CHILD DEATH REVIEW REPORT 2023

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health

Davidson County Child Death Review Report, 2023

Lead Author:
Christopher Johnson, MPH
Division of Epidemiology
Metro Public Health Department

Suggested Citation

Johnson, C., McKelvey, B., Ganis, A., Mukolo, A. (2026). *Davidson County Child Death Review Report, 2023*. Metro Public Health Department of Nashville/Davidson County.

Participating Agencies

Metro Public Health Department
Metro Nashville Police Department
Metro Nashville Public Schools
Metro Office of Family Safety
Metro Social Services
Office of the District Attorney
Juvenile Court
Nashville Fire Department
Medical Examiner's Office
Department of Children's Services
Monroe Carrell Jr. Children's Hospital
Vanderbilt University Medical Center
St. Thomas Midtown Hospital
Nurses for Newborns
Nashville Children's Alliance
Youth Villages
Office of Youth Safety

Table of **Contents**

Introduction

The Child Death Review process brings together a multidisciplinary team to examine child deaths in the community. The goal is to understand why children die and how such tragedies can be prevented.

This report shares the data and findings of the Child Death Review Team (CDRT) for deaths occurring in 2023. For the current analysis, the death was reviewed if:

- The child resided in Davidson County at the time of death;
- the child was between 0 and 17 years old; and
- the death occurred in Tennessee.

Infant deaths were reviewed if they were born on or after 23 weeks gestation or at a weight equal to or greater than 500 grams (1.1 pounds).

Not all child deaths among Davidson County residents met review criteria. As such, data presented in this report may be slightly different from other published reports based on different data sources.

This report presents population level data from publicly available sources to provide context, followed by review data grouped by cause of death. Demographic data is reported with social context information where applicable. Findings of the review team and related work in the community are also highlighted.

Technical notes about the analysis are included at the end of the report.

How We **Work**

The CDRT is empowered by state statute (T.C.A. 68-42-101) and Mayoral executive order (Executive Order 17, Jan. 17, 2024) to review deaths of Davidson County children under the age of 18 years in order to achieve the following goals:

- Ensure an accurate inventory of child deaths.
- Support adequate child death investigations.
- Enable multi-agency collaboration and communication at both the state and local levels.
- Analyze patterns and trends in mortality.
- Enhance community awareness of how and why children die.
- Develop recommendations to reduce preventable deaths.

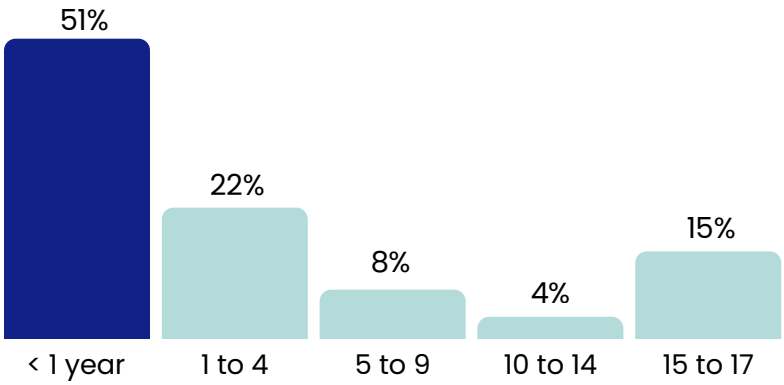
The review process is used to identify modifiable risk factors, gaps in systems and services, and opportunities for strategic prevention initiatives with the goal of building a community where all children have a strong chance to survive and thrive into adulthood.

Report Highlights

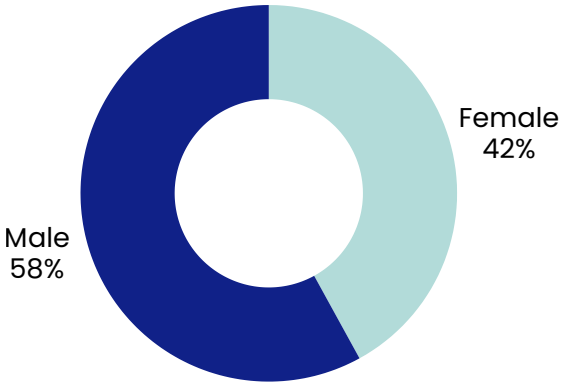
- In 2023, the CDRT reviewed 108 deaths. 51% were infants (children under 1 year of age).
- 43% of reviewed deaths were deemed to be preventable.
- Non-Hispanic Black (NHB) children died at a rate two and a half times higher than Non-Hispanic White (NHW) children.
- In 2023, the overall child mortality rate increased 16% from the rate measured in 2019.
- 29% of infant deaths were sleep-related. Of those, 62.5% occurred when the infant was placed to sleep somewhere other than in a crib or other safe space.
- Nearly 20% of reviewed deaths were the result of accidents including suffocation, motor vehicle crashes, poisonings, and drownings.
- Of the reviewed deaths 11% were the result of homicide. There were no reviewed suicides in 2023.
- 20% of deaths showed some evidence of maltreatment such as abuse, neglect, lack of supervision, or negligence.
- Nearly 59% of school-aged children who died had faced challenges in school.
- 62% of the families who experienced the loss of a child in 2023 were engaged with some type of social service.

