Child Deaths in Davidson County, Tennessee 2003

Ninth Annual Report
Released October 2005

Child Deaths in Tennessee
Davidson County, 2003

Author: Brook McKelvey, M.A., M.P.H
Epidemiologist II
Metropolitan Public Health Department

Leaders of the Child Death Review Team

Stephanie B. C. Bailey, M.D., M.S.H.S.A., **Team Chair**
Director, Metropolitan Public Health Department

Bruce Levy, M.D., **Team Vice-Chair**
Nashville and Davidson County Medical Examiner
State of Tennessee Medical Examiner

Jannie Williams, M.P.A., **Team Staff Support**
Executive Assistant to the Director of Health
Metropolitan Public Health Department

Table of Contents

Appendix

List of Figures

List of Tables

List of Maps

Executive Summary

The Child Death Review Team (CDRT) in Davidson County is a multi-disciplinary group that works to understand the causes of death of resident children under the age of 18 years. Founded in 1994 by a Mayoral Executive Order, the team is directed to affect system and policy change, thereby preventing future deaths. Members of the team represent a variety of disciplines including public health, law enforcement, medicine, and social service.

In Davidson County during the year 2003, 92 resident children died. The CDRT determined the manner of death to be natural causes for 80.4% (74 deaths) of the cases, and unintentional injuries for 12.0% (11 deaths). Homicide accounted for 4.3% (4 deaths) of the cases reviewed, and suicide accounted for 1.1% (1 death). The manner of death could not be determined for 2.2% (2 deaths) of the cases reviewed.

The largest group of child deaths occurred among children less than one year of age (71.7%, 66 deaths), and of those deaths, 45.5% (30 deaths) survived less than one day after birth. Nearly 92.4% (61 deaths) of those deaths to children less than one year of age resulted from natural causes. The next largest group of child deaths occurred among children aged 13 – 17 years (16.3%, 15 deaths). Of those deaths to children aged 13 – 17 years, 33.3% (5 deaths) died from unintentional injuries.

Each year, the CDRT makes recommendations for policy and service changes based on the results of child death investigations in an effort to prevent future childhood mortality. For the year 2003, the CDRT acknowledges that there may be a gap in services for pregnant women who are mentally challenged, and recommends case management for mentally challenged expecting women in order to improve compliance with prenatal care.

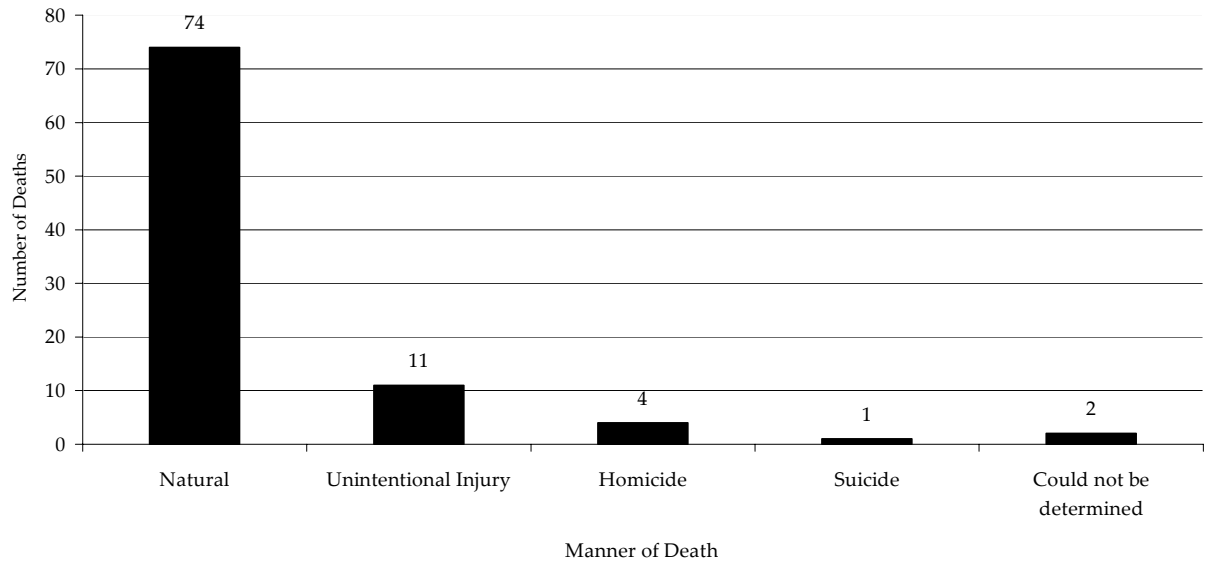
Overview of Child Deaths in Davidson County for 2003

There were a total of 92 fatalities recorded among resident children under the age of 18 in 2003 for Davidson County. The Child Death Review Team (CDRT) conducted a mutli-disciplinary team review of all 92 deaths. This report presents the findings and recommendations of the team.

The CDRT judged 10.9% of the birth certificates and 33.7% of the death certificates to be incomplete or inaccurate. Errors and incomplete information in vital statistics data have the potential of hindering the efforts of the CDRT. The types of errors found on birth certificates include inaccurate prenatal care information, incomplete recording of maternal medical risk factors, and incorrect recording of abnormalities of the child at birth. Death certificate errors tend to be primarily errors of omission. The fields most commonly left blank are manner of death and whether or not an autopsy was performed. Despite incomplete information, the CDRT agreed with the manner of death indicated on the death certificate in 89.1% of the cases. The manner of death was not indicated on the death certificate for 9.8% of the cases. In those instances, the manner of death was determined by the CDRT.

The CDRT determined the manner of death to be natural causes for 80.4% (74 deaths) of the cases and unintentional injuries for 12.0% (11 deaths). Homicide accounted for 4.3% (4 deaths) of the cases reviewed, and suicide accounted for 1.1% (1 death). The manner of death could not be determined for 2.2% (2 deaths) of the cases reviewed. (**See Figure 1.**)

Figure 1. Number of Deaths by Manner of Death, Davidson County, Tennessee, 2003



The largest group of child deaths occurred among children less than one year of age (71.7%, 66 deaths), and of those deaths, 45.5% (30 deaths) survived less than one day after birth. Nearly 92.4% (61 deaths) of those deaths to children less than one year of age resulted from natural causes. The next largest group of child deaths occurred among children aged 13 – 17 years (16.3%, 15 deaths). Of those deaths to children aged 13 – 17 years, 40.0% (6 deaths) died from natural causes. (**See Table 1., on page 3.**)

Table 1. Number and Percentage of Deaths by Manner of Death and Age, Race, and Sex, Davidson County, Tennessee, 2003

	Total		Age							Sex		Race			
			Detail of Cases < 1 year			All Cases									
Manner of Death	N	%	<1 day	1-28 days	29-364 days	< 1 year	1-5 years	6-12 years	13-17 years	Male	Female	White	Black	Other	Unknown
Natural	74	80.4	30	13	18	61	4	3	6	48	26	33	39	2	0
Unintentional Injury	11	12.0	0	0	2	2	2	2	5	7	4	6	5	0	0
Homicide	4	4.3	0	0	1	1	0	0	3	4	0	0	3	1	0
Suicide	1	1.1	0	0	0	0	0	0	1	1	0	1	0	0	0
Undetermined[1]	0	0.0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Determined[2]	2	2.2	0	0	2	2	0	0	0	1	1	2	0	0	0
Total	92	100	30	13	23	66	6	5	15	61	31	42	47	3	0
Percentage*	100		32.6	14.1	25.0	71.7	6.5	5.4	16.3	66.3	33.7	45.7	51.1	3.3	0.0

