

# **CHILD FATALITIES IN TENNESSEE 2000**



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

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## **Acknowledgments**

The Maternal and Child Health Section would like to acknowledge the professional assistance of The University of Tennessee Safety Center and the Tennessee Department of Health Office of Health Statistics and Research in the preparation of this report.

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

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This report is also available on the internet:

[www2.state.tn.us/health/Downloads/CFRT2000.pdf](http://www2.state.tn.us/health/Downloads/CFRT2000.pdf)

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## **Executive Summary**

### **Childhood Fatality Review -- 2000**

Child Fatality Review Teams (CFRT) are active in all judicial districts in the state. During 2000, the 33 teams reviewed 1,094 (93%) of the 1,175 fatalities of Tennessee resident children. Department of Health team leaders provided administration and coordination of the teams.

#### **MANNER OF DEATH**

The manner of death was determined by the CFRT to be natural causes for 71% (N=777) of the fatalities, unintentional injury (accidental) causes for 20% (N=216), homicide for 4% (N=44), suicide for 3% (N=27), not determined or undetermined 1% (N=14), suspicious nature for 0.6% (N=7) of fatalities, and 0.8% (N=9) cause unknown, respectively.

The CFRT agreed with the manner of death indicated on the death certificate in 82% (N=897) of the cases and determined a different manner of death in 2.2% (N=24) of the fatalities.

The CFRT judged the death certificate to be incomplete/inadequate in 24% (N=259) of cases.

#### **Manner of Death and Age**

Across all groups, the highest rate of fatalities was during the first year of life. Sixty-one percent (N=672) of child fatalities were less than one-year-old. Of the children less than one-year-old, 93% (N=625) died of natural causes and 24% (N=161) survived less than one day after birth.

The next largest group of child fatalities was among children aged 15-17 (14%; N=153). Among the 15-17 year-olds, 59% (N=90) of fatalities were due to unintentional injury.

#### **Manner of Death and Race**

Of the childhood fatalities, 58% of the children were reported as white, 36% as African-American, 3% as Asian, and 2% as other. The fatality rates (per 100,000) were 58.2 for white children, 140.3 for African-American children, 209.8 for Asian children, and 30.7 for all other children.

Natural death was the highest category of manner of fatalities for all races. The number of natural fatalities for white children was 427 (39%), for African-American children 308 (28%), for Asian children 20 (2%), and for others 14 (1%).

### **Manner of Death: Violence-related**

In 2000, there were 71 child fatalities due to violence-related injuries, through either homicide or suicide. This represents 25% of all injury deaths and 7% of all child fatalities.

### **Manner of Death by County**

Sixty-three percent (N=685) of all childhood fatalities occurred in 12 counties reporting 15 or more deaths each. The highly populated areas of Shelby and Davidson Counties reported over 100 deaths each and accounted for 37% of all childhood fatalities, with 24% of the total in Shelby County. Of the 12 counties reporting the most child fatalities, all but one ranked in the top 14 counties with the highest population ages 0-17 years.

## **CAUSE OF DEATH**

The 1,094 child fatalities were divided into the following categories by cause of death:

- Non-injury: 789 (72%).
- Injury-related: 283 (26%).
- Undetermined cause: 22 (2%).

### **Deaths Due to Non-Injury Causes**

There were 789 deaths due to natural (non-injury) causes among Tennessee children in 2000, representing 72% of all child fatalities. Of these, 355 (45%) resulted from illness, 341 (43%) from prematurity, and 89 (11%) from SIDS and 4 (1%) due to lack of medical care.

### **Deaths Due to Injury**

There were 283 deaths due to injury among children in 2000, representing 26% of all childhood fatalities. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (133 or 47% of all injury-related fatalities). Firearm fatalities were the next most common cause of death resulting in 40 fatalities (14%). Males were more likely to be involved in injury-related fatalities than females (24.9 versus 14.85 per 100,000). African-American children were more likely to be involved in an injury-related fatality than white children (28.3 versus 17.7 per 100,000).

## **Accomplishments of Child Fatality Review Teams: 2000**

Child Fatality Review Teams are active in all judicial districts in the state. During 2000, the 33 teams reviewed 1,094 (93%) of the 1,175 fatalities of Tennessee resident children. Department of Health team leaders provide administration and coordination of the teams. Some specific examples of team accomplishments are given below.

### ***Judicial District 5: Blount County***

- Continued to review all childhood deaths that occur in their district regardless of the child's resident location.
- Sent the "Investigative Questionnaire for Child Deaths" to all local law enforcement agencies.

### ***Judicial District 6: Knox County***

- Expanded collaboration between emergency medical services, law enforcement, the Medical Examiner's office and hospital staff to improve the death investigation, in particular, the preservation of evidence from the death scene and the hospital.

### ***Judicial District 7: Anderson County***

- Added a nurse from the local school district to their team.

### ***Judicial District 9: Loudon, Meigs, Morgan, and Roane Counties***

- Compiled information regarding the quantitative levels of being under the influence of marijuana.
- Added a member from the Department of Transportation to their team.

### ***Judicial District 30: Shelby County***

- Collaborated with the Citizen's Review Team for Shelby County and an intern from the UT School of Social Work to examine intentional injury child death cases from 1996-2000. There were 30 intentional injury cases during these years. Demographic information on the children and the offenders was compiled, as well as a summary of the disposition of each case in the court system.

## **Recommendations from Child Fatality Review Teams**

After reviewing the year's progress and concerns, the Child Fatality Review Teams (CFRT) submitted recommendations that were discussed and summarized by CFRT team leaders. Recommendations to the state child fatality prevention team follow:

### **Highest Priority**

1. Perform autopsies on all children under age 18 whose cause of death is not definitive.
2. Provide full funding by the state to the counties for autopsies performed on children under the age of 18 where the cause of death is not definitive.

### **High Priority**

3. Increase parent education on children's sleeping arrangements and the relationship to SIDS.
4. Increase school and community awareness of suicide prevention and risks.

### **Priority**

5. Re-address the intermediate driver's license law to prevent an intermediate license holder from having another passenger under the age of 21 in the vehicle without an unrestricted licensed driver. Make driver's education courses mandatory prior to applicant receiving license
6. Increase prevention of firearm-related injury and death:
  - a. Explore the feasibility of recommending a child access prevention law for the state of Tennessee so that adults are held criminally liable for failure to safely store firearms inaccessible to children.
  - b. Provide education on the dangers of having unlocked firearms in the presence of children of any age.
  - c. Provide education on the high-risk factor of the combination of teenagers and unlocked firearms.
  - d. Promote the use of gunlocks.
7. Provide storage of newborn umbilical cord blood for six months.
8. Provide education to both private and public agencies about the responsibilities and duties of the Child Fatality Review Team.
9. Provide training on how to properly complete a death certificate with an emphasis on completion of the entire certificate.
10. Provide public service announcements by late spring promoting pool safety.
11. Enact legislation to require emergency room physicians to report to the proper authorities all injuries resulting in a fatality or a near-fatality so the injuries are investigated.

## **Extremely Important**

12. Increase education/awareness regarding the dangers of smoking during pregnancy.
13. Collaborate with Safe Kids Coalition groups across the state in identifying prevention strategies as well as provide support to public awareness campaigns provided by these coalitions.
14. Support and provide funding for public awareness campaigns on fire safety.
15. Increase education on the importance of strong families.
16. Address motor vehicle accidents on rural roads including lack of maintenance and signage.
17. Coordinate with the March of Dimes to increase targeted education to reduce premature births and deaths in all socio-economic groups.
18. Develop new, and enforce current, legislation that ensures proper regulations for hauling objects in open vehicles on any roadway.
19. Increase education of the signs and symptoms of shaken baby syndrome in children who present routinely with problems to the offices of medical providers, Department of Children's Services workers, etc.
20. Enact legislation to prohibit children less than 13 years of age from riding four-wheel all terrain vehicles (ATVs).
21. Implement standardized drug testing for juveniles to incorporate all drugs and not just the drugs for which they are charged.
22. Provide parenting classes to parents with young children.
23. Provide counseling for abused women to prevent re-entry into another abusive relationship.
24. Share information among agencies regarding juvenile offenders and the limitations that are placed on their release. Establish a database with this information and provide access to law enforcement agencies.
25. Identify programs/agencies/services that can assist children in crisis.