Review Data **Summary**

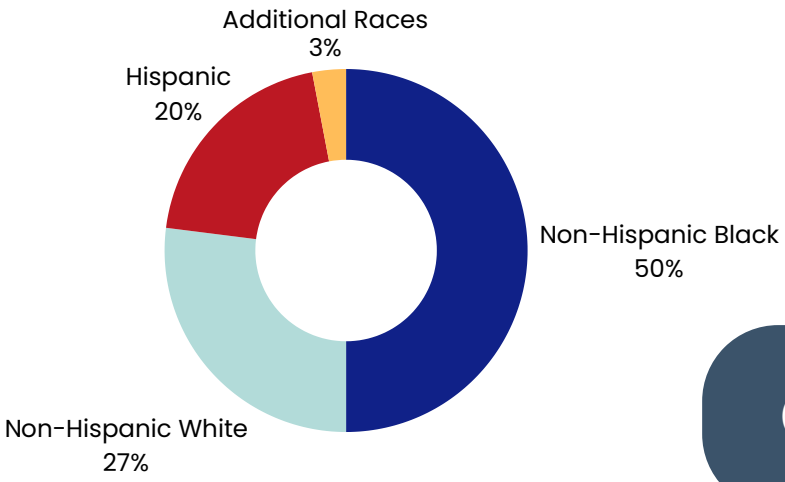
DEATHS BY AGE GROUP



SEX



RACE/ETHNICITY



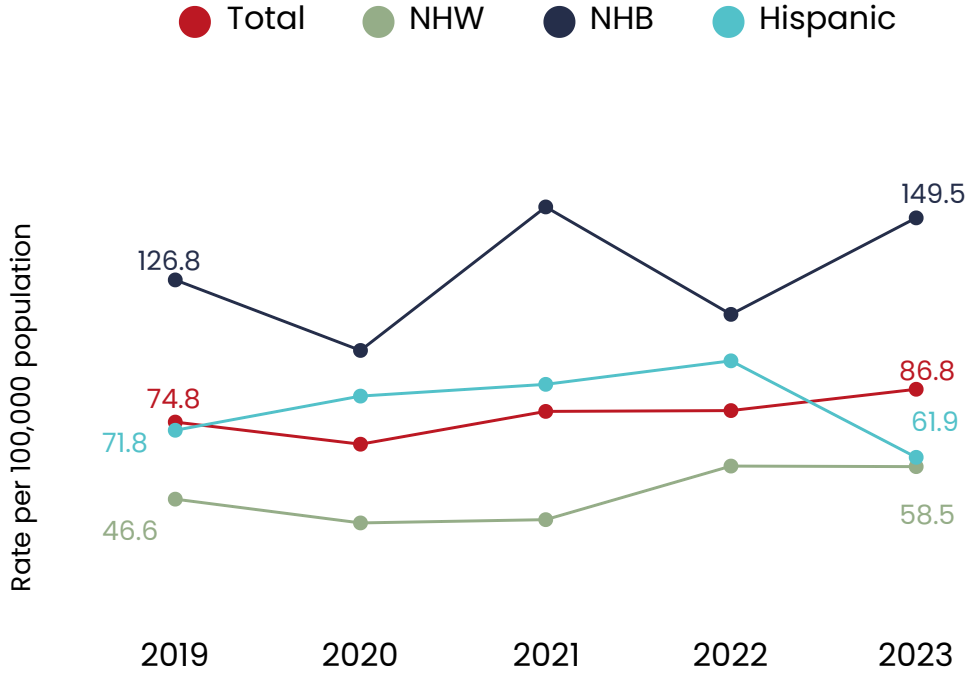
Additional Races may include Native Hawaiian/Pacific Islander, Asian, Native American and others. In order to protect the identity of these children they have been combined into one category.

43% of all reviewed deaths were determined to be **preventable**.

The Child Death Review Team (CDRT) reviewed the deaths of **108 children** who died in 2023.

Review Data **Summary**

TOTAL CHILD MORTALITY RATES (0-17) BY RACE/ETHNICITY, DAVIDSON COUNTY, 2019-2023

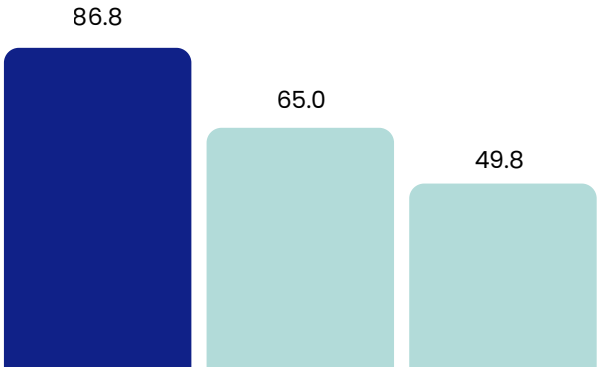


Source: TDH Vital Records; 2023 Davidson County estimates from CDC WONDER; ACS 1-year estimates, Census. 2020 uses bridged-race population estimates from NCHS.

In 2023 Non-Hispanic Black children died at a rate **two and a half times higher** than Non-Hispanic White children.

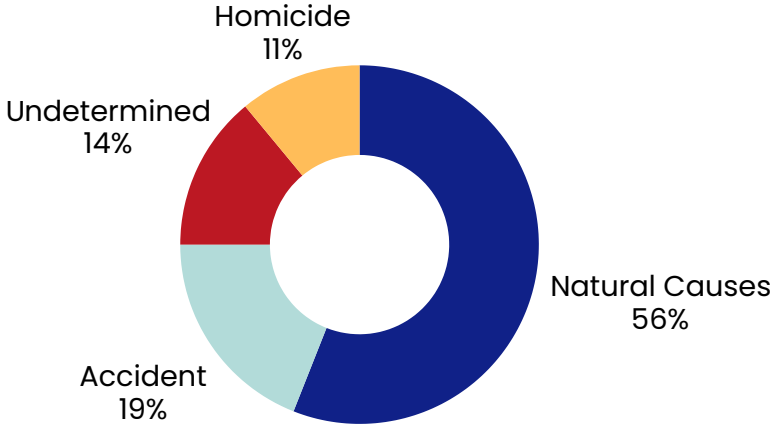
The overall mortality rate for children has **increased by 16%** from 2019 to 2023.

TOTAL CHILD (0-17) MORTALITY RATES, 2023



Source: CDC WONDER.

MANNER OF DEATH, REVIEWED CASES (N=108), 2023



Infant Mortality

Infants <1 year

Infant mortality is the death of an infant before their first birthday. The infant mortality rate is an important marker of the overall health of a society.[1]

Infant mortality rate calculation:

$$\frac{\text{number of infant deaths}}{\text{number of live births}} \times 1{,}000$$

Infant Mortality

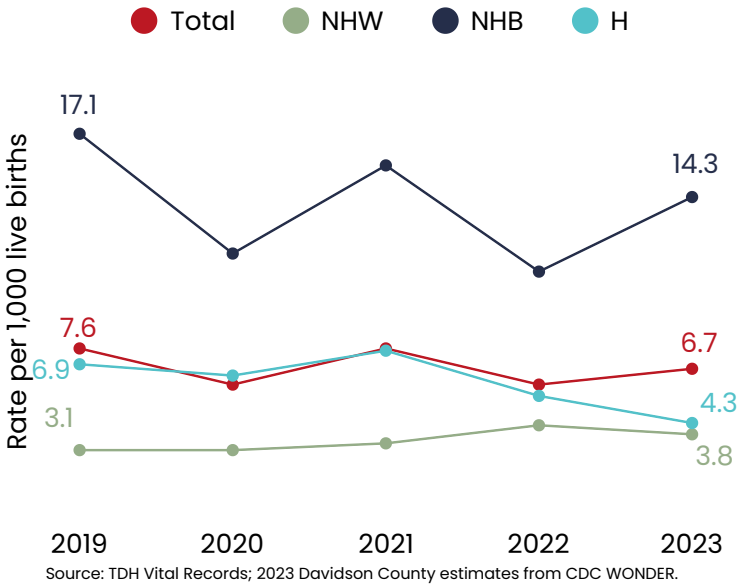
Infants <1 year

Non-Hispanic Black infants died at a rate **3.8 times higher** than Non-Hispanic White infants.

