Nashville Child Death Review Team Annual Report 2008

Davidson County Child Death Review Team Report

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Preface

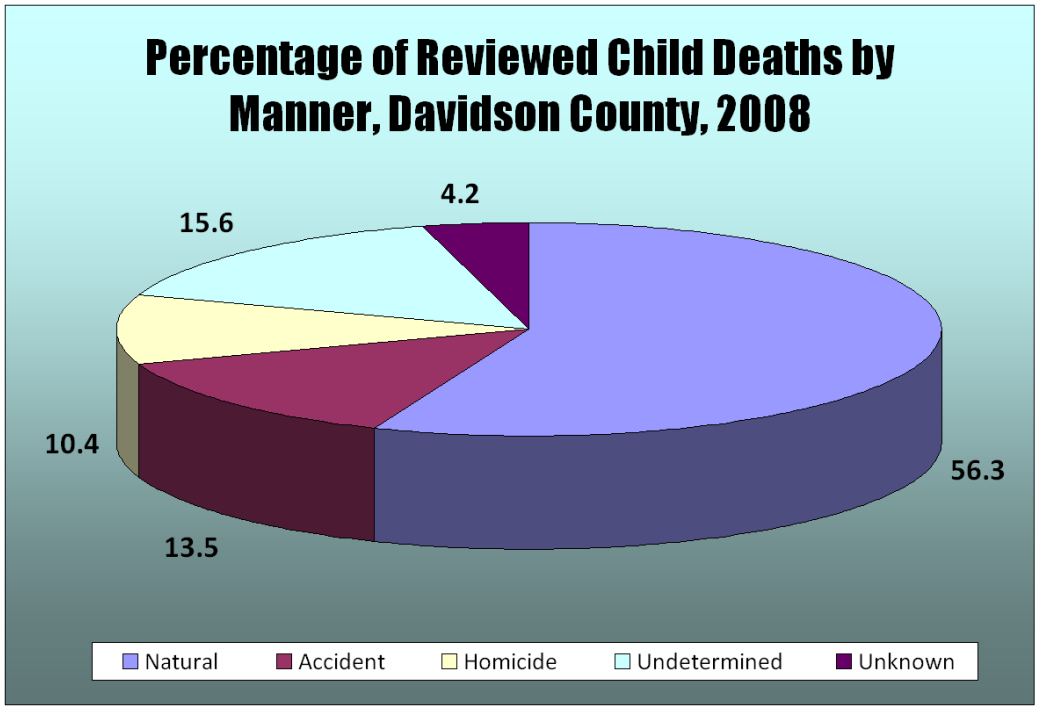
For the year 2008, the Davidson County Review Team (CDRT) reviewed 96 deaths of resident children under the age of 18. To better understand how and why these children died, the CDRT is empowered by a Mayoral Executive Order to conduct reviews with the following goals in mind:

1. Identify factors that put a child at risk of injury or death.
2. Share information among agencies that provide services to children and families or that investigate child deaths.
3. Improve local investigations of unexpected/unexplained child deaths by participating agencies.
4. Improve existing services and service delivery systems and identify areas in the community that require additional services.
5. Identify trends relevant to child injury and death.
6. Educate the public about the causes of child injury and death while also defining the public's role in helping to prevent such tragedies.

This report presents key findings and recommendations from the CDRT designed to help prevent future deaths of children in Davidson County.

Executive Summary

- In 2008, the CDRT reviewed the deaths of 96 resident children of Davidson County.
- 56 deaths (58.3%) occurred among male children.
- 47 deaths (49.0%) occurred among black children.
- 47 deaths (49.0%) occurred among white children.
- 12 deaths (12.5%) occurred among Hispanic children.
- 65 deaths (67.7%) occurred among children less than 1 year of age.
- 11 deaths (11.5%) occurred among children aged 1 to 4 years.
- 10 deaths (10.4%) occurred among children aged 15 to 17 years.
- 24 deaths (25.0%) were judged to have been preventable, and in 14 deaths (14.6%) preventability could not be determined.
- The manner of death of the cases reviewed as follows:
    - 54 deaths (56.3%) were due to natural causes:
        - 15 deaths (27.8% of naturals): congenital anomalies
        - 29 deaths (53.7% of naturals): prematurity.
    - 13 deaths (13.5%) were due to unintentional injuries:
        - 4 deaths (30.8% of unintentional injuries): motor vehicle crashes
        - 5 deaths (38.5% of unintentional injuries): asphyxia.
    - 10 deaths (10.4%) were due to homicide.
    - 15 deaths (15.6%) were undetermined.
    - 4 deaths (4.2%) were of unknown manner (left blank on the death certificate).



- The CDRT team disagreed with the official manner of death in 7 cases (7.3%), and disagreed with the official cause of death in 3 cases (3.1%).
- Confidentiality issues prevented the full exchange of information in 2 cases (2.1%).
- Review led to changes in either practice or policy in 2 cases (2.1%).
- Investigation found evidence of prior abuse in 4 cases (4.2%), and action was taken by Child Protective Services (CPS) as a result of the death in 10 cases (10.4%).

Recommendations

Each year, the CDRT makes recommendations for policy, infrastructure, and service changes based on the results of child death investigations in an effort to prevent future childhood mortality. In 2008, the CDRT made the following recommendations:

1. Where appropriate the CDRT will make every effort to obtain and evaluate records from home monitoring systems. The information gathered will be incorporated into the investigation.
2. The Davidson County CDRT acknowledges that the advent of electronic medical records will provide better and more integrated information to the review of child deaths. As such, the team officially declares its support for the development and implementation of electronic medical records.
3. A community education campaign should be developed that promotes putting babies to sleep on their backs as well as warning of the dangers of improper bedding and other unsafe sleeping environments.
4. All referrals for home visits of high risk pregnant women and children through age five should be sent through the Central Referral System.
5. Child death data systems should capture the number of children who die each year under suspicious circumstances while living in homes from which they or other children have been removed in the past.