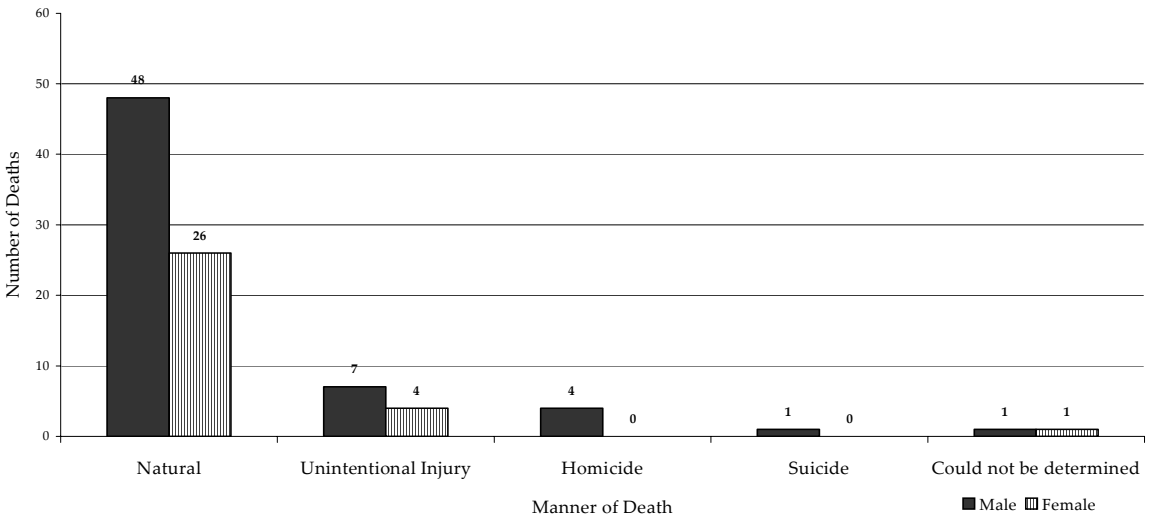
[1]Undetermined due to suspicious circumstances

[2]Could not be determined

*Percentage of total deaths

By sex, 66.3% of child deaths in Davidson County during 2003 were male. More males than females died of natural causes (48 male deaths, 26 female deaths), unintentional injuries (7 male deaths, 4 female deaths), homicide (4 male deaths, 0 female deaths), and suicide (1 male death, 0 female deaths). (**See Figure 2.**)

Figure 2. Number of Deaths by Manner of Death and Sex, Davidson County, Tennessee, 2003



By race, 45.7% of child deaths were reported as White, 51.1% were reported as Black, and 3.3% were reported as other races. Nearly 12% of child deaths were recorded as Hispanic. (Data not shown.) The number of Black deaths due to natural causes was 18.2% higher than the number of White deaths; however, the number of Black deaths due to unintentional injury was 16.7% lower than the number of White deaths. (**See Figure 3.**)

Figure 3. Number of Deaths by Manner of Death and Race, Davidson County, Tennessee, 2003

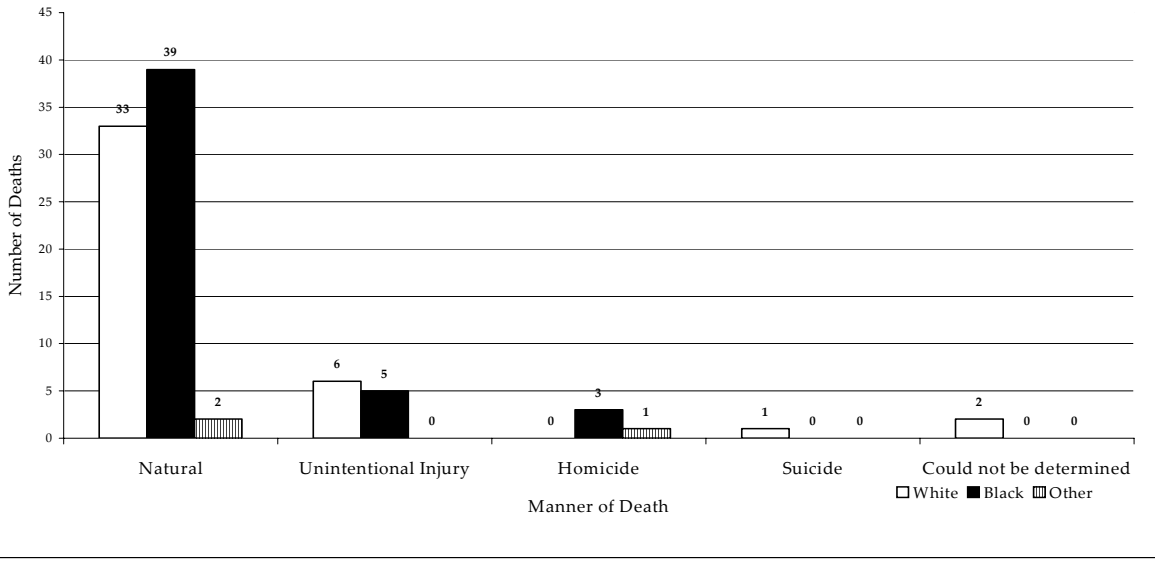


Table 2 depicts the number and percentage of child deaths by manner of death and maternal age at birth. In 2003, over half of all deaths occurred to children born to mothers between the ages of 20 and 29. Of these, 87.3% were due to natural causes. Approximately 19.0% of all deaths occurred in children born to mothers between the ages of 30 and 39. Of the deaths in this age category, nearly 68.8% were due to natural causes. The remaining deaths occurred to children born to mothers aged less than 20 years (11.9%) or 40 years old and older (3.6%).

Table 2. Number and Percentage of Deaths by Manner of Death and Maternal Age, Davidson County, Tennessee, 2003

	Total		Maternal Age in Years					
Manner of Death	**N**	**%**	**13-14**	**15-17**	**18-19**	**20-29**	**30-39**	**40+**
Natural	69	82.1	0	3	4	48	11	3
Unintentional Injury	8	9.5	0	0	0	5	3	0
Homicide	4	4.8	0	1	0	1	2	0
Suicide	1	1.2	0	0	0	1	0	0
Undetermined[1]	0	0.0	0	0	0	0	0	0
Not Determined[2]	2	2.4	0	1	1	0	0	0
Total[3]	84	100	0	5	5	55	16	3
Percentage*	100		0.0	6.0	6.0	65.5	19.0	3.6

[1]Undetermined due to suspicious circumstances

[2]Could not be determined

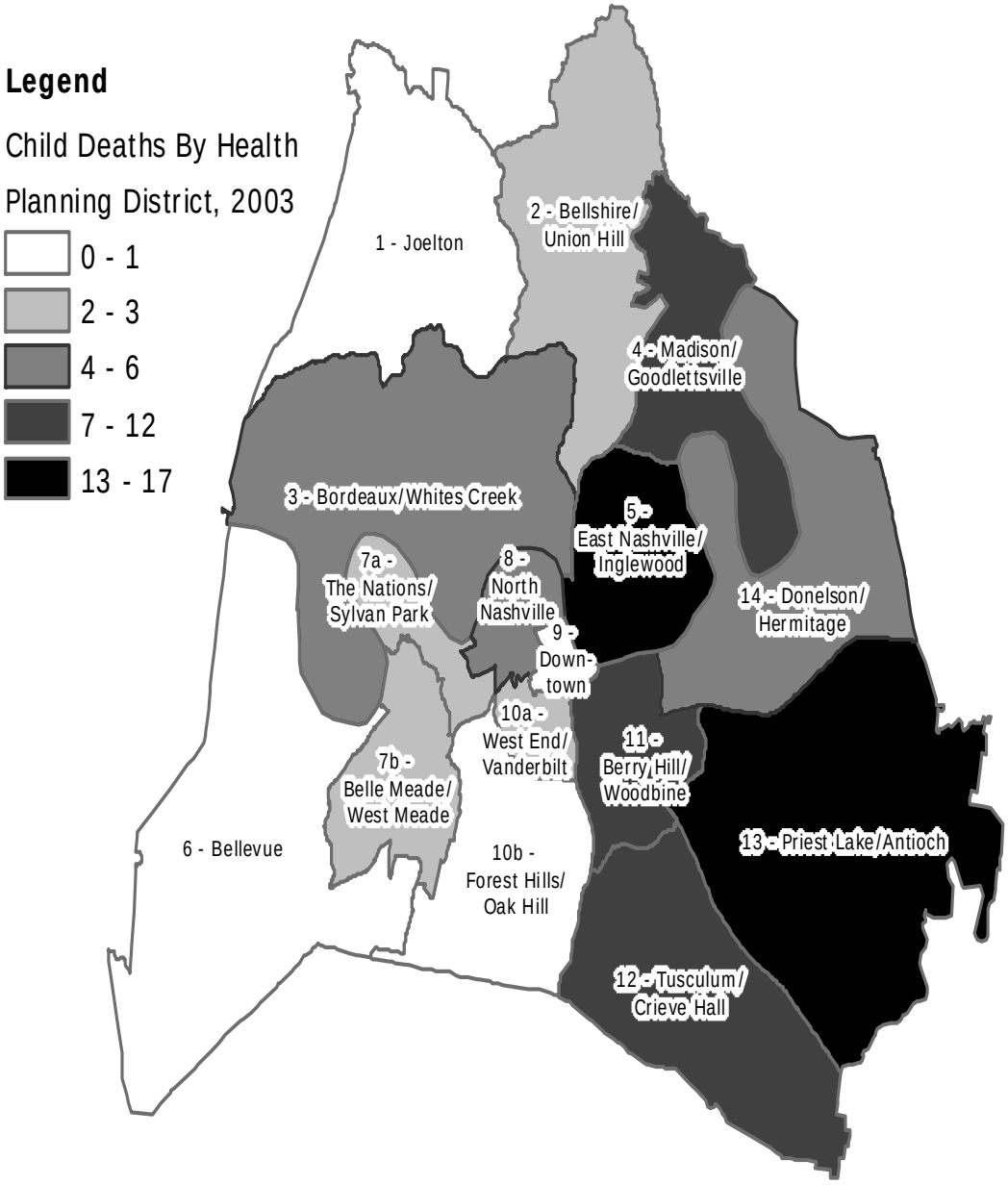
[3]Maternal age was not reported for 8 deaths. These deaths are excluded from this portion of the analysis.