## **Recommendations from the State Child Fatality Prevention Team**

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

1. Perform autopsies on all deaths of children under the age of 18 where the cause is not definitive and provide full state funding to the counties for those autopsies.
2. Increase school and community awareness of suicide prevention and risks, including access to firearms.

### **Child Fatality Review State Prevention Team 2002**

Stephanie Bailey, M.D., Davidson County Health Department  
Bonnie Beneke, Tennessee Professional Society on Abuse of Children  
Senator Charlotte Burks  
Representative Gene Caldwell, M. D.  
Representative Dennis Ferguson  
Senator David Fowler  
Representative Joe Fowlkes  
Judge Betty Adams Green, Davidson County Juvenile Court  
Bruce Levy, M.D., Center for Forensic Medicine  
Louis Martinez, Tennessee Department of Children's Services  
Linda O'Neal, Tennessee Commission on Children and Youth  
Kim Rush, Tennessee Department of Mental Health and Developmental Disabilities  
Paul G. Summers, State Attorney General  
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Mary Howard Hayes, Sumner County Health Department  
Bill Leach, Humphreys County Health Department  
Stephen May, M.D., Sullivan County Health Department  
Lawrence Moffatt, M.D., Washington County Health Department  
Flo Patton, Shelby County Health Department  
Pat Santel, Williamson County Health Department  
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## Manner of Death

The manner of death was determined by the CFRT to be natural causes for 71% (N=777) of the fatalities, unintentional injury (accidental) causes for 20% (N=216), homicide for 4% (N=44), suicide for 3% (N=27), not determined or undetermined 1% (N=14), and suspicious nature for 0.6% (N=7) of fatalities, respectively. The manner of death was not available for 0.8% (N=9) of the fatalities. (Figure 1)

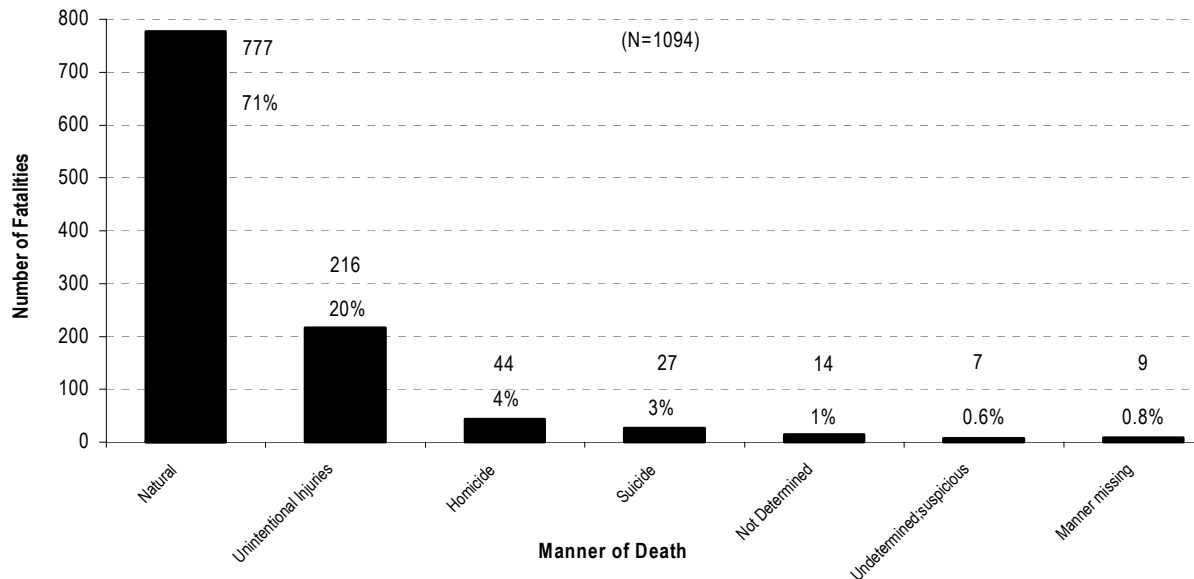
The CFRT agreed with the manner of death indicated on the death certificate in 82% (N=897) of the cases and determined a different manner of death in 2.2% (N=24) of the fatalities. For 15.0% (N=164) of the child fatalities, the manner of death was not indicated on the death certificate and was determined by the CFRT. The CFRT did not give manner of death determinations for 0.8% (N=9) cases.

The CFRT judged the death certificate to be incomplete/inadequate in 24% (N=259) of cases.

Sixty-one percent (N=672) of child fatalities were less than one-year-old. Of the children less than one-year-old, 93% (N=625) died of natural causes and 24% (N=161) survived less than one day after birth. The next largest group of child fatalities was among children aged 15-17 (14%; N=153). Among the 15-17 year-olds, 59% (N=90) of fatalities were due to unintentional injury.

The overall rate of child fatalities computed from the cases reviewed by the CFRT was 78.2 per 100,000.

**FIGURE 1**  
**Number of Fatalities by Manner of Death as Determined by Child Fatality Review Team, Tennessee, 2000**



## Manner of Death and Age

Across all groups, the highest rate of fatalities was during the first year of life. The second highest rate of fatalities occurred in youth aged 15-17. (Table 1)

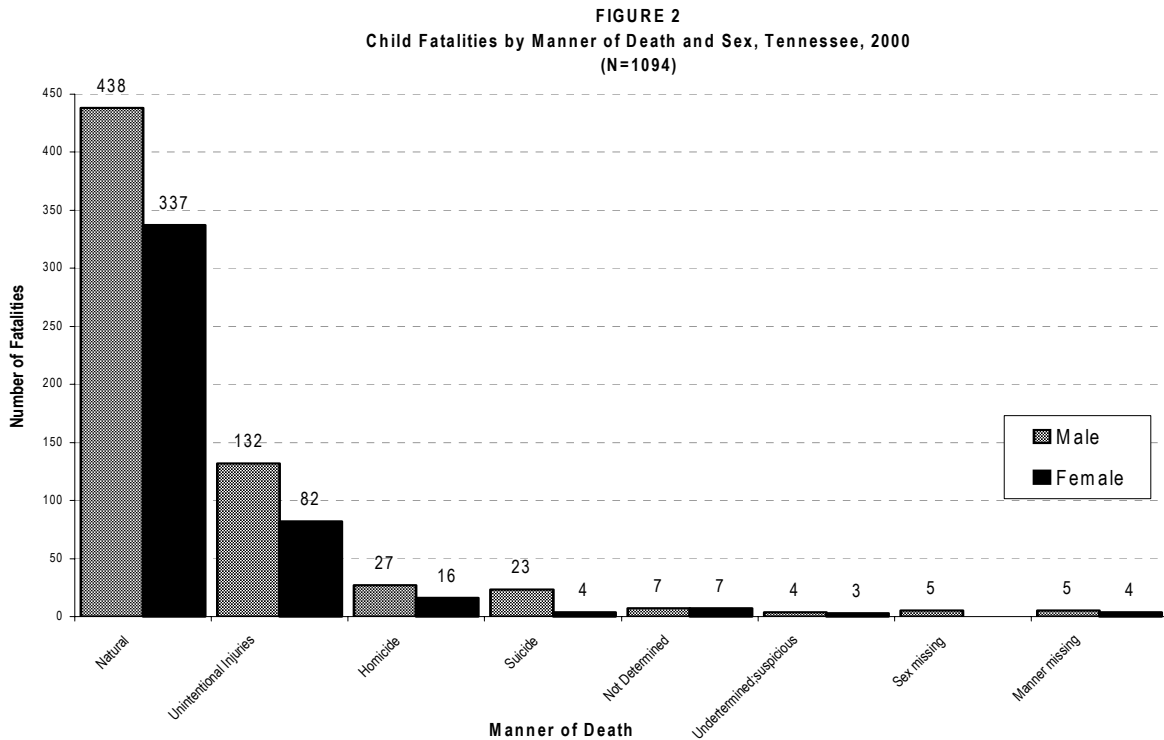
	<1	1-2	3-5	6-8	9-11	12-14	15-17	Total
Natural	625	32	20	15	26	30	28	776
Unintentional Injuries	18	23	23	18	17	25	90	214
Homicide	12	5	3	4	4	4	12	44
Suicide	0	0	0	0	0	8	19	27
Not Determined	7	0	0	1	1	2	3	14
Undetermined; Suspicious	4	1	0	0	0	2	0	7
<b>Total</b>	<b>666</b>	<b>61</b>	<b>46</b>	<b>38</b>	<b>48</b>	<b>71</b>	<b>152</b>	<b>1082**</b>
<b>Rate*</b>	894.5	41.4	20.3	16.1	20.0	30.4	65.8	78.0