The Child Death Review Process

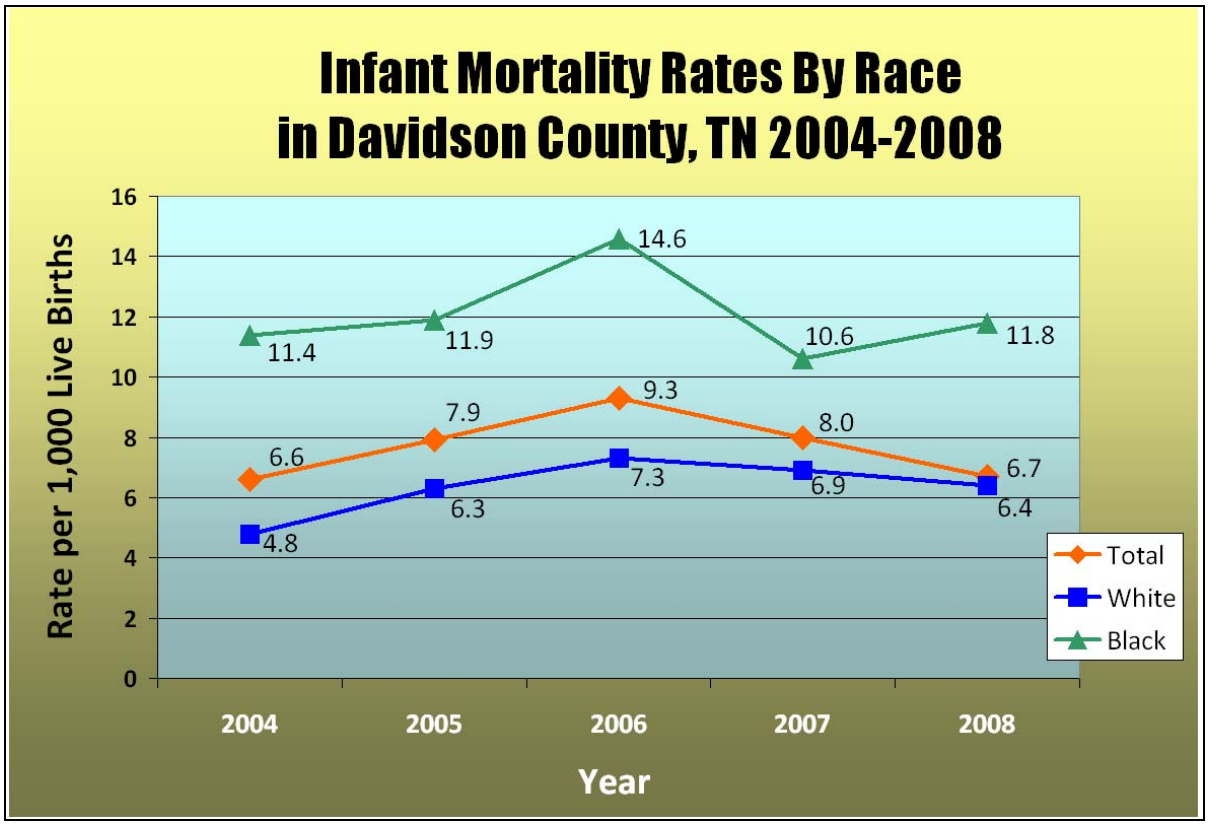
When a child dies:

- The birth and death certificates are sent from the Tennessee Department of Health (TDH) to the Metro Public Health Department (MPHD) Child Death Review Team data coordinator. These data are supplemented with records from the MPHD Office of Vital Records.
- Copies of birth and death records are sent to the Team members.
- All Team members search their agency/hospital files and bring either the records or case summaries to Team meetings. Available records are requested from programs within MPHD.
- The Team meets once a month. At these meetings, each case is reviewed and the TDH data collection form is completed.
- The Team reviews available information and comes to a consensus on whether the child death was preventable. A preventable death is defined as one in which some action or actions from individuals or systems would have alleviated the circumstances that led to an individual child death.
- The data coordinator enters the information obtained from the meetings into a statewide database managed by the National MCH Center for Child Death Review.
- An annual report is produced. The purpose of the report is to disseminate findings and assist in the development of data-driven recommendations for the prevention of child deaths.

Infant and Child Mortality in Davidson County

Infant Mortality:

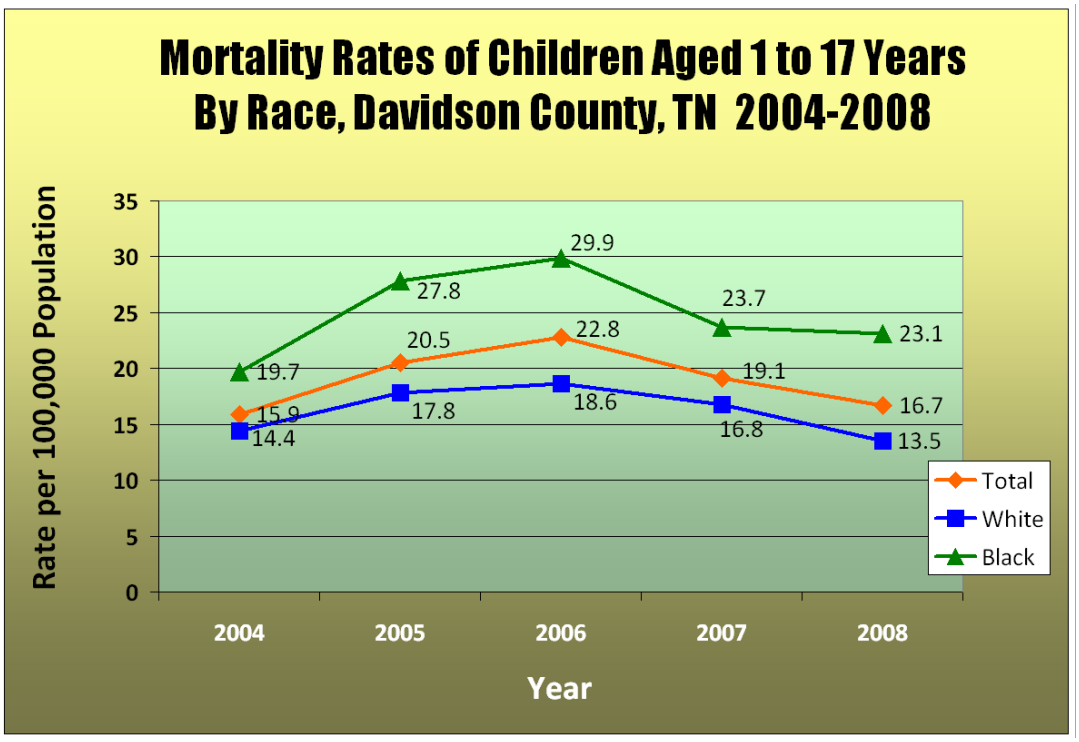
- In 2008, the infant mortality rate in Davidson County was 6.7 per 1,000 live births, a rate that was 48.9% higher than the Healthy People 2010 Objective (16-1c).
- The white infant mortality rate in 2008 was 6.4 deaths per 1,000 live births, and the black rate was 11.8. The black rate was 1.8 times higher than the white rate.
- From 2004 through 2006, the infant mortality rate increased 40.9%. The rate began a decline in 2007, and roughly returned to the 2004 rate. The decrease was greater for whites than blacks.



- Despite the overall rate returning to 2004 levels, the white infant mortality rate in 2008 was 33.3% higher than the white rate in 2004; the black infant mortality rate in 2008 was 3.5% higher than the black rate in 2004.

Child Mortality:

- In 2008, the mortality rate in Davidson County of children aged 1 to 17 years was 16.7 deaths per 100,000 population. There is no comparable Healthy People 2010 Objective for this measure, but the 2008 rate was 5.0% higher than the rate in 2004.
- The white child death rate in 2008 was 13.5 deaths per 100,000 population, and the black rate was 23.1. The black rate was 1.7 times higher than the white rate.



- From 2004 through 2006, the child death rate increased 43.4%. The rate began a decline in 2007, but has not returned to 2004 levels.
- The white child death rate in 2008 was 6.3% lower than the 2004 rate. The black child death rate in 2008 was 17.3% higher than the rate in 2004.

Demographics, Risk Characteristics, and Manner of Death by Age Group

The CDRT in Davidson County reviewed a total of 96 deaths in 2008. Sixty-five (67.7%) of the cases reviewed were of children less than 1 year of age. Of these:

- 33 (50.8%) were black.
- 31 (47.7%) were white.
- 1 (1.5%) was Asian.
- 10 (15.4%) were Hispanic.
- 50 (76.9%) were premature (less than 37 weeks gestation).
- 52 (80.0%) were low birth weight (less than 2500 grams).
- 9 (13.8%) experienced intrauterine smoke exposure.
- 1 (1.5%) experienced intrauterine drug exposure.
- 14 (21.5%) mothers received late or no prenatal care.

The leading causes of death for infants are as follows:

- 29 deaths (44.6%) resulted from prematurity.
- 13 deaths (20.0%) resulted from congenital anomalies.
- 4 deaths (6.2%) resulted from asphyxia.
- 1 death (1.5%) resulted from Sudden Infant Death Syndrome (SIDS).
- 9 deaths (13.8%) resulted from unknown causes.

Demographics and manner of death of the remaining 31 reviewed deaths are as follows:

- 11 deaths (11.5% of total) occurred to children aged 1 to 4:
    - 7 deaths: white
    - 4 deaths: black
    - 9 deaths: female

- 2 deaths: natural
- 4 deaths: unintentional injury
- 2 deaths: homicide

- 3 deaths (3.1% of total) occurred to children aged 5 to 9:
  - 3 deaths: white
  - 2 deaths: male
  - 1 death: natural
  - 2 deaths: unintentional injury

- 7 deaths (7.3% of total) occurred to children aged 10 to 14:
  - 4 deaths: white
  - 3 deaths: black
  - 5 deaths: male
  - 5 deaths: natural
  - 1 death: homicide
  - 1 death: undetermined

- 10 deaths (10.4% of total) occurred to children aged 15 to 17:
  - 7 deaths: black
  - 2 deaths: white
  - 1 death: Asian
  - 2 deaths: Hispanic
  - 9 deaths: male
  - 2 deaths: natural
  - 2 deaths: unintentional injury
  - 6 deaths: homicide

Medical Conditions

A total of 62 deaths (64.6%) reviewed by the CDRT were determined to involve a medical condition.

Demographics:

- 50 deaths (80.6%) were to infants aged less than 1 year.
- 5 deaths (8.1%) occurred to children aged 10 to 14.
- 34 children (54.8%) were male.
- 31 children (50.0%) were white.
- 30 children (48.4%) were black.
- 9 children (14.5%) were Hispanic.

Causes of Death:

- 2 (3.2%) deaths were due to cancer.
- 16 (25.8%) deaths were due to congenital anomalies.
- 1 (1.6%) death was due to malnutrition (homicide).
- 33 (53.2%) deaths were due to prematurity.

