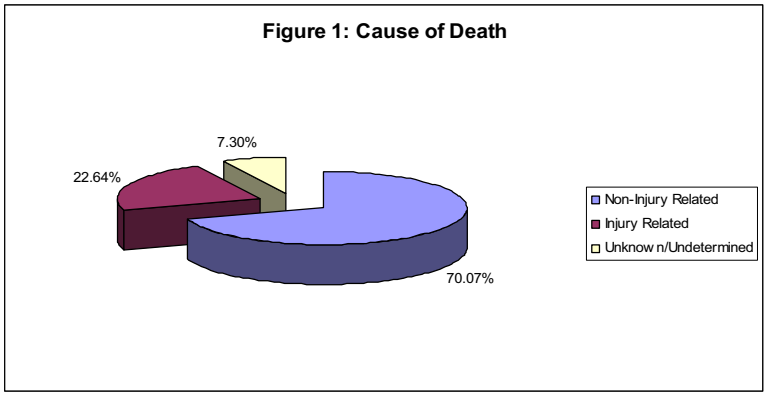

Figure 1: Cause of Death

There were 21 total categories reported for cause of death. The 749 deaths recorded as non-injury were reported in the categories of Asthma, Cancer, Cardiovascular, Congenital

Anomaly, Malnutrition, Neurological, Pneumonia, Prematurity, SIDS, and Other Medical. Injury-related deaths (242) were reported in the categories of Drowning, Exposure, Fall, Fire, Vehicular, Poisoning, Suffocation, Weapon, and Other Injury. Unknown and Undetermined (78) cause of death were reported separately (categories shown in Table 2).

Table 2: Cause of Death

Cause of Death	Number	Percent	Rate[1]
Non-injury	**749**	**70.07%**	**53.86**
Asthma	4	0.37%	0.29
Cancer	34	3.18%	2.45
Cardiovascular	29	2.71%	2.09
Congenital anomaly	108	10.10%	7.77
Malnutrition	2	0.19%	0.14
Neurological	20	1.87%	1.44
Pneumonia	29	2.71%	2.09
Prematurity	320	29.93%	23.01
SIDS	63	5.89%	4.53
Other medical	140	13.10%	10.07
Injury-related	**242**	**22.64%**	**17.40**
Drowning	29	2.71%	2.09
Exposure	1	0.09%	0.07
Fall	4	0.37%	0.29
Fire	22	2.06%	1.58
Vehicular	111	10.38%	7.98
Poisoning	3	0.28%	0.22
Suffocation	33	3.09%	2.37
Weapon	37	3.46%	2.66
Other injury	2	0.19%	0.14
Unknown/undetermined	**78**	**7.30%**	**5.61**
Undetermined	26	2.43%	1.87
Unknown	52	4.86%	3.74
Total[2]	**1,069**	**100.00%**	**76.88**

Deaths Due to Non-injury Causes

There were 749 deaths due to non-injury causes among Tennessee children in 2005, representing 70.07% of deaths. Of these, the greatest number of deaths resulted from illness (366) followed by prematurity (320), then SIDS (63).

Of the deaths where gestational age was reported, 132 involved extremely premature infants (i.e., less that 23 weeks gestation), 276 involved gestations of 23 to 37 weeks and 110 involved more than 37 weeks of gestation.

Deaths Due to Injury

In 2005, there were 242 deaths (22.64% of all childhood fatalities) due to injuries among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (111) or (45.86% of all injury-related fatalities). Death by a weapon fatalities were the next most common cause of injury-related death resulting in 37 deaths (15.28% of all injury-related fatalities). The third highest category of injury-related deaths was suffocation with 33 (13.63% of all injury-related fatalities). Overall, childhood fatalities due to injuries in 2005 occurred at a rate of 17.40 per 100,000.

Recommendations for the State Child Fatality Prevention Team

The State Child Fatality prevention team discussed the recommendations submitted by the child fatality review team leaders and felt that they were all important. The state prevention team decided the main items that needed to be brought before the legislature were recommendations to:

1. 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 a child remains in the vehicle.

2. 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 infants and children)

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

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

5. 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.

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

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

8. 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 truck. Law should be enacted that would suspend or revoke the driver's licenses of students involved in hood surfing.

9. Establish driver education requirements. Those requirements should include advanced driver education and assertive driver's training. Establish a 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.

10. 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.

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

Child Fatality Review State Prevention Team, 2007

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
Thomas Jones, Acting 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
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Susan R. Cooper, MDN, RN, Commissioner of the Department of Health
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Mike Herrmann, Tennessee Department of Education

Recommendations from the Local Child Fatality Review Teams
August 2007

After a review of the years 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. Require mandatory standardized driver education that includes an advanced driving-skills program for teens in conjunction with the Graduated Drivers License requirements. Further improve the components of Graduated Driver License requirements to either increase the time frame required to hold the Learner's Permit, or increase the age that one can receive the permit from age 15 to age 16.

   Background Information: For adolescents and young adults aged 10-24 both nationally and in Tennessee, over three-quarters of unintentional injury deaths are motor vehicle-related and based on miles driven, teenagers in this age group are involved in three times as many fatal crashes as are all drivers.

   The National Highway Transportation Safety Administration reported in the *2006 Annual Assessment Highlights* that, the number of motor vehicle fatalities declined for children of all ages from 2005-2006, with the largest decline being in the age range of children 8-15 years of age. However, the number of drivers aged 16-20 that were killed in motor vehicle crashes increased. For most states, the overall number of people killed in motor vehicle crashes declined, but Tennessee showed a 1.3% increase. In Tennessee, in 2004, there were 135 child deaths, in 2005, there were 105 and in 2006, there were 132.

   Tennessee Statute 49-1-204 - *Driver Education and Training Courses in Public Schools* directs the Department of Education to promote and expand driver education and training courses throughout the public schools but does not mandate driver education for students. The minimum standards require that the course shall be an elective that students at least 15 years of age may enroll in and receive one-half unit of credit. The course shall not include fewer than 30 class hours of instruction and six hours of experience behind the wheel.

   The local Child Fatality Team Leaders believe that strengthening the current law to require mandatory standardized driver education training that consists of in-car instruction in accident avoidance and defensive driving maneuvers along with improving the Graduated Driver License requirements would reduce the number of teen deaths resulting from motor vehicle crashes.

2. Develop statewide initiative surrounding safe-sleep practices for infants. This initiative should include an educational component on keeping cribs free of objects such as stuffed animals or toys, safe bedding, unsafe sleeping habits, i.e., co-sleeping and provide information to child-care providers regarding safe sleep practices. Health education should be provided following delivery prior to discharge from hospital

   Background Information: While infant deaths from SIDS remains the third highest cause in Tennessee, the State as well as the Nation has seen a dramatic increase in the number of deaths of infants that have died because of co-sleeping or other unsafe sleep habits. Between August 7, and September 12, one region had 7 out of 37 (18.91%) cases where the cause of death was positional asphyxia with co-sleeping as a contributing factor or related cause.

   The local Child Fatality Team Leaders believe deaths of this nature are preventable and it would be beneficial to the State to alert the public and develop public service announcements (PSAs) to discourage co-sleeping.

3. Develop a public awareness/educational campaign that provides emphasis on pre-conceptual and prenatal care. Encourage family practitioners to conduct pre-conceptual counseling and promote pre-natal vitamin use when conception age.

   Background information: The American College of Obstetricians and Gynecologist (ACOG) recommend that women have their first pre-natal visit within 12 weeks of their first missed period. Fetal development during the first trimester is rapid, and the risk of miscarriage is heightened. By the 12th week, the baby's brain while not the same size it will be at birth has developed and has the same structure. The fetus weighs approximately 14 grams and is approximately 3.54 inches in total length. The fetus also has reflexes and movements in the digestive tract. It may also be possible to hear the heart beat at 12 weeks gestation.

   The local Child Fatality Team leaders believe that seeing a doctor prior to 12 weeks would greatly reduce the likelihood of birth defects and infant mortality. If ACOG standards do not allow office visits until after 12 weeks, it is highly recommended that family practitioners provide prenatal care at this time.

Other Concerns by Category

Infant Mortality

1. Provide bassinets or cribs for families that cannot afford one.

   Background Information: Many of the infant deaths reviewed during the 2006 and 2007 year have been related to sleep practices, i.e., co-sleeping and rollovers. In many instances, the infant was sharing a bed with the parents and/or other siblings. A survey was developed by the SIDS program to determine sleep positions and where the infant sleeps. This survey has been utilized in Memphis, Davidson County and Chattanooga to determine the level of awareness of the Back to Sleep Campaign. In a number of the survey results, parents reported the infant sleeps in the bed with them, or in other inappropriate environments.