\*Rate per 100,000 in population.

\*\*Age data not supplied for 3 cases and manner of death not supplied for 9 cases.

## Manner of Death and Sex

Fifty-eight percent of child fatalities were males (N=636) and 42% were females (N=453), which corresponded to rates of 88.5 fatalities per 100,000 in the population for males and 66.6 per 100,000 in the population for females. The largest number of fatalities for both sexes occurred by natural manner. (Figure 2)

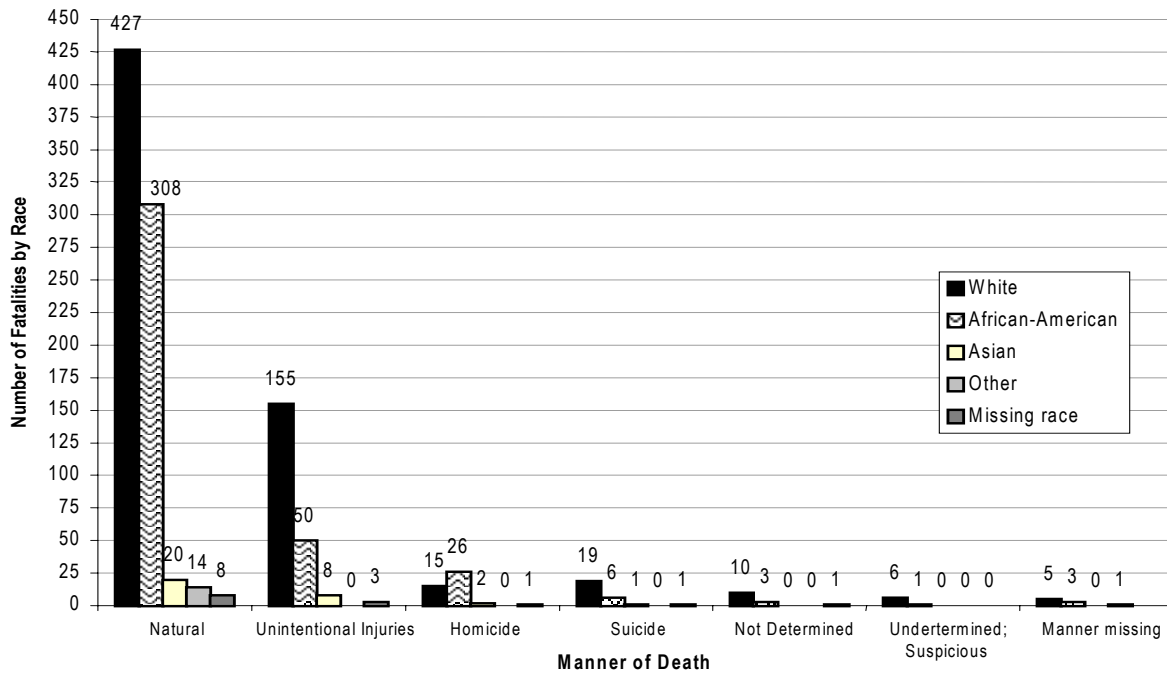


\*Sex data not supplied for 5 cases, and manner of death not supplied for 9 cases.

## Manner of Death and Race

Natural death was the highest category of manner of fatalities for all races. The number of natural fatalities for white children was 427 (39%), for African-American children 308 (28%), for Asian children 20 (2%), and for others 14 (1%). (Figure 3)

FIGURE 3  
Child Fatalities by Manner of Death and Race, Tennessee, 2000  
(N=1094)



\*Manner of death not supplied for 9 cases and race not supplied for 15 cases.

## Manner of Death by Age, Sex, and Race

Of the childhood fatalities, 58% of the children were reported as white, 36% as African-American, 3% as Asian, and 2% as other. The fatality rates (per 100,000) were 58.2 for white children, 140.3 for African-American children, 209.8 for Asian children, and 30.7 for all other children.

Using the CRFT data to determine child fatality rates by race is somewhat problematic because the CFRT data collection form treats race as five mutually exclusive categories: White, African-American, Asian, Other, and Hispanic. In the census data, which is used to calculate fatality rates, options for identifying ethnicity include: White, Black or African-American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander, or Other. Respondents could indicate whether they identified with two or more races, and Hispanic or Latino is classified as an ethnic origin rather than race. Death rates for any group other than white, African-American, Asian and other groups should be considered as estimates.

Across all groups, the highest rate of fatalities was during the first year of life. Taking age, race and sex into account, the highest fatality rate was for African-American

males under one year of age (2,145.5 per 100,000), followed by African-American females under one year of age (1,541.5 per 100,000). These rates were more than twice the rate of white males (703.9 per 100,000) and females (586.9 per 100,000) in the first year of life. (Table 2)

Past the first year of life, male youth aged 15-17 had the highest fatality rates. Among that age group, fatality rates for African-American males (99.5 per 100,000) were higher than white males (74.6 per 100,000).

<b>Table 2: Fatality Rates Per 100,000 by Age, Sex, and Race (N=1094)</b>												
	<b>Male (N=636**)</b>						<b>Female (N=453**)</b>					
	<b>White</b>		<b>African-American</b>		<b>Other</b>		<b>White</b>		<b>African-American</b>		<b>Other</b>	
<b>Age</b>	<b>Number</b>	<b>Rate*</b>	<b>Number</b>	<b>Rate*</b>	<b>Number</b>	<b>Rate*</b>	<b>Number</b>	<b>Rate*</b>	<b>Number</b>	<b>Rate*</b>	<b>Number</b>	<b>Rate*</b>
<1 year	199	703.9	166	2145.5	18	713.2	155	586.9	116	1541.5	11	454.4
1-2 years	21	38.9	9	570.0	0	0	15	28.2	16	104.7	1	22.5
3-5 years	17	26.1	7	27.9	1	16.5	11	13.6	8	33.8	1	16.8
6-8 years	13	14.6	8	29.8	0	0	13	15.5	3	11.5	0	0
9-11 years	20	21.3	11	40.6	1	20.6	10	11.3	5	19.1	1	22.2
12-14 years	27	28.7	9	36.1	1	23.0	21	24.6	6	25.1	2	48.9
15-17 years	68	74.6	24	99.5	7	143.6	41	47.9	9	39.5	1	24.3
<b>Total</b>	365	71.0	234	170.3	28	86.1	266	52.8	163	112.1	17	55.4
	34.8%		21.4%				24.3%		14.9%		1.6%	
<b>Total Number of Age, Sex, and Race = 1073**</b>												

\*Rate per 100,000 in population.

