CHILD FATALITIES IN TENNESSEE 2002

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

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Governor

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Commissioner

Acknowledgments

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Special thanks 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:

http://www2.state.tn.us/health/Downloads/cfr2002report.pdf

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Child Fatality Review Teams (CFRT) are active in all judicial districts in the state. During 2002, the teams completed review of 1,122 (97.3%) of the 1153 fatalities of Tennessee resident children. Department of Health team leaders provided administration and coordination of the teams. The CFRT reviewed the way children died (manner of death) and what caused the deaths (cause of death).

MANNER OF DEATH

The manner of death for 1,122 child fatalities reviewed in 2002, was determined by the CFRT to be natural causes for 72.28% (N=811); unintentional injury (accidental) causes 19.16% (N=215); homicide for 3.92% (N=44); suicide for 1.96% (N=22); could not be determined 1.87% (N=21); and undetermined due to suspicious circumstances 0.80% (N=9) (see Table 1 entitled Manner of Death).

Table 1: Manner of Death (N=1,122)

Manner of Death	Number	Percent**	Rate*
Homicide	44	4%	3.15
Accidental	215	19%	15.37
Natural	811	72%	57.99
Suicide	22	2%	1.57
Could Not Be Determined	21	2%	1.50
Undetermined due to suspicious circumstances	9	1%	0.64
All Manner	1122	100%	80.23

*Rates per 100,000 population

**Percentage rounded to nearest whole percent

CAUSE OF DEATH

The 1,122 child fatalities were divided into the following categories by cause of death: Non-injury 72.9% (N=818); Injury-related 24.3% (N=273); other cause not listed 1.16% (N=13); Unknown 1.6% (N=18).

Overall, the cause of death was reported in 13 categories. The 818 deaths reviewed as non-injury were reported in the categories of Sudden Infant Death Syndrome (SIDS), lack of adequate care, prematurity, and illness/other natural cause. Injury related deaths (N=273) were reported in the categories of drowning, suffocation/strangulation, vehicular, firearm, inflicted injury, poison/overdose, and fire/burn. Other Cause not Listed (N=13) and Unknown Cause (N=18) were reported separately (see Table 2 entitled Overall Cause of Death).

Table 2: Overall Cause of Death (N=1,122)			
Cause of Death	**Number**	**Percent**	**Rate***
Sudden Infant Death Syndrome	76	6.77	5.43
Lack of adequate care	1	0.09	0.07
Prematurity	343	30.57	24.53
Illness or other natural cause	398	35.47	28.46
Drowning	25	2.23	1.79
Suffocation/Strangulation	44	3.92	3.15
Vehicular	133	11.85	9.51
Firearm	35	3.12	2.50
Inflicted Injury	19	1.69	1.36
Poisoning/Overdose	7	0.62	0.50
Fire/Burn	10	0.89	0.72
Other cause not listed above	13	1.16	0.93
Unknown cause	18	1.60	1.29
Total	1122	100.00	80.23

*Rates per 100,000 population

Deaths Due to Non-injury Causes

There were 818 deaths due to natural (non-injury) causes among Tennessee children in 2002, representing 72.9% of all child fatalities reviewed including those that were not determined. Of these, the greatest number of deaths due to non-injury resulted from illness or other natural cause (N=398) followed by prematurity (N=343). Of the deaths from prematurity where gestational age was reported, 137 involved extremely premature infants (i.e., less than 23 weeks gestation) and 186 involved gestations of 23 to 39 weeks.

Deaths Due To Injury

In 2002 there were 273 deaths (24.3% of all childhood fatalities) due to injury among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (133) or 48.7% of all injury-related fatalities). Suffocation/strangulation fatalities were the second most common cause of injury-related death resulting in 44 fatalities (16.1% of all injury-related fatalities) and firearm fatalities (35 or 12.8%). The highest rate (22.93 per 100,000 population, 68 deaths) was reported for African-Americans. The rate of deaths for White children was 69 per 100,000 population with 191 deaths. Overall, childhood fatalities due to unintentional injuries in 2002 occurred at a rate of 19.52 per 100,000.

Further Information

Attached to this Executive Summary is the complete report for the *Tennessee Childhood Fatality Review 2002.*

Recommendations from the State Child Fatality Prevention Team

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

1. Provide full reimbursement to county governments of the costs of an autopsy performed according to Department of Health rules and regulations on any child, birth to age 18, when death is sudden and unexplained.
2. Promote public awareness around the signs of child abuse and neglect and the need to report them.
3. Increase public education on fire, firearms and water safety.
4. Provide additional training and support to the Department of Children's Services staff in investigating abuse and neglect of children, particularly in sex abuse allegations/ cases.
5. Boost education/ awareness regarding the dangers of smoking during pregnancy.
6. Ensure that all graduated drivers' license rules are included in driver's education and tests.
7. Work with the Tennessee Prevention Suicide Network to implement the youth strategic plan.
8. Promote education for caregivers and public on safe sleeping practices for children.

Child Fatality Review State Prevention Team, 2004

Karen Alexander, Assistant Special Agent in Charge, Tennessee Bureau of Investigation
Stephanie Bailey, M.D., Director, Davidson County Health Department
Bonnie Beneke, Tennessee Professional Society on Abuse of Children
Andy Bennett, Chief Deputy Attorney General
Senator Charlotte Burks
Representative Dennis Ferguson
Senator David Fowler
Judge Betty Adams Green, Juvenile Court
Beth Kasch, Executive Director, Child Safety
Bruce Levy, M.D., State Medical Examiner
Representative Joe McCord
Linda O'Neal, Tennessee Commission on Children and Youth
Cindy Perry, Select Committee, Children and Youth
Theodora Pinnock, M.D., Director Maternal and Child Health
Dr Judy Regan, Mental Health and Developmental Disabilities
Scott Ridgeway, Tennessee Suicide Prevention Network
Kenneth S Robinson, M.D., Commissioner of the Department of Health
Kim Rush, Program Director for Children and Youth Services
Senator Larry Trail

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Recommendations from Child Fatality Review Teams
October 2004

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. Provide full reimbursement to county governments of the costs of an autopsy performed according to Department of Health rules and regulations on any child, birth to age 18, when death is sudden and unexplained.

2. Develop strategies to reduce infant mortality and disparities related to it.

3. Increase school and community awareness of suicide prevention and risks.

4. Promote education for caregivers and public on safe sleeping practices for children.

5. Increase the level of awareness of the dangers to families, especially children, presented by methamphetamine (meth) and meth labs.

Other Concerns by Category

Agency

1. Ensure enforcement of curfews and underage sale of alcohol.
2. Investigate and address causes of motor vehicle accidents on rural roads including maintenance and signs.
3. Share information regarding juvenile offenders and the limitations placed on releasing such information among agencies.
4. Establish a twenty four hour hotline for families in crisis to prevent deaths related to shaken baby syndrome and other domestic violence.

Education

1. Increase community awareness/conduct a public awareness campaign stressing that substance abuse, alcohol abuse and inappropriate use of any drug (including prescribed drugs) during pregnancy may lead directly and indirectly to childhood deaths and are harmful to the unborn child.
2. Boost education/ awareness regarding the dangers of smoking during pregnancy.
3. Increase prevention of firearm related injury and death through education on the dangers of the combination of teenagers and firearms, the high-risk factor of the combination of teenagers and firearms and encourage use of gunlocks.

4. Provide additional training and support to the Department of Children's Services staff in investigating abuse of children, particularly in sex abuse allegations/ cases.
5. Intensify awareness, especially to parents, regarding the dangers and signs/symptoms of Shaken Baby Syndrome.
6. Identify and increase awareness of community programs/ agencies/services which can assist women and children in crisis.
7. Increase public education on fire and pool safety.
8. Expand education on the importance of seeking genetic counseling whenever a child dies from a chromosomal abnormality.
9. Increase education around the importance of strong families and offer parenting classes to parents with small children.

Law

1. Establish a statute requiring a safety course before the purchase of an all terrain vehicle (ATV) and enact legislation to limit access to children less than thirteen years of age from riding four-wheeler type vehicles.
2. Establish a statute which makes it mandatory that children use a flotation device when playing in bodies of water where there are no lifeguards on duty.
3. Standardize drug testing for juveniles to incorporate all drugs and not just the drugs for which they are charged.
4. Establish a statute requiring shatterproof glass for vehicle windows.

Health Department Regions, Judicial Districts, and CFR Team Leaders

Region	CFR Team Leader, Judicial District (JD) and Counties
Northeast	Dr. Lawrence Moffatt; Dr. Barbara Skelton JD 1: Carter, Johnson, Unicoi, and Washington JD 3: Greene, Hamblen, Hancock, and Hawkins
Sullivan	Dr. Stephen May JD 2: Sullivan
East	Dr. Paul Erwin/ Gail Harmon 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

Tennessee Childhood Fatality Review 2002

MANNER OF DEATH

The manner of death for 1,122 child fatalities in 2002 was determined by the CFRT to be natural causes 72.28% (N=811); unintentional injury (accidental) causes for 19.16% (N=215); homicide for 3.92% (N=44); suicide for 1.96% (N=22); could not be determined 1.87% (N=21); and undetermined due to suspicious circumstances 0.80% (N=9) (Table 1).