In 2023 there were **55 infant deaths**.

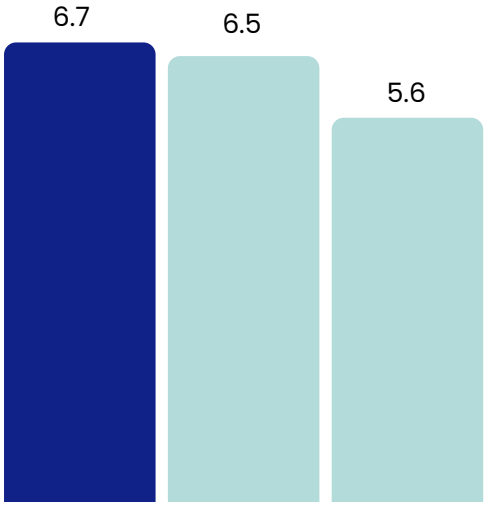
The Non-Hispanic Black infant mortality rate **decreased 16%** from 2019 to 2023.

TOTAL INFANT MORTALITY RATES BY RACE/ETHNICITY, DAVIDSON COUNTY



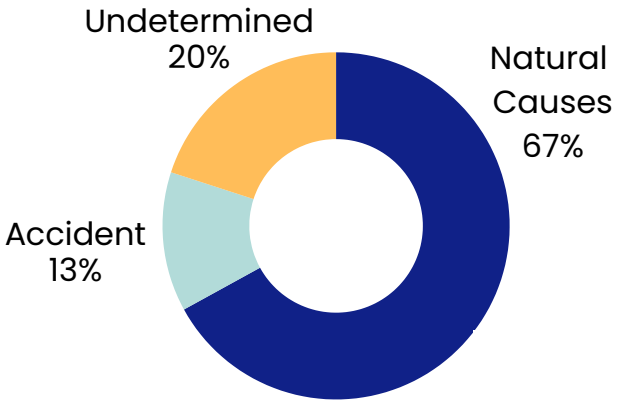
Source: TDH Vital Records; 2023 Davidson County estimates from CDC WONDER.

TOTAL INFANT MORTALITY RATES, 2023

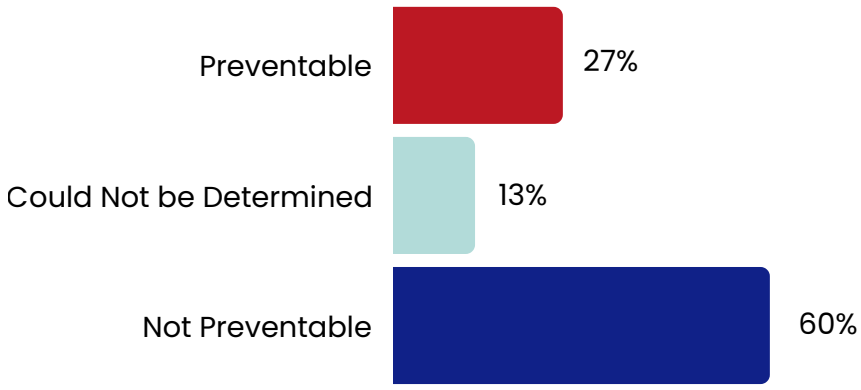


Source: CDC WONDER.

MANNER OF INFANT DEATH, REVIEWED CASES (N=55), 2023



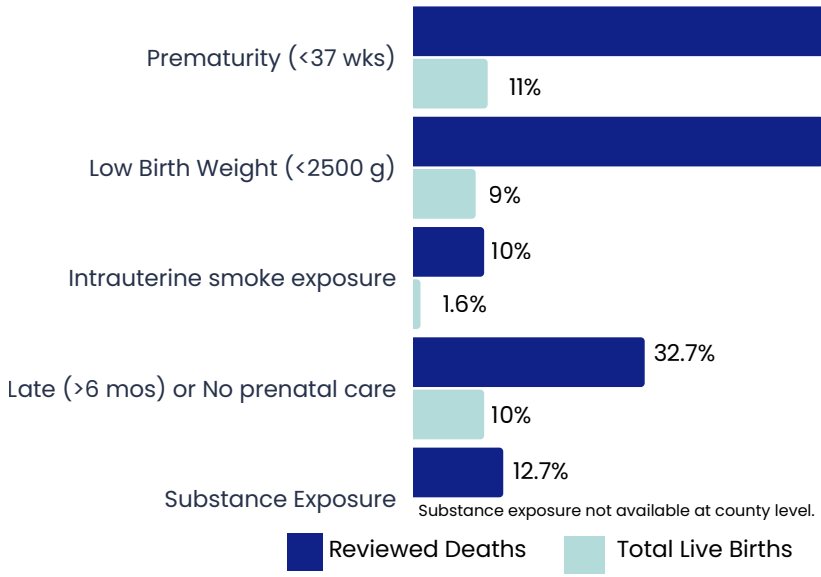
PREVENTABILITY OF INFANT DEATH (N=55), 2023



Infants < 1 year

Infant Deaths

RISK FACTORS FOR INFANTS, 2023

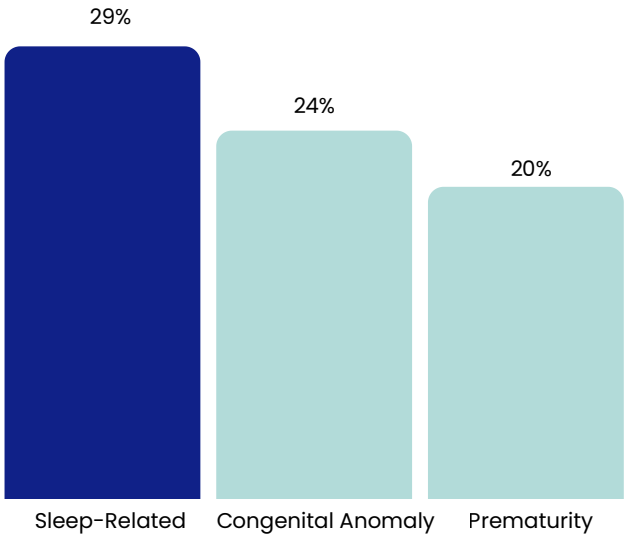


Source: CDR, 2023. Davidson county estimates from CDC WONDER.

