




# Child Fatality Review



**CHATTANOOGA-HAMILTON  
COUNTY  
HEALTH DEPARTMENT**

**SARAH STUART CHEWNING, MPH  
EPIDEMIOLOGIST**





“Tennessee is part of a national movement to identify **why** children are dying and what **preventative** measures can be taken.”

- Tennessee Department of Health




# TN State Child Fatality Prevention Team

- Reviews reports from local teams
- Analyzes data
  - Incidences
  - Causes of death
- Makes recommendations to the Governor and General Assembly
  - promote the safety and well being of children



# **Child Fatality Review and Prevention Act of 1995**



- **Established statewide network of CFRTs**
  - **CFRTs established in TN's 31 judicial districts**
  - **Review all deaths of children 17 years or younger**
- 

# Who's required to be on the CFRT?

- Supervisor of social services in the dept of children's services
- Regional health officer in the dept of health
- Medical examiner
- Prosecuting attorney
- Employee of local education agency
- Local law enforcement officer
- Firefighter or EMS provider
- Mental health professional
- Pediatrician or family practice physician
- Juvenile court rep


# Local CFRT Duties

- Review all deaths of children 17 years or younger
- Collect data
- Submit data quarterly
- Submit recommendations annually
  - Advocate for system improvements and resources
- Participate in training provided by state team



# The Child Death Review Process




- Take a look at the form...
  - Let's take a closer look a couple of sections:
    - Incident Information
    - Investigation Information
- 



# The Child Death Review Process



- **Official Manner and Primary Cause of Death**
    - ◆ **Suffocation and Strangulation**
    - ◆ **Medical Condition**
  - **Other circumstances of incident**
  - **Prevention Initiatives Resulting from the Review**
- 

# Conducting an Effective Review

- **Share, question and clarify all case information**
- **Discuss the investigation**
- **Discuss the delivery of services**
- **Identify risk factors**
- **Recommend system improvements**
- **Identify and take action to implement prevention recommendations**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: Law Enforcement**

- **Provide the team with information on:**
  - **Case status and investigation of the death scene**
  - **Criminal histories of family members and suspects**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: Law Enforcement**

- **Provide the team with expertise on law enforcement practices such as:**
  - **Death scene investigation, interviews and interrogations of witnesses and others**
  - **Evidence collection**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: Law Enforcement**

- **Support the team with assistance, particularly by acting as a liaison to other law enforcement agencies by:**
  - **Persuading officers from other agencies and/or jurisdictions to participate on the CDR team when there is a death in that jurisdiction.**
  - **Providing access to and information from other law enforcement agencies**
  - **Providing assistance to member agencies in working with area law enforcement**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: Law Enforcement**

- **Help build bridges by:**
  - **Learning about the policies and practices of other agencies through team participation.**
  - **Acting as liaison between the CDR team and the jurisdiction's other law enforcement agencies.**
  - **Explaining to the team how to improve coordination with law enforcement agencies.**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: EMS**

- **Provide the team with information on:**
  - **EMS run reports**
  - **Details on the scene, including the persons at the scene**
  - **Medical information related to the emergency procedures performed**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: EMS**

- **Provide the team with expertise by:**
  - **Giving detailed explanations of EMS procedures and protocols**
  - **Sharing general knowledge based on EMS training and experience**
  - **Helping the team understand and/or participate in critical stress debriefings**

**Source: National MCH Center for Child Death Review**

# Selected Team Member Roles: EMS



- **Support the team by:**
  - **Understanding EMS procedures and protocols**
  - **Addressing issues regarding scene preservation practices**

**Source: National MCH Center for Child Death Review**

## **Selected Team Member Roles: EMS**

- **Help build bridges by:**
  - **Learning about scene preservation practices essential to investigation and prosecution**
  - **Acting as liaison between the team and the jurisdiction's EMS community**
  - **Working with law enforcement and district attorneys to resolve issues related to scene investigation**