Several other states have a "Cribs for Kids" program and have reported a reduction in the number of infant deaths related to co-sleeping and rollovers. It is the belief of the local team leaders that a similar program in Tennessee would greatly reduce the number of deaths attributed to co-sleeping and rollovers.

Pre-Conceptual/Prenatal Issues

1. Create a public educational awareness campaign that provides emphasis on tobacco, drug and alcohol use during pregnancy.

   Background information: With estimates of at least one in five women smoking cigarettes or drinking alcohol during pregnancy, use of harmful substances by pregnant women remains a serious concern. The use of tobacco, illicit drugs and alcohol has an affect on the mother and the fetus. These substances:

   - Interfere with the woman's ability to support the pregnancy
   - Directly impair prenatal development
   - Are linked to poor health outcomes, infant mortality and developmental disabilities.

   Smoking during pregnancy may raise the risk of miscarriage or premature labor, and has recently been linked to SIDS. Drinking alcohol increases the risk of a birth defect known as Fetal Alcohol Syndrome. The defects include small skull, abnormal facial features, heart defects and learning disabilities. Use of illicit drugs during pregnancy are associated with premature birth; low birth weight; babies born drug dependent; learning and developmental disabilities; and emotional or mental problems along with many other disabilities.

   The local Child Fatality Team Leaders would like to see a statewide public awareness campaign including public service announcements both television and radio that provides information on tobacco, drug and alcohol use during pregnancy. The team leaders believe the educational campaign should also provide resources for getting help with these problems. Reducing the number of pregnant women using tobacco, illicit drugs and alcohol could help in reducing the rate of infant mortality.

Safety

1. Create and launch a public awareness campaign regarding the dangers of hood surfing. Law should be enacted that would suspend or revoke the driver's license of anyone involved in hood surfing.

   Background Information: Car surfing is defined as a form of acrobatics or an illegal stunt if performed in public traffic in which passengers of moving vehicles perform various stunts including hanging out of the car or 'surfing' on the hood while it is in motion. Car surfing has caused several deaths nationwide as well as in Tennessee. During the 2004 data collection period, several teens were injured and killed in the rural areas of Tennessee while performing this stunt.

   It is believed by the local team leaders that revoking the license of the participants will further reduce and prevent deaths of this nature.

2. Require mandatory safety classes and license prior to operation of an All Terrain Vehicle (ATV).

Background Information: According to data from the Consumer Product Safety Commission, at least 136,700 people were injured by all-terrain vehicles in 2005. About one-third of those injured were children under 16. At least 120 children younger than 15 were killed by ATVs that year. Between February 2004 and December 2006, 24 children were killed because of all-terrain vehicle accidents in Tennessee. The ages of these children ranged from age seven to age 18. There have also been several deaths reported in 2007 because of all-terrain vehicle accidents.

Thirty-five percent (35%) of all ATV-related deaths were children under the age of 16. An average size ATV weighs 1,000 pounds and can travel at speeds of up to 75 miles per hour. In Tennessee, ATVs can be operated without any age restrictions, training requirements, licenses or certification. Public Chapter 481 (June 6, 2007) amended T.C.A. 55-10, 55-52 and 70-9 and established provisions for children under age 18 operating or riding off-road vehicles to wear to helmets. According to the Specialty Vehicle Institute of America (SVIA), many states have age restrictions as well as safety education, training and certification prior to operation.

The local Child Fatality Team Leaders are very much in agreement with this provision of helmet use while riding and operating off road vehicles, but also believe that requiring mandatory training and license for operation of all-terrain vehicles would further reduce the number of deaths resulting from all terrain vehicle accidents.

3. Require mandatory safety classes prior to license issuance for motorcycle.

Background Information: Motorcycle riders face much of the same dangers as passengers in cars, only they are far more susceptible to injury and loss of life. Most motorcycle accidents result in at least a serious injury if not death. Most injured motorcyclists are males between the age of 16 and 24 with less than 5 months experience riding a motorcycle. Approximately 80% of the reported motorcycle accidents result in injury or death and the majority of these accidents occur because the operator is inexperienced. In Tennessee, between March 2004 and December 2006, there were 11 child deaths because of motorcycle accidents. These children ranged in age from 12 to 17 years old.

Tennessee Code Annotated 55-51-102 *Motorcycle Rider Education Program* authorizes the Department of Safety to establish standards for and administer the motorcycle rider education program. This program is inclusive of but not limited to rider training courses and instructor training. The Department of Safety may also include public awareness, alcohol and drug effects as well as driver improvements for motorcyclists, licensing improvement, program promotion or other motorcycle safety programs.

The concern of the Child Fatality Team Leaders is that the education program is not mandatory and individuals are being licensed to operate motorcycles that may not have the necessary skills and experience to do so. Again, mandatory training prior to license would further reduce and prevent child deaths from motorcycle accidents.

4. Require safety helmets for horse back riding.

   Background Information: Currently, there is no statistical information or research available on this subject. One of our local teams brought the recommendation because a child was killed during a horseback riding accident. The death occurred to a male child between the age of 11 and 12 that was a skilled horse rider whose family owns horses and are avid riders. The young man was hour riding and the horse was spooked and reared throwing the child from its back. The child suffered a serious head injury that resulted in his death.

   The local team and team leader believe that this death could possibly have been prevented if the young man had been wearing protective headgear.

5. Require physical examinations for band members same as athletes and those participating in sports activities.

   Background Information: There is currently no statistical data available for this recommendation, however one of the local team leaders asked that this recommendation be forwarded to the State Prevention Team because the judicial district had a death occur to a marching band member while performing. The death occurred to a high school student who played a heavy instrument. The child had a pre-existing condition that was not known by school officials nor his family.

   The team leaders discussed this recommendation and in many school districts, band members are required to receive the same physical examination as athletes prior to participation in band, but in many other school districts, this examination is not required for band members. It is the belief of the team leaders that band members should be considered as any other athlete in the local school systems and physical examinations should be a requirement prior to participation statewide.

6. Cultural Education for families of different cultures on usage of child restraints.

   Background Information: Currently, there is no statistical background information for this recommendation. During the Annual Team Leader's meeting, a discussion was held regarding the problem with children being killed because of vehicle accidents in which the victim was not restrained or the restraints were not properly used. Further discussion led to the recommendation being made that since Tennessee has such a large and diverse population that more needed to be done for families of different cultures on the correct installation of infant and child safety seats and the correct usage of seat belts.

   It is the belief that the provision of culturally competent education surrounding child restraint and seat belt usage will reduce and prevent the number of fatalities resulting from improper or incorrect usage.

Health Department Regions, Judicial Districts, and CFR Team Leaders

Region	CFR Team Leader, Judicial District (JD) and Counties
Northeast	Dr. Lawrence Moffatt JD 1: Carter, Johnson, Unicoi, and Washington Dr. Barbara Skelton JD 3: Greene, Hamblen, Hancock, and Hawkins
Sullivan	Dr. Stephen May JD 2: Sullivan
East	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. Stephanie Bailey/ Brook McKelvey JD 20: Davidson
Mid Cumberland	Sharon A. Woodard/ Dr. Alison Asaro 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

2005 Tennessee Child Fatality Review

Tennessee Child Fatality Review 2005

Manner of Death

The manner of death for 1069 child fatalities in 2005, determined by the CFRT to be natural causes for 62.68% (670); unintentional injury (accidental) causes for 17.49% (187); homicide for 3.93% (42); suicide for 1.31% (14); could not be determined for 5.89% (63); and unknown causes for 8.61% (92) (Table 3).

The overall rate of child fatalities as reviewed by the CFRT was 76.88 per 100,000. Fatality rates identified in this report are based on population census data and reported as the number of cases per 100,000 in the population of children less than 18 years of age (Table 3, Figure 2 and Endnote 1 in the Appendix).