The overall rate of child fatalities for 2002 computed from the cases reviewed by the CFRT was 80.23 per 100,000. Fatality rates identified in this report were computed based on census data for Tennessee in 2000 and reported as the number of cases per 100,000 in the population of children less than 18 years of age.

Table 1: Manner of Death (N=1,122)

Manner of Death	Number	Percent**	Rate*
Homicide	44	4%	3.15
Accidental	215	19%	15.37
Natural	811	72%	57.99
Suicide	22	2%	1.57
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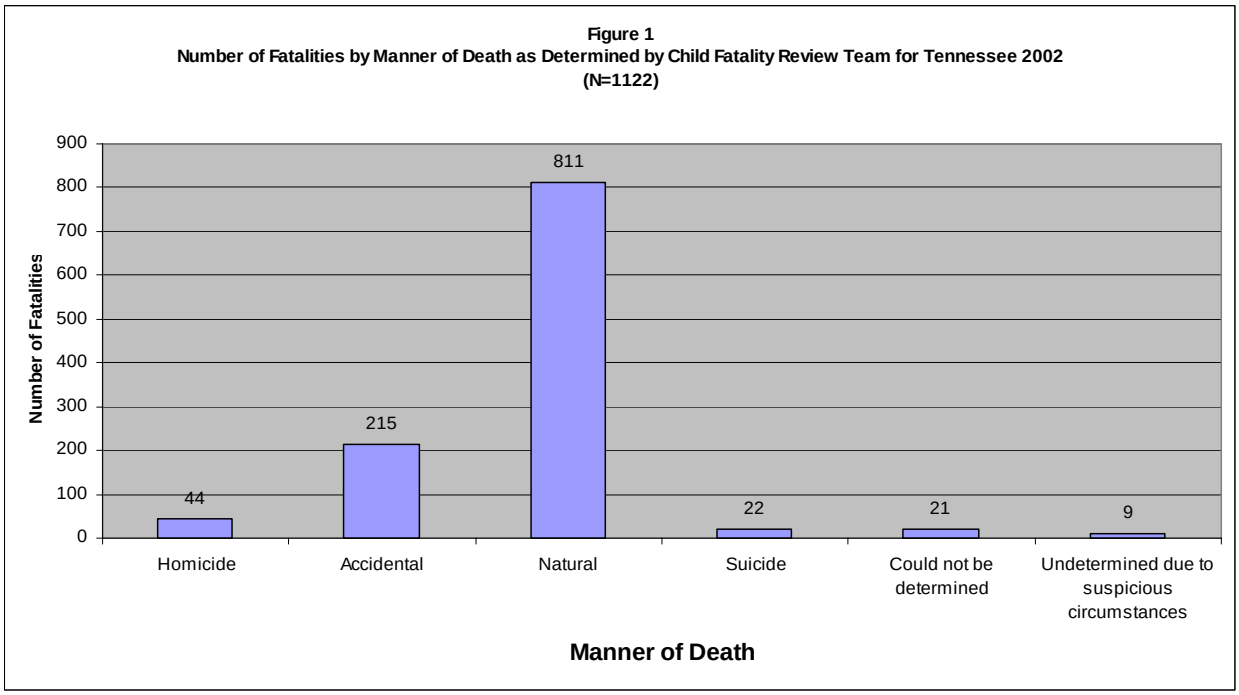
Undetermined due to suspicious circumstances	9	1%	0.64
All Manner	1122	100%	80.23

*Rates per 100,000 population

**Percentage rounded to nearest whole percent



Manner of Death as Determined by CFRT

The CFRT on average, agreed with the manner of death indicated on the death certificate in 65.15% (N=731) (Table 2). The CFRT concluded 44 of the cases were homicides (versus 31 on death certificate); 215 were accidental (versus 200 on death certificate); 811 were natural deaths (versus 610 on death certificates); 22 suicides (versus 17 on death certificate); 21 could not be determined (versus 13 on death certificate). Nine deaths were undetermined by the CFRT versus 69 deaths that listed pending investigation. All of the CFRT reports were marked versus 175 death certificates that were blank or not listed. The CFRT noted differences with the death certificate in 34.85% (N=391) of cases.

When the death certificate indicated a manner of death, the CFRT agreed that the manner of death as declared on the death certificate was natural 75% of the time (811 versus 610); accidental 93% (215 versus 200); homicide 70% (44 versus 31); could not be determined 62% (21 versus 13); and agreed that the manner of death was suicide 77% (22 versus 17).

Table 2: Differences in Death Certificate and CFRT Determination (N=731)

	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT	Death Cert.	CFRT
Age	**Homicide**		**Accidental**		**Natural**		**Suicide**		**Could Not Be Determined**		**Blank/ Unmarked**		**Pending Investigation/ Undetermined**	
<1	7	10	26	32	487	652	0	0	9	13	139	0	44	7
1-2	6	7	14	15	24	31	0	0	2	3	3	0	6	1
3-5	4	5	19	21	25	29	0	0	0	0	5	0	2	1
6-8	0	1	22	22	14	20	0	0	0	1	7	0	1	0
9-11	3	3	15	18	21	23	0	1	1	1	3	0	2	0
12-14	1	3	26	26	18	24	0	0	0	1	7	0	2	0
15-17	10	15	78	81	21	32	17	21	1	2	11	0	12	0
Total	31	44	200	215	610	811	17	22	13	21	175	0	69	9
%Agree		**70.45**		**93.02**		**75.22**		**77.27**		**61.9**		**0**		**13.04**
Average Agreement		**65.15%**												

Manner of Death and Age

Across all groups the highest rate of fatalities in 2002 was during the first year of life (950.39 per 100,000). The second highest rate of fatalities occurred in youth aged 15-17 (64.9 per 100,000) (Table 3).

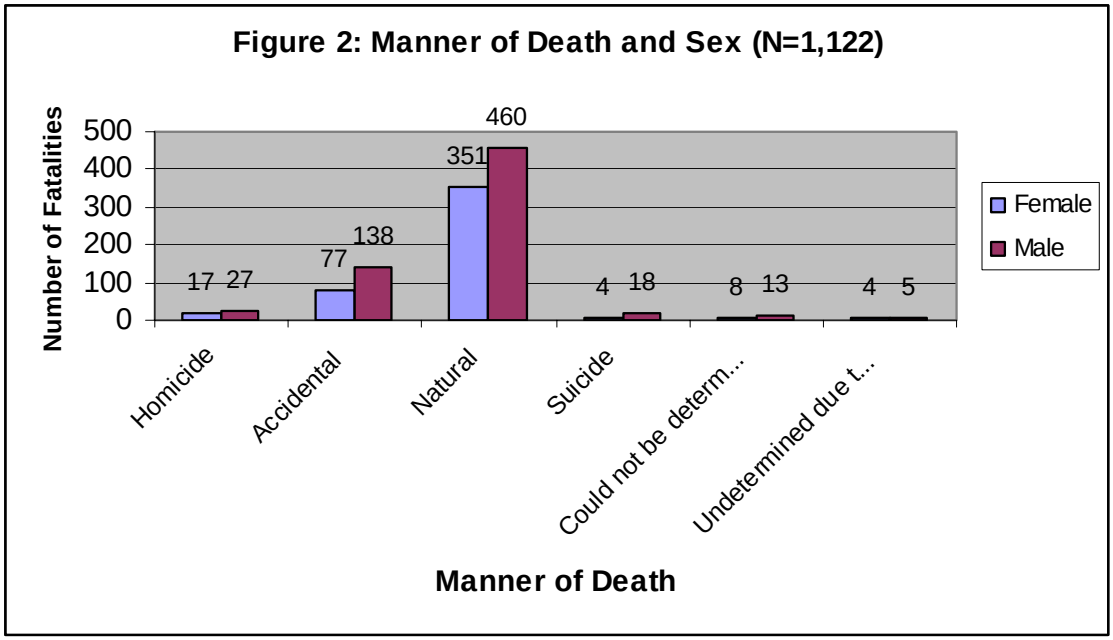
Table 3: Number and Rates of Fatalities by Manner of Death and Age (N=1,122)										
		Homicide	**Accidental**	**Natural**	**Suicide**	**Could Not Determined**	**Undetermined/ Suspicious**	**Not Marked**	**Total**	**Rate***
Age	<1	10	32	652	0	13	7	0	714	950.39
	1-2	7	15	31	0	3	1	0	57	38.08
	3-5	5	21	29	0	0	1	0	56	24.70
	6-8	1	22	20	0	1	0	0	44	18.61
	9-11	3	18	23	1	1	0	0	46	18.80
	12-14	3	26	24	0	1	0	0	54	23.15
	15-17	15	81	32	21	2	0	0	151	64.90
Total		44	215	811	22	21	9	0	1122	**80.23**
Percent		3.92%	19.16%	72.28%	1.96%	1.87%	0.80%	0%	100.00 %	
Rate		3.15	15.37	57.99	1.57	1.50	0.64		80.23	

*Rates per 100,000 population

Manner of Death and Sex (Gender)

Fifty-nine percent of child fatalities were males (N=661) and 41% were females (N=461), which corresponded to rates of 91.99 per 100,000 for males and 67.80 per 100,000 for females. The largest number of fatalities for both sexes occurred by natural manner (Table 4 and Figure 2).