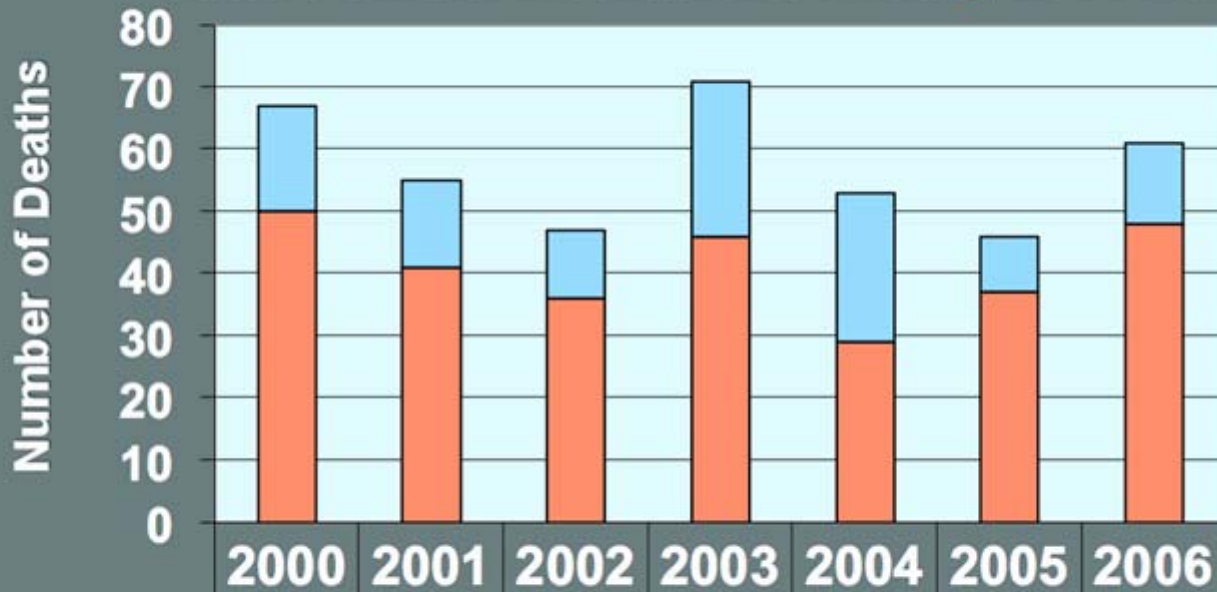
**Source: National MCH Center for Child Death Review**

# The BIG Picture: CFR Data

- **Yearly report to the CFRT**
- **Includes all CFs from the previous year**
- **Identify trends**
- **Spatial component?**