*Percentage of total deaths

The CDRT evaluates the existence of a history with Child Protective Services (CPS), the presence of abuse and neglect, and evidence of a delay in seeking medical treatment with each child death. In some cases, there is enough evidence to raise suspicion of abuse or neglect, but not enough evidence to provide a definitive answer. In those situations, the CDRT marks the case as unknown.

In 2003, 8.7% (8 deaths) of cases had prior involvement with Child Protective Services. The CDRT suspected child abuse and neglect in 2.2% (2 cases) of the child death cases. One case of suspected abuse and neglect also had Child Protective Services involvement. Approximately 2.2% (2 cases) of cases demonstrated evidence of a delay in seeking medical treatment for the child.

As depicted in the map on page 6, most of the child deaths in Davidson County during 2003 occurred in two planning districts, namely the 13th planning district of Priest Lake/Antioch, and the 5th planning district of East Nashville/Inglewood with 13 – 17 deaths each. Planning Districts with the next highest rankings (7-12 deaths) are Madison/Goodlettsville (4th district), Berry Hill/ Woodbine (11th district), and Tusculum/Crieve Hall (12th planning district).



Note: This map is based on 92 child deaths in Davidson County during 2003.

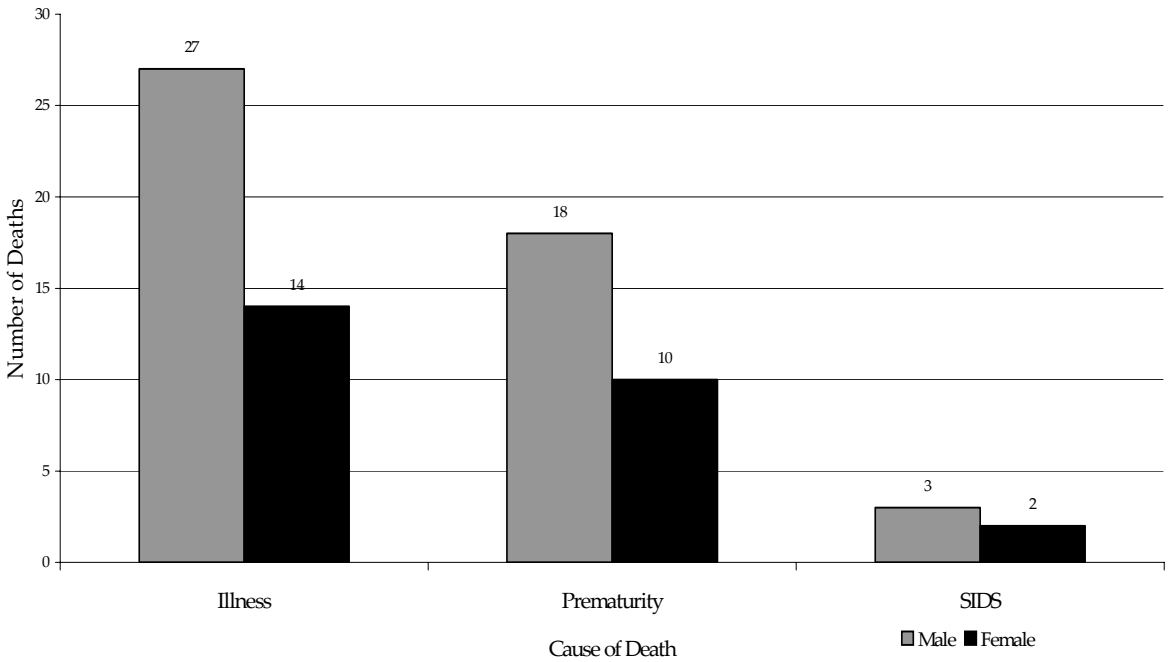
Deaths Due to Natural Causes

In Davidson County during 2003, there were 74 child deaths due to natural causes. These 74 deaths represented 80.4% of all child deaths. Of these deaths due to natural causes, 55.4% resulted from illness or other natural cause, 37.8% resulted from prematurity, and 6.8% were due to Sudden Infant Death Syndrome (SIDS). (**See Table 3., on page 8.**)

The majority of deaths due to a natural cause involved infants, with 82.4% occurring among children less than one year of age. Among these infant deaths due to natural causes, 49.2% involved newborns less than one day old, 21.3% involved infants less than one month old, and 29.5% involved infants less than one year old. Beyond one year of age, the age group with the greatest number of deaths was children 13-17 years of age (8.1%).

There were more male deaths due to natural causes (64.9%, 48 deaths) than female deaths (35.1%, 26 deaths). Male deaths outnumbered female deaths for each specific cause of death as well. The number of male deaths due to illness or other natural cause was 92.9% higher than the number of female deaths. Additionally, the number of male deaths due to prematurity was 80.0% higher than the number of female deaths. (**See Figure 4.**)

Figure 4. Number of Deaths Due to Natural Causes by Sex, Davidson County, Tennessee, 2003

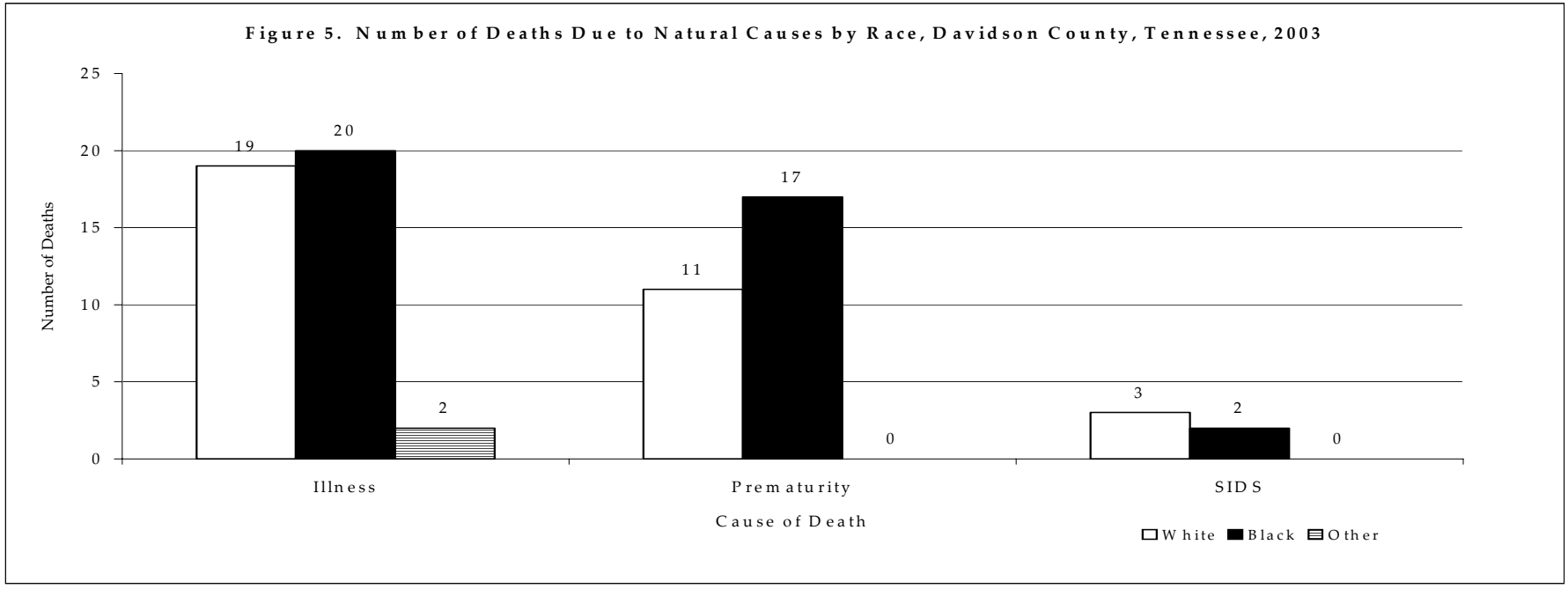


By race, 44.6% of natural deaths were reported as White, 52.7% were reported as Black, and 2.7% were reported as other races. The number of Black deaths due to illness or other natural causes was 5.3% higher than the number of White deaths. Similarly, the number of Black deaths due to prematurity was 54.5% higher than the number of White deaths due to the same cause. (**See Figure 5., on page 8.**)