Circumstances:

- 5 children (8.1%) were not receiving treatment for the medical condition.
- 45 children (72.6%) were receiving treatment for the medical condition within 48 hours of death.
- In 46 cases (74.2%), death was the expected result of the medical condition.
- Out of the 5 cases for which family compliance was necessary for treatment, 2 (40.0%) were not compliant.
- None of the cases were associated with any type of outbreak.

Sleep-Related Deaths

A total of 18 deaths (18.8%) reviewed by the CDRT were determined to be sleep-related: (All 5 unintentional asphyxia deaths (4 infants, 1 child aged 1 to 4 years) are included.)

Demographics:

- 17 deaths (94.4%) occurred to children less than one year of age.
- 10 deaths (55.6%) occurred to white children.
- 8 deaths (44.4%) occurred to black children.
- 1 death (5.6%) occurred to a Hispanic child.
- 11 deaths (61.1%) were male.

Risk factors:

- 12 children (66.7%) were not placed to sleep in a crib or bassinette.
- 8 children (44.4%) were not sleeping on their back.
- 7 children (38.9%) were placed to sleep on unsafe bedding or with toys.
- 8 children (44.4%) were sleeping with other people.
- 2 children (11.1%) were sleeping with an obese adult.
- In 1 case (5.6%) the supervising adult was drug impaired.
- In 1 case (5.6%) there was poor or absent supervision.
- In 2 cases (11.1%) child neglect or other negligence was involved.

Circumstances:

- 7 children (38.9%) were found with nose and mouth unobstructed by person or object.
- 1 child (5.6%) was found dead on top of another person.
- 3 children (16.7%) were found under an object (blankets, towels, stuffed animals, etc.).
- 2 children (11.1%) were found wedged (i.e. between mattress and wall).
- 2 children (11.1%) were found pressed into an object (i.e. mattress or blankets).
- The circumstances were unknown in 3 deaths (16.7%).

Motor Vehicle Deaths

There were a total of 4 deaths (4.2%) due to motor vehicle crashes.

Demographics:

- 2 deaths (50.0%) occurred to teens aged 15 to 17.
- 1 death (25.0%) occurred to a child aged 1 to 4.
- 1 death (25.0%) occurred to a child aged 5 to 9.
- 3 deaths (75.0%) were male.
- 2 deaths (50.0%) were black.

Circumstances:

- 2 children were passengers in the vehicle.
- 2 children were on bicycles that were hit by a vehicle.
- Seatbelts were present and not used in 1 incident, and used incorrectly in 1 incident.
- A helmet was needed but not present in 1 incident.
- A child seat was needed but not present in 1 incident.
- Speeding was indicated in 1 incident, and driver inexperience was a factor in 1 incident.
- Driving conditions were normal in 3 incidents, and in 1 incident the road was snowy.
- The child was responsible for causing the incident in 1 case, and the child's driver was responsible in 1 case.

Poisoning, Fire/Burn, and Fall/Crush Deaths

There were a total of 5 deaths (5.2%) resulting from poisoning, fires, and crushing.

Poisoning

There were 3 deaths that resulted from poisoning.

Demographics:

- 2 deaths (66.7%) occurred to children aged 1 to 4.
- 2 deaths (66.7%) were female.
- 2 deaths (66.7%) were white.

Circumstances:

- 1 poisoning death was a homicide, 1 was unintentional, and the intent was undetermined on 1 death.
- The poisoning involved prescription drugs in 2 cases, and illegal drugs in 1 case.
- The substances were stored in an open area in 2 cases.
- Supervision was needed but absent in 2 cases.
- The Poison Control Center was not called in any of the deaths.

Fire/Burns

There were 2 deaths (2.1%) that resulted from fire.

Demographics:

- 1 child was less than 1 year, and the other child was aged 1 to 4 years.
- 1 death was male.
- 1 death was black.

Circumstances:

- A working smoke detector was present in 1 case.

Fall/Crush

There was 1 death that resulted from playground equipment tipping over and crushing a child.

Weapon-related Deaths

A total of 8 cases (8.3%) involved the use of weapons.

Demographics:

- 6 deaths (75.0%) occurred among teens aged 15 to 17 years.
- 7 deaths (87.5%) were male.
- 2 deaths (25.0%) were Hispanic.
- 6 deaths (75.0%) were black.

- 1 death (12.5%) was white.
- 1 death (12.5%) was Asian.

Circumstances:

- All weapon-related deaths were homicides.
- 7 cases involved firearms, and 1 case involved a child being beaten to death.
- 3 incidents were gang-related.
- 2 incidents involved someone playing with the weapon.
- 2 incidents followed an argument.
- 1 incident was a drive-by shooting.
- 1 incident involved the use of the weapon during the commission of a crime.
- In 1 case, the victim had a history of weapon-related offenses.
- In 2 cases, someone in the child's family either had a history of weapon offenses, or had a previous member of the family die from weapon-related causes.

Acts of Omission or Commission

Acts of omission or commission are defined as any act or failure to act that either causes or substantially contributes to the death of a child. This section is designed to elucidate any human behaviors that may be involved in a child's death. A total of 20 deaths reviewed by the CDRT involved an act of omission (i.e. neglect) or commission (i.e. abuse or assault).

Demographics:

- 4 deaths (20.0%) occurred among infants.
- 6 deaths (30.0%) occurred among children aged 1 to 4 years.
- 7 deaths (35.0%) occurred among teens aged 15 to 17 years.
- 12 (60.0%) deaths were male.
- 2 (10.0%) deaths were Hispanic.
- 12 (60.0%) deaths were black.
- 7 (35.0%) deaths were white.
- 1 (5.0%) death was Asian.