\*\*21 complete cases of age, sex, and race data not supplied.

**Manner of Death: Violence-related**

In 2000, there were 71 child fatalities due to violence-related injuries. These injuries are the result of violence, through either homicide or suicide. This represents 25% of all injury deaths and 7% of all child fatalities. (Table 3)

Males (N=50; 7.3 per 100,000 in population) were more likely than females (N=20; 2.9 per 100,000 in population) to die from inflicted injuries. African-American children (N=32; 11.3 per 100,000 in population) were most likely to die from inflicted injuries, followed by children in the “Other” racial category (N=3; 4.7 per 100,000 in population). The least likely to die from inflicted injuries were white children (N=34; 3.3 per 100,000 in population).

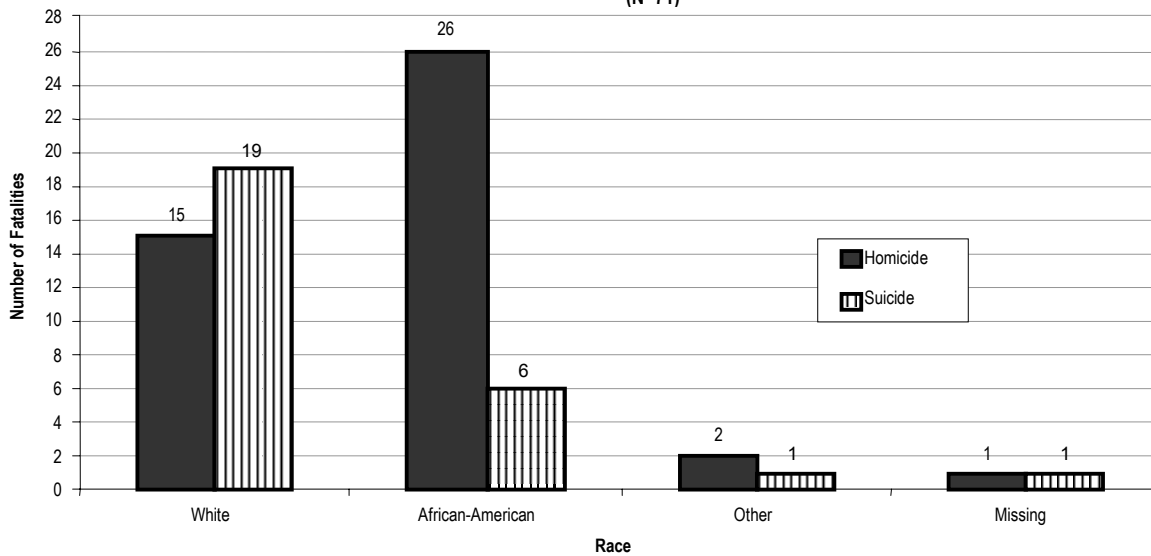
Children less than one year old had the highest rate of fatalities (16.0), followed by youth ages 15-17 (13.3).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	12	16.0	Male	50	7.3	White	34	3.3
1-2 years	5	3.7	Female	20	2.9	African-American	32	11.3
3-5 years	3	1.5				Other	3	4.7
6-8 years	4	1.7						
9-11 years	4	1.6						
12-14 years	12	5.1						
15-17 years	31	13.3						
<b>Total</b>	<b>71**</b>	<b>5.1</b>	<b>Total</b>	<b>70**</b>	<b>5.0</b>	<b>Total</b>	<b>69**</b>	<b>4.9</b>

\*Rate per 100,000 in population.

\*\*Sex data not supplied for 1 case, and race data not supplied for 2 cases.

**FIGURE 4**  
**Violence-related Child Fatalities by Manner and Race, Tennessee, 2000**  
**(N=71)**



## Homicide

In 2000, there were 44 child fatalities due to homicides. This represents 15% of all injury deaths and 4% of all child fatalities. (Table 4)

Males (N=27; 3.9 per 100,000 in population) were more likely than females (N=16; 2.4 per 100,000 in population) to die from homicides. African-American children (N=26; 9.2 per 100,000 in population) were most likely to die from homicides, followed by children in the other category (N=2; 3.2 per 100,000 in population). Least likely to die by homicide were white children (N=15; 1.5 per 100,000 in population).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	12	16.0	Male	27	3.9	White	15	1.5
1-2 years	5	3.7	Female	16	2.4	African American	26	9.2
3-5 years	3	1.5				Other	2	3.2
6-8 years	4	1.7						
9-11 years	4	1.6						
12-14 years	4	1.7						
15-17 years	12	5.2						
<b>Total</b>	<b>44</b>	<b>3.2</b>	<b>Total</b>	<b>43**</b>	<b>3.1</b>	<b>Total</b>	<b>43**</b>	<b>3.1</b>

\*Rate per 100,000 in population.

\*\*Sex data not supplied for 1 case, and race data not supplied for 1 case.

## Suicide

During 2000, 27 young people committed suicide (Table 5). Using data provided, 48% (N=13) of these suicides were in the 16-17 year old age bracket. Males (3.2 per 100,000 in population; N=23) were more likely than females (0.59 per 100,000 in population; N=4) to die from suicide. Slight racial differences emerged with African-American racial identification having the highest adjusted rate, 2.1 per 100,000 in population. The white racial category was second with 1.9 suicides per 100,000 in population, followed by the other racial category at 1.6 suicides per 100,000 in population.

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	0		Male	23	3.2	White	19	1.9
1-2 years	0		Female	4	0.59	African American	6	2.1
3-5 years	0					Other	1	1.6
6-8 years	0							
9-11 years	0							
12-14 years	8	3.4						
15-17 years	19	8.2						
<b>Total</b>	<b>27</b>	<b>2.0</b>	<b>Total</b>	<b>27</b>	<b>2.0</b>	<b>Total</b>	<b>26**</b>	<b>1.9</b>

\*Rate per 100,000 in population.

\*\*Race data not supplied for 1 case.



## **Manner of Death Undetermined**

In 2000, there were 21 fatalities that the CFRT reported the manner of death was undetermined or could not be determined (Table 6). This represents 1.6% of all child fatalities reviewed in 2000. Children less than one year of age were disproportionately represented in cases where the manner of death were unknown or could not be determined. Prior Child Protective Services involvement was noted in two cases where the CFRT team indicated the manner of death could not be determined and one case where the manner of death was undetermined due to suspicious circumstances.

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	11	14.6	Male	11	1.5	White	16	1.6
1-2 years	1	0.7	Female	10	1.5	African American	4	1.4
3-5 years	0	0				Other	0	0
6-8 years	1	0.4						
9-11 years	1	0.4						
12-14 years	4	1.7						
15-17 years	3	1.3						
<b>Total</b>	<b>21</b>	<b>1.5</b>	<b>Total</b>	<b>21</b>	<b>1.5</b>	<b>Total</b>	<b>20**</b>	<b>1.4</b>

\*Rate per 100,000 in population.

\*\*Race data not supplied for 1 case.

## **Manner of Death by County**

Sixty-three percent (N=685) of all childhood fatalities occurred in 12 counties reporting 15 or more deaths each. The highly populated areas of Shelby and Davidson Counties reported over 100 deaths each and accounted for 37% of all childhood fatalities, with 24% of the total in Shelby County. Three additional counties (Hamilton, Knox, and Rutherford) reported between 31 and 100 deaths each. The remaining seven counties had between 15 and 30 deaths each. (Table 7) Of the 12 counties reporting the most child fatalities, all but one rank in the top 14 counties with the highest population ages 0-17 years.