Table 3: Manner of Death

Manner of Death	Number	Percent	Rate[1]
Natural	670	62.68%	48.18
Accident	187	17.49%	13.45
Homicide	42	3.93%	3.02
Suicide	14	1.31%	1.01
Pending	1	0.09%	0.07
Undetermined	63	5.89%	4.53
Unknown	92	8.61%	6.62
Total[2]	1,069	100.0%	76.88

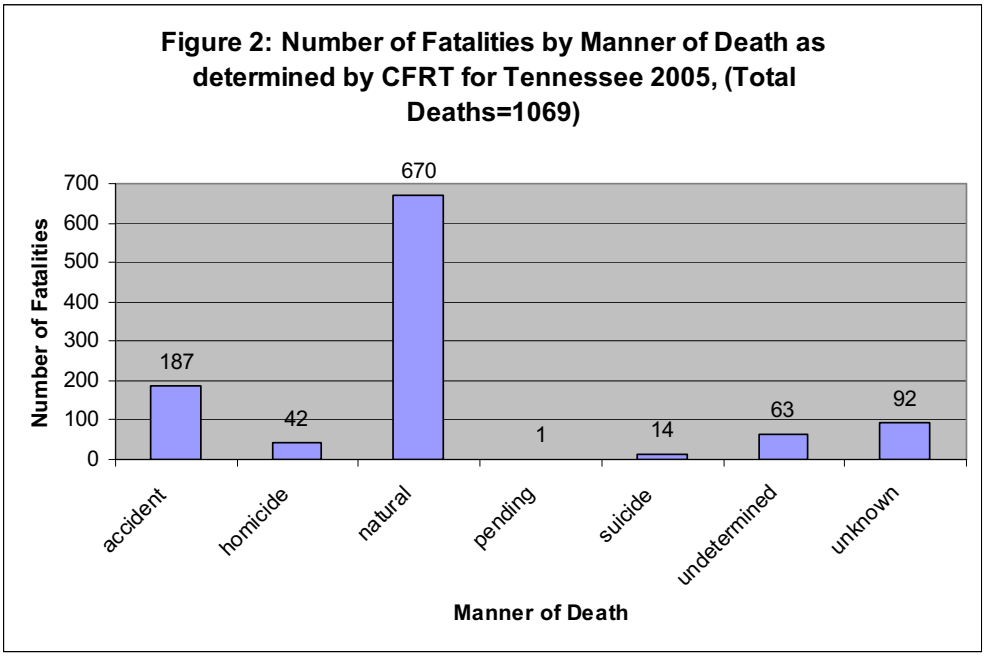

Figure 2: Manner of Death

Manner of Death and Age

Across all groups the highest rate of fatalities in 2005 was during the first year of life at 888.28 (66.14%). The second highest fatality rate occurred in youth aged 15-17 at 55.23 (12.54%) and the third highest rate was in the 1-2 years of age at 38.73 (5.61%) (Table 4).

Table 4: Number and Rates of Fatalities by Manner of Death and Age

Age	Natural	Accident	Homicide	Suicide	Undetermined	Unknown	Pending	Total	Percent	Rate[1]
<1	542	30	9	0	52	73	1	707	66.14%	888.28
1-2	26	24	4	0	4	2	0	60	5.61%	38.73
3-5	21	18	5	0	3	2	0	49	4.58%	21.53
6-8	13	13	1	0	0	3	0	30	2.81%	13.57
9-11	18	13	2	0	0	1	0	34	3.18%	14.99
12-14	22	25	2	2	1	3	0	55	5.14%	23.11
15-17	28	64	19	12	3	8	0	134	12.54%	55.23
Total	**670**	**187**	**42**	**14**	**63**	**92**	**1**	**1,069**	**100.00%**	**76.88**

Manner of Death and Sex

In 2005, 41.72% of child fatalities were female and 58.28% were male that corresponded to rates of 65.87 for females and 87.33 for males. The largest number of deaths for both sexes was by natural manner (Table 5 and Figure 3).

Table 5: Manner of Death and Sex

	Female			Male			Total		
Manner of Death	**N**	**%**	**Rate[1]**	**N**	**%**	**Rate[1]**	**N**	**%**	**Rate[1]**
Accident	82	7.67%	12.11	105	9.82%	14.72	187	17.49%	13.45
Homicide	15	1.40%	2.22	27	2.53%	3.78	42	3.93%	3.02
Natural	285	26.66%	42.09	385	36.01%	53.97	670	62.68%	48.18
Suicide	2	0.19%	0.30	12	1.12%	1.68	14	1.31%	1.01
Pending	0	0.00%	0.00	1	0.09%	0.14	1	0.09%	0.07
Undetermined	24	2.25%	3.54	39	3.65%	5.47	63	5.89%	4.53
Unknown	38	3.55%	5.61	54	5.05%	7.57	92	8.61%	6.62
Total	**446**	**41.72%**	**65.87**	**623**	**58.28%**	**87.33**	**1,069**	**100.00%**	**76.88**

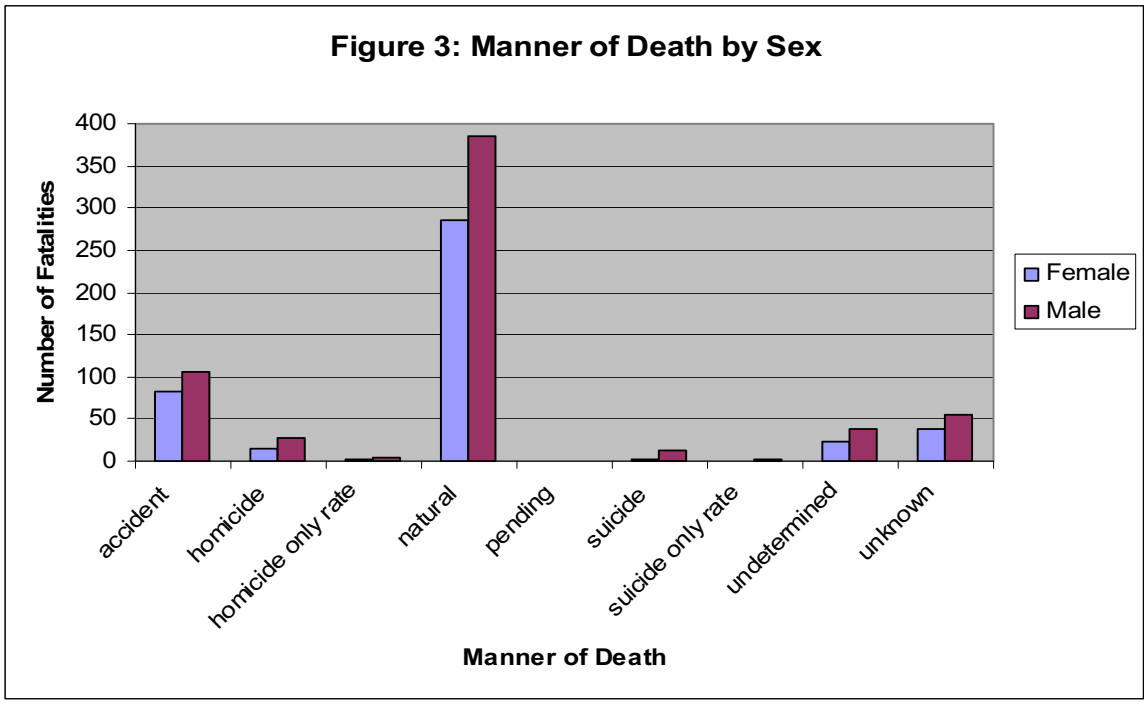

Figure 3: Manner of Death by Sex

Manner of Death and Race

Natural was the highest category of death for all races (670 or 62.68%). The total number of natural fatalities for White children was 406 (37.98%), for African-American children 248 (23.20%), for Asian children 13 (1.22%) and no natural deaths attributed to Other. Three natural deaths (0.28%) were categorized as Unknown (Table 6).

Table 6: Manner of Death and Race

Manner	White		African American		Asian		Other		Unknown		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Accident	150	14.03%	35	3.27%	0	0.00%	0	0.00%	2	0.19%	187	17.49%
Homicide	19	1.78%	22	2.06%	1	0.09%	0	0.00%	0	0.00%	42	3.93%
Natural	406	37.98%	248	23.20%	13	1.22%	0	0.00%	3	0.28%	670	62.68%
Suicide	11	1.03%	2	0.19%	0	0.00%	0	0.00%	1	0.09%	14	1.31%
Pending	1	0.09%	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.09%
Undetermined/ Unknown	107	10.01%	44	4.12%	1	0.09%	1	0.09%	2	0.19%	155	14.50%
Total	**694**	**64.92%**	**351**	**32.83%**	**15**	**1.40%**	**1**	**0.09%**	**8**	**0.75%**	**1,069**	**100.00%**

Manner of Death and Ethnicity

Natural was the highest category of death for all ethnicities (670). The total number of natural fatalities for Hispanic children was 44, for Non-Hispanic children 609. Seventeen natural deaths were categorized as unknown (Table 7).