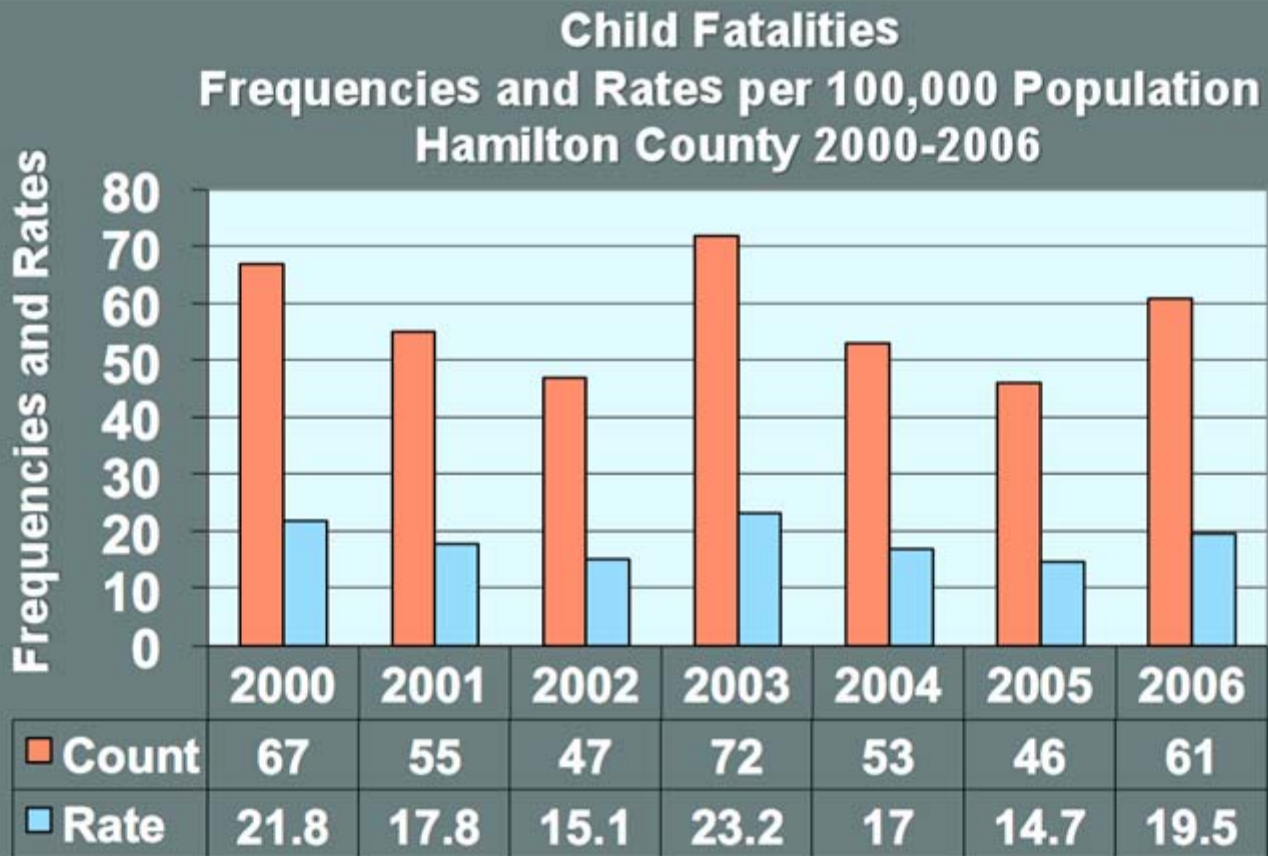
# CFR Report Data

## Child Fatalities: Hamilton County 2000-2006