Table 4: Manner of Death and Sex (N=1,122)									
		Homicide	**Accidental**	**Natural**	**Suicide**	**Could Not Determine**	**Undetermined/ Suspicious**	**Not Marked**	**Total**
Sex	Female	17	77	351	4	8	4	0	461
	Male	27	138	460	18	13	5	0	661
	Not Marked	0	0	0	0	0	0	0	0
Total		**44**	**215**	**811**	**22**	**21**	**9**	**0**	**1122**



Manner of Death and Race

Natural death was the highest category of manner of death for all races (N=811). The total number of natural fatalities for White children was 449 (55%), for African-American children 316 (39%), and for Other 37 (5%). Five of the natural fatalities were classified as Asian (Table 5).

Table 5: Manner of Death and Race (N=1,122)

		Homicide	Accidental	Natural	Suicide	Could Not Determine	Undetermined Suspicious	Not Marked	Total
RACE	African-American	20	50	316	1	4	2	0	393
	White	23	150	449	20	13	7	0	664
	Other	1	8	37	0	0	0	0	46
	Asian	0	3	5	0	0	0		8
	Missing	0	4	4	0	3	0	0	11
Total		**44**	**215**	**811**	**22**	**21**	**9**	**0**	**1122**

Manner of Death by Age, Sex, and Race*

Of the 1,122 childhood fatalities, 664 (59%) were reported as White, 393 (35%) were reported as African-American, and 46 (4%) were reported as Other race. Eight deaths were reported in 2002 as Asian; however, census data were not available to calculate death rate. Race was not available for 11 cases. The rate of all fatalities for African-American children was 132.2 per 100,000 or more than twice the rate for White children of 63.5 per 100,000. The rate for Other race was 72.8 per 100,000.

Across all races, the highest rate of fatalities was during the first year of life. Taking age, race, and sex into account, the highest fatality rate was African-American males less than one year of age (3053.54 per 100,000), followed by African-American females under one year of age (2108.09 per 100,000). The rates for both male and female African-American children under one year of age were twice the rates for White males (1388.1 per 100,000) and White females (1005.57 per 100,000) in the first year of life (Table 6).

*Note: Child deaths with ethnic origin of Hispanic was 50 (4.5%); 1,018 (90.7%) were not Hispanic and 54 (4.8%) not reported. These children can be listed as part of African-American, White or Other groups by race.

Table 6: Overall Manner of Death Fatality Rates by Age, Sex and Race, (N=1,122)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	714	950.39	Female	461	67.80	African-American	393	132.21
1-2	57	38.08	Male	661	91.99	White	664	63.53
3-5	56	24.70				Other	46	72.79
6-8	44	18.61				Asian	8	
9-11	46	18.80				Not Marked	11	
12-14	54	23.15						
15-17	151	64.90						
Total	**1122**	**80.23**		**1122**	**80.23**		**1122**	**80.23**

*Rates per 100,000 population

Manner of Death: Violence-related

In 2002 there were 66 child fatalities due to violence-related injuries that were the result of either homicide (N=44) or suicide N=22). This represents 6% of all child fatalities (Figure 3).

Males (N=45; 6.26 per 100,000) were more than two times more likely than females (N=21; 3.09 per 100,000) to die from violence-related injuries. African-American children (N=21; 7.08 per 100,000) were nearly two times more likely to die of violence-related injuries as White children (N= 44; 4.24 per 100,000) followed by children in the "Other" racial category (N=21; 104.43 per 100,000) (Table 7).

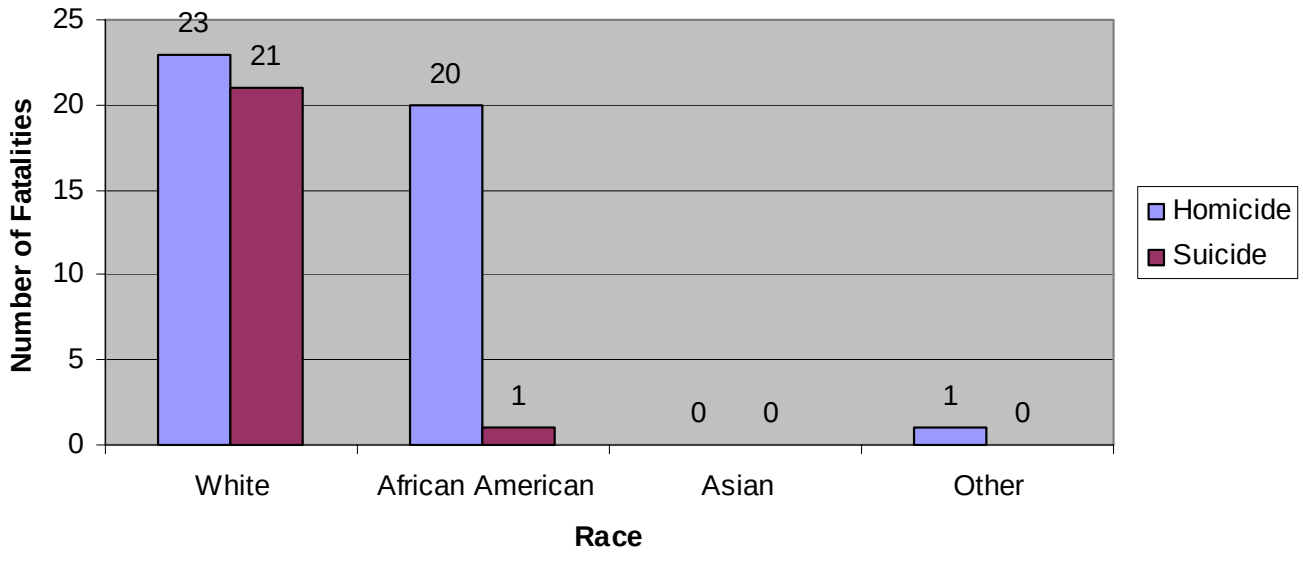
The 15-17 years age group had the highest rate of violence-related fatalities (N=36; 15.47 per 100,000), followed by children less than one year (N=10; 13.31 per 100,000) (Table 7).

Table 7: Violence-related Fatalities by Age, Sex, and Race (N=66)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	10	13.31	Female	21	3.09	African-American	21	7.08
1-2	7	4.68	Male	45	6.26	White	44	4.24
3-5	5	2.21				Other	1	104.43
6-8	1	0.42				Asian	0	
9-11	4	1.63						
12-14	3	1.29						
15-17	36	15.47						
Total	**66**	**4.72**		**66**	**4.72**		**66**	**4.72**

*Rates per 100,000 population

Figure 3
Violence-related Child Fatalities by Manner and Race
(N=66)



Homicide

In 2002 there were 44 child fatalities due to homicides. This represents 67% of all violence-related deaths and 4% of all child fatalities (Table 8).
Males (N=27; 3.76 per 100,000) were more likely than females (N=17; 2.5 per 100,000) to die from homicides. African-American children (N=20; 6.75 per 100,000) died at a rate higher than that of white children (N=23; 2.21 per 100,000) followed by children of other races (N=1; 1.58 per 100,000).

Table 8: Homicide Fatalities by Age, Sex, and Race (N=44)

Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	10	13.31	Female	17	2.5	African-American	20	6.75
1-2	7	4.68	Male	27	3.76	White	23	2.21
3-5	5	2.21				Other	1	1.58
6-8	1	0.42						
9-11	3	1.23						
12-14	3	1.29						
15-17	15	6.45						
Total	**44**	**3.15**		**44**	**3.15**		**44**	**3.15**

*Rates per 100,000 population

Suicide

During 2002, 22 young people committed suicide. Most of these deaths were by children in the 15 to 17 year age group (N=21; 9.03 per 100,000). One child in the 9 to 11 years age group committed suicide (0.41per 100,000). Males (N=18; 2.51 per 100,000) were more likely than females (N=4; 0.59 per 100,000) to die from suicide. Slight racial differences emerged with African-American children having 0.34 suicides per 100,000. The White children were 2.02 suicides per 100,000 (Table 9).

Table 9: Suicide Fatalities by Age, Sex, and Race (N=22)

Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	0	0	Female	4	0.59	African-American	1	0.34
1-2	0	0	Male	18	2.51	White	21	2.02
3-5	0	0				Other	0	0
6-8	0	0						
9-11	1	0.41						
12-14	0	0						
15-17	21	9.03						
Total	**22**	**1.57**						

*Rates per 100,000 population
*Note: There were 17 suicides in 2001, a 29.4% increase.

Manner of Death by County

Sixty-one percent (N=679) of all childhood fatalities occurred in twelve counties with 15 or more deaths each (Table 10). In 2002 the highly populated counties of Shelby and Davidson reported a total of 404 fatalities and accounted for 36% of all childhood fatalities. Shelby County had the highest percentage of all childhood fatalities (N=282; 25%) followed by Davidson (N=122; 11%), Knox (N=53; 5%), and Hamilton(N=47; 4%). Of the 12 counties reporting the most child fatalities, all ranked in the top 14 counties with the highest population age 0-17 years (Table 10). Notably absent from the list is Madison County that ranked 11th in population size but with only 7 deaths, Madison ranked 37th in the state with a death rate of 29.51 per 100,000.