Risk factors associated with reviewed infant deaths were present at elevated rates as compared to those for all live births in Davidson County. **Increasing access to smoking cessation supports, substance use treatment, and prenatal care may help increase infant vitality.**

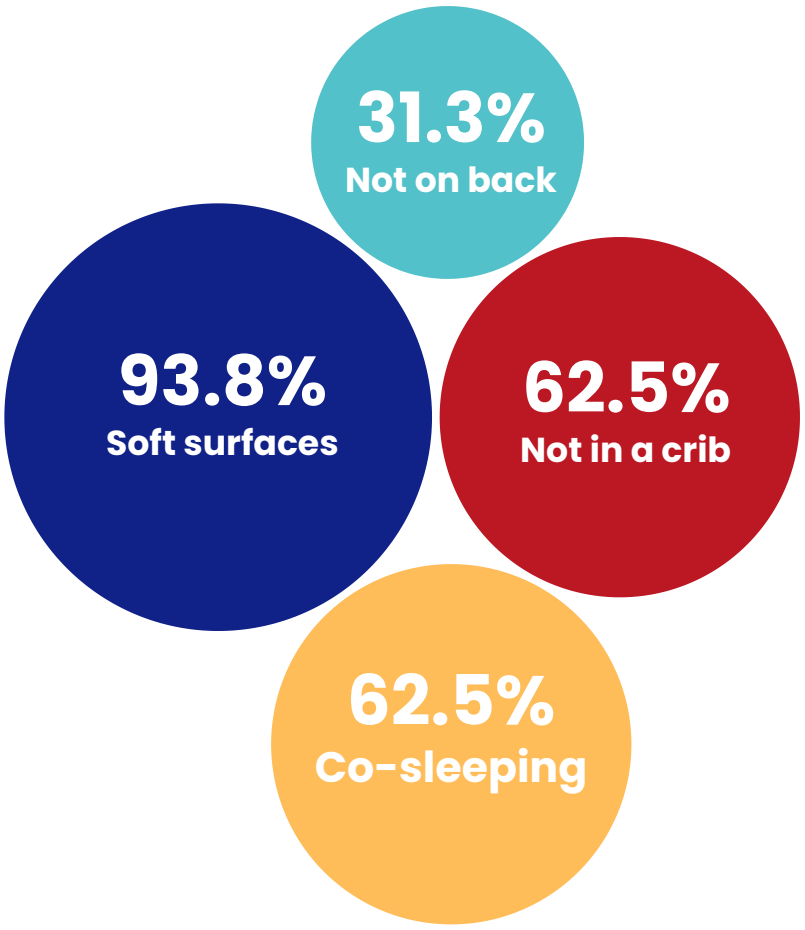
LEADING CAUSES OF INFANT DEATH, 2023

67% of reviewed infant deaths were due to natural causes. The largest contributors were birth defects and complications of being born too early and too small. **The leading cause of preventable death was sleep-related suffocation,** accounting for approximately **one-third of all reviewed infant deaths**.



Sleep-Related Deaths

Infants < 1 year



These categories are not mutually exclusive and will add up to more than 100%.

SLEEP-RELATED RISK FACTORS

Unsafe sleeping environments are the leading causes of preventable death in infants. The safest place for infants to sleep is **Alone** on their sleep surface, on their **Back**, and in an empty **Crib**. This means a safe sleep environment should have no soft sleeping surfaces such as bumper pads, pillows, blankets, or stuffed animals, and no other objects such as toys, or baby supplies.[2]

SOCIAL FACTORS

Housing instability and overcrowding may lead to caregivers improvising sleeping arrangements, particularly when there is insufficient room for a crib. **Nearly 40% of sleep-related infant deaths occurred in overcrowded housing.** Addressing core problems like affordable housing and financial security can help families follow safe sleep guidelines effectively.

Sleep-Related Death Highlights

50%
Infants sleeping in an adult bed

69%
Families receiving The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) within 12 months prior to death

63%
Homes with a crib or other safe sleeping space available

Child Mortality

Children
1- 17 years

Child mortality is the death of a child before their 18th birthday. The child mortality rate is another important marker of the overall health of a society.

Child mortality rate calculation:

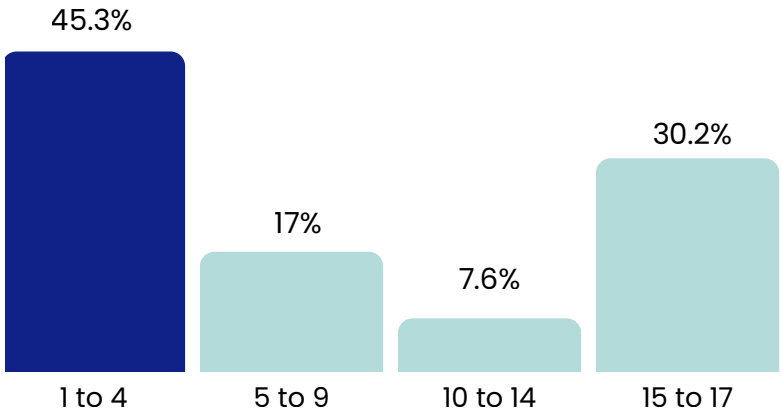
$$\frac{\text{number of child deaths}}{\text{number of living children}} \times 100{,}000$$

Child Mortality

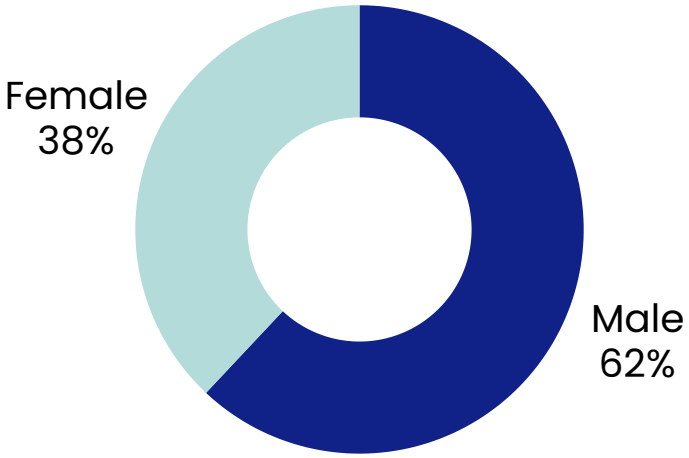
Children
1- 17 years

In 2023 there were **53 child deaths** between the ages of 1 and 17.