Circumstances:

- 3 cases involved poor or absent supervision.
- 2 cases involved physical child abuse.
    - In 1 case, the abuse was chronic with the child.
    - In 1 case, the abuse was a pattern within the family.
    - There was an open Child Protective Services (CPS) case at the time of 1 death, and CPS action was taken as a result of both deaths.
    - In both cases, the biological parent was responsible for the abuse and had a history of previous child maltreatment as a perpetrator.
    - The biological parent had a history of substance abuse in 1 case.
- 4 cases involved child neglect.
    - 1 case involved abandonment.
    - 1 case involved a failure to provide necessities.
    - 2 cases involved a failure to protect from hazards.
    - The neglect was chronic with the child in 1 case and a pattern in the family in 1 case.
    - 2 cases had open CPS investigations at time of death, and CPS took action in all 4 cases as a result of the death.
    - The biological parent was responsible for the neglect in all 4 cases.
- 6 cases involved other negligence.
- In half of the cases, the acts of omission or commission caused the death of the child, and among these 8 were intentional.
- Among the other half of the cases, the act of omission or commission contributed to the death of the child, and among these 3 were intentional.

Child Deaths from 2006 to 2008

Small numbers of events often makes it difficult to discern patterns and possibilities for prevention. For this reason, all deaths reviewed by the Davidson County CDRT from 2006 through 2008 were analyzed in aggregate.

The CDRT reviewed a total of 330 deaths from 2006 to 2008.

- 75 deaths (22.7%) were judged to have been preventable, and in 32 deaths (9.7%)

preventability could not be determined.

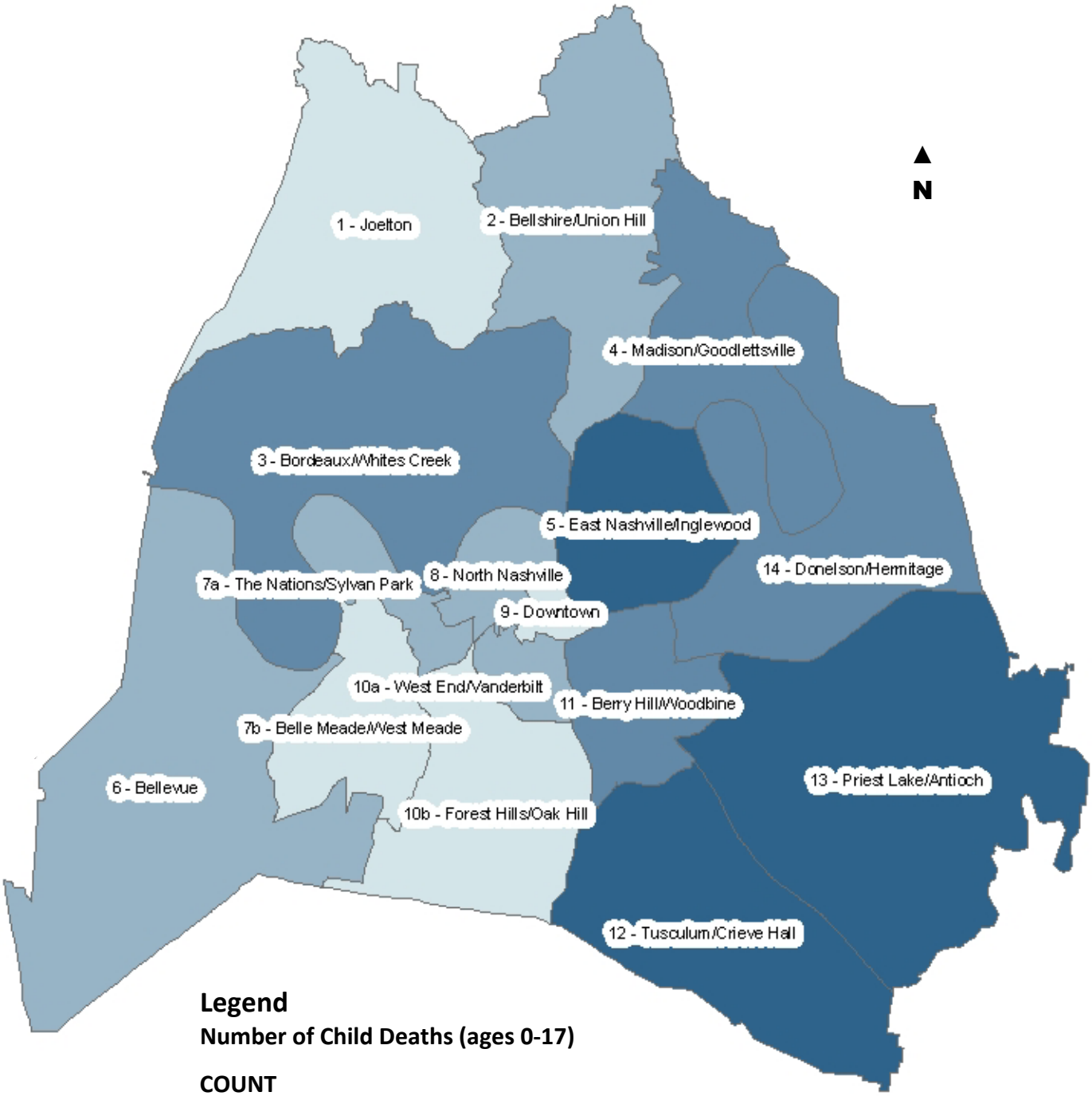
- The CDRT team disagreed with the official manner of death in 18 cases (5.5%), and disagreed with the official cause of death in 9 cases (2.7%).
- Investigation found evidence of prior abuse in 9 cases (2.7%), and action was taken by Child Protective Services (CPS) as a result of the death in 14 cases (4.2%).

See map, next page.

The Priest Lake/Antioch, Tusculum/Crieve Hall, and East Nashville/Inglewood health planning districts had the greatest number of deaths (32-53 deaths) to children aged 0 to 17 during the years 2006 through 2008.