Table 7: Manner of Death and Ethnicity

Hispanic	Manner							Total	Rate[1]
	Accident	Homicide	Natural	Suicide	Pending	Undetermined	Unknown		
Hispanic	9	3	44	0	0	2	8	66	113.33
Non-Hispanic	175	36	609	14	1	60	82	977	73.33
Unknown	3	3	17	0	0	1	2	26	1.95
Total	**187**	**42**	**670**	**14**	**1**	**63**	**92**	**1069**	**76.88**

Manner of Death by Age, Sex and Race

In 2005, the total highest rate of fatalities occurred during the age of one year or less (888.28). African-Americans had the highest fatality rate at 118.71. Asians had the third highest fatality rate at 86.64 (Table 8).

Table 8: Manner of Death by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	707	888.28	Female	446	65.87	White	694	69.98
1-2	60	38.73	Male	623	87.33	African-American	351	118.71
3-5	49	21.53				Asian	15	86.64
6-8	30	13.57				Other	1	1.17
9-11	34	14.99				Unknown	8	0.58
12-14	55	23.11						
15-17	134	55.23						
Total	**1,069**	**76.88**		**1,069**	**76.88**		**1,069**	**76.88**

Manner of Death: Violence-Related

In 2005, there were 56 child fatalities due to violence-related injuries. These injuries were the result of either homicide (42) or suicide (14). This represents 5.24% of all child fatalities (Table 6).

Children in the 15-17 years age group had the highest rate of violence-related fatalities (12.78 per 100,000), followed by children less than 1 year (11.31 per 100,000). Males (5.47 per 100,000) were more likely than females (2.51 per 100,000) to die from violence-related injuries. African-American children had a higher rate of violence-related deaths (8.12 per 100,000) than Asian children (5.78 per 100,000) and White children (3.02 per 100,000) (Table 9 and Figure 4).

Table 9: Violence-Related Fatalities by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	9	11.31	Female	17	2.51	White	30	3.02
1-2	4	2.58	Male	39	5.47	African-American	24	8.12
3-5	5	2.20				Asian	1	5.78
6-8	1	0.45				Other	0	0.00
9-11	2	0.88				Unknown	1	0.07
12-14	4	1.68						
15-17	31	12.78						
Total	**56**	**4.03**		**56**	**4.03**		**56**	**4.03**

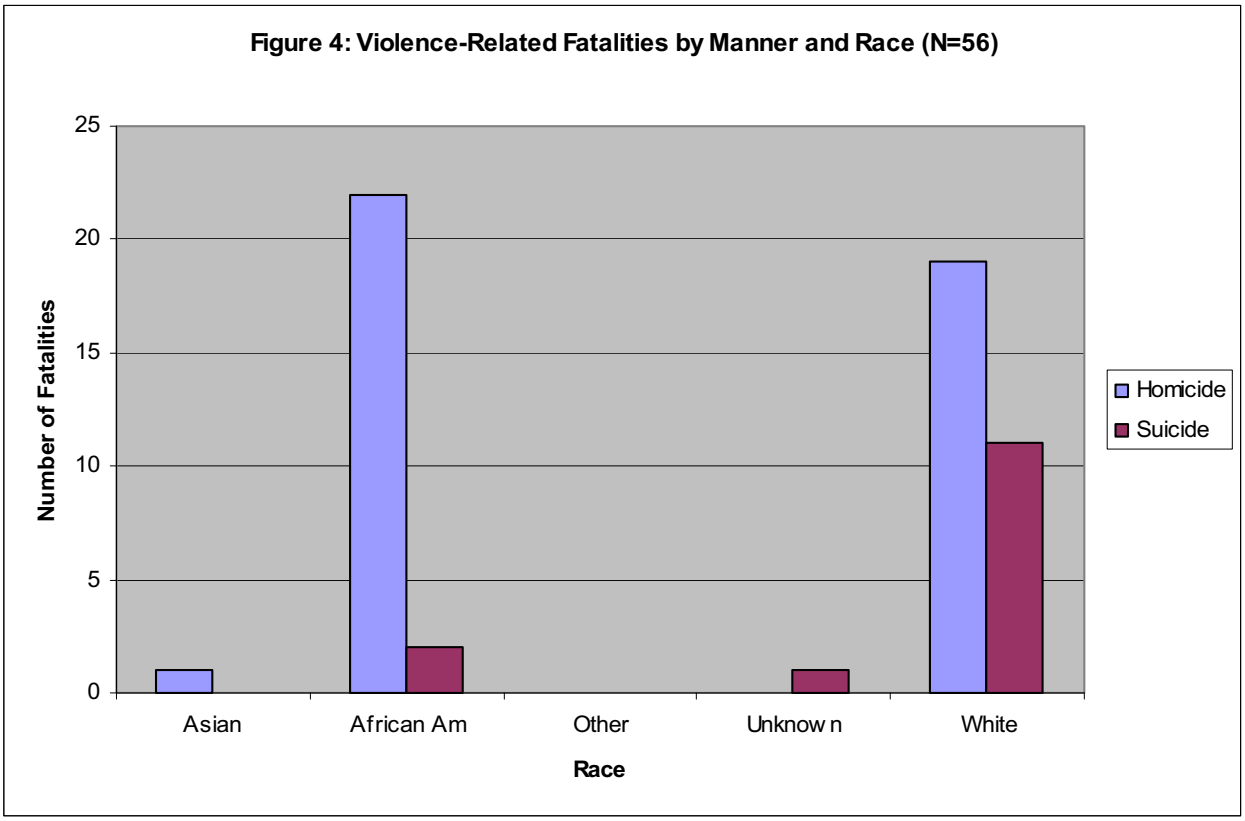

Figure 4: Violence-Related Fatalities by Manner and Race

Homicide

In 2005, there were 42 child fatalities due to homicide. This represents 75% of all violence-related deaths and 3.93% of all child fatalities. It is also an increase of 35.48% from 2004[a]

Males (27; 3.78 per 100,000) were more likely than females (15; 2.22 per 100,000) to die from homicides. African-American children (22; 7.44 per 100,000) died at a higher number than other races followed by White children (19; 1.92 per 100,000). Children ages 15-17 (19; 7.83 per 100,000) and less than one year of age (9; 11.31 per 100,000) had a higher rate of death by homicide (Table 10).

Table 10: Homicide Fatalities by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	9	11.31	Female	15	2.22	White	19	1.92
1-2	4	2.58	Male	27	3.78	African-American	22	7.44
3-5	5	2.20				Asian	1	5.78
6-8	1	0.45				Other	0	0.00
9-11	2	0.88				Unknown	0	0.00
12-14	2	0.84						
15-17	19	7.83						
Total	**42**	**3.02**		**42**	**3.02**		**42**	**3.02**

[a] Note: There were 31 homicides in 2004.

Suicide

During 2005, 14 young people committed suicide. This was a decrease in the numbers of suicides by 22.22%[b] from the previous year. Most of these deaths were by children in the 15-17 age group (12; 4.95 per 100,000) and/or Male (12; 1.68 per 100,000). Eleven White children (1.11 per 100,000) and two African-American children (0.68 per 100,000) died as a result of suicide (Table 11).

Table 11: Suicide Fatalities by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	0	0.00	Female	2	0.30	White	11	1.11
1-2	0	0.00	Male	12	1.68	African-American	2	0.68
3-5	0	0.00				Asian	0	0.00
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	1	0.07
12-14	2	0.84						
15-17	12	4.95						
Total	**14**	**1.01**		**14**	**1.01**		**14**	**1.01**

Manner of Death by County with 15 or More Fatalities

Six hundred and sixty (61.74%) of all child fatalities occurred in 12 counties with 15 or more deaths each (Table 12). In 2005, the highly populated counties of Shelby and Davidson reported a total of 368 fatalities and accounted for 34.43% of all child fatalities. Shelby County had the highest percentage of all childhood fatalities (231; 21.61%), followed by Davidson (137; 12.82%), Knox (64; 5.99%) and Hamilton (51; 4.77%). Eleven of the 12 counties rank in the highest population per county with the exception of Bedford County (17; 1.59%), which had the highest rate of child death (155.93 per 100,000) of all the counties (Table 12).

Table 12: Fatalities from Counties with 15 or More Fatalities

County	Total	Percent	Rate[1]	Rank in Population Ages 0-17
1. Shelby	231	21.61%	89.98	1
2. Davidson	137	12.82%	105.83	2
3. Knox	64	5.99%	72.69	3
4. Hamilton	51	4.77%	72.70	4
5. Rutherford	30	2.81%	56.39	5
6. Sullivan	28	2.62%	83.41	9
7. Madison	25	2.34%	102.72	10
8. Montgomery	24	2.25%	59.23	7
9. Sumner	22	2.06%	60.03	8
10. Bedford	17	1.59%	155.93	12
11. Williamson	16	1.50%	37.97	6
12. Washington	15	1.40%	62.85	11
Total	**660**	**61.74%**	**81.53**	

[b] There were 18 suicides in 2004.