Table 10: Fatalities from Counties with15 or More Fatalities (N=641)

County	Fatalities	Rank in Population Ages 0-17*
SHELBY	282	1
DAVIDSON	122	2
KNOX	53	3
HAMILTON	47	4
RUTHERFORD	36	5
SUMNER	32	8
MONTGOMERY	25	6
WILSON	18	12
BLOUNT	17	10
BRADLEY	16	14
SULLIVAN	16	9
WILLIAMSON	15	7
	679	**TOTAL**

***Based on 2000 census**

COUNTY	Accidental	Natural	Homicide/ Suicide	Could not be determined	Undetermined due to suspicious circumstances	Total	*Rate
ANDERSON	3	3	2	0	0	8	48.38
BEDFORD	2	5	1	0	0	8	82.58
BENTON	0	1	0	0	0	1	27.46
BLEDSOE	0	2	0	0	0	2	70.08
BLOUNT	4	12	1	0	0	17	70.45
BRADLEY	5	9	1	1	0	16	76.81
CAMPBELL	2	2	0	0	0	4	43.83
CANNON	0	0	0	0	0	0	0
CARROLL	1	8	0	0	0	9	131.58
CARTER	1	3	0	1	1	6	49.51
CHEATHAM	4	1	0	1	0	6	60.42
CHESTER	1	4	0	0	0	5	132.91
CLAIBORNE	0	2	0	1	0	3	42.59
CLAY	0	0	0	0	0	0	0
COCKE	3	0	2	0	0	5	65.27
COFFEE	1	11	0	0	0	12	99.62
CROCKETT	0	3	0	0	0	3	82.10
CUMBERLAND	4	4	1	0	0	9	89.90
DAVIDSON	14	100	6	2	0	122	96.48
DECATUR	1	4	1	0	0	6	235.39
DEKALB	1	0	0	0	0	1	24.68
DICKSON	0	9	1	0	0	10	87.06
DYER	1	10	0	0	1	12	125.04
FAYETTE	0	9	0	1	0	10	134.97
FENTRESS	1	2	0	0	0	3	74.57
FRANKLIN	1	3	0	0	0	4	44.23
GIBSON	1	7	0	0	0	8	69.34
GILES	3	6	0	0	0	9	124.65
GRAINGER	0	3	0	0	0	3	63.40
GREENE	2	4	0	1	0	7	50.03
GRUNDY	0	2	1	0	0	3	83.31
HAMBLEN	4	2	0	0	0	6	44.35
HAMILTON	7	39	1	0	0	47	65.79
HANCOCK	1	0	0	0	0	1	63.69
HARDEMAN	0	7	0	0	0	7	104.14
HARDIN	1	2	0	0	0	3	50.87
HAWKINS	1	3	1	0	0	5	40.07
HAYWOOD	2	7	0	0	0	9	167.29
HENDERSON	1	3	0	0	0	4	64.39
HENRY	2	3	0	0	0	5	72.33
HICKMAN	2	3	1	0	0	6	109.03
HOUSTON	0	2	0	0	0	2	101.52
HUMPHREYS	1	4	0	0	0	5	116.77
JACKSON	0	1	3	0	0	4	163.53

COUNTY	Accidental	Natural	Homicide/ Suicide	Could not be determined	Undetermined due to suspicious circumstances	Total	*Rate
JEFFERSON	2	2	1	0	0	5	49.31
JOHNSON	0	2	1	0	0	3	86.98
KNOX	15	30	4	0	4	53	62.28
LAKE	1	0	1	0	0	2	141.74
LAUDERDALE	1	7	0	0	0	8	119.07
LAWRENCE	5	7	0	2	0	14	133.93
LEWIS	0	0	0	0	0	0	0
LINCOLN	2	3	0	0	0	5	66.86
LOUDON	4	7	2	0	0	13	151.87
MCMINN	0	2	0	0	1	3	25.58
MCNAIRY	1	11	0	0	0	12	206.01
MACON	0	1	0	0	0	1	18.82
MADISON	1	6	0	0	0	7	29.51
MARION	1	8	0	1	0	10	151.65
MARSHALL	3	6	0	0	0	9	131.50
MAURY	1	3	0	0	0	4	21.94
MEIGS	0	7	0	0	0	7	251.26
MONROE	2	5	1	1	0	9	93.37
MONTGOMERY	3	17	5	0	0	25	65.22
MOORE	0	0	0	0	0	0	0
MORGAN	2	2	0	0	0	4	87.28
OBION	2	4	0	0	0	6	78.89
OVERTON	0	2	0	0	0	2	43.20
PERRY	0	1	0	0	0	1	53.71
PICKETT	0	1	0	0	0	1	94.61
POLK	1	4	0	1	1	7	193.00
PUTNAM	0	5	1	0	0	6	43.23
RHEA	2	2	0	0	0	4	59.34
ROANE	3	1	0	0	0	4	34.50
ROBERTSON	1	4	0	0	0	5	34.29
RUTHERFORD	9	24	1	2	0	36	74.83
SCOTT	1	2	0	0	0	3	54.49
SEQUATCHIE	0	1	0	0	0	1	35.82
SEVIER	1	10	1	0	0	12	73.29
SHELBY	45	219	18	0	0	282	111.34
SMITH	4	3	0	0	0	7	154.83
STEWART	2	5	0	0	0	7	236.49
SULLIVAN	4	11	0	0	1	16	47.89
SUMNER	6	24	2	0	0	32	93.19
TIPTON	0	7	1	0	0	8	53.24
TROUSDALE	1	0	0	0	0	1	56.92
UNICOI	2	0	0	0	0	2	55.17
UNION	0	1	0	0	0	1	21.85
VAN-BUREN	0	1	0	0	0	1	79.05

Table 11: Manners of Fatalities from All Counties (N=1,122*)

COUNTY	Accidental	Natural	Homicide/ Suicide	Could not be determined	Undetermined due to suspicious circumstances	Total	*Rate
WARREN	1	8	1	0	0	10	107.76
WASHINGTON	1	7	1	5	0	14	61.30
WAYNE	1	3	0	0	0	4	111.14
WEAKLEY	0	1	0	0	0	1	13.24
WHITE	2	2	1	0	0	5	91.93
WILLIAMSON	1	12	1	1	0	15	40.16
WILSON	3	15	0	0	0	18	77.24
Total	**215**	**811**	**66**	**21**	**9**	**1122**	**80.23**

*Rates per 100,000 population
Note: Counties with no reviewed deaths: Cannon, Clay, Lewis, and Moore

CAUSE OF DEATH

The 1,122 child fatalities were divided into the following categories by cause of death:

- Non-injury 818 (72.90%)
- Injury-related 273 (24.30%)
- Other cause not listed 13 (1.16%)
- Unknown 18 (1.60%)

Overall, the cause of death was reported in thirteen categories. The 818 deaths recorded as non-injury were reported in the categories of SIDS, lack of adequate care, prematurity, and illness/other natural cause. Injury related deaths (N=273) were reported in the categories of drowning, suffocation/strangulation, vehicular, firearm, inflicted injury, poison/overdose, and fire/burn. Other Cause Not Listed (N=13) and Unknown Cause(N=18) were reported separately (Table 13).

Table 13: Overall Cause of Death (N=1,122)

Cause of Death	**Number**	**Percent**	**Rate***
SIDS	76	6.77	5.43
Lack of adequate care	1	0.09	0.07
Prematurity	343	30.57	24.53
Illness or other natural cause	398	35.47	28.46
Drowning	25	2.23	1.79
Suffocation/strangulation	44	3.92	3.15
Vehicular	133	11.85	9.51
Firearm	35	3.12	2.50
Inflicted Injury	19	1.69	1.36
Poisoning/overdose	7	0.62	0.50
Fire/burn	10	0.89	0.72
Other cause not listed above	13	1.16	0.93
Unknown cause	18	1.60	1.29
Total	**1122**	**100.00**	**80.23**

*Rates per 100,000 population

A summary of cause of death by age, sex and race are reported in Tables 14, 15, and 16.

Table 14: Cause of Death by Age (N=1,122)								
Cause of Death	**<1**	**1-2**	**3-5**	**6-8**	**9-11**	**12-14**	**15-17**	**Total**
SIDS	76	0	0	0	0	0	0	76
Lack of adequate care	1	0	0	0	0	0	0	1
Prematurity	343	0	0	0	0	0	0	343
Illness or other natural cause	238	32	29	20	24	23	32	398
Drowning	2	5	5	3	0	4	6	25
Suffocation/strangulation	27	7	1	0	1	0	8	44
Vehicular	2	4	10	19	13	16	69	133
Firearm	0	1	2	0	4	3	25	35
Inflicted Injury	7	4	4	0	0	0	4	19
Poisoning/overdose	1	0	1	0	0	0	5	7
Fire/burn	1	2	4	1	2	0	0	10
Other cause not listed above	4	0	0	0	2	6	1	13
Unknown cause	13	2	0	1	0	1	1	18
All Causes	714	57	56	44	46	54	151	1122

Table 15: Cause of Death by Sex (N=1,122)			
Cause of Death	**Female**	**Male**	**Total**
SIDS	30	46	76
Lack of adequate care	0	1	1
Prematurity	150	193	343
Illness or other natural cause	176	222	398
Drowning	11	14	25
Suffocation/strangulation	16	28	44
Vehicular	45	88	133
Firearm	5	30	35
Inflicted Injury	8	11	19
Poisoning/overdose	5	2	7
Fire/burn	4	6	10
Other cause not listed above	5	8	13
Unknown cause	6	12	18
TOTAL	**461**	**661**	**1122**