Table 3. Number and Percentage of Deaths Due to Natural Causes by Age, Sex, and Race, Davidson County, Tennessee, 2003

	Total		Age							Sex		Race			
			Detail of Cases < 1 year			All Cases									
Cause of Death	N	%	<1 day	1-28 days	29-364 days	< 1 year	1-5 years	6-12 years	13-17 years	Male	Female	White	Black	Other	Unknown
Illness or Other Natural Cause	41	55.4	10	6	12	28	4	3	6	27	14	19	20	2	0
Prematurity	28	37.8	20	6	2	28	0	0	0	18	10	11	17	0	0
SIDS	5	6.8	0	1	4	5	0	0	0	3	2	3	2	0	0
Total	74	100	30	13	18	61	4	3	6	48	26	33	39	2	0
Percentage*	100		40.5	17.6	24.3	82.4	5.4	4.1	8.1	64.9	35.1	44.6	52.7	2.7	0.0

*Percentage of total deaths

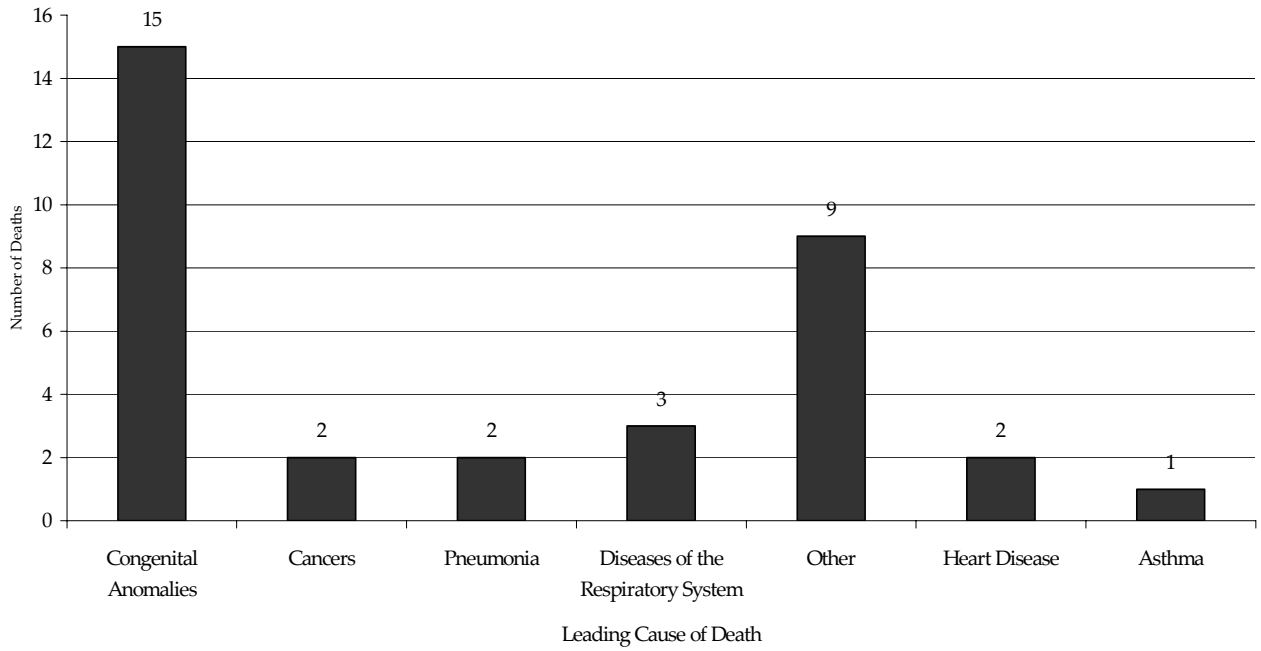


Deaths Due to Natural Causes: Illness or Other Natural Cause

Forty-one children died from illnesses or other natural conditions in Davidson County during the year 2003. These 41 deaths represented 55.4% of all deaths due to natural causes and nearly 44.6% of all child deaths for the year. The majority (68.3%) of all deaths due to illnesses involved children less than 1 year of age. The percentage of male deaths (65.9%) from illness or other natural causes was higher than the percentage of female deaths (34.1%). The number of Black deaths due to illness and other natural causes was 5.3% higher than the number of White deaths. (**See Table 3.**)

The leading natural cause of death was congenital anomalies, accounting for 15 deaths (36.6%). The second leading cause of death was conditions originating in the perinatal period, accounting for 6 deaths (14.6%). The category labeled as "other" contained deaths of undetermined cause and deaths that did not fit into any other category. As such, it was a remainder grouping and did not count as a true cause of death. (**See Figure 6.**)

Figure 6. Leading Causes of Death Due to Illness and Other Natural Causes, Davidson County, Tennessee, 2003



Deaths Due to Natural Causes: Prematurity

Twenty-eight infants died from complications due to prematurity in Davidson County during the year 2003. These 28 deaths represented 37.8% of all deaths due to natural causes and 30.4% of all deaths of children in 2003.

Examining prematurity deaths by gestational age revealed that 7 deaths (26.9%) were 22 weeks or less gestational age (very premature), 19 (73.1%) were between 23 and 37 weeks gestational age (premature), and the gestational age was not reported for 2 cases. Among the deaths due to prematurity born at 22 weeks or less gestation, 100.0% died within 24 hours of birth. By birth weight, 5 (71.4%) of these very premature births weighed less than 500 grams, and 2 (28.6%) very premature births weighed between 500 and 1,499 grams.

Among the infants born at 23 to 37 weeks gestational age, 13 (68.4%) died within 24 hours of birth, 4 (21.1%) died within the first 28 days of life, and 2 (10.5%) died between 29 and 364 days of life. By birth weight, 4 (21.1%) premature births weighed less than 500 grams, and 15 (78.9%) weighed between 500 and 1,499 grams. (**See Table 4., on page 11.**)

There were disparities in deaths due to prematurity for both sex and race. More male deaths (64.3%) were due to prematurity than female deaths (35.7%). Similarly, the number of Black deaths due to prematurity was 60.0% higher than the number of deaths for Whites.

Deaths Due to Natural Causes: SIDS

Five children died as a result of SIDS in Davidson County during the year 2003. These 5 deaths represented 6.8% of all deaths due to natural causes and 5.4% of all child deaths.

Examining risk factors related to SIDS, sleeping position was not reported for 2 of the 5 deaths. Among cases where sleeping position was reported, all 3 were put to sleep on their back. The presence of smoking in the house was not reported for 1 of the 5 deaths. Of the remaining 4 deaths for which information is available, 2 reported having a smoker in the household.

Deaths Due to Unintentional Injury

Eleven children died due to unintentional injuries in Davidson County during 2003. These 11 deaths represented 12.0% of all childhood deaths. The majority of these deaths resulted from vehicular incidents (72.7%). The next most common cause of unintentional injury death was suffocation (18.2%), followed by drowning (9.1%). (**See Table 5., on page 11**).