County	Total Child Fatalities	Rank in Population Ages 0-17 Years
Shelby	266	1
Davidson	136	2
Hamilton	61	4
Knox	44	3
Rutherford	33	5
Sullivan	29	9
Montgomery	27	6
Madison	23	11
Williamson	19	7
Washington	16	13
Greene	16	20
Bradley	15	14
<b>TOTAL</b>	<b>685</b>	

Table 8: Child Fatalities by County and Manner of Death (N=1094)*							
County	Manner of Death					Population Ages 0-17	Fatality Rate***
	Accidental	Natural	Violent**	Undetermined	Total		
Anderson	2	2	1		5	16,535	30.2
Bedford		7			7	9,687	72.3
Benton	4	1		1	6	3,641	164.8
Bledsoe		1			1	2,854	35.0
Blount	2	9	1		12	24,130	49.7
Bradley	1	11	2		14	20,831	67.2
Campbell	2	5			7	9,127	76.7
Cannon		2			2	3,259	61.4
Carroll	2	9			11	6,840	160.8
Carter		4			4	12,119	33.0
Cheatham	2	3			5	9,930	50.4
Chester	1	4			5	3,762	132.9
Claiborne	1	2	1		4	7,044	56.8
Clay		1			1	1,714	58.3
Cocke	2	2			4	7,661	52.2
Coffee	3	6	1		10	12,046	83.0
Crockett	1				1	3,654	27.4
Cumberland	1	6	1	1	9	10,011	89.9
Davidson	29	107	7	2	145	126,447	114.7
Decatur		1			1	2,549	39.2
Dekalb		2			2	4,052	49.4
Dickson	2	2			4	11,486	34.8
Dyer		6	1		7	9,597	72.9
Fayette	2	2			4	7,409	54.0
Fentress		4			4	4,023	99.4
Franklin	6	1	1		8	9,043	88.5
Gibson		8	1		9	11,538	78.0
Giles		2			2	7,220	27.7
Grainger	3	1			4	4,732	84.5
Greene	5	9	1	1	16	13,991	114.4
Grundy	1	1			2	3,601	55.5
Hamblen	3	7	1		11	13,530	81.3
Hamilton	8	46	5	2	61	71,442	85.4
Hancock		1			1	1,570	63.7
Hardeman		3			3	6,722	44.6
Hardin		6			6	5,897	101.7
Hawkins		6		1	7	12,479	56.1
Haywood		1			1	5,380	18.6
Henderson	1	3		1	5	6,212	80.5
Henry	2	5	1		8	6,913	115.7
Hickman	1	2		1	4	5,503	72.7
Houston	2	1			3	1,970	152.3
Humphreys	2	4			6	4,282	140.1
Jackson	1	1			2	2,446	81.8
Jefferson		4			4	10,140	39.4
Johnson						3,449	
Knox	10	30	4		44	85,093	51.7
Lake						1,411	
Lauderdale		9			9	6,719	133.9
Lawrence	3	5		2	10	10,453	95.7
Lewis	1	1			2	2,938	68.1
Lincoln		4			4	7,478	53.5
Loudon	2	5			7	8,560	81.8

County	Manner of Death					Population Ages 0-17	Fatality Rate***
	Accidental	Natural	Violent**	Undetermined	Total		
McMinn	3	2			5	11,727	42.6
McNairy	5	3			8	5,825	137.3
Macon		1			1	5,314	37.6
Madison	6	16	1		23	23,717	97.0
Marion	4	2	1		7	6,594	106.2
Marshall	1	2			3	6,844	43.8
Maury	3	6		1	10	18,234	54.8
Meigs		1			1	2,786	35.9
Monroe	3	9		2	14	9,639	145.2
Montgomery	2	23	2		27	38,329	70.4
Moore						1,340	
Morgan	1	2			3	4,583	65.5
Obion	2	1			3	7,606	39.4
Overton	1	4			5	4,630	108.0
Perry						1,862	
Pickett						1,057	
Polk	1				1	3,627	27.6
Putnam	2	5	1		8	13,879	57.6
Rhea		2	1		3	6,741	44.5
Roane	1	3		2	6	11,595	51.7
Robertson	3	4	1	1	9	14,582	61.7
Rutherford	10	22	1	1	34	48,111	70.7
Scott	2				2	5,506	36.3
Sequatchie	1	1			2	2,792	71.6
Sevier	5	2			7	16,373	42.8
Shelby	22	218	27		267	253,270	105.4
Smith	2	1			3	4,521	66.4
Stewart		1			1	2,960	33.8
Sullivan	4	23	1	1	29	33,411	86.8
Sumner	2	8	2	1	13	34,337	37.9
Tipton	4	8			12	15,025	79.9
Trousdale	1	1			2	1,757	113.8
Unicoi						3,625	
Union		1			1	4,576	21.9
Van Buren						1,265	
Warren						9,280	
Washington	6	9	1		16	22,837	70.1
Wayne		2			2	3,599	55.6
Weakley	1	4			5	7,551	66.2
White		2			2	5,439	36.8
Williamson	7	13			20	37,350	53.5
Wilson	3	5	2		10	23,305	42.9
<b>State Totals</b>	<b>216</b>	<b>773</b>	<b>70</b>	<b>21</b>	<b>1080*</b>	<b>1,398,521</b>	<b>77.2</b>

\*County data not supplied for 14 cases; \*\*Violent=Homicide/Suicide; \*\*\*Deaths per 100,000.

## Cause of Death

The 1094 child fatalities were divided into the following categories by cause of death:

- Non-injury: 789 (72%)
- Injury-related: 283 (26%)
- Undetermined cause: 22 (2%)

### Deaths Due to Non-Injury Causes

There were 789 deaths due to natural (non-injury) causes among Tennessee children in 2000, representing 72% of all child fatalities. Of these, 355 (45%) resulted from illness, 341 (43%) from prematurity, 89 (11%) from SIDS, and 4 (1%) due to lack of medical care. Each of these is discussed in more detail in later sections of this report.

The greatest number of deaths due to non-injury resulted from illness (N=355) followed by prematurity (N=341). Of the deaths due to prematurity, 142 involved extremely premature infants (i.e., 22 weeks gestation or less) and 197 involved gestations of 23 to 37 weeks. Gestational data were not given for two prematurity cases.

### **Illness or Other Conditions**

In 2000, 355 children died from illnesses or other conditions. This represents 45% of all deaths due to non-injury and 32% of all childhood fatalities for the year. More than half (57%) of all fatalities due to illnesses involved children of less than one year of age. (Table 9)

<b>Age</b>	<b>Number</b>	<b>%</b>	<b>Gender</b>	<b>Number</b>	<b>Rate</b>	<b>Race</b>	<b>Number</b>	<b>Rate</b>
<1 day	32	9	Male	186	27.2	White	226	22.2
1-6 days	43	12	Female	167	24.6	African-American	105	37.1
7-28 days	41	12				Other	20	31.6
29-364 days	84	24						
<b>All cases</b>	<b>Number</b>	<b>Rate</b>						
<1 year	200	267.1						
1-2 years	31	22.9						
3-5 years	20	9.7						
6-8 years	16	6.8						
9-11 years	28	11.5						
12-14 years	30	12.9						
15-17 years	29	12.5						
<b>Total</b>	<b>354**</b>	<b>25.3</b>	<b>Total</b>	<b>353**</b>	<b>25.2</b>	<b>Total</b>	<b>351**</b>	<b>25.1</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 1 case, sex data not supplied for 2 cases, and race data not supplied for 4 cases.

## Prematurity

A total of 341 children died from complications due to prematurity. One hundred forty-two of these deaths occurred in infants with a gestational age of 22 weeks or less at birth. This represents 42% of all deaths due to prematurity. One hundred ninety-seven of these deaths occurred in infants with a gestational age of 23-37 weeks at birth. This represents 4% of all deaths due to prematurity. Overall, prematurity was the manner of death for 43% of all deaths due to non-injury and 31% of all childhood deaths in 2000.