Table 16: Cause of Death by Race (N=1,122)						
Cause of Death	**African American**	**White**	**Asian**	**Other**	**Not Marked**	**Total**
SIDS	30	43	0	3	0	76
Lack of adequate care	1	0	0	0	0	1
Prematurity	171	158	0	13	1	343
Illness or other natural cause	115	254	5	21	3	398
Drowning	7	17	1	0	0	25
Suffocation/strangulation	14	28	1	1	0	44
Vehicular	22	101	1	5	4	133
Firearm	14	21	0	0	0	35
Inflicted Injury	7	11	0	1	0	19
Poisoning/overdose	1	6	0	0	0	7
Fire/burn	3	7	0	0	0	10
Other cause not listed above	5	6	0	2	0	13
Unknown cause	3	12	0	0	3	18
All Causes	**393**	**664**	**8**	**46**	**11**	**1122**

Deaths Due to Non-injury Causes

There were 818 deaths due to natural (non-injury) causes among Tennessee children in 2002, representing 72.9% of all child fatalities reviewed including those that were recorded as not determined. Of these, the greatest number of deaths due to non-injury resulted from illness or other natural causes (N=398) followed by prematurity (N=343). Of the 343 deaths due to prematurity where gestational age was reported (gestational age not reported for 20 prematurity deaths), 137 involved extremely premature infants (i.e., less than 23 weeks gestation) and 186 involved gestations of 23 to 37 weeks.

Illness or Other Conditions

In 2002, 398 children died due to illness or other conditions. This represents 48.7% of all non-injury deaths and 35.5% of all childhood fatalities for 2002. More than half (N=238) of all fatalities due to illness involved children of less than one year of age (Table 17).

Table 17: Fatalities Due To Illness or Other Natural Causes by Age, Sex and Race (N=398)								
Age	Number	Rate*	**Sex**	Number	Rate	**Race**	Number	Rate
<1	238	316.80	Female	176	25.88	African-American	115	38.78
1-2	32	21.38	Male	222	30.90	White	254	24.45
3-5	29	12.79				Other	21	33.23
6-8	20	8.46				Asian	5	**
9-11	24	9.81				Missing	3	**
12-14	23	9.86						
15-17	32	13.75						
Total	**398**	**28.46**		**398**	**28.46**		**398**	**28.46**

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

Prematurity

A total of 343 child fatalities were reported from complications due to prematurity in 2002 (Table 18). One hundred and thirty seven of these deaths in 2002 occurred in infants with a gestational age of less than 23 weeks. This represents 40% of all deaths due to prematurity in 2002. One hundred eighty-six deaths due to prematurity occurred in infants with a gestational age of 23 to 37 weeks and is 54% of prematurity deaths. Gestational age was not reported for 6% (N=20) premature deaths. Overall, prematurity was the manner of death for 42% of deaths due to non-injury and 31% of all childhood deaths.

Of the 137 fatalities due to prematurity with less than 23 weeks of gestational age where age at death was known:

One hundred twenty one (88%) died within 24 hours of birth
Eleven (8%) died within 1 and 6 days of birth
Two (2%) died between 7 and 28 days
Three died between 29-364 days of birth

Of the 186 fatalities due to prematurity with 23-37 weeks of gestational age where age at death was known:

Sixty seven (36%) died within 24 hours
Fifty-eight (31%) died between 1 and 6 days of age
Thirty-three (18%) died between 7 and 28 days
Twenty eight (15%) died between 29 and 364 days of age

There were no reported deaths due to prematurity for children with a gestational age of greater than 37 weeks. Twenty deaths due to prematurity did not report the gestational age.

Table 18: Fatalities Due To Prematurity by Age, Sex, Race and Gestational Age (N=343)*								
Gestational Age Less than 23 Weeks (N=137)								
Age	Number	%	**Sex**	Number	%	**Race**	Number	%
<1 day	121	88	Female	68	50	African-American	81	59
1-6 days	11	8	Male	69	50	White	53	39
7-28 days	2	2				Other	3	2
29-364 days	3	2				Not Marked	0	0
Total	**137**	**100**		**137**	**100**		**137**	**100**
Gestational Age 23-37 Weeks (N=186)								
Age	Number	%	**Sex**	Number	%	**Race**	Number	%
<1 day	**67**	36	Female	73	39	African-American	74	40
1-6 days	58	31	Male	113	61	White	101	54
7-28 days	33	18				Other	10	5
29-364 days	28	15				Not Marked	1	1
Total	**186**	**100**		**186**	**100**		**186**	**100**

Childhood fatalities among infants born at 22 weeks gestation or earlier were most frequent among women who's age was reported between 31 to 40 years of age (N=36). Childhood fatalities among infants born between 23 and 37 weeks of gestation were most frequent among mother's who were 18 to 21 years of age (N=46) (Table 19).

Table 19: Fatalities Due Prematurity by Mother's Age and Gestational Age (N=311)								
Less than or equal to 22 weeks			**23-37 weeks**			**More than 37 weeks**		
Mother's Age	Number	Percent	Mother's Age	Number	Percent	Mother's Age	Number	Percent
14-17	10	0	14-17	13	1	14-17	0	0
18-21	24	26	18-21	46	23	18-21	0	0
22-25	31	19	22-25	39	19	22-25	0	0
26-30	29	22	26-30	39	22	26-30	0	0
31-40	36	34	31-40	38	34	31-40	0	0
41-45	2	2	41-45	4	2	41-45	0	0
Total	**132**	**100**	**Total**	**179**	**100**	**Total**	**0**	**0**

Sudden Infant Death Syndrome (SIDS)

In 2002, 76 deaths were reported as sudden infant death syndrome (SIDS). This represents 13% of deaths due to non-injury and 7% of all childhood deaths in 2002. The most frequently occurring age of death was 9 to 12 weeks (N=22). Fifty five percent (N=42) of all fatalities due to SIDS occurred between 5 and 12 weeks of age.

Of the 76 reported SIDS deaths, sleeping position for 32 (42%) was either not reported or unknown. Among the 44 whose position was reported 27 (62%) were on their stomachs with face down, 1 (2%) was on his/her stomach with face to the side, 2 (5%) were on their side, and 14 (32%) were on their back. Of the 71 who were reported sleeping with another person 29 (38%) were sleeping with another person, 27 (36%) were not and 15 (21%) were unknown or not reported. Regarding a smoker in the household, of the 71 total reported, 35 (46%) reported yes
and 8 (11%) marked no, the rest (N=33, 43%) were unknown (Figure 4).

Deaths Due To Sudden Infant Death Syndrome

In 2002 there were 76 deaths that reported Cause of Death as Sudden Infant Death Syndrome (SIDS) (see Figure 4 below). This was a 13.43% increase from 2001 when there were 67 deaths due to SIDS.

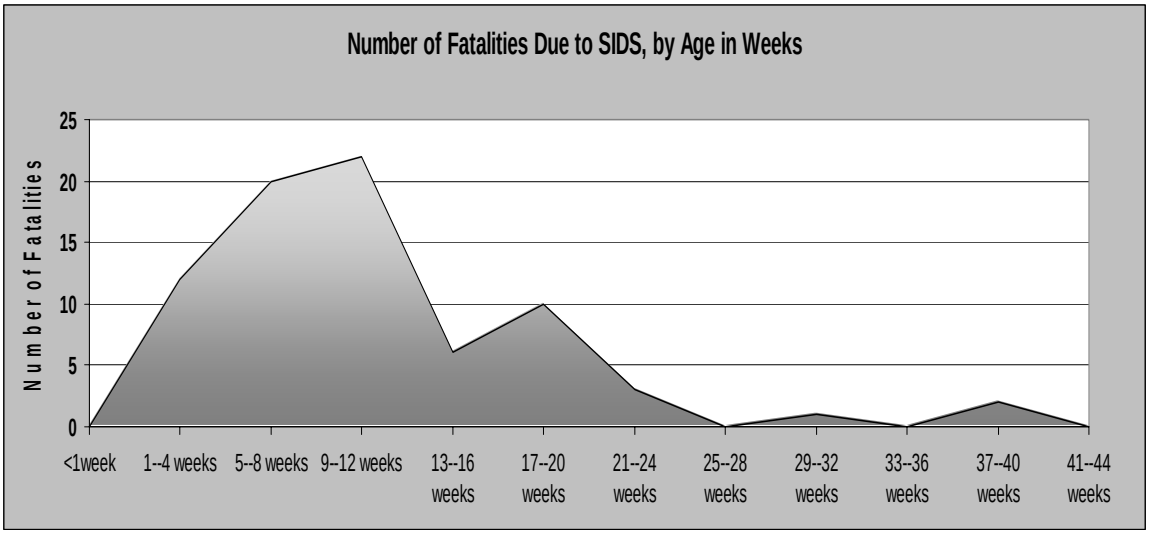


Figure 4: Sudden Infant Death Syndrome (SIDS) (N=76)

Fatalities Due To Lack of Medical Care

In 2002, one fatality was attributed to delayed, inadequate, or lack of medical care (Table 20).