Table 13: Fatalities by Manner of Death for All Counties

Table 13: Fatalities by Manner of Death for All Counties									
County	**Natural**	**Accident**	**Homicide**	**Suicide**	**Pending**	**Undetermined**	**Unknown**	**Total**	**Rate[1]**
Anderson	6	2	0	1	0	0	1	10	60.76
Bedford	11	4	1	0	0	1	0	17	155.93
Benton	3	0	0	0	0	0	0	3	82.28
Bledsoe	1	0	0	0	0	0	1	2	66.42
Blount	1	1	0	0	0	2	1	5	19.84
Bradley	10	1	0	1	0	0	0	12	54.55
Campbell	5	4	0	0	0	0	0	9	99.03
Cannon	1	0	0	0	0	0	0	1	29.33
Carroll	2	5	0	0	0	1	0	8	116.94
Carter	7	1	0	0	0	1	1	10	81.50
Cheatham	4	0	0	0	0	0	0	4	37.70
Chester	2	0	0	0	0	0	0	2	48.10
Claiborne	2	1	1	0	0	0	1	5	71.28
Clay	1	0	0	0	0	0	0	1	58.86
Cocke	3	2	0	0	0	0	1	6	76.47
Coffee	9	2	0	0	0	0	0	11	89.17
Crockett	3	0	0	0	0	0	0	3	78.10
Cumberland	1	0	0	0	0	3	0	4	38.60
Davidson	94	15	12	0	0	5	11	137	105.83
Decatur	1	0	0	0	1	0	1	3	117.83
Dekalb	0	0	0	0	0	1	0	1	23.57
Dickson	7	3	0	0	0	0	0	10	82.61
Dyer	4	1	1	0	0	0	0	6	61.67
Fayette	2	1	1	0	0	1	0	5	66.37
Fentress	3	1	0	0	0	0	0	4	98.81
Franklin	6	1	0	0	0	0	0	7	75.10
Gibson	0	3	0	0	0	2	1	6	50.34
Giles	3	1	0	0	0	0	0	4	55.45
Grainger	0	1	0	0	0	0	0	1	19.97
Greene	7	6	0	0	0	0	0	13	89.36
Grundy	3	0	0	0	0	0	0	3	81.37
Hamblen	5	4	0	2	0	0	2	13	92.32
Hamilton	35	7	2	0	0	4	3	51	72.70
Hancock	1	0	0	0	0	0	0	1	66.09
Hardeman	5	3	0	0	0	0	1	9	128.17
Hardin	4	2	0	0	0	0	0	6	98.54
Hawkins	2	2	0	0	0	0	0	4	30.64
Haywood	8	0	0	0	0	0	0	8	147.90
Henderson	2	0	0	0	0	0	0	2	31.16
Henry	6	1	0	0	0	0	1	8	115.72

Table 13: Fatalities by Manner of Death for All Counties									
County	**Natural**	**Accident**	**Homicide**	**Suicide**	**Pending**	**Undetermined**	**Unknown**	**Total**	**Rate[1]**
Hickman	3	2	0	0	0	0	0	5	82.88
Houston	1	0	0	0	0	1	0	2	95.51
Humphreys									0.00
Jackson									0.00
Jefferson	4	3	1	1	0	0	1	10	88.43
Johnson	2	2	0	0	0	0	0	4	113.09
Knox	30	13	2	1	0	0	18	64	72.69
Lake	1	0	0	0		0	0	1	69.64
Lauderdale	6	1	0	0	0	0	1	8	114.43
Lawrence	4	5	0	0	0	0	0	9	84.65
Lewis	2	1	0	0	0	0	0	3	98.52
Lincoln									0.00
Loudon	1	2	0	0	0	0	2	5	56.68
Macon	1	2	0	1	0	0	0	4	70.98
Madison	4	2	0	0	0	0	19	25	102.72
Marion	4	1	0	0	0	1	0	6	92.81
Marshall	3	3	0	0	0	0	0	6	83.57
Maury	4	1	0	0	0	0	3	8	42.33
McMinn	7	4	0	0	0	0	1	12	96.11
McNairy	0	1	0	0	0	1	1	3	50.28
Meigs	2	0	0	0	0	0	0	2	65.83
Monroe	7	3	0	0	0	0	0	10	97.26
Montgomery	19	3	1	0	0	1	0	24	59.23
Moore	1	1	0	0	0	0	0	2	142.96
Morgan	1	1	0	0	0	2	0	4	84.73
Obion	2	0	0	0	0	0	1	3	37.69
Overton	1	0	0	0	0	0	0	1	20.88
Perry									0.00
Pickett	0	1	0	0	0	0	0	1	94.34
Polk	2	1	0	0	0	0	0	3	78.55
Putnam	3	1	0	0	0	4	1	9	61.94
Rhea	5	1	0	1	0	0	0	7	104.70
Roane	1	5	0	0	0	0	0	6	49.83
Robertson	4	2	0	0	0	1	0	7	45.70
Rutherford	17	2	2	0	0	6	3	30	56.39
Scott	2	1	1	0	0	0	0	4	70.11
Sequatchie	2	1	0	0	0	0	0	3	98.46
Sevier	6	2	0	1	0	4	1	14	81.24
Shelby	184	20	14	3	0	9	1	231	89.98
Smith	0	0	0	0	0	1	0	1	20.93
Stewart	4	0	0	0	0	0	0	4	124.46

Table 13: Fatalities by Manner of Death for All Counties									
County	**Natural**	**Accident**	**Homicide**	**Suicide**	**Pending**	**Undetermined**	**Unknown**	**Total**	**Rate[1]**
Sullivan	19	4	1	0	0	3	1	28	83.41
Sumner	14	4	0	1	0	1	2	22	60.03
Tipton	5	6	0	0	0	0	3	14	89.09
Trousdale									0.00
Unicoi	1	1	0	0	0	0	0	2	54.60
Union	1	0	0	0	0	0	0	1	19.83
Van Buren									0.00
Warren	1	0	0	0	0	2	0	3	31.13
Washington	6	2	1	0	0	2	4	15	62.85
Wayne	1	1	0	0	0	0	0	2	54.73
Weakley	0	2	0	0	0	0	1	3	37.17
White	1	1	0	0	0	0	0	2	35.89
Williamson	10	3	1	1	0	0	1	16	37.97
Wilson	1	0	0	0	0	3	1	5	19.70
Total	**670**	**187**	**42**	**14**	**1**	**63**	**92**	**1,069**	**76.88**

Cause of Death

The 1069 child fatalities were divided into the following categories by Cause of Death:

- Non-injury 749 (70.05%)
- Injury-related 242 (22.63%)
- Undetermined/Unknown 78 (07.29%)

Overall, the cause of death was reported in 21 categories. The 749 deaths recorded as non-injury were reported in the categories of Asthma, Cancer, Cardiovascular, Congenital Anomaly, Malnutrition, Neurological, Other Medical, Pneumonia, Prematurity and SIDS. Injury-related deaths (242) were reported in the categories of Drowning, Exposure, Fall, Fire, Vehicular, Other Injury, Poisoning, Suffocation and Weapon. Undetermined cause (26) and Unknown cause (52) were reported separately (Table 14).

Table 14: Cause of Death Categories

Cause	Frequency	Percent	Rates[1]
1. Asthma	4	0.37%	0.29
2. Cancer	34	3.18%	2.45
3. Cardiovascular	29	2.71%	2.09
4. Congenital Anomaly	108	10.10%	7.77
5. Drowning	29	2.71%	2.09
6. Exposure	1	0.09%	0.07
7. Fall	4	0.37%	0.29
8. Fire	22	2.06%	1.58
9. Malnutrition	2	0.19%	0.14
10. Vehicular	111	10.38%	7.98
11. Neurological	20	1.87%	1.44
12. Other Injury	2	0.19%	0.14
13. Other Medical	140	13.10%	10.07
14. Pneumonia	29	2.71%	2.09
15. Poisoning	3	0.28%	0.22
16. Prematurity	320	29.93%	23.01
17. SIDS	63	5.89%	4.53
18. Suffocation	33	3.09%	2.37
19. Weapon	37	3.46%	2.66
20. Undetermined	26	2.43%	1.87
21. Unknown	52	4.86%	3.74
Total	**1,069**	**100.00%**	**76.88**

A summary of cause of death by age, sex, race and ethnicity are reported in Tables 15 through 18.