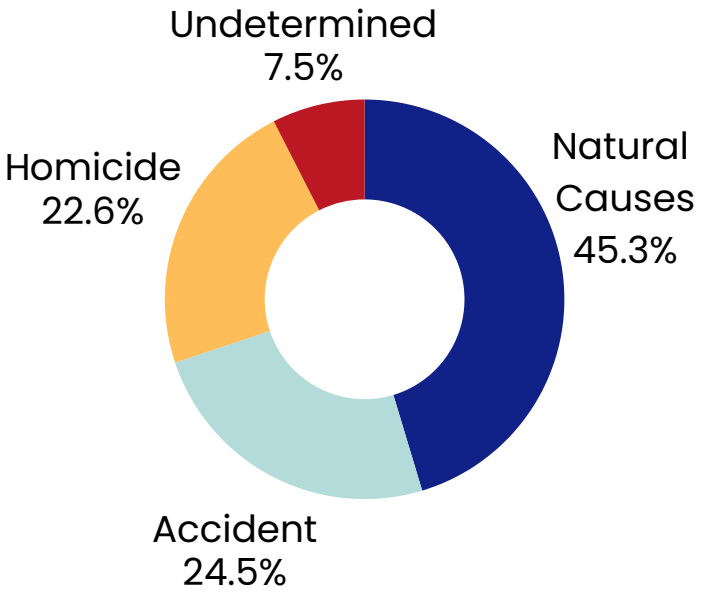
DEATHS BY AGE GROUP (N= 53)



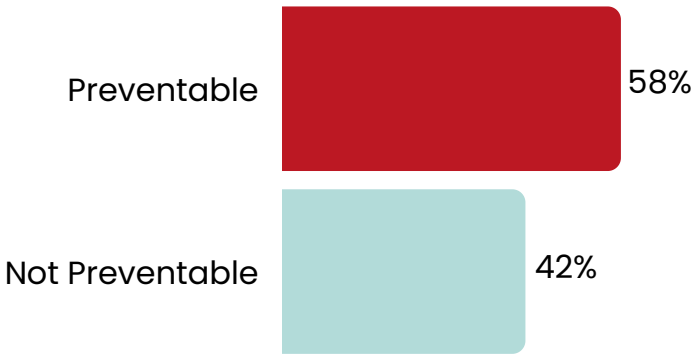
SEX



MANNER OF DEATH, REVIEWED CASES (N=53), 2023



PREVENTABILITY OF CHILD DEATH (N=53), 2023



Causes of Death

Children
0- 17 years

This section of the report investigates different causes of death grouped into the categories of Accidental, Violent and Natural deaths.

- Accidental deaths are the result of injuries not deliberately inflicted by oneself or another person.[3]
- Violent deaths result from the intentional use of physical force against oneself or another person.[3]
- Natural deaths may be the result of disease, illness or medical conditions.

Children
0- 17 years

Accidental **Deaths**

10%
Motor Vehicle

45%
Suffocation

30%
Poisoning

15%
Drowning

Nearly **20%** of reviewed deaths of all ages were caused by **accidents**.

Nearly all suffocation incidents were **sleep-related infant deaths.**

Accidental Death Highlights

70%
Children who died from accidental causes aged 0-4

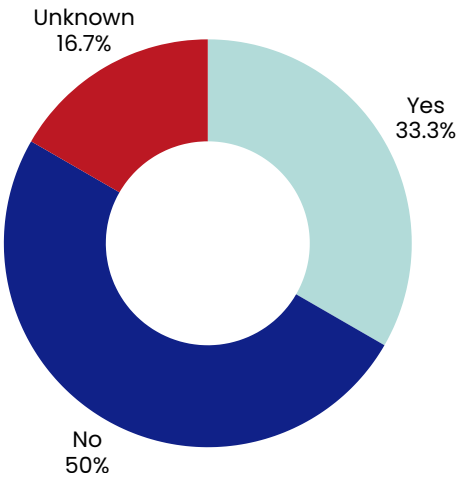
55%
Child deaths who were male youth

60%
Children who died from accidental causes were Non-Hispanic Black

Children
0- 17 years

Accidental **Deaths**

PREVIOUS INCIDENT OF NONFATAL OVERDOSE IN PREVIOUS 12 MONTHS, 2023



POISONING DEATHS

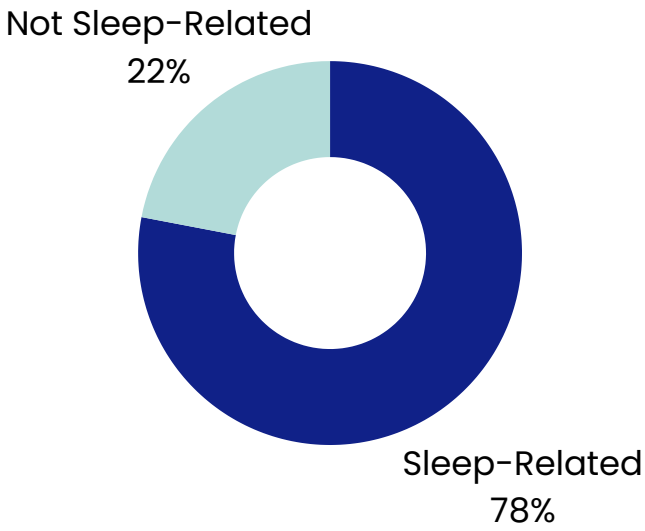
All children among reviewed cases who died from accidental poisoning had traces of illicit fentanyl in their system. Among these, 33% had experienced a previous nonfatal overdose event. Among school-aged children, themes such as skipping school, behavioral challenges, and mental health issues emerged. **Properly storing medications and promoting resilience among school-aged children may help prevent unintentional poisonings.**[4]

Children
0- 17 years

Accidental **Deaths**

SUFFOCATION DEATH BY TYPE, 2023

Sleep-related infant deaths comprised 78% of all accidental suffocations. 22% of the suffocation deaths were over the age of 1 and were attributed to toys or were linked to a natural disaster.



Children
0- 17 years

Accidental Deaths

DROWNING DEATHS

Unintentional drowning is a significant cause of death for children under 15 years of age nationwide.[5] Among reviewed Davidson County cases, drownings occurred most commonly in private pools, followed by public pools. **Key factors included insufficient supervision, lack of swimming ability, and absences of swimming aids.**