Of the 142 fatalities due to prematurity with 22 weeks or less gestational age (Table 10):

- One hundred twenty-four (87%) died within 24 hours of birth
- Seventeen (12%) died within 1- 6 days of birth
- One (1%) died between 7 and 28 days

Of the 197 fatalities due to prematurity with 23-37 weeks gestational age (Table 10):

- Sixty-four (32%) died within 24 hours of birth
- Sixty-five (33%) died between 1 and 6 days after birth
- Thirty-five (18%) died between 7 and 28 days of age
- Thirty-three (17%) died between 29 and 364 days of age

<b>Table 10: Fatalities Due to Prematurity by Gender, Race and Gestational Age (N=341)*</b>								
<b>Gestational Age ≤ 22 Weeks (N=142)*</b>								
<b>Age</b>	<b>Number</b>	<b>%</b>	<b>Gender</b>	<b>Number</b>	<b>%</b>	<b>Race</b>	<b>Number</b>	<b>%</b>
< 1 day	124	87	Male	79	56	White	50	35
1-6 days	17	12	Female	63	44	African-American	86	61
7-28 days	1	1				Other	5	4
29-364 days	0							
<b>Total</b>	<b>142</b>	<b>100</b>	<b>Total</b>	<b>142</b>	<b>100</b>	<b>Total</b>	<b>141*</b>	<b>100</b>
<b>Gestational Age 23-37 Weeks (N=197)**</b>								
<b>Age</b>	<b>Number</b>	<b>%</b>	<b>Gender</b>	<b>Number</b>	<b>%</b>	<b>Race</b>	<b>Number</b>	<b>%</b>
< 1 day	64	32	Male	124	63	White	104	54
1-6 days	65	33	Female	73	37	African-American	84	43
7-28 days	35	18				Other	6	3
29-364 days	33	17						
<b>Total</b>	<b>197**</b>	<b>100</b>	<b>Total</b>	<b>197**</b>	<b>100</b>	<b>Total</b>	<b>197**</b>	<b>100</b>

\*Race not supplied for 1 case of ≤ 22 weeks.

\*\*Race data not supplied for 2 cases of 23-37 weeks.

Childhood fatalities among infants born at 22 weeks gestation or earlier were most frequent among women who were 31-40 years old with mothers age 22-25 years old a close second in frequency. Childhood fatalities among infants born between 23-37 weeks gestation or earlier were most frequent among women who were 18-21 years old. (Table 11)

Table 11: Fatalities Due to Prematurity by Mother's Age (N=341)*					
Gestational Age ≤ 22 Weeks			Gestational Age 23-37 Weeks		
Mother's Age	Number	%	Mother's Age	Number	%
15-17	4	3	15-17	11	6
18-21	28	20	18-21	52	26
22-25	32	23	22-25	34	17
26-30	30	21	26-30	44	22
31-40	33	23	31-40	43	21
41-43	1	1	41-43	1	1
Missing data*	13	9	Missing data*	14	7
<b>Total</b>	<b>141</b>	<b>100</b>	<b>Total</b>	<b>199</b>	<b>100</b>

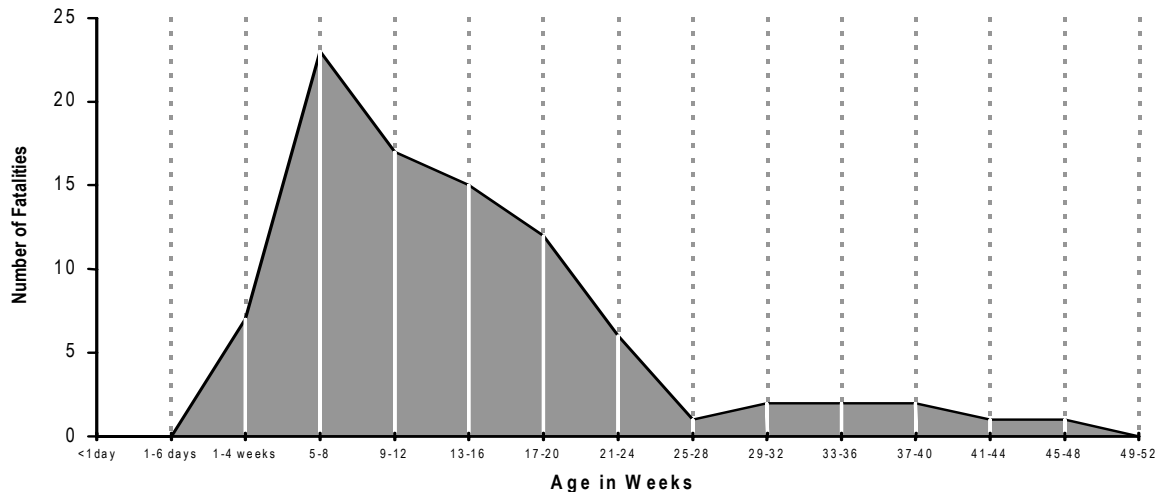
\*Data by mother's age not supplied in 27 total cases.

### SIDS (Sudden Infant Death Syndrome)

In 2000, 89 deaths were reported as SIDS (Sudden Infant Death Syndrome). This represents 11% of all deaths due to non-injury, and 8% of all childhood deaths in 2000. The most frequently occurring age of death was 5-8 weeks (23 fatalities), followed by 9-12 weeks (17 fatalities) and 13-16 weeks (15 fatalities). Thus, 62% of fatalities due to SIDS occurred between 9 and 16 weeks of age (Figure 5; Tables 12a, 12b)

The sleeping position for 65 (73%) fatalities was either not reported or unknown. However, among those whose positions were reported, nine (38%) were on their stomach face down, one (4%) was on his/her stomach with face to the side, eight (33%) were on their side, and six (25%) were on their back.

FIGURE 5  
Number of Fatalities Due to SIDS, by Age, Tennessee, 2000  
(N = 89)



<b>Age</b>	<b>Number</b>	<b>Percent</b>
< 1 day	0	
1-6 days	0	
7-28 days	7	8
29-364 days	82	92
<b>Total</b>	<b>89</b>	<b>100</b>

<b>Sex</b>	<b>Number</b>	<b>*Rate</b>	<b>Race</b>	<b>Number</b>	<b>*Rate</b>
Male	52	7.2	White	52	5.1
Female	33	4.9	African-American	33	11.1
<b>Total</b>	<b>85**</b>	<b>6.1</b>	<b>Total</b>	<b>85**</b>	<b>6.1</b>

\*Rate per 100,000 in population.

\*\*Sex and race data not supplied for 4 cases.

### Fatalities Due to Lack of Medical Care

Four fatalities were attributed to delayed, inadequate, or lack of medical care (Tables 13a, 13b).

<b>Age</b>	<b>Number</b>	<b>%</b>
< 1 day	3	75
1-6 days	0	
7-28 days	0	
29-364 days	1	25
<b>Total</b>	<b>4</b>	<b>100</b>