Table 15: Cause of Death by Age

Cause	<1	1-2	3-5	6-8	9-11	12-14	15-17	Total
Asthma	0	1	1	0	0	1	1	4
Cancer	1	3	5	5	6	8	6	34
Cardiovascular	14	4	2	1	3	2	3	29
Congenital Anomaly	95	4	5	2	0	2	0	108
Drowning	2	10	8	2	3	1	3	29
Exposure	0	1	0	0	0	0	0	1
Fall	0	1	1	0	0	1	1	4
Fire	3	6	5	2	4	2	0	22
Malnutrition	1	0	1	0	0	0	0	2
Neurological	7	1	2	0	2	3	5	20
Other Injury	0	0	0	0	0	0	2	2
Other Medical	87	13	6	4	5	11	14	140
Pneumonia	21	3	2	1	2	0	0	29
Poisoning	0	0	0	0	0	0	3	3
Prematurity	320	0	0	0	0	0	0	320
SIDS	62	1	0	0	0	0	0	63
Suffocation	22	0	2	0	0	4	5	33
Undetermined	26	0	0	0	0	0	0	26
Unknown	36	4	1	3	1	1	6	52
Vehicular	7	7	5	8	7	18	59	111
Weapon	3	1	3	2	1	1	26	37
Total	**707**	**60**	**49**	**30**	**34**	**55**	**134**	**1,069**

Table 16: Cause of Death by Sex

Cause	Female	Male	Total
Asthma	0	4	4
Cancer	13	21	34
Cardiovascular	15	14	29
Congenital Anomaly	49	59	108
Drowning	10	19	29
Exposure	0	1	1
Fall	2	2	4
Fire	13	9	22
Malnutrition	2	0	2
Neurological	8	12	20
Other Injury	1	1	2
Other Medical	63	77	140
Pneumonia	8	21	29
Poisoning	1	2	3
Prematurity	126	194	320
SIDS	31	32	63
Suffocation	11	22	33
Undetermined	7	19	26
Unknown	25	27	52
Vehicular	53	58	111
Weapon	8	29	37
Total	**446**	**623**	**1,069**

Table 17: Cause of Death by Race

Cause	White	African-American	Asian	Other	Unknown	Total
Asthma	0	4	0	0	0	4
Cancer	26	6	2	0	0	34
Cardiovascular	22	7	0	0	0	29
Congenital Anomaly	81	23	3	0	1	108
Drowning	24	4	1	0	0	29
Exposure	1	0	0	0	0	1
Fall	3	1	0	0	0	4
Fire	17	5	0	0	0	22
Malnutrition	1	1	0	0	0	2
Neurological	12	8	0	0	0	20
Other Injury	2	0	0	0	0	2
Other Medical	109	29	0	0	2	140
Pneumonia	18	11	0	0	0	29
Poisoning	3	0	0	0	0	3
Prematurity	152	159	7	1	1	320
SIDS	41	21	1	0	0	63
Suffocation	25	6	1	0	1	33
Undetermined	22	4	0	0	0	26
Unknown	30	21	0	0	1	52
Vehicular	92	18	0	0	1	111
Weapon	13	23	0	0	1	37
Total	**694**	**351**	**15**	**1**	**8**	**1,069**

Table 18: Cause of Death by Ethnicity

	Hispanic			
Cause	No	Yes	Unknown/ Unmarked	Total
Asthma	4	0	0	4
Cancer	29	5	0	34
Cardiovascular	27	2	0	29
Congenital Anomaly	94	10	4	108
Drowning	26	1	2	29
Exposure	1	0	0	1
Fall	2	2	0	4
Fire	21	1	0	22
Malnutrition	2	0	0	2
Neurological	19	1	0	20
Other Injury	2	0	0	2
Other Medical	132	7	1	140
Pneumonia	24	3	2	29
Poisoning	3	0	0	3
Prematurity	287	22	11	320
SIDS	62	1	0	63
Suffocation	31	2	0	33
Undetermined	23	2	1	26
Unknown	50	1	1	52
Vehicular	104	5	2	111
Weapon	34	1	2	37
Total	**977**	**66**	**26**	**1,069**

Deaths Due to Non-injury Causes

There were 749 deaths due to non-injury causes among Tennessee children in 2005, representing 70.05% of all child fatalities. Of these, the greatest number of deaths due to non-injury resulted from illness (366) followed by prematurity (320) then SIDS (63).

Table 19: Non-Injury Causes of Death

Non-injury	Total	Percent of Non-Injury Causes
Asthma	4	0.37%
Cancer	34	3.18%
Cardiovascular	29	2.71%
Congenital Anomaly	108	10.10%
Malnutrition	2	0.19%
Neurological	20	1.87%
Other Medical	140	13.10%
Pneumonia	29	2.71%
Prematurity	320	29.93%
SIDS	63	5.89%
Total	**749**	**70.05%**

Deaths Due to Illness or Other Conditions

In 2005, 366 children died due to illness or other medical conditions. This represents 48.87% of all non-injury deaths and 34.24% of all child fatalities. More than half or 61.75% (226) of all fatalities due to illness involved children of less than one year of age (Table 20).

Table 20: Fatalities Due to Illness or Other Medical Causes by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	226	283.95	Female	158	23.33	White	269	27.12
1-2	29	18.72	Male	208	29.16	African-American	89	30.10
3-5	24	10.55				Asian	5	28.88
6-8	13	5.88				Other	0	0.00
9-11	18	7.94				Unknown	3	0.22
12-14	27	11.34						
15-17	29	11.95						
Total	**366**	**26.32**		**366**	**26.32**		**366**	**26.32**

Deaths Due to Prematurity

A total of 320 deaths were from complications due to prematurity in 2005. Gestational age was recorded for 273 children. Of these, 129 (47.25%) 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, 144 (52.75%) were recorded. There were no premature deaths over 37 weeks of gestation (Table 21). Overall, prematurity was the manner of death for 42.72% of deaths due to non-injury and 29.93% of all childhood deaths.

Table 21: Fatalities Due to Prematurity by Age, Sex, Race and Gestational Age
Total Number = 273 of 320

Gestational Age Less than 23 Weeks								
Age			**Sex**			**Race**		
	Number	%		Number	%		Number	%
<1 days	117	90.70%	Female	48	37.21%	White	44	34.11%
1-6 days	9	6.98%	Male	81	62.79%	African-American	81	62.79%
7-28 days	0	0.00%				Asian	4	3.10%
29-364 days	1	0.78%				Other	0	0.00%
Not reported	2	1.55%				Unknown	0	0.00%
Total	**129**	**100.00%**		**129**	**100.00%**		**129**	**100.00%**

Gestational Age 23-37 Weeks								
Age			**Sex**			**Race**		
	Number	%		Number	%		Number	%
<1 days	50	34.72%	Female	53	36.81%	White	85	59.03%
1-6 days	40	27.78%	Male	91	63.19%	African-American	55	38.19%
7-28 days	36	25.00%				Asian	2	1.39%
29-364 days	18	12.50%				Other	1	0.69%
						Unknown	1	0.69%
Total	**144**	**100.00%**		**144**	**100.00%**		**144**	**100.00%**

Deaths Due to Sudden Infant Death Syndrome (SIDS)

In 2005 there were 63 deaths that were reported as sudden infant death syndrome (SIDS) (see Figure 5). This represents 8.41% of deaths due to non-injury and 5.89% of all childhood deaths in 2005. The most frequently occurring age of death was 5 to 8 weeks (19). Of all fatalities due to SIDS, 45 (71.43%) occurred between 1 and 12 weeks of age. One SIDS death reported did not indicate an age. SIDS deaths decreased 7.35% from 2004.