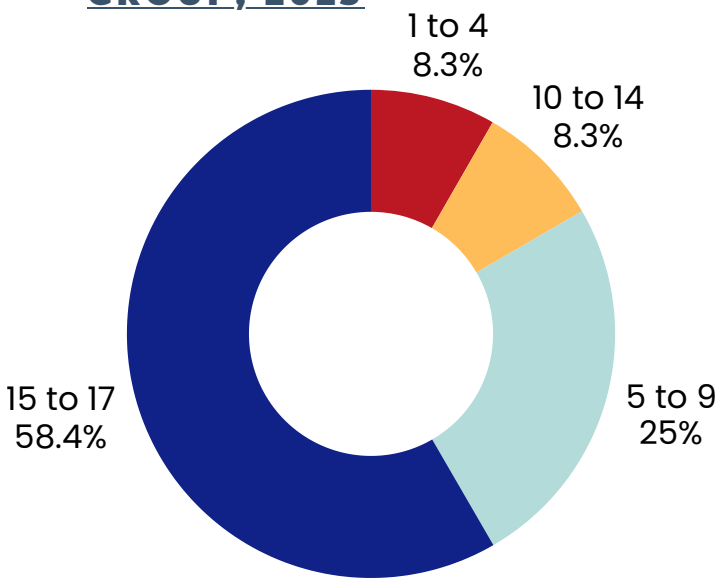
MOTOR VEHICLE DEATHS

Among teens aged 15-19 in the United States, the leading cause of unintentional injury death is motor vehicle crashes. These accidents are attributed to factors such as lack of experience, impaired driving, speeding, distracted driving, and driving with teen passengers.[6] These elements contributed to the motor vehicle deaths reviewed in Davidson County. **In each, speeding was a major factor in the child's death.**

Children
0- 17 years

Violent Deaths

HOMICIDES BY AGE GROUP, 2023

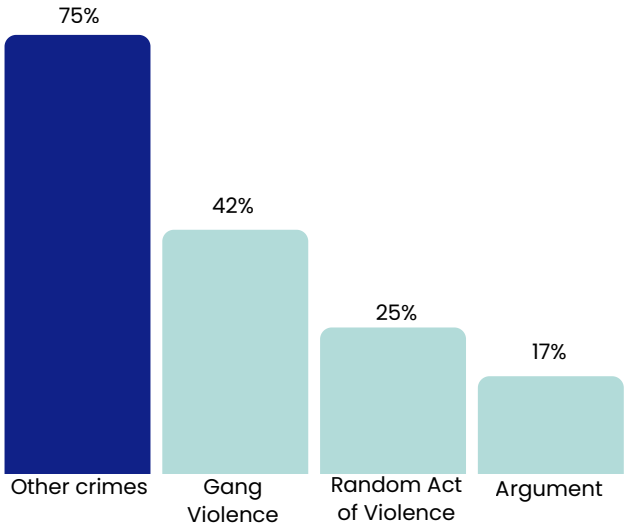


HOMICIDES AND SUICIDES BY AGE

Although teens 10 years and older comprised nearly 67% of deaths, homicide adversely impacts all age groups. **In 2023, 11% of child deaths were caused by homicide. There were no reviewed suicides. All homicide deaths involved firearms.**

FIREARM USE AT INCIDENT, 2023

75% of firearm-related incidents were associated with other crimes. These offenses included gang violence, drive-by shootings, robbery, interpersonal violence, and assault. **Gang violence was related to approximately 42% of incidents involving weapons.**



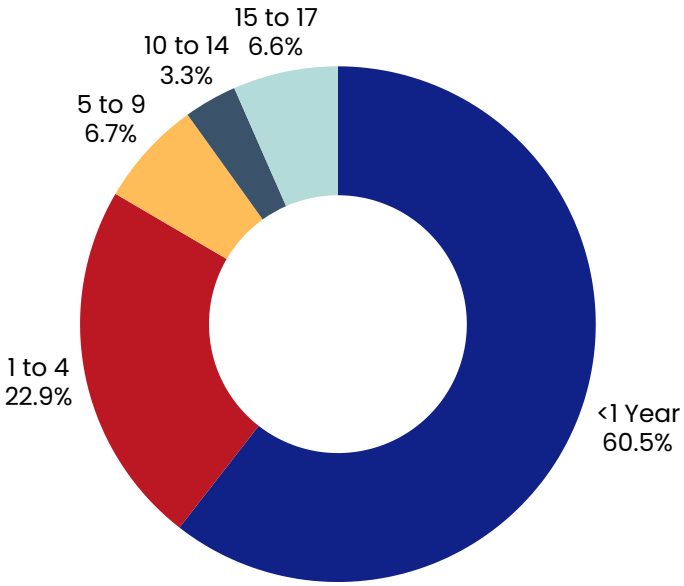
These Crime Categories are not mutually exclusive and will add up to more than 100%.

Natural Deaths

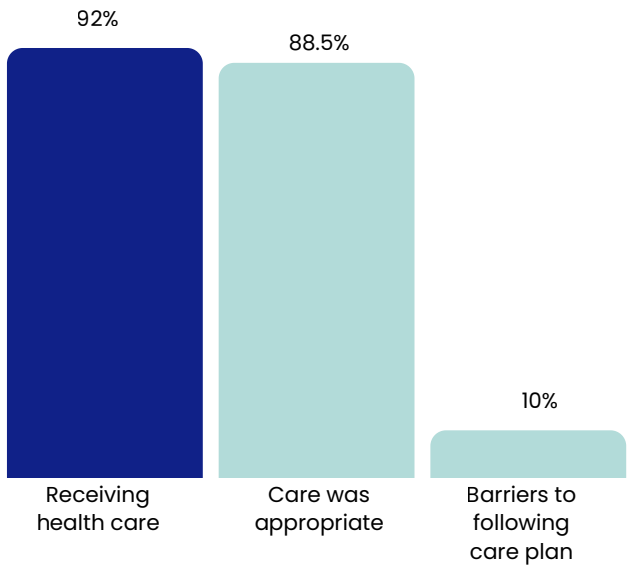
Children
0- 17 years

NATURAL DEATHS BY AGE GROUP, 2023

61% of deaths due to natural causes occurred among infants with the leading causes being birth defects and medical complications from being born too early and too small. The remaining deaths encompassed a broad spectrum of causes including asthma, cancer, cardiovascular causes, and infections.



FACTORS AND BARRIERS TO CARE, 2023



Case review showed that **10% of families faced obstacles in adhering to the prescribed care plan**. Challenges included transportation difficulties, poor communication between the parents and hospital, and inconsistency in educational class attendance.

Social Factors

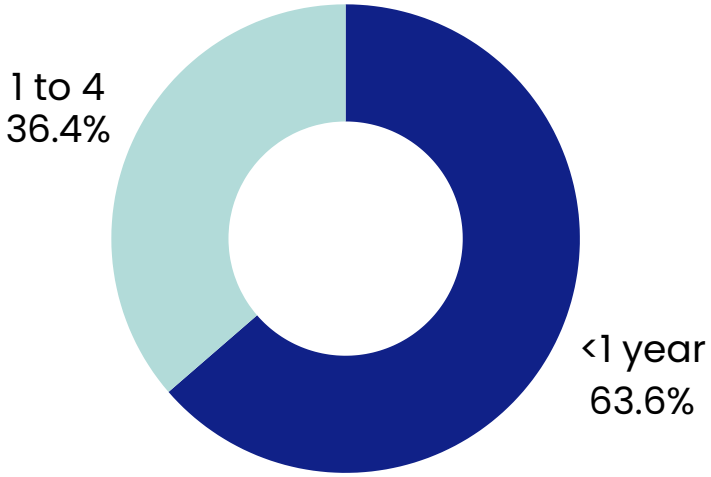
There are many non-medical factors that influence health outcomes. The environment that someone lives in has a direct impact on their overall health. Collaboration across government, the private sector and the community is required to improve health.