By age, the greatest number of deaths due to unintentional injury occurred among children aged 13 to 17 years (5 cases). Deaths among males (7 cases) were higher than the number of deaths among females (4 cases). Whites comprised the majority of injury related deaths (54.5%), while Blacks accounted for 45.5% of these deaths. (**See Table 5., on page 11.**)

Table 4. Number and Percentage of Deaths Due to Prematurity by Gestational Age, Age at Death, Birth Weight, Sex, and Race, Davidson County, Tennessee, 2003

	Total		Age			Birth weight in grams					Sex		Race			
Gestational Age	N	%	<1 day	1-28 days	29-364 days	<500	500-1499	1500-2499	2500+	Unknown	Male	Female	White	Black	Other	Unknown
22 weeks or less	7	26.9	7	0	0	5	2	0	0	0	4	3	2	5	0	0
23 - 37 weeks	19	73.1	13	4	2	4	15	0	0	0	14	5	8	11	0	0
Total[1]	26	100	20	4	2	9	17	0	0	0	18	8	10	16	0	0
Percentage[2]	100		76.9	15.4	7.7	34.6	65.4	0.0	0.0	0.0	69.2	30.8	38.5	61.5	0.0	0.0

[1]Gestational age was not reported on 2 deaths. These deaths were excluded from this part of the analysis.

[2]Percentage of total deaths

Table 5. Number and Percentage of Deaths Due to Unintentional Injury by Age, Sex, and Race, Davidson County, Tennessee, 2003

	Total		Age				Sex		Race		
Cause of Death	N	%	< 1 year	1-5 years	6-12 years	13-17 years	Male	Female	White	Black	Other
Vehicular	8	72.7	1	0	2	5	4	4	5	3	0
Firearm	0	0.0	0	0	0	0	0	0	0	0	0
Drowning	1	9.1	0	1	0	0	1	0	1	0	0
Suffocation	2	18.2	1	1	0	0	2	0	0	2	0
Fire/Burn	0	0.0	0	0	0	0	0	0	0	0	0
Poisoning	0	0.0	0	0	0	0	0	0	0	0	0
Total	11	100	2	2	2	5	7	4	6	5	0
Percentage*	100		18.2	18.2	18.2	45.5	63.6	36.4	54.5	45.5	0.0

*Percentage of total deaths

Table 6. Number and Percentage of Deaths Due to Violence by Age, Sex, and Race, Davidson County, Tennessee, 2003

		Total		Age All Cases				Sex		Race		
Manner of Death	Cause of Death	N	%	< 1 year	1-5 years	6-12 years	13-17 years	Male	Female	White	Black	Other
Homicide	Fire/Burn	0	0.0	0	0	0	0	0	0	0	0	0
	Firearm	3	60.0	0	0	0	3	3	0	0	3	0
	Inflicted Injury	1	20.0	1	0	0	0	1	0	0	0	1
	Suffocation	0	0.0	0	0	0	0	0	0	0	0	0
Suicide	Suffocation	0	0.0	0	0	0	0	0	0	0	0	0
	Vehicular	0	0.0	0	0	0	0	0	0	0	0	0
	Firearm	1	20.0	0	0	0	1	1	0	1	0	0
	Total	5	100	1	0	0	4	5	0	1	3	1
	Percentage[1]	100		20.0	0.0	0.0	80.0	100.0	0.0	20.0	60.0	20.0

[1]Percentage of total deaths

Deaths Due to Unintentional Injury: Motor Vehicle Crashes

Eight children died in motor vehicle crashes in Davidson County during the year 2003. These eight deaths represented 72.7% of all deaths due to unintentional injuries and 8.7% of all child deaths. The numbers of deaths for males and females were equivalent (4 deaths each). Whites comprised the majority of all vehicular deaths (62.5%), with Blacks accounting for 37.5% of vehicular deaths. (**See Table 5., on page 12.**)

With regards to age, 62.5% of vehicular deaths occurred among children aged 13 to 17 years. The next highest number of deaths occurred among children aged 6 to 12 years (25.0%), followed by children aged less than 1 year (12.5%). There were no vehicular deaths in 2003 to children aged 1 to 5 years.

The fatally injured child was the driver in 2 of the incidents resulting in death, the passenger in 3 of the incidents, and a pedestrian in 1 fatal incident. The position of the victim was unknown for 2 incidents. Regarding safety belt usage, 3 incidents reported a safety belt in the vehicle, but not being used, and no case recorded proper safety belt usage. The details regarding safety belt usage were unknown for 3 incidents and not applicable for 2 deaths.

Examining the circumstances surrounding the motor vehicle crashes revealed that excessive speed was indicated in 5 cases, and other violations were indicated in 1 death. In one case, the victim was riding in the bed of a pick-up truck when the accident occurred. Normal road conditions were reported for 6 cases, and wet conditions were reported for 1 death. Information regarding road conditions was unknown in 1 death.

Deaths Due to Unintentional Injury: Drowning, Suffocation, Poisoning, Fire and Burns

During 2003 there were no unintentional deaths due to a firearm, fire, burns, or poisoning. There was 1 death due to drowning, and 2 deaths due to suffocation, and no cases due to either fire and burns or poisoning. Together these 3 deaths represented approximately 27.3% of all deaths due to unintentional injuries and 3.3% of all child deaths in 2003.

The single drowning death occurred in a swimming pool and the child was not using a flotation device. Overlying, or an individual rolling over or lying on top of the child, was the cause of 1 unintentional death due to suffocation. The other suffocation death resulted from the child being left in a closed hot vehicle.

Deaths Due to Violence: Homicide and Suicide

Violence-related deaths were those determined to be either suicides or homicides. There were a total of 5 violence-related deaths in Davidson County during the year 2003: 4 (80.0%) homicides and 1 suicide. Together, violence-related deaths comprised 5.4% of all childhood deaths. All of these deaths were male. Blacks comprised 60.0% of violence-related deaths, and Whites and other races comprised 20.0% each.

Four of the violence-related deaths were due to firearms, 3 homicides and 1 suicide. One death was caused by a shotgun, and the remaining firearm deaths involved the use of handguns. The home was the source of the firearm in 2 cases, was not the source of the firearm in 1 case, and was unknown in 1 case. The remaining homicide was a case of shaken baby syndrome.

Child Death Review Team Accomplishments for 2003

- ☐ The team reviewed 92 cases during 2003.
- ☐ The team remained cohesive and committed to the review of all cases. The team continues to show a high level of trust as they share very sensitive information.

Child Death Review Team Recommendations for 2003

- ☐ The team acknowledged that there may be a gap in services for pregnant women who are mentally challenged; case management of mentally challenged expecting women would likely improve compliance with prenatal care.

Overview of Child Deaths in Davidson County in 1994-2003

The Child Death Review Team in Davidson County has been actively reviewing cases since 1994. This section of the report shows the results of examining child deaths through time.

Methods

Since the state reporting form that guides the review process has changed through time, a retrospective review of each case was performed in 2003. Where applicable, categories were updated to conform to the most recent collection form in order to allow for comparability through time. For example, in 1994, premature deaths were categorized as illness or other natural cause deaths. During the review process, deaths that clearly resulted from prematurity were marked as such to allow for a more accurate measurement of the number of prematurity deaths through time.

Consistency was also applied to the racial designation assigned to the child. Race was typically recorded as the race of the child listed on the death certificate. If no race was listed, then the race assigned to the child was the race of the mother as listed on the birth certificate. Additionally, Hispanic status of the child was rarely recorded correctly on the death certificate. The child was designated as Hispanic if either the mother or the father was reported as Hispanic on the birth certificate.

Each address in the database was compared to information provided by the U.S. Census Bureau and assigned a census tract number based on the results. If the address indicated residence outside of Davidson County, that death was excluded from this analysis. Additionally, duplicate records were also excluded. For these two reasons, the numbers presented here may differ from those in previous reports. Table 7 depicts the number of deaths excluded due to residence for each year.