The next highest frequency of child deaths (17-31 deaths) occurred in the Bordeaux/Whites Creek, Madison/Goodlettsville, Donelson/Hermitage, and Berry Hill/Woodbine health planning districts.

Child Deaths by Health Planning District
Davidson County, TN 2006-2008



Legend

Number of Child Deaths (ages 0-17)

COUNT

1-7 8-16 17-31 32-53

Data Sources: Child Death Review Team
Map Layout: Burns Rogers, Epidemiology, Feb. 19, 2010
This map and/or data is for general reference only. The Metro Public Health Department assumes no liability for the misuse or misinterpretation of the data.

Demographics, Risk Characteristics, and Manner of Death by Age Group

The CDRT in Davidson County reviewed a total of 330 deaths from 2006 through 2008. 233 (70.6%) of the cases reviewed were of children less than 1 year of age. Of these:

- 120 (51.5%) were white.
- 106 (45.5%) were black.
- 1 (0.4%) was a Pacific Islander.
- 4 (1.7%) were Asian.
- 37 (15.9%) were Hispanic.
- 167 (71.7%) were premature (less than 37 weeks gestation).
- 169 (72.5%) were low birth weight (less than 2500 grams).
- 38 (16.3%) experienced intrauterine smoke exposure.
- 14 (6.0%) experienced intrauterine drug exposure.
- 61 (26.2%) mothers received late or no prenatal care.

The leading causes of death for reviewed infants are as follows:

- 111 deaths (47.6%) resulted from prematurity.
- 42 deaths (18.0%) resulted from congenital anomalies.
- 14 deaths (6.0%) resulted from asphyxia.
- 5 deaths (2.1%) resulted from pneumonia.
- 6 deaths (2.6%) resulted from Sudden Infant Death Syndrome (SIDS).
- 22 deaths (9.4%) resulted from unknown causes.

Demographics and manner of death of the remaining 97 reviewed deaths are as follows:

- 35 deaths (10.6% of total) occurred to children aged 1 to 4:
    - 19 deaths: black
    - 15 deaths: white
    - 1 death: Asian

- 4 deaths: Hispanic
- 18 deaths: female
- 12 deaths: natural
- 13 deaths: unintentional injury
- 4 deaths: homicide

- 12 deaths (3.6% of total) occurred to children aged 5 to 9:
  - 7 deaths: white
  - 5 deaths: black
  - 8 deaths: male
  - 5 deaths: natural
  - 5 deaths: unintentional injury
- 20 deaths (6.1% of total) occurred to children aged 10 to 14:
  - 13 deaths: black
  - 7 deaths: white
  - 2 deaths: Hispanic
  - 11 deaths: male
  - 14 deaths: natural
  - 2 deaths: unintentional injury
  - 1 deaths: homicide
- 30 deaths (9.1% of total) occurred to children aged 15 to 17:
  - 15 deaths: black
  - 13 deaths: white
  - 2 deaths: Asian
  - 5 deaths: Hispanic
  - 25 deaths: male
  - 5 deaths: natural
  - 10 deaths: unintentional injury
  - 13 deaths: homicide

Medical Conditions

A total of 233 deaths (70.6%) reviewed by the CDRT were determined to involve a medical condition.

Demographics:

- 192 deaths (82.4%) were to infants aged less than 1 year.
- 15 deaths (6.4%) occurred to children aged 1 to 4.
- 16 deaths (6.9%) occurred to children aged 10 to 14.
- 132 children (56.7%) were male.
- 117 children (50.2%) were white.
- 109 children (46.8%) were black.
- 31 children (13.3%) were Hispanic.

Causes of Death:

- 49 deaths (21.0%) were due to congenital anomalies.
- 10 deaths (4.3%) were due to cancer.
- 2 deaths (0.9%) were due to malnutrition (homicide).
- 120 deaths (51.5%) were due to prematurity.
- 8 deaths (3.4%) were due to pneumonia.
- 7 deaths (3.0%) were due to neurological and seizure disorders.
- 1 death (0.4%) was due to asthma.
- 6 deaths (2.6%) were due to SIDS.

Circumstances:

- 8 children (3.4%) were not receiving treatment for the medical condition.
- 189 children (81.1%) were receiving treatment for the medical condition within 48 hours of death.
- In 187 cases (80.3%), death was the expected result of the medical condition.

- Out of the 45 cases for which family compliance was necessary for treatment, 4 (8.9%) were not compliant.
- None of the cases were associated with any type of outbreak.
- Environmental tobacco exposure was a contributing factor in 4 (1.7%) deaths.

Sleep-Related Deaths

A total of 51 deaths (15.5%) reviewed by the CDRT were determined to be sleep-related: (This includes 6 SIDS deaths, 16 asphyxia deaths, and 3 deaths from known medical conditions.)

Demographics:

- 46 deaths (90.2%) occurred to children less than one year of age.
- 25 deaths (49.0%) occurred to white children.
- 26 deaths (51.0%) occurred to black children.
- 6 deaths (11.8%) occurred to Hispanic children.
- 25 deaths (49.0%) were male.

Risk factors:

- 34 children (66.7%) were not placed to sleep in a crib or bassinette.
- 26 children (51.0%) were not sleeping on their back.
- 17 children (33.3%) were placed to sleep on unsafe bedding or with toys.
- 22 children (43.1%) were sleeping with other people.
- 3 children (5.9%) were sleeping with an obese adult.
- In 2 cases (3.9%), the supervising adult was drug impaired.

Circumstances:

- 19 children (37.3%) were found with nose and mouth unobstructed by person or object.
- 1 child (2.0%) was found dead on top of another person.
- 3 children (5.9%) were found under an object (blankets, towels, stuffed animals, etc.).
- 7 children (13.7%) were found wedged (i.e. between mattress and wall).