Children
0- 17 years

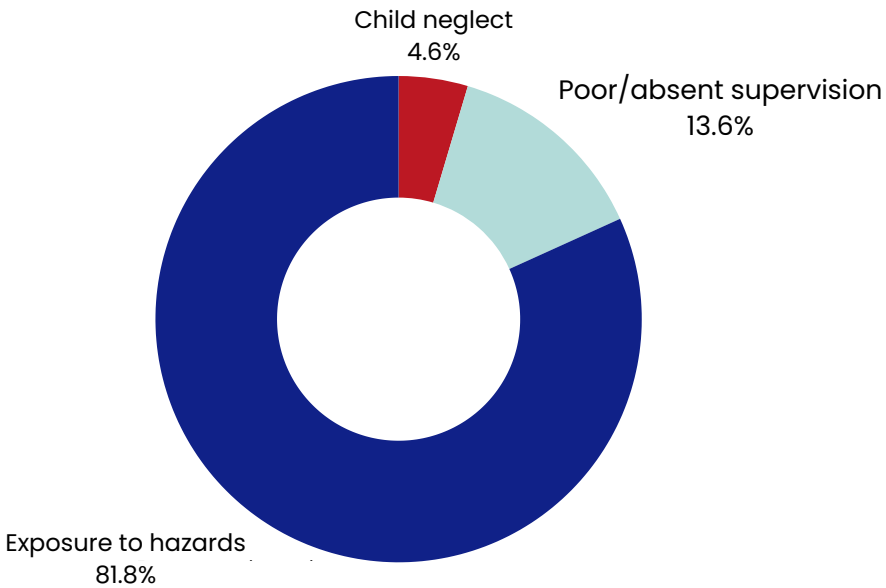
Child Maltreatment

MALTREATMENT DEATHS BY AGE GROUP, 2023

Roughly **20% of reviewed deaths showed evidence of abuse, neglect, or negligence**. Most cases occurred among infants. In nearly 76% of cases, the perpetrator was the parent or primary caregiver.



MALTREATMENT BY TYPE, 2023

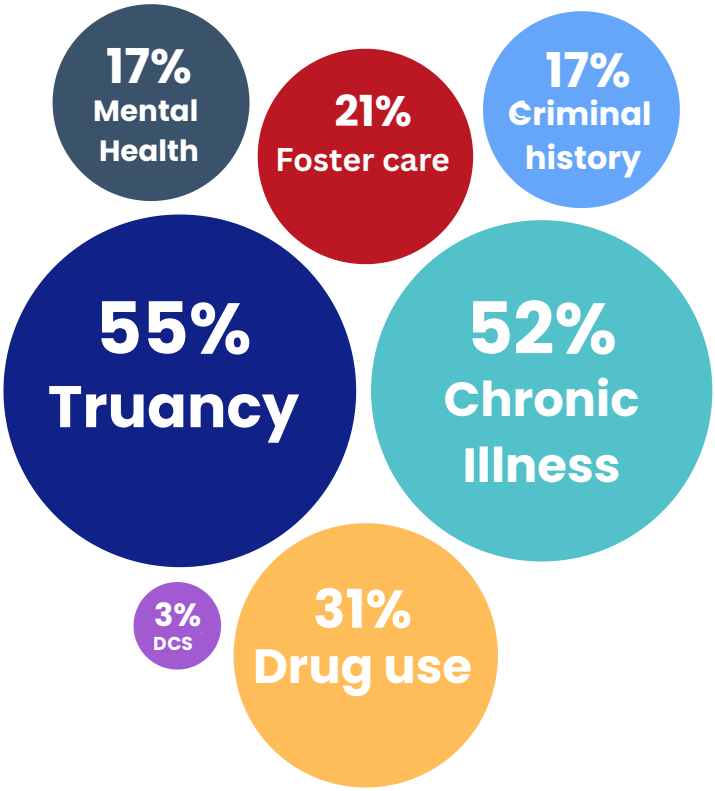


Unintentional exposure to hazards comprised nearly 82% of these cases. Hazards included improperly stored medication or firearms in the home, exposure to water or motor vehicle hazards, or unsafe infant bedding.

Addressing **Trauma**

TRAUMA-INFORMED CARE

In 2023, roughly 27% of child deaths were among school-aged children. Schools play a crucial role in preventing such tragedies due to the frequent interaction with this age group. A trauma-informed school provides support to children and teenagers dealing with trauma or mental health issues that affect their behavior and learning. It creates a supportive network that allows teachers, school staff, students and their families, and the larger community to identify and address the impact of traumatic stress on behavior, relationships, and academics.[7] This is essential as **nearly 59% of school-aged children who died faced challenges in school.**



CHALLENGES BY TYPE

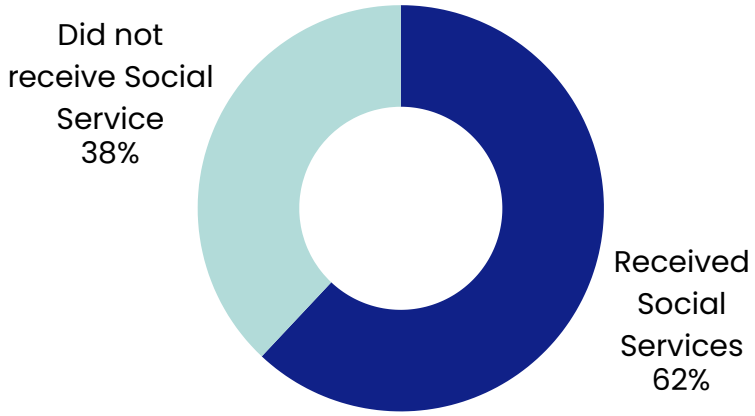
Truancy, defined as excessive absenteeism from school, is often a symptom of deeper challenges, and can be a signal that a student or family needs support.[8] **Nearly 55% of students who died in 2023 had a history of truancy**. Other challenges these students experienced included drug use, chronic illness or disability, and mental health needs.