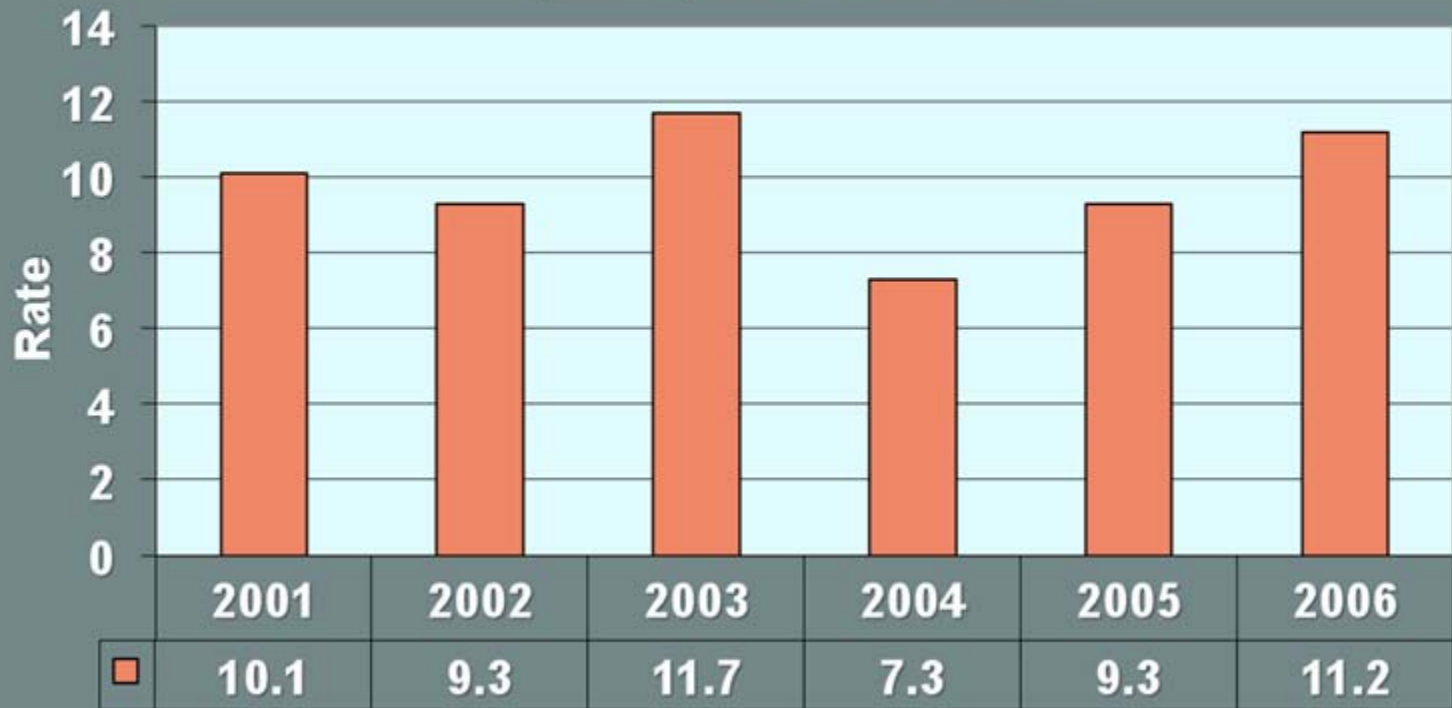
	2000	2001	2002	2003	2004	2005	2006
■ Ages 1-17	17	14	11	25	24	9	13
■ Infants	50	41	36	46	29	37	48