Table 7. Total Number of Cases Reviewed by the Child Death Review Team and the Number of Cases Excluded, Davidson County, Tennessee, 1994 - 2003

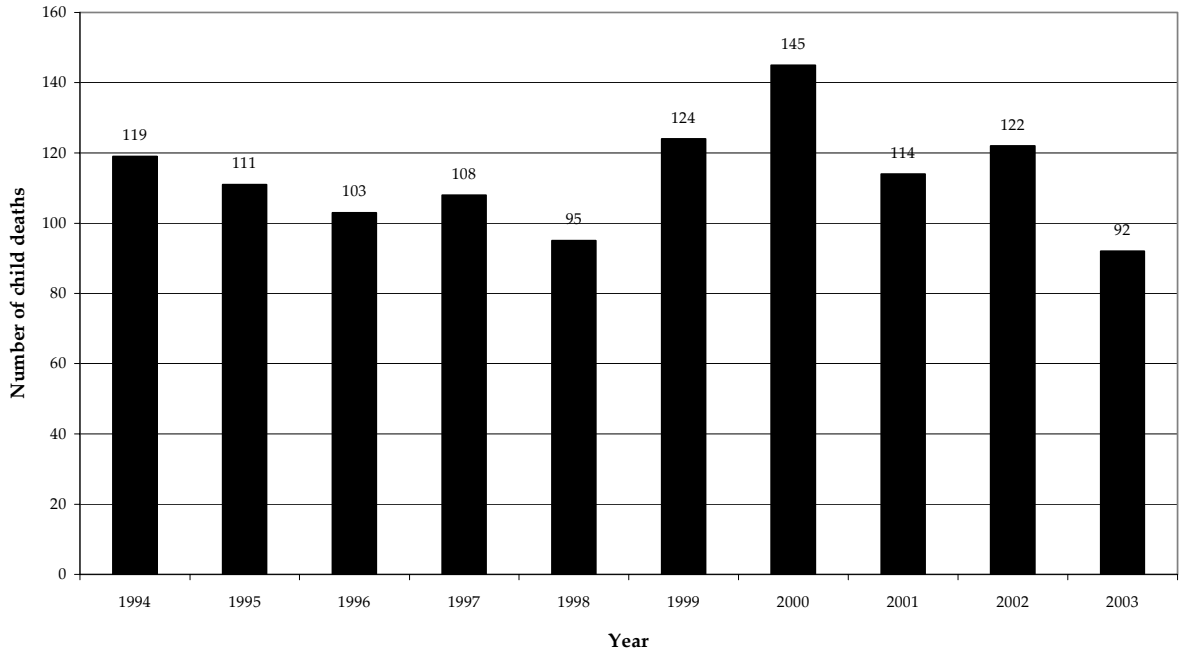
Year	Number of Cases	Number Excluded	Total Cases Reviewed
1994	129	10	119
1995	116	5	111
1996	105	2	103
1997	109	1	108
1998	95	0	95
1999	125	1	124
2000	145	0	145
2001	114	0	114
2002	123	1	122
2003	92	0	92

Results

Figure 7 shows the number of resident child deaths the team reviewed each year. There appears to be no steady trend, and the number of deaths in 2003 was 22.7% lower than the number of deaths in 1994.

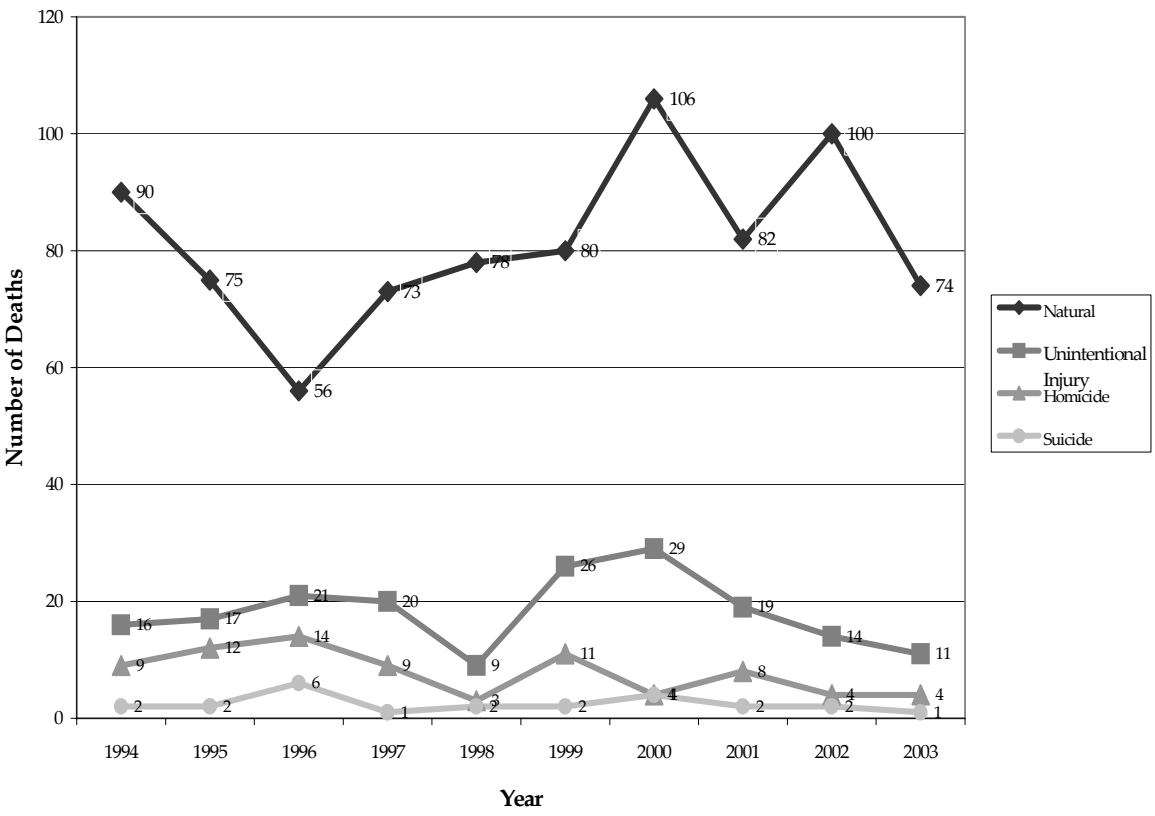
In 1994, the team reviewed a total of 119 deaths. This number steadily decreased to a low of 95 in 1998. From 1999 onward, the numbers of deaths have always been higher than 110, but show no discernable pattern until 2003 when there were only 92 deaths, the least ever reviewed by the CDRT. The greatest number of cases the team reviewed is 145 in the year 2000.

Figure 7. Number of Deaths to Resident Children Aged 17 Years and Younger, Davidson County, Tennessee, 1994 - 2003



When examining the number of cases by manner of death, the greatest number of child deaths in Davidson County occurred from natural causes. (**See Figure 8.**) This has been true from the time the Review Team was established until the most recent review year of 2003. The second leading manner of death is unintentional injuries, followed by homicide and suicide. Homicides and suicides consistently account for only a small number of child deaths.

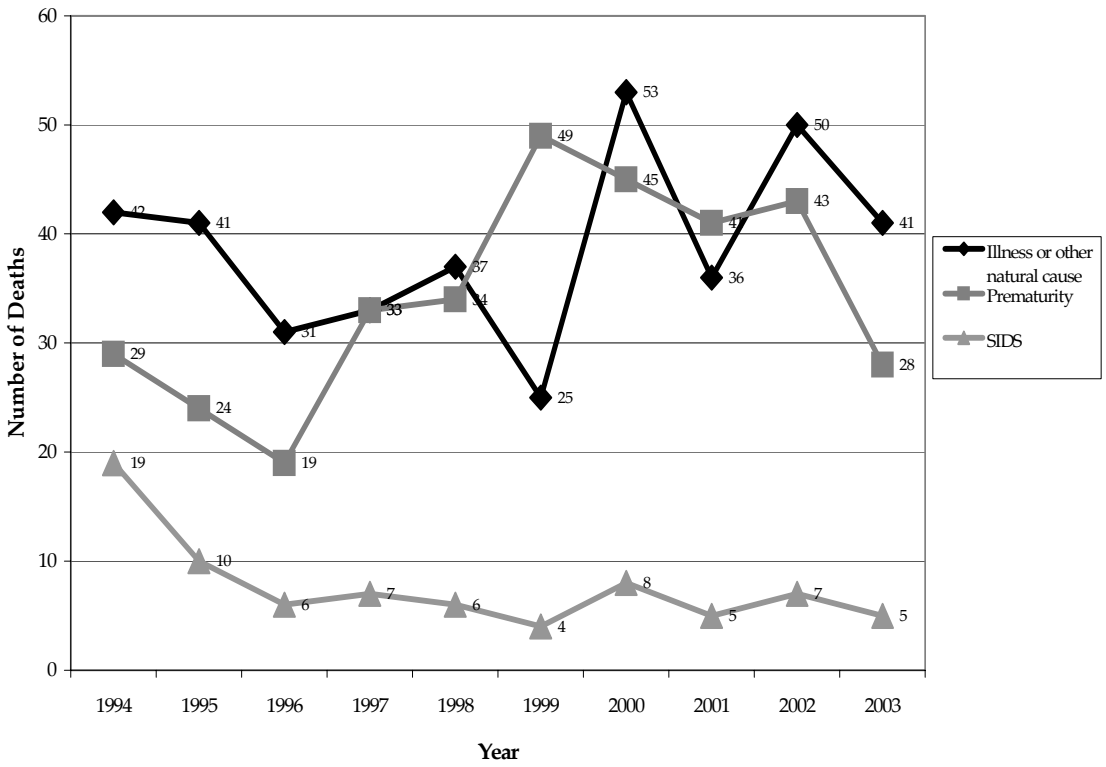
Figure 8. Number of Deaths to Resident Children Aged 17 Years and Younger by Manner of Death, Davidson County, Tennessee, 1994 - 2003



Although interrupted by distinct increases in 2000 and 2002, there was an 17.8% decrease in the number of deaths due to natural causes from 1994 to 2003.