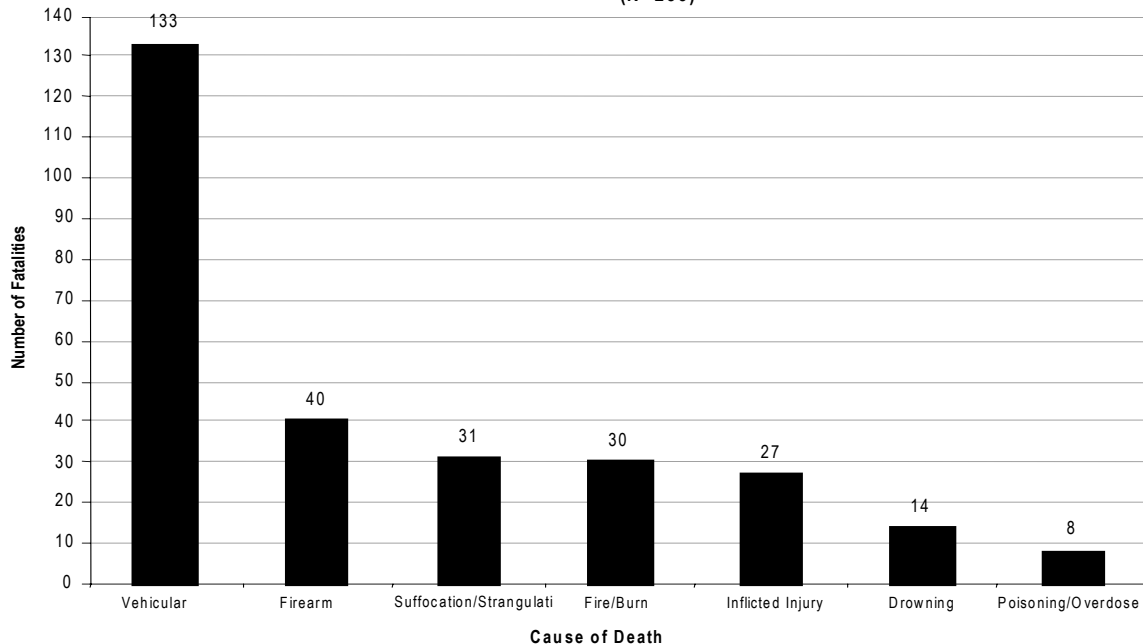
<b>Sex</b>	<b>Number</b>	<b>*Rate</b>	<b>Race</b>	<b>Number</b>	<b>*Rate</b>
Male	1	0.1	White	4	0.4
Female	3	0.4	African-American	0	
			Other	0	
<b>Total</b>	<b>4</b>	<b>0.3</b>	<b>Total</b>	<b>4</b>	<b>0.3</b>

\*Rate per 100,000 in population.

## Deaths Due to Injury

There were 283 deaths due to injury among children in 2000, representing 26% of all childhood fatalities. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (133 or 47% of all injury-related fatalities). Firearm fatalities were the next most common cause of death resulting in 40 (14%) fatalities (Figure 4). Males were more likely to be involved in injury-related fatalities than females (24.9 vs. 14.85 per 100,000). African-American children were more likely to be involved in an injury-related fatality than White children (28.3 vs. 17.7 per 100,000) (Table 14, Figure 6). Overall, childhood fatalities due to injuries occurred at a rate of 20.2 per 100,000 in the population.

**FIGURE 6**  
**Number of Injury-Related Child Fatalities, Tennessee, 2000**  
**(N=283)**



Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	31	41.4	Male	179	24.9	White	184	17.7
1-2 years	29	21.4	Female	101	14.9	African-American	84	28.3
3-5 years	22	10.6				Other	9	14.2
6-8 years	6	2.5						
9-11 years	20	8.2						
12-14 years	38	31.7						
15-17 years	118	98.2						
<b>Total</b>	<b>264**</b>	<b>18.9</b>	<b>Total</b>	<b>280**</b>	<b>20.0</b>	<b>Total</b>	<b>277**</b>	<b>19.8</b>

\*Rate per 100,000 in population.

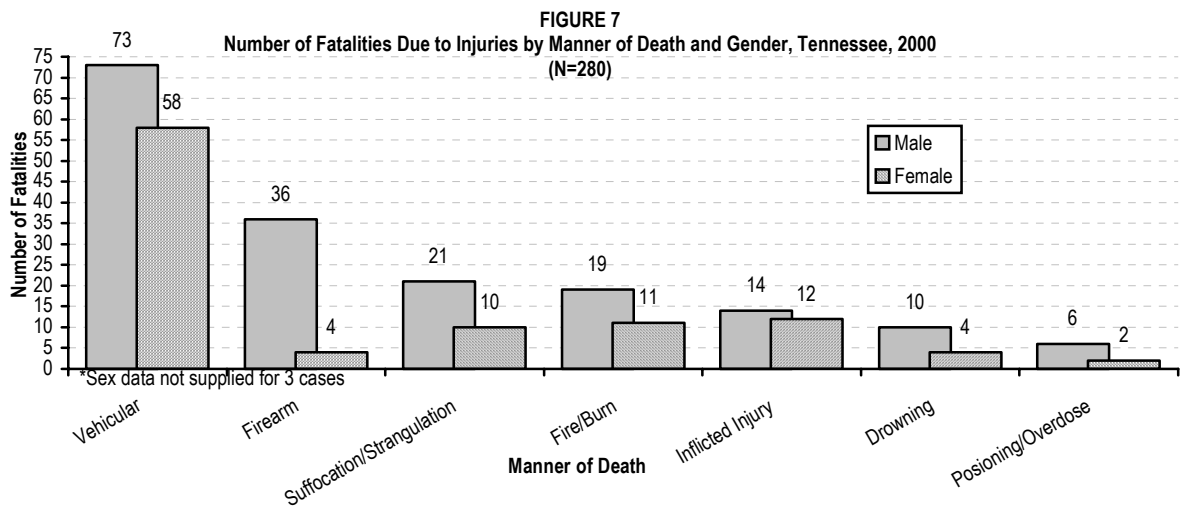
\*\*Age data not supplied for 19 cases; sex data not supplied for 3 cases; and race data not supplied for 6 cases.



Childhood fatalities due to unintentional injuries were more prevalent among males (N=179; 24.9 per 100,000 in the population) than females (N=101; 14.9 per 100,000 in the population).

Children ages 16-17 had the greatest incidence of unintentional injury deaths (N=100; 64.4 per 100,000 in the population). Infants less than one year of age had the next highest unintentional injury death rate at 41.4 per 100,000 in the population.

Fatalities due to unintentional injuries were most prevalent among white children, (N=184; 17.7 per 100,000 in the population). This represents 66% of all unintentional injury deaths. There were 84 (28.3 per 100,000 in the population) African-American children and nine (14.2 per 100,000 in the population) children of other races whose deaths were due to unintentional injuries.



## Vehicle Crashes

In 2000, 133 children died in vehicle crashes. This represented 47% of all injury-related deaths and 26% of all child fatalities for 2000. Males (10.6 deaths per 100,000) are slightly more likely to die in a vehicle-related accident than females (8.5 deaths per 100,000). Racial differences emerged with white individuals (10.5 deaths per 100,000) more likely to die in a vehicle-related crash than African-American youths (6.4 deaths per 100,000) and other races (6.3 deaths per 100,000). (Table 15)

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	4	5.3	Male	73	10.6	White	109	10.5
1-2 years	10	7.4	Female	58	8.5	African-American	19	6.4
3-5 years	9	4.4				Other	4	6.3
6-8 years	9	3.8						
9-11 years	11	4.5						
12-14 years	14	6.0						
15-17 years	75	32.2						
<b>Total</b>	<b>132**</b>	<b>9.4</b>	<b>Total</b>	<b>131**</b>	<b>9.4</b>	<b>Total</b>	<b>132**</b>	<b>9.4</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 1 case, sex data not supplied for 2 cases, and race data not supplied for 1 case.

## Firearms

In 2000, 40 children died due to firearm injuries. This represents 14% of all injury deaths and 3% of all childhood fatalities (Table 16).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	2	2.7	Male	36	5.3	White	18	1.8
1-2 years			Female	4	1.0	African-American	19	6.7
3-5 years						Other	3	4.7
6-8 years								
9-11 years								
12-14 years	8	3.4						
15-17 years	27	11.6						
<b>Total</b>	<b>37**</b>	<b>2.7</b>	<b>Total</b>	<b>40</b>	<b>2.9</b>	<b>Total</b>	<b>40</b>	<b>2.9</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 3 cases.

## Suffocation or Strangulation

In 2000, there were 31 child fatalities due to suffocation or strangulation. This represents 11% of all unintentional injury deaths and 2% of all child fatalities. Among these deaths, 45% (N=14) involved a child less than one year old. Overall, a child less than one year of age was more likely to die from suffocation or strangulation than any other age group (Table 17). Information regarding the child's sleeping arrangements and other mechanisms of strangulation are not available.