# CFR Report Data



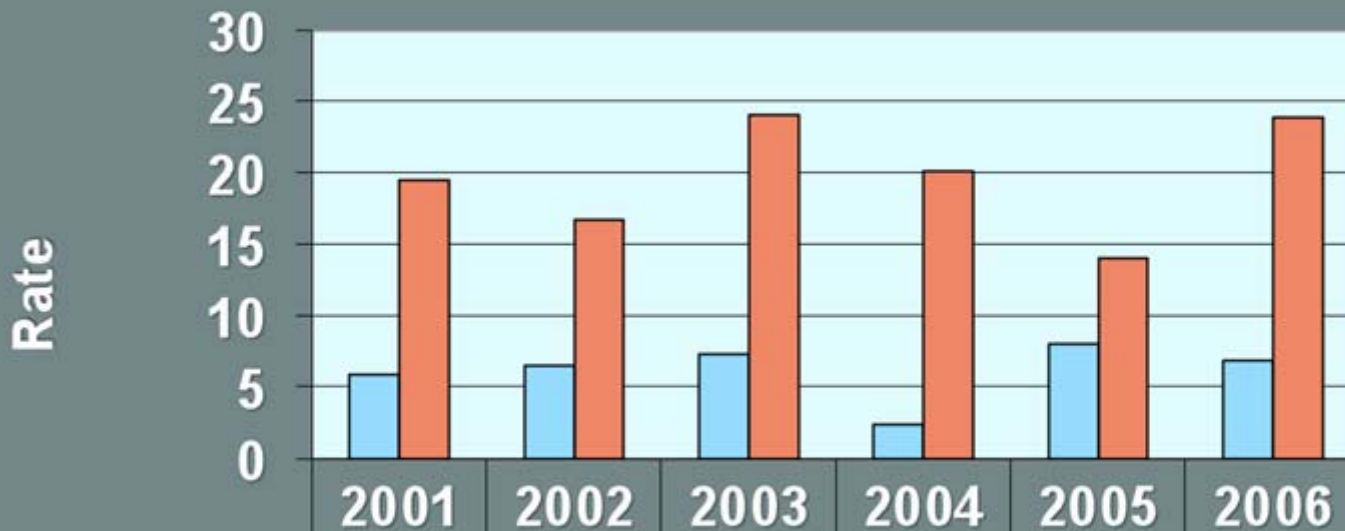
# CFR Report Data

## Hamilton County Infant Mortality Rates per 1,000 Live Births



# CFR Report Data

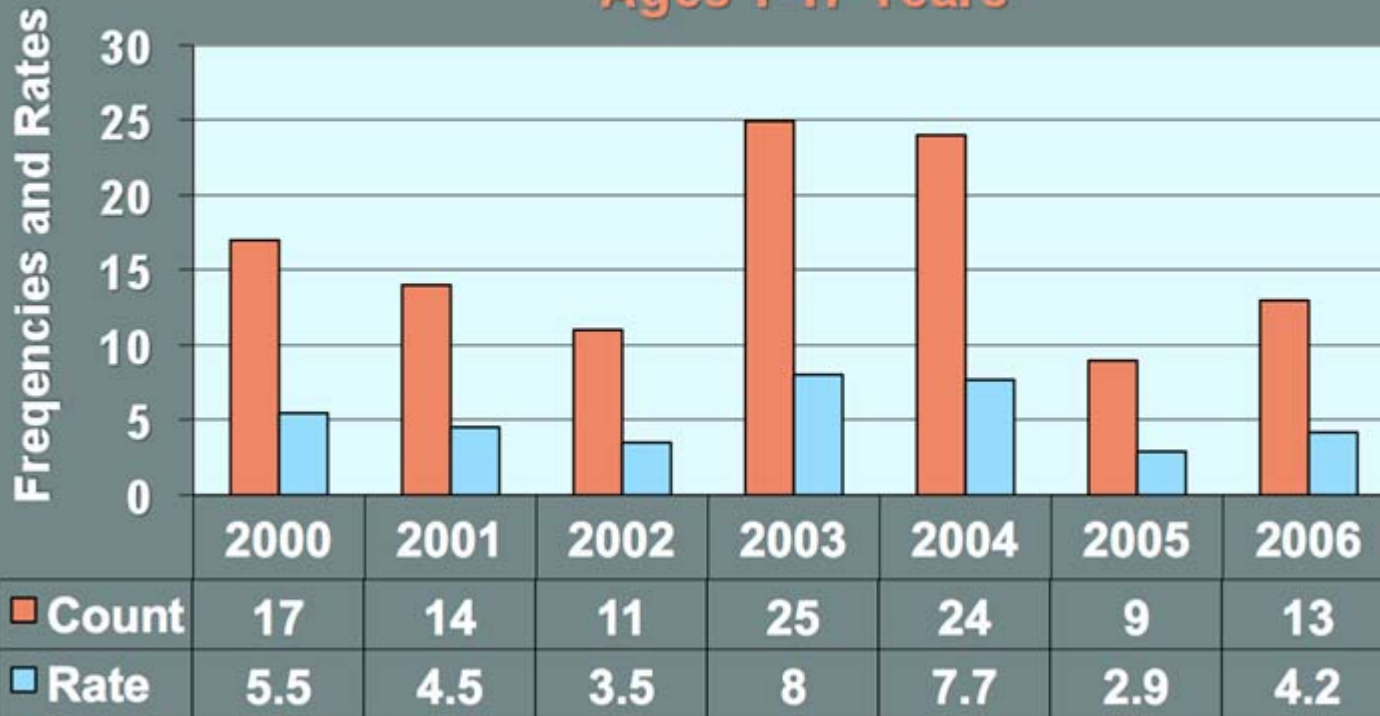
## Hamilton County Infant Mortality Rates by Race per 1,000 Live Births



■ White	5.9	6.5	7.3	2.4	8	6.9
■ Black	19.5	16.7	24.1	20.1	14	23.9

# CFR Report Data

**Child Fatalities Hamilton County  
Frequencies and Rates per 100,000 Population  
Ages 1-17 Years**



**Thank You**

- **Questions?**

# Contact Information

- **Sarah Stuart Chewning, MPH**
  - [sarahc@hamiltontn.gov](mailto:sarahc@hamiltontn.gov)
  - **423-209-8067**