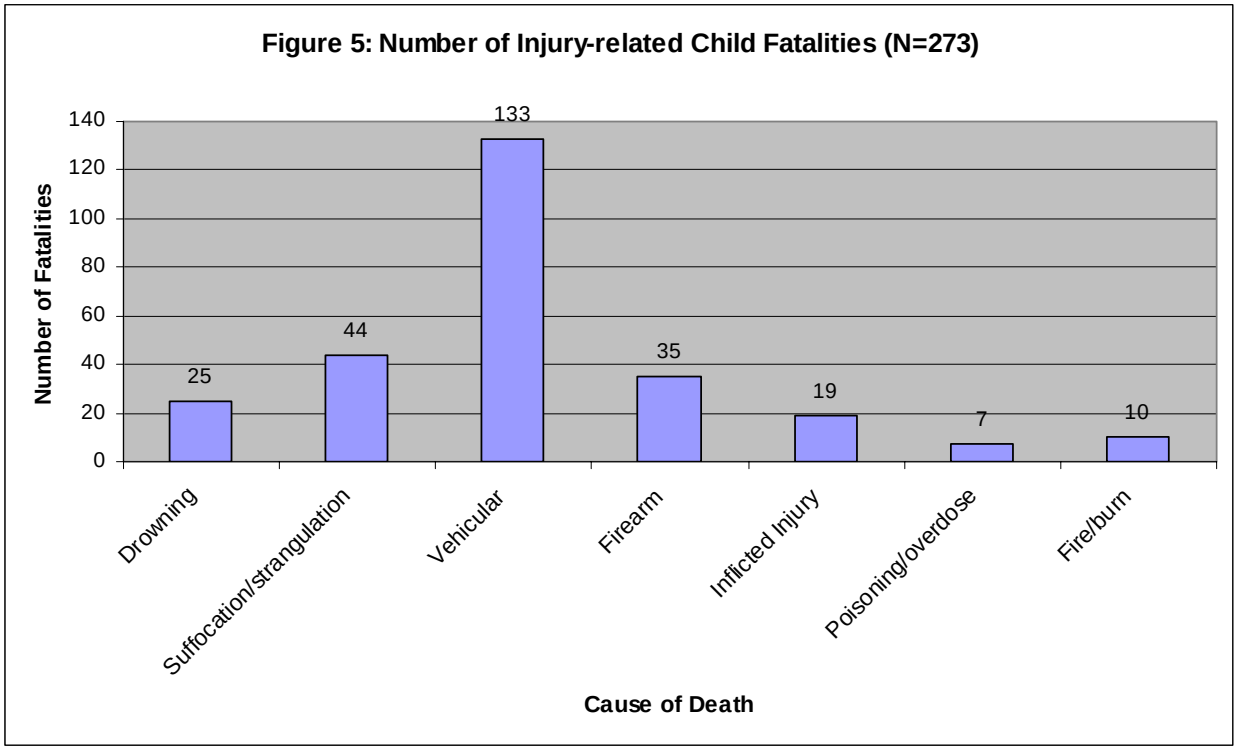
Table 20: Fatalities Due To Lack of Care by Age, Sex and Race (N=1)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	1	1.33	Female	0	0	African-American	1	0.34
1-2	0	0	Male	1	0.14	White	0	0
3-5	0	0				Other	0	0
6-8	0	0						
9-11	0	0						
12-14	0	0						
15-17	0	0						
Total	**1**	**0.07**		**1**	**0.07**		**1**	**0.07**

*Rates per 100,000 population

Deaths Due To Injury

In 2002 there were 273 deaths (24% of all childhood fatalities) due to injury among children. The greatest number of childhood fatalities due to injuries resulted from vehicular incidents (133) or 49% of all injury-related fatalities). Suffocation/strangulation fatalities were the next most common cause of injury-related death resulting in 44 fatalities (16% of all injury-related fatalities) (Figure 5).



African-American children and children from races other than white, were more likely to be involved in an injury-related fatality than White children (Table 21). Overall, childhood fatalities due to unintentional injuries in 2002 occurred at a rate of 19.52 per 100,000.

Table 21: Fatalities Due To Injury by Age, Sex and Race (N=273)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	41	54.57	Female	94	13.82	African-American	68	22.93
1-2	25	16.70	Male	179	24.91	White	191	18.39
3-5	30	13.23				Other	7	11.08
6-8	27	11.42				Asian	3	**
9-11	25	10.22				Missing	4	**
12-14	29	12.43						
15-17	124	53.29						
Total	**273**	**19.52**		**273**	**19.52**		**273**	**19.52**

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

Childhood fatalities to injuries were more prevalent among males (N= 179; 24.91per 100,000) than females (N= 94; 13.82 per 100,000). Children ages 15 to 17 years had the highest incidence of unintentional injury deaths (N=124; 53.29 per 100,000). Infants less than one year of age had the next highest number of deaths at 41 but were the highest injury-related death rate at 54.57 per 100,000.

Fatalities due to injuries were most prevalent among African-American children (N=68; 22.93 per 100,000). There were 191 (18.39 per 100,000) White children and 7 (11.08 per 100,000) Other race children whose deaths were due to unintentional injuries. Seven were reported as Asian or were missing (Table 22).

Table 22: Fatalities Due to Injury by Race (N=273)

	African-American	White	Other	Missing	Total
Drowning	7	17	0	1	25
Suffocation/Strangulation	14	28	1	1	44
Vehicular	22	101	5	5	133
Firearm	14	21	0		35
Inflicted Injury	7	11	1		19
Poison/Overdose	1	6	0		7
Fire/Burn	3	7	0		10
TOTAL	**68**	**191**	**7**	**7**	**273**
Rate*	22.93	18.39	11.08		19.52

*Rates per 100,000 population

Vehicle-Related Deaths

In 2002, 133 children died in vehicle-related incidents. This represents 49% of all injury-related deaths and 12% of all child fatalities for 2002. Infants less than one year (N=2; 2.66 per 100,000 in the population) were most likely to die in a vehicle-related incident. Males (12.25 per 100,000 in the population) were nearly twice as likely to die in a vehicle-related death than females (6.62 per 100,000 in the population). Whites had a slightly higher rate of vehicle-related incidents than African-Americans (9.72 versus 7.42 respectively) (Table 23).

Table 23: Fatalities Due To Vehicular by Age, Sex and Race (N= 133)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	2	2.66	Female	45	6.62	African-American	22	7.42
1-2	4	2.67	Male	88	12.25	White	101	9.72
3-5	10	4.41				Other	5	7.91
6-8	19	8.04				Asian	1	**
9-11	13	5.31				Missing	4	**
12-14	16	6.86						
15-17	69	29.66						
Total	**133**	**9.51**		**133**	**9.51**		**133**	**9.51**

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

Firearms

In 2002, 35 children died due to firearm injuries. This represents 13% of all injury deaths and 3% of all childhood fatalities (Table 24). Males (N=30; 4.18 per 100,000) were more likely to die due to firearm injuries than females (N=5; 0.74 per 100,000). Seventy-one percent (N=25) of all firearm deaths occurred in age groups of 15-17 years old.

Table 24: Fatalities Due To Firearm by Age, Sex and Race (N=35)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	0	0	Female	5	0.74	African-American	14	4.72
1-2	1	0.67	Male	30	4.18	White	21	2.02
3-5	2	0.88				Other	0	0
6-8	0	0						
9-11	4	1.63						
12-14	3	1.29						
15-17	25	10.74						
Total	**35**	**2.50**		**35**	**2.50**		**35**	**2.50**

*Rates per 100,000 population.

Suffocation or Strangulation

In 2002, there were 44 child fatalities due to suffocation or strangulation. This represents 16% of all injuries and 4% of all child fatalities in 2002. Among these deaths, 61% (N=27) involved a child less than one year old (Table 25).

Table 25: Fatalities Due To Suffocation or Strangulation by Age, Sex and Race (N= 44)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1 day	*1*		Female	16	2.35	African-American	14	4.72
1-6 days	*1*		Male	28	3.90	White	28	3.90
7-28 days	*2*					Other	1	1.58
29-364 days	*23*							
Total <1 year	*27*							
< 1 year	27	35.94						
1-2 years	7	4.68						
3-5 years	1	0.44						
6-8 years	0	0						
9-11 years	1	0.41						
12-14 years	0	0						
15-17 years	8	3.44						
Total	**44**	**3.15**		**44**	**3.15**		**44**	**3.15**

*Rates per 100,000 population.

Fire/Burns

In 2002 there were 10 child fatalities due to fire or burn injuries. This represents 4% of all injury fatalities and 1% of all child fatalities in 2002 (Table 26).

Table 26: Fatalities Due To Fire or Burn by Age, Sex and Race (N=10)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	1	1.33	Female	4	0.59	African-American	3	1.01
1-2	2	1.34	Male	6	0.84	White	7	0.67
3-5	4	1.76				Other	0	0
6-8	1	0.42						
9-11	2	0.82						
12-14	0	0						
15-17	0	0						
Total	**10**	**0.72**		**10**	**0.72**		**10**	**0.72**

*Rates per 100,000 population.

Inflicted Injury

In 2002 there were 19 child fatalities due to inflicted injuries. This represents 7% of all injury-related fatalities and 2% of all child fatalities in 2002.