The observed trend line for unintentional injuries appears to be more stable through time than the trend for natural deaths with a decrease annually from 2000 to 2003. The number of deaths due to unintentional injury in 2003 was 31.3% lower than in 1994.

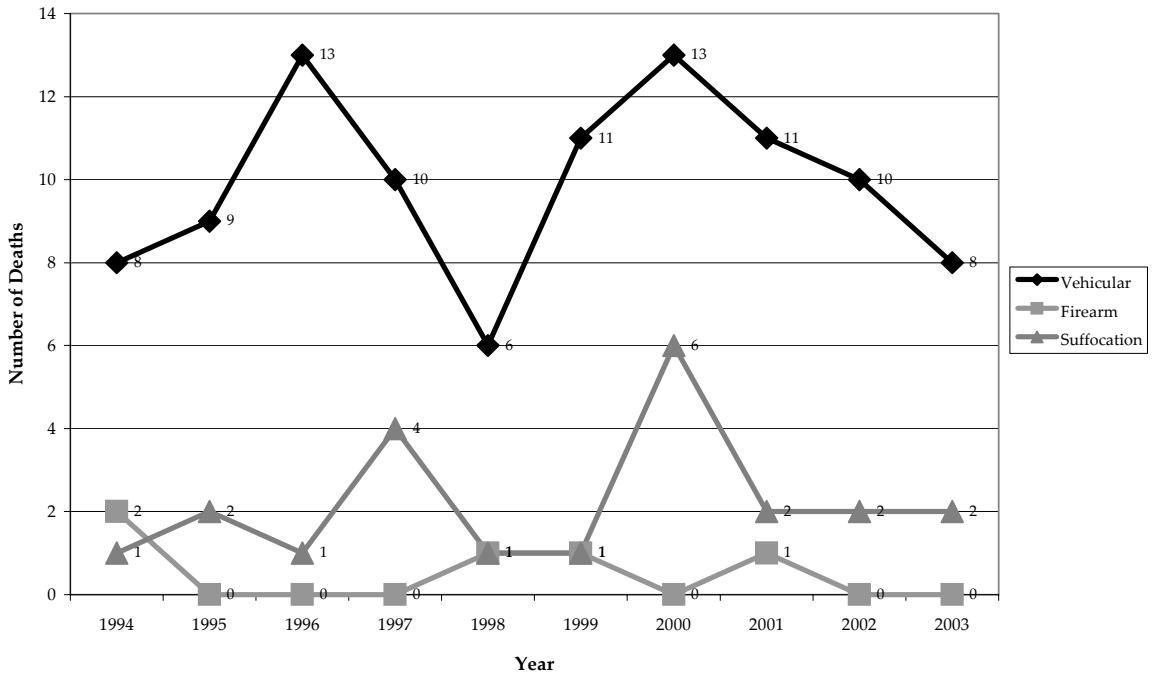
Figure 9. Number of Natural Deaths to Resident Children Aged 17 Years and Younger for Selected Causes of Death, Davidson County, Tennessee, 1994 - 2003



The leading causes of natural death in Davidson County to children aged 17 and younger from 1994 through 2003 were illnesses, prematurity, and SIDS. (**See Figure 9.**) The number of deaths due to illnesses and other natural causes increased 19% from 1994 until 2002 before declining 2003. Deaths due to prematurity have declined since 1999 with a 34.9% decrease from 2002 to 2003.

SIDS deaths decreased over time from 19 deaths in 1994 to 5 deaths in 2003 (73.7% decrease). The number of deaths due to this cause has remained fairly stable since 1996, ranging from a low of 4 deaths in 1999 to a high of 8 deaths in 2000.

Figure 10. Number of Deaths Due to Unintentional Injury to Resident Children Aged 17 Years and Younger for Selected Causes of Death, Davidson County, Tennessee, 1994 - 2003



When examining unintentional injury, there were consistently more vehicular deaths observed than any other cause of unintentional injury, including deaths due to firearms and suffocation. **(See Figure 10.)**

Comparison to Selected Counties in Tennessee

Table 8. Age-Specific Mortality Rates for Children Aged 0 to 17 Years for Selected Counties in Tennessee, 2003

County	Total Deaths	Population[1]	Rate[2]
Davidson	92	128104	71.8
Hamilton	72	70652	101.9
Knox	61	86822	70.3
Shelby	283	255113	110.9

[1]Population estimates and the data for Hamilton and Knox Counties were provided by the Tennessee State Department of Health.

[2]All Rates are per 100,000 population aged 0-17 years.

As seen in Table 8, when age-specific mortality rates for children aged 0 to 17 years in Davidson County were compared to rates for other metropolitan counties, Shelby County (110.9 per 100,000 population) had the highest rate of the areas compared. Hamilton County (101.9) followed Shelby County as the next highest, with Davidson County ranking third (71.8). Knox County (70.3) had the lowest mortality rate for children aged 0 to 17 years of all the areas compared.

Appendix

The Child Fatality Review Process

When a child dies:

1. The birth and death certificates are sent from the Metropolitan Public Health Department (MPHD) Vital Statistics staff to the Child Death Review Team data coordinator.

2. Copies of the birth and death records are sent to the Team members. Available records are requested from programs within the MPHD (HUG, Healthy Start, WIC, etc.).

3. All team members search their agency/hospital files and bring either the records or case summaries to team meetings.

4. The team meets once a month. At these meetings, each case is reviewed and the paperwork is completed.

5. The data coordinator enters the data into a database and sends the completed data forms to the State Fatality Review Program.

6. 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.

Child Death Review Team Data Collection Form, Side 1

This information is confidential

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

MCH 12/02

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

Child's Name: _____ (Last) _____ (First) _____ (Middle)

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

Address: _____ (Street) _____ (City) Zip Code: _____

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) Mother's Marital Status (at time of Child's birth): ☐ S ☐ M ☐ D ☐ W

Census Tract: _____ County of Residence _____

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

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: ___/___/___ | 4th 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 ☐ Unknown

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

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

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

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

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

Additional information for State office:

_____

_____

_____

_____

_____

Date case closed by CFRT: ___/___/___

PH-3668

Child Death Review Team Data Collection Form, Side 2

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:**
_____
_____
_____

BILL PURCELL, MAYOR

EXECUTIVE ORDER NO. 005

SUBJECT: Executive Order

The following Executive Orders are hereby reaffirmed:

Executive Order No. 88-02
Executive Order No. 88-08
Executive Order No. 89-04
Executive Order No. 89-06 Amended
Executive Order No. 89-08
Executive Order No. 89-09
Executive Order No. 89-15
Executive Order No. 90-04
Executive Order No. 90-06
Executive Order No. 91-01
Executive Order No. 91-02
Executive Order No. 91-03
Executive Order No. 91-04 Amended
Executive Order No. 91-05
Executive Order No. 91-06
Executive Order No. 91-07 Amended
Amened Executive Order No. 91-07 Revised
Executive Order No. 92-02
Executive Order No. 94-01
Executive Order No. 94-02
Executive Order No. 94-03
Executive Order No. 94-05
Executive Order No. 94-06
Executive Order No. 95-01
Executive Order No. 95-02
Executive Order No. 95-03
Executive Order No. 95-04
Executive Order No. 95-05
Executive Order No. 97-01
Executive Order No. 98-01
Executive Order No. 99-01
Executive Order No. 99-02
Executive Order No. 99-03 Revised
Executive Order No. 99-04
Executive Order No. 99-05
Executive Order No. 99-06
Executive Order No. 99-07