- 6 children (11.8%) were found pressed into an object (i.e. mattress or blankets).
- The circumstances were unknown in 6 deaths (11.8%).

Motor Vehicle Deaths

There were a total of 20 deaths (6.1%) due to motor vehicle crashes.

Demographics:

- 8 deaths (40.0%) occurred to teens aged 15 to 17.
- 7 deaths (35.0%) occurred to a child aged 1 to 4.
- 4 deaths (20.0%) occurred to a child aged 5 to 9.
- 12 deaths (60.0%) were male.
- 11 deaths (55.0%) were black.
- 9 deaths (45.0%) were white.
- 2 deaths (10.0%) were Hispanic.

Circumstances:

- 13 children (65.0%) were passengers in the vehicle.
- 2 children (10.0%) were drivers.
- 2 children (10.0%) were on bicycles that were hit by a vehicle.
- Seatbelts were present and not used in 5 incidents (25.0%) and used incorrectly in 2 incidents (10.0%).
- A helmet was needed but not present in 1 incident (5.0%).
- A child seat was needed but not present in 2 incidents (10.0%).
- Speeding was a factor in 5 incidents (25.0%), unsafe driving was a factor in 2 incidents (10.0%), and reckless driving was involved in 2 incidents (10.0%).
- Drugs and alcohol were involved in 5 incidents (25.0%).
- Driving conditions were normal in 15 incidents (75.0%).
- The child was responsible for causing the incident in 2 cases (10.0%), and the driver of the child's vehicle was responsible in 8 cases (40.0%).

Poisoning, Fire/Burn, and Fall/Crush Deaths

There were a total of 10 deaths (3.0%) resulting from poisoning, fires, and falls or crush injuries.

Poisoning

There were 3 deaths that resulted from poisoning.

Demographics:

- 2 deaths occurred to children aged 1 to 4.
- 2 deaths were female.
- 2 deaths were white.

Circumstances:

- 1 poisoning death was a homicide, 1 was unintentional, and the intent was undetermined on 1 death.
- The poisoning involved prescription drugs in 2 cases and other substances in 1 case.
- The substances were stored in an open area in 2 cases.
- Supervision was needed but absent in 2 cases.
- The Poison Control Center was not called in any of the deaths.

Fire/Burns

There were 3 deaths (0.9%) that resulted from fire.

Demographics:

- 1 child was less than 1 year, 1 child was aged 1 to 4 years, and 1 child was aged 10 to 14 years.
- 2 deaths were female.
- 2 deaths were black.

Circumstances:

- A working smoke detector was present in 1 case.
- None of the cases involved arson.

Fall/Crush

There was 1 death due to a fall and 3 deaths due to crush injuries. In the fall death, the child fell from stairs on to concrete. Objects causing crushing injuries include playground equipment and a television.

Weapon-related Deaths

A total of 21 cases (6.4%) involved the use of weapons.

Demographics:

- 13 deaths (61.9%) occurred among teens aged 15 to 17 years.
- 17 deaths (81.0%) were male.
- 6 deaths (28.6%) were Hispanic.
- 13 deaths (61.9%) were black.
- 7 deaths (33.3%) were white.
- 1 death (4.8%) was Asian.

Circumstances:

- 20 weapon-related deaths were homicides, and 1 was an unintentional injury death.
- 12 cases involved firearms, 3 cases involved the use of sharp instruments, 4 cases involved a child being beaten or otherwise physically abused, and 1 case involved the use of a blunt instrument.
- Child supervision was needed but not provided in 2 cases.
- 4 incidents involved the commission of a crime.
- 6 incidents were gang-related.
- 3 incidents involved someone playing with the weapon.
- 4 incidents followed an argument.
- 1 incident was a drive-by shooting.
- In 3 cases the victim had a history of weapon-related offenses.

- In 3 cases someone in the child's family either had a history of weapon offenses or had a previous member of the family die from weapon-related causes.

Suicide

The CDRT reviewed 3 incidents (0.9%) of suicide during the years 2005 through 2008. All 3 cases resulted from self-induced asphyxia. One child was aged 5 to 9, and the remaining 2 children were aged 15 to 17.

Acts of Omission or Commission

Acts of omission or commission are defined as any act or failure to act that either causes or substantially contributes to the death of a child. This section is designed to elucidate any human behaviors that may be involved in a child's death. A total of 28 deaths (8.5%) reviewed by the CDRT involved an act of omission (i.e. neglect) or commission (i.e. abuse or assault).

Demographics:

- 7 deaths (25.0%) occurred among infants.
- 11 deaths (39.3%) occurred among children aged 1 to 4 years.
- 7 deaths (25.0%) occurred among teens aged 15 to 17 years.
- 16 (57.1%) deaths were male.
- 6 (21.4%) deaths were Hispanic.
- 16 (57.1%) deaths were black.
- 11 (39.3%) deaths were white.
- 1 (3.6%) death was Asian.

Circumstances:

- 3 cases involved poor or absent supervision.
- 6 cases involved physical child abuse.
    - In 2 cases, the abuse was chronic with the child.
    - In 2 cases, the abuse was a pattern within the family.

- In 1 case, the abuse was an isolated incident.
- There was an open Child Protective Services (CPS) case at the time of 2 deaths, and CPS action was taken as a result of the death in 4 cases.
- The biological parent was responsible for the abuse in 5 cases and had a history of previous child maltreatment as a perpetrator in 4 cases.
- The biological parent had a history of substance abuse in 2 cases.