Children under one year of age were the most likely to die from inflicted injuries (N=7; 9.32 per 100,000 in the population) and males N=11; 1.53 per 100,000 in the population). African-American children (N=7; 2.36 per 100,000 in the population) were more likely to die from inflicted injuries than White children (N=11; 1.53 per 100,000 in the population) or children of other races (N=1; 1.58 per 100,000 in the population) (Table 27).

Table 27: Fatalities Due To Inflicted Injury by Age, Sex and Race (N= 19)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	7	9.32	Female	8	1.18	African-American	7	2.36
1-2	4	2.67	Male	11	1.53	White	11	1.53
3-5	4	1.76				Other	1	1.58
6-8	0	0						
9-11	0	0						
12-14	0	0						
15-17	4	1.72						
Total	**19**	**1.36**		**19**	**1.36**		**19**	**1.36**

*Rates per 100,000 population.

Drowning

In 2002 25 children died from accidental drowning. This represents 9% of all injury-related deaths and 2% of all child fatalities in 2002. White children (17; 1.64 per 100,000 in the population) were more than twice as likely to die due to drowning than African-American children (N=7; 2.36 per 100,000 in the population) (Table 28).

Table 28: Fatalities Due To Drowning by Age, Sex and Race (N=25)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1	2	2.66	Female	11	1.62	African-American	7	2.36
1-2	5	3.34	Male	14	1.95	White	17	1.64
3-5	5	2.21				Other	0	0
6-8	3	1.27						
9-11	0	0						
12-14	4	1.71						
15-17	6	2.58						
Total	**25**	**1.79**		**25**	**1.79**		**25**	**1.79**

*Rates per 100,000 population.

Poisoning or Overdose

In 2002 there were seven child fatalities due to poisoning or overdose. This represents 3% of all injury deaths and 1% of all child fatalities in 2002. Females (N=5; 0.74 per 100,000 in the population) were more likely than males (N=2; 0.28 per 100,000 in the population) to die from poisonings or overdose (Table 29).

Table 29: Fatalities Due To Poisoning or Overdose by Age, Sex and Race (N= 7)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race***	Number	Rate*
<1	1	1.33	Female	5	0.74	African-American	1	0.34
1-2	0	0	Male	2	0.28	White	6	0.58
3-5	1	0.44				Other	0	0
6-8	0	0						
9-11	0	0						
12-14	0	0						
15-17	5	2.15						
Total	**7**	**0.50**		**7**	**0.50**		**7**	**0.50**

*Rates per 100,000 population.

Other or Unknown Cause of Death

In 2002 there were 31 total fatalities where the cause of death was other cause not listed (N=13) or listed as unknown cause (N=18) (Tables 30 and 31). This represents 3% of all child fatalities in 2002.

Table 30. Fatalities Due To Other Cause Not Listed by Age, Sex and Race (N=13)

Age	Number	Rate	**Sex**	Number	Rate	**Race***	Number	Rate*
<1	4	5.32	Female	5	0.74	African-American	5	1.69
1-2	0	0	Male	8	1.11	White	6	0.58
3-5	0	0				Other	2	3.16
6-8	0	0						
9-11	2	0.82						
12-14	6	2.57						
15-17	1	0.43						
Total	**13**	**0.93**		**13**	**0.93**		**13**	**0.93**

*Rates per 100,000 population.

Table 31: Fatalities Due To Unknown Causes by Age, Sex and Race (N= 18)

Age	Number	Rate*	**Sex**	Number	Rate*	**Race**	Number	Rate*
<1 year	13	17.30	Female	6	0.88	African-American	3	1.01
1-2 years	2	1.34	Male	12	1.67	White	12	1.16
3-5 years	0	0				Other	0	**
6-8 years	1	0.42				Missing	3	**
9-11 years	0	0						
12-14 years	1	0.43						
15-17 years	1	0.43						
Total	**18**	**1.29**		**18**	**1.29**		**18**	**1.29**

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

Place of Death

When asked to mark the place of death, the CFR team indicated most deaths occurred as hospital inpatients (N=634) with 16% of the deaths in the hospital emergency room (N=179). One hundred fifty deaths (13%) occurred at the child's residence and 94 (8%) at the scene of incident. One death each occurred in an institutional setting or child care facility (Table 32).

Table 32: Fatalities and Place of Death

Place of Death	Number	Percent
Hospital Inpatient	634	56.51
Hospital Emergency Room	179	15.95
In Transit	13	1.16
Institutional Setting	1	0.09
At Scene of Incident	94	8.38
Child's Residence	150	13.37
Relative's/Friend's Home	5	0.45
Child Care	1	0.09
Not Listed	1	0.09
Not Marked, Blank or Other	44	3.92
Total	**1122**	**100.00**

Note: Percentages rounded to nearest whole percent for illustration purposes

Vehicular

Most vehicular deaths occurred in either a car (N=75; 56% or truck/rv (N=25; 19%) with decedent as passenger (N=59; 44%). Forty-six deaths (35%) occurred as decedent as driver of the vehicle and 59 (44%) as passenger. Fifteen (11%) were pedestrians and three (2%) were riding in the back of a truck. Where the age of driver of the vehicle in which decedent was occupant was reported, 42 or 31% were age 16 or 17.

Safety belts were present in vehicle but not used in 46 (35%) of deaths and speed/recklessness was indicated in 32 (24%) of deaths (Table 33).

Table 33: Fatalities Due To Vehicular (N=133)								
Safety Belt Use?	Number	Percent	Helmet?	Number	Percent	Vehicle in which decedant was occupant	Number	Percent
Present in vehicle, but not used	46	35%	Yes	2	20%	Operator driving impaired	14	11%
None in vehicle	2	2%	No	8	80%	Speed/recklessness indicated	32	24%
Restraint used	26	20%				Other violation by operator	9	7%
Unknown	22	17%				Other	11	8%
NA	29	22%				Unknown	15	11%
Not Marked	8	6%				NA	25	19%
						Not Marked	27	20%
Total	**133**	**100%**				**Total**	**133**	**100%**

Note: Percentages rounded to nearest whole percent for illustration purposes

Inflicted Injury

Most injuries were inflicted by the parent of the child (N=6;32%) and most of the injured were reported as male (10 males versus 2 females). When race was reported or known (N=12) five were white and 7 were African American (Table 34).

Table 34: Relationship, Gender, and Race of Person Inflicting Injury (N=19)								
Who Inflicted Injury?	Number	Percent	**Gender of Person Inflicting Injury**	Number	Percent	**Race of Person Inflicting Injury**	Number	Percent
Parent	6	32%	Male	10	53%	White	5	26%
boyfriend	3	16%	Female	2	11%	African American	7	37%
caregiver	1	5%	Not Marked	7	37%	Unknown	5	26%
mother's boyfriend	1	5%				Not Marked	2	11%
step-mother	1	5%						
unknown	1	5%						
Not Marked	6	32%						
Total	**19**	**100%**	**Total**	**19**	**100%**	**Total**	**19**	**100%**

Note: Percentages rounded to nearest whole percent for illustration purposes

Manner and Location of Inflicted Injury

Most inflicted injury deaths occurred when a child was shaken (N=9; 47%) and hands/feet were used to inflict the injury (N=6; 32%). The child's residence was the location of most deaths (N=13; 68%) (Table 35).

Table 35: Manner and Location where Injury was Inflicted (N=19)								
Manner in which Injury was Inflicted	Number	Percent	**Injury Inflicted With?**	Number	Percent	**Where did Injury Occur?**	Number	Percent
Shaken	9	47%	Sharp object	1	5%	Child's residence	13	68%
Struck	3	16%	Blunt object	1	5%	Relative/ friend's home	1	5%
Thrown	1	5%	Hands/feet	6	32%	Other	4	21%
Cut/stabbed	1	5%	Fire	3	16%	Unknown	1	5%
Other	3	16%	Other	1	5%			
Unknown	2	11%	Unknown	6	32%			
			Not Marked	1	5%			
Total	**19**	**100%**	**Total**	**19**	**100%**	**Total**	**19**	**100%**

Note: Percentages rounded to nearest whole percent for illustration purposes

APPENDIX

Child Fatality Review and Prevention Act

Section

68-142-101. Short title

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

[Acts 1995, ch.511,§ 1.]

68-142-102. Child fatality prevention team

There is hereby created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

[Acts 1995, ch. 511, § 1.]

68-142-103. Composition

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

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

(15) Two senators to be appointed by the speaker of the senate at least one of whom shall be a member of the senate general welfare, health and human resources committee.

[Acts 1995, ch. 511, § 152.]

68-142-104. Voting members-Vacancies

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.

[Acts 1995, ch. 511, § 1.]

68-142-105. Duties of state team

The state team shall:

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

[Acts 1995, ch. 511, § 2.]

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

(a) There shall be a minimum of one local team in each judicial district;
(b) Each local team shall include the following statutory members or their designees;
(1) A supervisor of social services in the department of children's services within the area served by the team;
(2) The regional health officer in the department of health in the area served by the team or such officer's designee, who shall serve as interim chair pending the election by the local team;
(3) A medical examiner who provides services in the area served by the team;
(4) A prosecuting attorney appointed by the district attorney general;
(5) The interim chair of the local team shall appoint the following members to the local team:
(a) A local law enforcement officer;
(b) A mental health professional;
(c) A pediatrician or family practice physician;

(d) An emergency medical service provider or firefighter; and
(e) A representative from a juvenile court.