The following Executive Orders are not continued if effect beyond the date of this Order:

Executive Order No. 88-03
Executive Order No. 88-04
Executive Order No. 91-10
Executive Order No. 91-11
Executive Order No. 92-01
Executive Order No. 92-03
Executive Order No. 92-04
Executive Order No. 92-05
Executive Order No. 92-06
Executive Order No. 96-01

Ordered, Effective and Issued:

Bill Purcell
Mayor

Date: November 19, 1999

http://www.nashville.gov/mc/executive/bp_005.htm 6/3/2003

Executive Order No. 94-01

EXECUTIVE ORDER NO. 94-01

Subject: **Establishment of Child Death Review Team of the Metropolitan Government**

I, Philip Bredesen, Mayor of The Metropolitan Government of Nashville and Davidson County, by virtue of the power and authority vested in me, do hereby direct and order that:

1. A Child Death Review Team is hereby established for The Metropolitan Government of Nashville and Davidson County.

2. The Team shall have 10 members, consisting of the following:

   Director of the Metropolitan Department of Health
   Director of the Metropolitan Department of Social Services
   Chief of the Department of Metropolitan Police
   County Medical Examiner of Davidson County
   Medical Director of "Our Kids, Inc."

   The following elected officials are requested to serve as members of the Team or to designate representatives from their offices to do so:

   District Attorney General of the 20th Judicial District of Tennessee
   Judge of the Juvenile Court for Davidson County

   In addition, the Commissioner of the Tennessee Department of Human Services is requested to designate a representative to serve on the team.

   In addition to the foregoing, there shall be two other members, at least one of whom shall be a board certified pediatrician or a board certified child psychiatrist.

3. The purpose of the Team is to review the death of any child below 18 years of age legally residing in Davidson County at the time of death, irrespective of the location where the death occurred. In connection with its investigation, the Team shall assist in identifying information which could be pertinent in determining the manner of death in any unexpected child fatalities; identify preventable deaths and strategies for the prevention of future childhood fatalities, including any which might be related to limited access to health care; and collect statistical and other data and report annually to the Mayor relating how children are dying in Nashville and recommending appropriate strategies for prevention.

4. The Director of the Metropolitan Department of Health shall serve as the Chair of the Team.

Executive Order No. 94-01, Continued

5. The Team shall meet monthly. Special meetings may be called at the discretion of the Chair; the District Attorney; or the Medical Examiner.

6. Members of the Team shall serve without compensation; however, travel and related expenses may be reimbursed pursuant to the Metropolitan Government's travel regulations, with the approval of the Director of Finance.

7. The Team shall observe confidentiality to the maximum extent permitted by law.

8. The Director of Law or a designee from the Department of Law shall serve as legal advisor to the Team.

9. Subject to the approval of the appropriate department head, the Team may utilize the services of any staff or resources of the Metropolitan Government. The Chair may include non-voting advisory members on an ad hoc basis to assist with specific cases or issues under review.

This order shall become effective on January 1, 1994.

ORDERED THIS 7th DAY OF MARCH, 1994.

Philip Bredesen
Mayor

Child Fatality Review and Prevention Act of 1995

CHAPTER 142
CHILD FATALITY REVIEW AND PREVENTION

Section
68-142-101. Short title.
68-142-102. Child fatality prevention team.
68-142-103. Composition.
68-142-104. Voting members-Vacancies
68-142-105. Duties of state team.
68-142-106. Local teams-Composition-Vacancy-Chair-Meetings
68-104-107. Duties of local teams.
68-104-108. Powers of local team-Limitations-Confidentiality of state and local team records.
68-104-109. Staff and consultants.

68-104-101. 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.]

68-104-102. 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.]

68-141-103. 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;
(9) The executive director of the commission of children and youth;
(10)The president of the state professional society on the abuse of children;

Child Fatality Review and Prevention Act of 1995, Continued

(11)A team coordinator, to be appointed by the commissioner of health;
(12)The chair of the select committee on children and youth;

(11)A team coordinator, to be appointed by the commissioner of health;
(12)The chair of the select committee on children and youth;
(13)Two (2) members of the house of representatives to be appointed by the speaker of the house, at least one (1) of whom shall be a member of the house health and human resources committee; and
(14)Two (2) senators to be appointed by the speaker of the senate at least one (1) of whom shall be a member of the 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.]

Child Fatality Review and Prevention Act of 1995, Continued

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

(a) There shall be a minimum of one (1) local team in each judicial district;
(b) Each local team shall include the following statutory members or their designees;
(1) A supervisor of social services in the department of children's services within the area served by the team;
(2) The regional health officer in the department of health in the area served by the team 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.]

Child Fatality Review and Prevention Act of 1995, Continued

68-142-108. Posers 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 not 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.

Nashville Child Death Review Team Members

Stephanie B. C. Bailey, M.D., M.S.H.S.A
Director, Metropolitan Nashville Health Department
311 Twenty Third Avenue North
Nashville, TN 37203

Bonnie Beneke, LCSW
Old Harding Psychological Consultants
5819 Old Harding Road, Suite 204
Nashville, TN 37205

Andrea Bracikowski, M.D.
Vanderbilt University Medical Center
Director of Pediatric Emergency Medicine
703 Oxford House
1313 Twenty First Avenue South
Nashville, TN 37232-4700

Susan B. Campbell, M.D.
Middle Tennessee Neonatology Associates
Centennial Medical Center
2300 Patterson Street
Nashville, TN 37203

Mark Chesnut, Sergeant
Metropolitan Nashville Police Department
Youth Services Division
200 James Robertson Parkway
Nashville, TN 37201

Wilo Clark
Caring for Children
700-2nd Ave. South, Suite 200
Nashville, TN 37210

Margie Davis
Metropolitan Nashville Juvenile Court
100 Woodland Street
Nashville, TN 37213

Jessica Doyle
Juvenile Court of Nashville Davidson County
100 Woodland Street
Nashville, TN 37213

Eureva Elmore
Department of Children's Services
900 Second Avenue North
Nashville, TN 37243

Nashville Child Death Review Team Members, Continued

Christopher Greeley, M. D.
Vanderbilt Medical Center
5028 Medical Center East
Nashville, TN 37232-8555

Veronica Gunn, M.D, Asst. Professor
Division of General Pediatrics
Vanderbilt Medical Center
5028 Medical Center East
Nashville, TN 37232-8555

Brian K. Holmgren
Assistant District Attorney General
Office of the District Attorney General
222 2nd Avenue North
Nashville, TN 37201-1649

Bruce Levy, M.D., Medical Examiner
Tennessee Department of Health
Office of State Medical Examiner
Forensic Medicine Center
850 R.S. Gass Blvd.
Nashville, TN 37216-2640

Brook McKelvey, M.A., M.P.H.
Maternal and Child Health Epidemiologist
Metro Public Health Department
311 23rd Avenue North
Nashville, TN 37203

Michael Meadors, M. D.
301 Baptist Plaza I
2011 Church Street
Nashville, TN 37203

Katy Miller
Assistant District Attorney
District Attorney's Office Davidson County
222 Second Avenue North, Suite 500
Nashville, TN 37201

Olayinka Onadeko, M.S., M.D.
Chief of Pediatrics
Metropolitan Nashville General Hospital
1818 Albion Street
Nashville, TN 37208

Sue Ross, RNC, MSN, P.N.P
"Our Kids"
1804 Hayes Street
Nashville, TN 37203

Nashville Child Death Review Team Members, Continued

Patricia Slade, MBA, MSN, RN
Nursing Specialist
Department of Children's Services
900 Second Avenue, North
Nashville, TN 37243

Joaquin Toon, District Chief
Nashville Fire Department
Metro Ambulance Service
63 Hermitage Avenue
Nashville, TN 37210

Jannie Williams, M.P.A
Metro Public Health Department
311 23rd Avenue North
Nashville, TN 37203

Julius Witherspoon, M.P.A.
Metro Social Services
25 Middleton Street
Nashville, TN 37210

Kimberlee Wyche-Etheridge, M.D., M.P.H.
Metro Public Health Department
311 23rd Avenue, North
Nashville, TN 37203