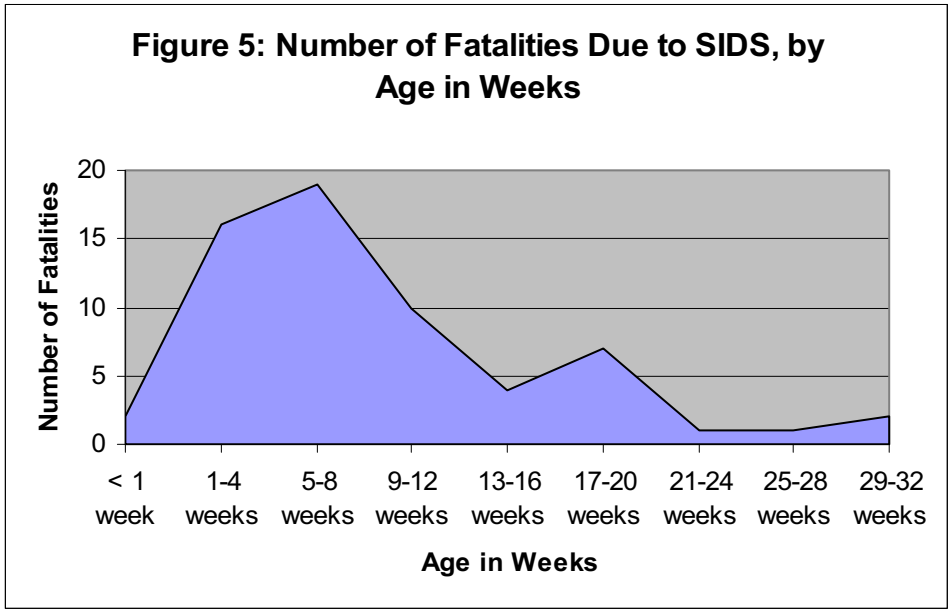

Figure 5: Number of Fatalities Due to SIDS, by Age in Weeks

Deaths Due to Injury

In 2005, there were 242 deaths (22.63% of all childhood fatalities) due to injury among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (111 or 45.87% of all injury-related fatalities). Death by weapon was the next most common cause of injury-related death resulting in 37 fatalities (15.29% of all injury-related fatalities) (Figure 6). The highest rate of child death fatalities due to injuries occurred in the less than one year age category (37). The highest number of deaths were White (180 or 74.38%) (Table 22). Overall, childhood fatalities due to injury-related causes occurred at a rate of 17.40 per 100,000.

Table 22: Fatalities Due to Injury-related Causes by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	37	46.49	Female	99	14.62	White	180	18.15
1-2	26	16.78	Male	143	20.04	African-American	57	19.28
3-5	24	10.55				Asian	2	11.55
6-8	14	6.33				Other	0	0.00
9-11	15	6.61				Unknown	3	0.22
12-14	27	11.34						
15-17	99	40.81						
Total	**242**	**17.40**		**242**	**17.40**		**242**	**17.40**

The highest number of fatalities for White children in 2005 were from vehicular (92) while African-American children died most frequently from incidents involving weapons (23) and had the highest over-all rate of injury-related deaths (19.28 per 100,000) (Table 23).

Table 23: Fatalities Due to Injury by Race
(Total Number = 233 of 242)

Cause	White	African-American	Asian	Other	Unknown	Total
Drowning	24	4	1	0	0	29
Exposure	1	0	0	0	0	1
Fall	3	1	0	0	0	4
Fire	17	5	0	0	0	22
Other Injury	2	0	0	0	0	2
Poisoning	3	0	0	0	0	3
Suffocation	25	6	1	0	1	33
Vehicular	92	18	0	0	1	111
Weapon	13	23	0	0	1	37
Total	**180**	**57**	**2**	**0**	**3**	**242**
Rate[1]	**18.15**	**19.28**	**11.55**	**0**	**0.22**	**17.40**

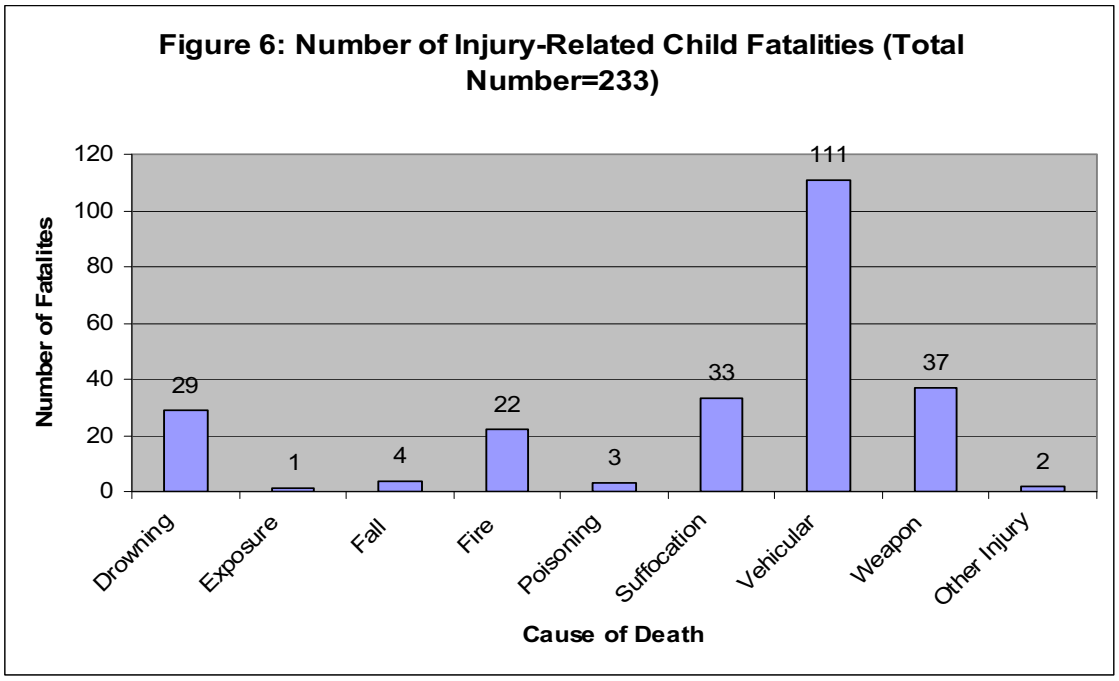

Figure 6: Number of Injury -Related Child Fatalities

Deaths Due to Vehicle-Related Incidents

In 2005, 111 children died in vehicle-related incidents. This represents 45.87% of all injury-related deaths and 10.38% of all child fatalities for 2005. Children ages 15-17 were most likely to die as a result of a vehicle-related injury (59; 24.32 per 100,000) and children 12-14 (18; 7.56 per 100,000) were the second most likely to die in vehicular-related incident. Females (53; 7.83 per 100,000) were only slightly less likely to die in a vehicle-related death as males (58; 8.13 per 100,000). Whites (92; 9.28 per 100,000) had a higher rate of death by vehicle than African-Americans (18; 6.09 per 100,000) (Table 24).

Table 24: Fatalities Due to Vehicular by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	7	8.79	Female	53	7.83	White	92	9.28
1-2	7	4.52	Male	58	8.13	African-American	18	6.09
3-5	5	2.20				Asian	0	0.00
6-8	8	3.62				Other	0	0.00
9-11	7	3.09				Unknown	1	0.07
12-14	18	7.56						
15-17	59	24.32						
Total	**111**	**7.98**		**111**	**7.98**		**111**	**7.98**

Deaths Due to Suffocation or Strangulation

In 2005, there were 33 deaths due to suffocation or strangulation. This represents 13.63% of all injury-related deaths and 3.09% of all child fatalities for 2005. Among these deaths, 22 (66.67%) involved a child less than one year old (Table 25).

Table 25: Fatalities Due to Suffocation or Strangulation by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	22	27.64	Female	11	1.62	White	25	2.52
1-2	0	0.00	Male	22	3.08	African-American	6	2.03
3-5	2	0.88				Asian	1	5.78
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	1	0.07
12-14	4	1.68						
15-17	5	2.06						
Total	**33**	**2.37**		**33**	**2.37**		**33**	**2.37**

Deaths Due to Weapons

In 2005, 37 children died due to weapons injuries. This represents 15.29% of all injury-related deaths and 3.46% of all childhood fatalities. Males (29; 4.07 per 100,000) were significantly more likely to die due to weapon injuries than females (8; 1.18 per 100,000). Over 70% (26) of all weapon deaths occurred in age groups of 15-17 years old (Table 26).

Table 26: Fatalities Due to Weapons by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	3	3.77	Female	8	1.18	White	13	1.31
1-2	1	0.65	Male	29	4.07	African-American	23	7.78
3-5	3	1.32				Asian	0	0.00
6-8	2	0.90				Other	0	0.00
9-11	1	0.44				Unknown	1	0.07
12-14	1	0.42						
15-17	26	10.72						
Total	**37**	**2.66**		**37**	**2.66**		**37**	**2.66**

Deaths Due to Drowning

In 2005, 29 children died from accidental drowning. This represents 11.98% of all injury-related deaths and 2.71% of all child fatalities for 2005. The highest rate occurred in the age group of 1-2 years of age (10; 6.45 per 100,000). More White children died by drowning (24; 2.42 per 100,000) but Asian children died at a higher rate (1; 5.78 per 100,000) (Table 27).