(c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families;
(d) The local team may include non-statutory members to assist them in carrying out their duties. Vacancies on a local team shall be filled by the original appointing authority;
(e) A local team shall elect a member to serve as chair;
(f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

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

68-142-107. Duties of local teams

(a) The local child fatality review teams shall:
(1) Be established to cover each judicial district in the state;
(2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger;
(3) Collect data according to the protocol developed by the state team;
(4) Submit data on child deaths quarterly to the state team;
(5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and
(6) Participate in training provided by the state team.
(b) Nothing in this chapter shall preclude a local team from providing consultation to any team member conducting an investigation.
(c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.

[Acts 1995, ch. 511, § 4.]

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

(a) The local team shall have access to and subpoena power to obtain all medical records and records maintained by any state, county or local agency, Including, but not limited to, police investigations data, medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality.
(b) The local team shall not, as part of the review authorized under this chapter, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.
(c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality; such persons may include the person or persons who first responded to a report concerning the child.
(d) Meetings of the state team and each local team shall not be subject to the provisions of title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection.

However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.

(e) (1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams.

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

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

(f) Each statutory member of a local child fatality review team and each non-statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

[Acts 1995, ch. 511, § 5.]

68-142-109. Staff and consultants

To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.

State Child Fatality Prevention Team Members
10/13/04

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

Serves by request of the Commissioner of the Tennessee Department of Health

Kenneth S. Robinson, MD, Commissioner
425 5th Avenue North
Cordell Hull Building, 3rd Floor
Nashville, TN. 37247
615-741-3111

Serves by virtue of position as the Commissioner of the Tennessee Department of Health

Voting Members

Beth Kasch
Executive Director, Child Safety
436 Sixth Avenue North
Cordell Hull Building, 8th Fl.
Nashville, TN. 37243-1290
615-741-8278

Serves as designee for the Commissioner of the Department of Children's Services

Stephanie Bailey, M.D.
Davidson County Health Department
311 23rd Avenue North
Nashville, TN. 37203
615-340-5622

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

Bruce Levy, M.D.
Center for Forensic Medicine
850 R.S. Gass Blvd.
Nashville TN. 37216
615-743-1800 x 0
blevy@forensicmed.com

Serves as a physician who has credentials in forensic pathology, preferably with experience in pediatric forensic pathology.

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

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

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

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

Senator David Fowler
War Memorial Building, Room 304
Nashville, TN. 37243
615-741-1764

Appointed by: Tennessee Speaker of the Senate
Serves by virtue of position as a member of the Tennessee Senate and as a member of the Senate General Welfare, Health, and Human Resources Committee

Senator Larry Trail
8A Legislative Plaza
Nashville, TN. 37243
(615) 741-1066

Serves by virtue of position as the Chair of the Select Committee on Children and Youth.

Representative Dennis Ferguson
34 Legislative Plaza
Nashville, TN. 37243
615-741-7658

Appointed by: Tennessee Speaker of the House
Serves by virtue of position as a member of the Tennessee House of Representatives and a member of the House Health and Human Resources Committee

Representative Joe McCord
214 War Memorial Building
Nashville, TN 37243
Phone (615) 741-5481

Appointed by: Tennessee Speaker of the House
Serves by virtue of position as a member of the Tennessee House of Representatives.

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

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

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

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

Karen Alexander
Assistant Special Agent in Charge
Tennessee Bureau of Investigation
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Nashville, TN. 37215-2639
615-744-4216; 24 hour: 744-4000; fax 744-4513

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Dr. Judy Regan
Mental Health & Developmental Disabilities
425 5th Avenue North
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Nashville, TN. 37243-6564
615-532- 6564

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

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

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

ExOfficio/Non-voting participants

Cindy Perry
Select Committee, Children & Youth
James K Polk Building, 3rd Fl.
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Joy Cook, Ed.D.
Director, Child Fatality Review Program
615-741-2452

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

TENNESSEE CHILD FATALITY REVIEW TEAM LEADERS

CFRT Leader	Phone	Judicial Districts (JD) and Counties
Dr. Lawrence Moffatt Washington County Health Dept. 415 State of Franklin Johnson City, TN 37604	Phone: (423) 975-2200 Kathy Carver Region (423) 979-4627	**JD 1**: Carter, Johnson, Unicoi, and Washington Counties
Dr. Stephen May Dana Osborne Sullivan Co. Health Dept. PO Box 630 (154 Blountville Bypass) Blountville, TN 37617	Phone: (423) 279-2794 Fax: (423) 279 2797	**JD 2**: Sullivan County
Dr. Barbara Skelton Greene Co. Health Dept. PO Box 159 Greenville, TN 37744	Phone: Rogersville (Base): (423) 272-7641 x 129 Churchill 423-357-5341	**JD 3**: Greene, Hamblen, Hancock, and Hawkins Counties (Sandy J. Malone, Admin.)
Dr. Paul Erwin / Stephanie Hoglund East 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	**JD 4 –** Priscilla Garner: Cocke, Grainger, Jefferson, and Sevier Counties **JD 5 –** Dr. Ken Marmon: Blount County **JD 7 –** Patti Campbell: Anderson County **JD 8 –** Kerri Byrd-Hamby: Campbell, Claiborne, Fentress, Scott, and Union Counties **JD 9 –** Dr. Bud Guider: Loudon, Meigs, Morgan, and Roane Counties
Dr. Kelly Boggan Knox County Health Dept. 140 Dameron Ave. Knoxville, TN 37917	Phone: (865) 544-4259 (865) 215-5437 Mary Campbell Linda Weber (ASA) 865-215-5272	**JD 6**: Knox County

Dr. Jan BeVille Southeast Regional Health Office State Office Building 540 McCallie Avenue Chattanooga, TN 37402	Phone: (423) 634-3124 Eloise Waters 423-476-0568 x 105	**JD 10**: Bradley, McMinn, Monroe, and Polk Counties **JD 12**: Bledsoe, Franklin, Grundy, Marion, Rhea, and Sequatchie Counties
Kaye Greer Chattanooga/Hamilton Co. Health Dept. 921 East Third Street Chattanooga, TN 37403	Phone: (423) 209-8155	**JD 11**: Hamilton County
Dr. 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 South Central Regional Health Office 1216 Trootwood Avenue Columbia, TN 38401-4809	Phone: (931) 380-2532 x 146 Brandy Fox, Sec. Peggy Michonski x 123	**JD 14**: Coffee County **JD 17**: Bedford, Lincoln, Marshall, and Moore Counties **JD 2101**: Hickman, Lewis, and Perry Counties **JD 2201**: Giles, Lawrence, and Wayne Counties **JD 2202**: Maury County
Sharon A. Woodard / **Dr. Alison Asaro** Mid Cumberland Reg. Health Office 710 Hart Lane Nashville, TN 37247-0801	Phone: (615) 650-7015 Fax 262-6139 Melissa Crook 650-4008	**JD 16**: Cannon and Rutherford Counties **JD 18**: Sumner County **JD 1901**: Montgomery County **JD 1902**: Robertson County **JD 2102**: Williamson County **JD 23**: Cheatham, Dickson, Houston, Humphreys, and Stewart Counties
Dr. Stephanie Bailey/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 Regional Health Officer West TN Regional Health Office 295 Summar Street Jackson, TN 38301	Phone: (731) 423-6600 Carolyn West Regional Health Office PO Box 190 Union City, TN 38281	**JD 24**: Benton, Carroll, Decatur, Hardin, and Henry Counties **JD 25**: Fayette, Hardeman, Lauderdale, McNairy, and Tipton Counties **JD 27**: Obion and Weakley Counties **JD 28**: Crockett, Gibson, and Haywood Counties **JD 29**: Dyer and Lake Counties
Dr. Tony Emison, Director Jackson/Madison Co. Health Dept. 544 Rowland Ave. Jackson, TN 38301	Phone: (731) 423-3020	**JD 26**: Chester, Henderson, and Madison Counties
Flo Patton Shelby County Health Department 814 Jefferson Avenue Memphis, TN 38105-5099	Phone: (901) 544-7380	**JD 30**: Shelby County
Dr. Bruce Levy State Medical Examiner Lisa Robison	Phone: (615) 743-1800 Phone: (615) 743-1801	

TENNESSEE DEPARTMENT OF HEALTH
CHILD FATALITY REVIEW TEAM
***2002*_____ REVIEW/DATA COLLECTION**

MCH 1/01

This information is confidential

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 ☐ Asian ☐ Other: _____ Ethnicity: Hispanic origin? ☐ Yes ☐ No

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

Mother's Date of Birth: _____ / _____ / _____
Month Day Year

Census Tract: _____ County of Residence _____

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

Abnormal Conditions: _____ Congenital Anomalies: _____

Prenatal Care Questions:

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

Number of Prenatal Visits _____ ☐ No Visits ☐ Unknown

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

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

Chemical Substance Abuse: ☐ Yes ☐ No Specify _____

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

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

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

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

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

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

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

_____
_____
_____
_____
_____

Recommended for additional review? ☐ Yes ☐ No

Which reports/records were requested for full review?

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

1st Review: __/__/__ | 2nd Review: __/__/__ | 3rd Review: __/__/__

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

Additional information for State office:

_____
_____
_____
_____
_____

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. 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:**
_____
_____ **2002**
_____