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	14	18.7	Male	21	2.9	White	20	1.9
1-2 years	2	1.5	Female	10	1.5	African-American	9	3.0
3-5 years	1	1.0				Other	0	0
6-8 years	0							
9-11 years	3	1.2						
12-14 years	6	2.6						
15-17 years	4	1.7						
<b>Total</b>	<b>30**</b>	<b>2.2</b>	<b>Total</b>	<b>31</b>	<b>2.2</b>	<b>Total</b>	<b>29**</b>	<b>2.1</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 1 case and race data not supplied for 2 cases.

## Fire/Burns

In 2000, there were 30 childhood fatalities due to fire and burn injuries. This represents 11% of all unintentional injury fatalities and 3% of all childhood fatalities (Table 18).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	1	1.3	Male	19	2.6	White	10	1.0
1-2 years	10	7.4	Female	11	1.6	African-American	19	6.4
3-5 years	8	3.9				Other	0	
6-8 years	4	0.4						
9-11 years	3	1.2						
12-14 years	1	0.4						
15-17 years	2	0.9						
<b>Total</b>	<b>29**</b>	<b>2.1</b>	<b>Total</b>	<b>30**</b>	<b>2.1</b>	<b>Total</b>	<b>29**</b>	<b>2.1</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 1 case and race data not supplied for 1 case.

## Inflicted Injury

In 2000, there were 27 child fatalities due to inflicted injuries. This represents 2.5% of all child fatalities (Table 19).

Children under one year of age were the most likely to die from inflicted injuries (N=10; 13.3 per 100,000 in population). Males (N=14; 1.9 per 100,000 in population) were more likely than females (N=12; 1.8 per 100,000 in population) to die from inflicted injuries. African-American children (N=13; 4.4 per 100,000 in population) were most likely to die from inflicted injuries than the other races.

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	10	13.3	Male	14	1.9	White	11	1.1
1-2 years	5	3.3	Female	12	1.8	African-American	13	4.4
3-5 years	2	0.9				Other	1	1.6
6-8 years	3	1.3						
9-11 years	3	1.2						
12-14 years	3	1.3						
15-17 years	1	0.4						
<b>Total</b>	<b>27</b>	<b>1.9</b>	<b>Total</b>	<b>26**</b>	<b>1.9</b>	<b>Total</b>	<b>25**</b>	<b>1.8</b>

\*Rate per 100,000 in population.

\*\*Sex data not supplied for 1 case, and race data not supplied for 2 cases.

## Drowning

In 2000, 14 children died from accidental drowning. This represents 41% of all unintentional injury deaths and 1% of all child fatalities (Table 20).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	0		Male	10	1.5	White	10	1.0
1-2 years	1	0.7	Female	4	0.1	African-American	3	1.1
3-5 years	3	0.2				Other	1	1.6
6-8 years	1	0.4						
9-11 years	0							
12-14 years	5	2.1						
15-17 years	3	1.3						
<b>Total</b>	<b>13*</b>	<b>0.9</b>	<b>Total</b>	<b>14</b>	<b>1.0</b>	<b>Total</b>	<b>14</b>	<b>1.0</b>

\*Rate per 100,000 in population.

\*\*Age data not supplied for 1 case.

## Poisoning/Overdose

In 2000, there were eight child fatalities due to poisoning or overdoses. This represents 3% of all unintentional injury deaths and .007% of all child fatalities (Table 21).

Males (N=6; 0.9 per 100,000 in population) were more likely than females (N=2; 0.3 per 100,000 in population) to die from poisonings or overdoses. African-American children (N=2; 0.7 per 100,000 in population) were most likely to die from poisonings or overdoses, followed by white children (N=6; 0.6 per 100,000 in population).

Age	Number	Rate*	Sex	Number	Rate*	Race	Number	Rate*
< 1 year	0		Male	6	0.9	White	6	0.6
1-2 years	1	0.7	Female	2	0.3	African-American	2	0.7
3-5 years	0					Other	0	0
6-8 years	0							
9-11 years	0							
12-14 years	1	0.6						
15-17 years	6	2.6						
<b>Total</b>	<b>8</b>	<b>0.6</b>	<b>Total</b>	<b>8</b>	<b>0.6</b>	<b>Total</b>	<b>8</b>	<b>0.6</b>

\*Rate per 100,000 in population.

## Undetermined Cause of Death

In 2000, there were 22 fatalities where the cause of death was listed as 'Other cause not listed above' and 'Unknown cause' (Table 22). This represents 2% of all child fatalities in 2000.

<b>Age</b>	<b>Number</b>	<b>Rate*</b>	<b>Sex</b>	<b>Number</b>	<b>Rate*</b>	<b>Race</b>	<b>Number</b>	<b>Rate*</b>
< 1 year	7	9.3	Male	14	2.0	White	16	1.6
1-2 years	2	1.3	Female	8	1.2	African-American	4	1.4
3-5 years	2	0.9				Other	2	3.2
6-8 years	1	0.4						
9-11 years	1	0.4						
12-14 years	3	1.3						
15-17 years	6	2.6						
<b>Total</b>	<b>22</b>	<b>1.6</b>	<b>Total</b>	<b>22</b>	<b>1.6</b>	<b>Total</b>	<b>22</b>	<b>1.6</b>

\*Rate per 100,000 in population.

# Appendix

# Child Fatality Review and Prevention Act

## Section

### **68-142-101. Short title**

### **68-142-102. Child fatality prevention team**

### **68-142-103. Composition.**

### **68-142-104. Voting members-Vacancies**

### **68-142-105. Duties of state team**

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

### **68-142-107. Duties of local teams**

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

### **68-142-109. Staff and consultants**

### **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.

**2000 Data Collection Form**

**TENNESSEE DEPARTMENT OF HEALTH  
CHILD FATALITY REVIEW TEAM**

The information on this form was entered into the data system on \_\_\_\_\_ by \_\_\_\_\_.

*This form is confidential*

**2000 REVIEW/DATA COLLECTION FORM**

Judicial District No.: \_\_\_\_\_ Child Death Year/No.: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ - \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Child's Name: \_\_\_\_\_  
 Last First Middle

Date of Death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Street City

Race:  White  African American  Hispanic  Asian  
 Other: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
 Last Maiden First Middle

Mother's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Month Day Year

Census Tract: \_\_\_\_\_ County of Residence \_\_\_\_\_

Birth Weight: \_\_\_\_ / \_\_\_\_ kg gm / \_\_\_\_ lb Clinical Estimate of Gestation (weeks): \_\_\_\_\_ 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 \_\_\_\_\_

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

Is the Death Certificate adequate/complete?  Yes  No  
 Was an autopsy performed?  Yes  No  Unknown  
 If Yes, location:  Medical Examiner \_\_\_\_\_  Hospital \_\_\_\_\_  Other \_\_\_\_\_

**Review team comments/recommendations and prevention issues:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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

**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

1<sup>st</sup> Review: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | 2<sup>nd</sup> Review: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ | 3<sup>rd</sup> Review: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Recommended for additional review?  Yes  No  
 Which reports/records were requested for full review?  
 Law enforcement  School  DHS  Med. Exam autopsy  
 Hospital autopsy  Court  DA report  Health Dept.  
 Attending physician  Other: \_\_\_\_\_

Date case closed by CFRT: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**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. 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.  Bathhtub 4.  Swimming pool  
 5.  Bucket 6.  Wading pool  
 7.  Other: \_\_\_\_\_ 8.  Unknown  
 B. Wearing flotation device?  
 1.  Yes 2.  No 3.  Unknown 5.  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  
 6.  Other farm vehicle 7.  Truck/RV  
 8.  Other: \_\_\_\_\_ 8.  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?  
 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.  Circumstances unknown

**12. Other Cause Not Listed Above:**  
 \_\_\_\_\_  
 \_\_\_\_\_