Table 27: Fatalities due to Drowning by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	2	2.51	Female	10	1.48	White	24	2.42
1-2	10	6.45	Male	19	2.66	African-American	4	1.35
3-5	8	3.52				Asian	1	5.78
6-8	2	0.90				Other	0	0.00
9-11	3	1.32				Unknown	0	0.00
12-14	1	0.42						
15-17	3	1.24						
Total	**29**	**2.09**		**29**	**2.09**		**29**	**2.09**

Deaths Due to Fire/Burns

In 2005, there were 22 child fatalities due to fire and/or burns. This represents 9.09% of all injury-related deaths and 2.06% of all child fatalities for 2005 (Table 28).

Table 28: Fatalities Due to Fire/Burns by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	3	3.77	Female	13	1.92	White	17	1.71
1-2	6	3.87	Male	9	1.26	African-American	5	1.69
3-5	5	2.20				Asian	0	0.00
6-8	2	0.90				Other	0	0.00
9-11	4	1.76				Unknown	0	0.00
12-14	2	0.84						
15-17	0	0.00						
Total	**22**	**1.58**		**22**	**1.58**		**22**	**1.58**

Deaths Due to Falls

In 2005, there were four child fatalities due to falls. This represents 1.65% of all injury-related deaths and 0.37% of all child fatalities for 2005 (Table 29).

Table 29: Fatalities Due to Falls by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	0	0.00	Female	2	0.30	White	3	0.30
1-2	1	0.65	Male	2	0.28	African-American	1	0.34
3-5	1	0.44				Asian	0	0.00
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	0	0.00
12-14	1	0.42						
15-17	1	0.41						
Total	**4**	**0.29**		**4**	**0.29**		**4**	**0.29**

Deaths Due to Poisoning

In 2005, there were three child fatalities due to poisoning. This represents 1.24% of all injury-related deaths and 0.28% of all child fatalities for 2005. All deaths occurred in the 15-17 age category (3; 0.22 per 100,000) (Table 30).

Table 30: Fatalities Due to Poisoning by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	0	0.00	Female	1	0.15	White	3	0.30
1-2	0	0.00	Male	2	0.28	African-American	0	0.00
3-5	0	0.00				Asian	0	0.00
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	0	0.00
12-14	0	0.00						
15-17	3	1.24						
Total	**3**	**0.22**		**3**	**0.22**		**3**	**0.22**

Deaths Due to Exposure

In 2005, one child died of exposure. This represents 0.41% of all injury-related deaths and 0.09% of all child fatalities for 2005 (Table 31).

Table 31: Fatalities Due to Exposure by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	0	0.00	Female	0	0.00	White	1	0.10
1-2	1	0.65	Male	1	0.14	African-American	0	0.00
3-5	0	0.00				Asian	0	0.00
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	0	0.00
12-14	0	0.00						
15-17	0	0.00						
Total	**1**	**0.07**		**1**	**0.07**		**1**	**0.07**

Deaths Due to Other Injury

In 2005, there were two child fatalities determined to be other injury. This represents 0.83% of all injury-related deaths and 0.19% of all child fatalities for 2005 (Table 32).

Table 32: Fatalities Due to Other Injury by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	0	0.00	Female	1	0.15	White	2	0.20
1-2	0	0.00	Male	1	0.14	African-American	0	0.00
3-5	0	0.00				Asian	0	0.00
6-8	0	0.00				Other	0	0.00
9-11	0	0.00				Unknown	0	0.00
12-14	0	0.00						
15-17	2	0.82						
Total	**2**	**0.14**		**2**	**0.14**		**2**	**0.14**

Undetermined or Unknown Deaths

In 2005, there were 78 total fatalities that were selected as Undetermined (26) or Unknown (52) Cause of Death. This represents 7.29% of all child fatalities for 2005 (Table 33).

Table 33: Fatalities Due to Undetermined or Unknown Causes by Age, Sex and Race

Age			Sex			Race		
	Number	Rate[1]		Number	Rate[1]		Number	Rate[1]
<1	62	77.90	Female	32	4.73	White	52	5.24
1-2	4	2.58	Male	44	6.45	African-American	25	8.45
3-5	1	0.44				Asian	0	0.00
6-8	3	1.36				Other	0	0.00
9-11	1	0.44				Unknown	1	0.07
12-14	1	0.42						
15-17	6	2.47						
Total	**78**	**5.61**		**78**	**5.61**		**78**	**5.61**

Appendix

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.]

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.

(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.]

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Voting Members

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(615) 741-2035

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Representative Dennis Ferguson
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Serves by virtue of position as a member of the Tennessee House of Representatives

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Serves as designee for the Department of Mental Health & Developmental Disabilities

Vacant

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Serves by virtue of position as member of the judiciary selected from a list submitted by the Chief Justice of the State Supreme Court

Dr. Lisa Piercey
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Tennessee Child Fatality Review Team Leaders

CFRT Leader	Phone	Judicial Districts (JD) and 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 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 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 3**: Greene, Hamblen, Hancock, and Hawkins Counties (Sandy J. Malone, Admin.)
Frank Bristow **E**ast TN Regional Health Office PO Box 59019 1522 Cherokee Trail Knoxville, TN 37950-9019	Phone: SH: (865) 549-5252 Office: (865) 549-5253 Fax: (865) 594 5738 FB :865-549-5364 Fax: 865-594-6291	**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
Dr. Kathy Brown Phd. Knox County Health Dept. 140 Dameron Ave. Knoxville, TN 37917	Phone: (865) 215-5469 (865) 215-5437 Mary Campbell Linda Weber (ASA) 865-215-5272	**JD 6**: Knox County
Dr. Jan BeVille Southeast Regional Health Office State Office Building 540 McCallie Avenue Chattanooga, TN 37402	Phone: (423) 634-5887	**JD 10**: Bradley, McMinn, Monroe, and Polk Counties **JD 12**: Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie Counties

CFRT Leader	Phone	Judicial Districts (JD) and Counties
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Dr. Don Tansil Upper Cumberland Reg. Health Office 200 West 10th Street Cookeville, TN 38501-6067	Phone: (931)528-7531 Infirmary (931) 372-3320	**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. Langdon Smith/Peggy Michonski South Central Regional Health Office 1216 Trotwood Avenue Columbia, TN 38401-4809	Phone: (931) 490-8388 Jan Winters (931) 490-8343 Fax: (931) 380-3364	**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: (615) 253-3178	**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. 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	**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

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

This information is confidential

TENNESSEE DEPARTMENT OF HEALTH
CHILD FATALITY REVIEW TEAM
_____ REVIEW/DATA COLLECTION

MCH 12/02

Judicial District No.: _____ Child Death Year/No.: ___/___/___-___/___/___

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 _____

1. CAUSE AND CIRCUMSTANCES OF DEATH
(Complete on back)

☐ Sudden Infant Death Syndrome ☐ Firearm
☐ Lack of adequate care ☐ Inflicted Injury
☐ Prematurity ☐ Poisoning/overdose
☐ Illness or other natural cause ☐ Fire/burn
☐ Drowning ☐ Other cause not listed above
☐ Suffocation/strangulation ☐ Unknown cause
☐ Vehicular

2. Family has prior child protective services involvement?
☐ Yes ☐ No ☐ Unknown

3. Other public/private agency involvement?
☐ Yes ☐ No ☐ Unknown
If yes, name of agency:
Health Department: ☐ Immunizations ☐ CSS ☐ WIC ☐ Home visiting program ☐ Other
DHS: ☐ FF ☐ Food Stamps ☐ Other
☐ Counseling/Mental Health ☐ Police/Sheriff
☐ TennCare ☐ Juvenile Court
☐ Other: _____

4. Was there an apparent delay in seeking medical treatment?
☐ Yes ☐ No ☐ Unknown

5. Suspected child abuse/neglect fatality?
☐ Yes ☐ No ☐ Unknown

6. Overall was the investigation adequate? ☐ Yes ☐ No
If no, was the problem with:
☐ Autopsy ☐ Police follow-up
☐ Hospital review ☐ Death Scene Investigation
☐ Interagency Cooperation ☐ CPS Follow-up
☐ Other _____

7. Manner of death as determined by the CFRT team:
☐ Homicide ☐ Accidental ☐ Natural ☐ Suicide
☐ Could not be determined
☐ Undetermined due to suspicious circumstances

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: _____

Additional information for State office:

_____
_____
_____
_____
_____

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:**
_____
2003 _____
_____

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Endnotes

[1] Rates based on TN population per 100,000 less than 18 years of age; Population variables used from the Annie E. Casey Foundation, KIDS COUNT Data Center www.kidscount.org

[2] Percentage rounded for reporting purposes

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