- 6 cases involved child neglect.
  - 1 case involved abandonment.
  - 2 cases involved a failure to provide necessities.
  - 2 cases involved a failure to protect from hazards.
  - The neglect was chronic with the child in 3 cases and a pattern in the family in 1 case.
  - 3 cases had open CPS investigations at time of death, and CPS took action as a result of the death in 5 cases.
  - The biological parent was responsible for the neglect in 6 cases.
- 8 cases involved other negligence.
- The acts of omission or commission caused the death of the child in 14 incidents, and among these 12 were intentional.
- The act of omission or commission contributed to the death of the child in 17 incidents, and among these 3 were intentional.

Child Death Review Team Members For 2008

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Appendix

Manner of Death by Age Group, Davidson County, 2008 and 2006-2008

	Age Group					
2008						
Manner	**<1**	**1-4**	**5-9**	**10-14**	**15-17**	**Total**
Natural	44	2	1	5	2	54
Unintentional Injury	5	4	2	0	2	13
Suicide	0	0	0	0	0	0
Homicide	1	2	0	1	6	10
Undetermined	11	3	0	1	0	15
Unknown	4	0	0	0	0	4
Total	65	11	3	7	10	96
2006-2008						
Natural	177	12	5	14	5	213
Unintentional Injury	16	13	5	2	10	46
Suicide	0	0	1	0	2	3
Homicide	3	4	1	1	13	22
Undetermined	27	6	0	2	0	35
Unknown	10	0	0	1	0	11
Total	233	35	12	20	30	330

Deaths by Manner and Preventability, Davidson County, 2008 and 2006-2008

Could the Death Have Been Prevented?					
2008					
Manner	**No**	**Yes**	**Could not determine**	**Unknown**	**Total**
Natural	50	0	2	2	54
Unintentional Injury	0	13	0	0	13
Suicide	0	0	0	0	0
Homicide	0	10	0	0	10
Undetermined	2	1	12	0	15
Unknown	4	0	0	0	4
Total	56	24	14	2	96
2006-2008					
Natural	204	2	5	2	213
Unintentional Injury	0	46	0	0	46
Suicide	0	3	0	0	3
Homicide	0	22	0	0	22
Undetermined	6	2	27	0	35
Unknown	11	0	0	0	11
Total	221	75	32	2	330

Characteristics of Infant Deaths by Manner of Death Listed on Death Certificate, Davidson County, 2008 and 2006-2008

	Manner of Death on Death Certificate						
	Natural	Unintentional Injury	Homicide	Undetermined	Unknown	Total	
2008	N	N	N	N	N	N	%
Deaths Reviewed	44	5	1	11	4	65	100.0
Premature (<37 weeks)	42	3	0	1	4	50	76.9
Low Birth Weight (<2500 grams)	42	3	0	3	4	52	80.0
Intrauterine Smoke Exposure	3	1	0	4	1	9	13.8
Intrauterine Drug Exposure	0	0	0	0	1	1	1.5
Late(>6 weeks) or No Prenatal Care	11	0	0	1	2	14	21.5
2006-2008							
Deaths Reviewed	177	16	3	27	10	233	100.0
Premature (<37 weeks)	149	5	0	4	9	167	71.7
Low Birth Weight (<2500 grams)	147	5	1	7	9	169	72.5
Intrauterine Smoke Exposure	23	4	0	10	1	38	16.3
Intrauterine Drug Exposure	10	1	0	2	1	14	6.0
Late(>6 weeks) or No Prenatal Care	46	3	2	6	4	61	26.2

*Categories are not mutually exclusive.

Appendix

Factors Involved in Sleep-Related Deaths By Age Group, Davidson County, 2008 and 2006-2008

	Age Group							
2008	**0-1 mos**	**2-3 mos**	**4-5 mos**	**6-7 mos**	**8-11 mos**	**1-4 years**	**Total**	**%**
Deaths Reviewed	4	6	3	1	3	1	18	100.0
Not in a crib or bassinette	3	4	1	1	2	1	12	66.7
Not sleeping on back	1	5	2	0	0	0	8	44.4
Placed on unsafe bedding or with toys	0	4	1	1	0	1	7	38.9
Sleeping with other people	3	3	0	0	2	0	8	44.4
Obese adult sleeping with child	1	1	0	0	0	0	2	11.1
Adult was alcohol or drug impaired	0	0	0	0	0	1	1	5.6
2006-2008								
Deaths Reviewed	12	16	7	4	7	5	51	100.0
Not in a crib or bassinette	9	10	4	3	4	4	34	66.7
Not sleeping on back	6	11	5	2	2	0	26	51.0
Placed on unsafe bedding or with toys	2	9	3	2	0	1	17	33.3
Sleeping with other people	6	9	1	1	3	2	22	43.1
Obese adult sleeping with child	1	2	0	0	0	0	3	5.9
Adult was alcohol or drug impaired	0	0	0	0	0	2	2	3.9

*Categories are not mutually exclusive

Appendix

Acts of Omission and Commission By Age Group, Davidson County, 2008 and 2006-2008

2008	Deaths Reviewed	Poor/Absent Supervision	Child Abuse	Child Neglect	Other Negligence	Assault (not child abuse)	Suicide	Other
<1 year	4	0	1	2	2	0	0	0
1-4 years	6	2	1	1	2	0	0	0
5-9 years	1	0	0	0	1	0	0	0
10-14 years	2	1	0	1	0	0	0	1
15-17 Years	7	0	0	0	1	3	0	3
Total	20	3	2	4	6	3	0	4
2006-2008								
<1 year	7	0	3	3	2	0	0	0
1-4 years	11	2	3	2	4	0	0	1
5-9 years	1	0	0	0	1	0	1	0
10-14 years	2	1	0	1	0	0	0	1
15-17 Years	7	0	0	0	1	3	2	3
Total	28	3	6	6	8	3	3	5

*Categories are not mutually exclusive

Appendix