Social Services

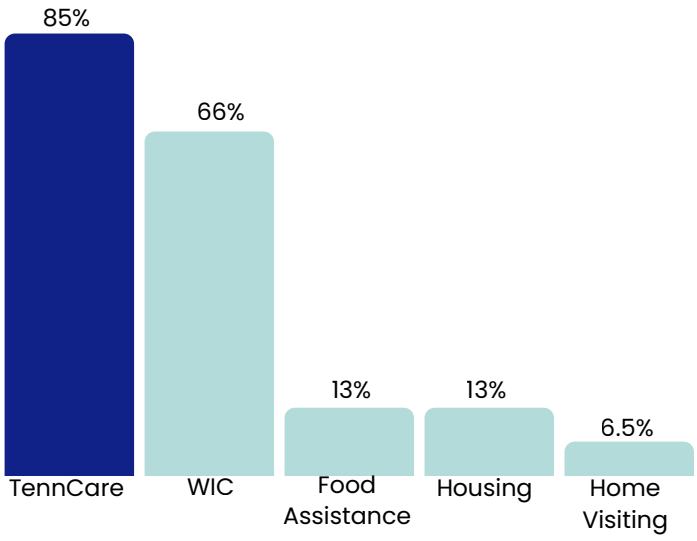
Children
0- 17 years

SOCIAL SERVICE UTILIZATION, 2023

In 2023, **more than half of the families who faced the heartbreaking loss of a child were receiving social services at the time of the child's death**. These engagements create opportunities to offer assistance, address needs, and potentially avert child fatalities. The CDRT's efforts are crucial in pinpointing service shortcomings and obstacles.



TYPE OF SOCIAL SERVICE UTLIZED, 2023



Families who made use of services mainly benefited from TennCare and WIC, while **home visiting referrals, food assistance and housing assistance were the least utilized services.** Voluntary home visiting programs play a crucial role in enhancing infant and maternal health, fostering positive child development and parent-child relationships, promoting early learning and future academic success, and providing referrals and coordinating services.[9]

Team Findings

Findings from the Child Death Review Team in Davidson County.

Team Findings

Our mission is to understand why children die and use that understanding to prevent future losses. **This report section highlights recurring patterns observed in reviewed fatalities, which can guide the development of new safety protocols, collaborations, and policies.** Within this section, themes and ideas may be repeated more than once and found in different sections. This repetition highlights the needs of the community and how issues are multifaceted and require a multipronged approach to address them. Stated themes may have active projects working to address the issue by collaborating with different organizations in Davidson County and the State of Tennessee. Active projects are noted in the Data to Action Section.

Themes

Structural Barriers
Exposure to Violence
Sleep Related Infant Suffocation
Health System
Mental Health and Substance Misuse
Maternal Risk Factors
Social Services
Data to Action

Structural Barriers

Structural Barriers are defined as system hinderances to basic needs. Access to basic needs may be complicated and not easily navigated by individuals or families.

TRANSPORTATION

- A lack of affordable and reliable transportation can delay access to care. Delays may also occur in obtaining other services necessary to maintain health for infants, children, and families.

HOUSING

- Affordable housing in the Davidson County area is limited and there is a continuing loss of low-income housing.[10] During reviews it was determined that this lack of affordable housing contributed to homelessness, overcrowding, and unstable housing (poor living conditions, frequent moves, financial burdens).

CHILDCARE

- Access to affordable, accessible, high-quality childcare remains limited in the community. Hours of operation, financial burden and distance are all factors that contribute to parents' inability to find reliable care for their children. The limited childcare options force parents to improvise childcare such as using unlicensed and unregulated childcare providers, posing a risk to infants and toddlers.

SOCIAL SUPPORT

- Some mothers did not feel like they had adequate community or social support during their pregnancies.
- For immigrant families, the cultural adjustment can be difficult when navigating a new society without a support network.
- There is misinformation on social media that can mislead. This has deepened the community distrust of the Public Health System and Healthcare System.

Exposure to Violence

There were many instances of violence being witnessed or experienced by the children reviewed in 2023. Violence can come in many forms.

COMMUNITY VIOLENCE

- Community violence happens between individuals who may or may not know each other. This violence generally occurs outside of the home, in places like schools and on the streets. Examples include assaults or fights among groups and shootings in public places.[11]
- Interpersonal violence, drive-by shootings, assaults and arguments were all examples of community violence that contributed to these child deaths.

DOMESTIC VIOLENCE

- Domestic violence is a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, psychological, or technological actions or threats.[12]
- Domestic violence was witnessed by some of the children who died. There were also instances of mothers experiencing domestic abuse while pregnant or after giving birth. The abuse of mothers was introduced in meetings to discuss the impact on the child that died or any other child present.

GANG VIOLENCE

- There is no single accepted definition of a “gang”, however there are criteria used to classify a group as a gang. The group has three or more members, generally aged 12-24, and there is an identity such as a name and/or other symbols. There is also some form of organization and elevated levels of criminal activity.[13]
- In 4.6% of reviewed deaths it was reported that the children were killed as a result of gang conflict. It was noted that some children had affiliation with gang activity or were part of a gang. Exposure to this violence contributed to their deaths.

Sleep-Related Infant Suffocation

The suffocation of infants during sleep can happen in many different ways and is often labeled as sleep-related death.

SOFT ITEMS IN CRIB/SLEEP SPACE

Many of the infant suffocation related deaths that were reviewed had soft items found in the crib/sleep space of the infant. A few examples of these soft items include:

- Blankets
- Pillows
- Bumper pads

CO-SLEEPING

Co-sleeping is when another person is sleeping with an infant on the same surface. This sleeping arrangement is a risk for suffocation for infants. There were instances of co-sleeping among the reviewed deaths. 50% of these infants were sleeping in adult beds with either parents or alternate caregivers.

IMPROVISED SLEEPING ARRANGEMENTS

There are many reasons why improvised sleeping arrangements are made for infants. Examples noted during review included :

- Overcrowding in the home limiting available safe sleeping spaces.
- Alternate caregivers lacking safe sleep education or a safe space for the infant to sleep responsible for infant care.
- Lack of crib, portable crib or other safe place to sleep due to financial barriers or inability to access services.

Health System

For many families and individuals it can be difficult to navigate the healthcare system. Both healthcare providers and insurance coverage provided challenges for these families.

PRENATAL

Quality prenatal care is critical to the health of both mother and child. The reviews confirmed that there is an increasingly limited number of Obstetric (OB) providers accepting Medicaid. Reviews also showed that some families are choosing home births and unlicensed midwifery care, further increasing the risks of poor outcomes. The transition from general medical care to OB care for women with chronic medical conditions is challenging, requires coordination and often results in delays in care. Additionally, difficulties navigating the current healthcare system can result in delays in seeking and obtaining potentially life saving medical care.

PEDIATRIC

Some of the cases showed evidence of missed opportunities for children to be diagnosed and treated for illnesses. Barriers were seen in seeking regular medical care for infants. Insurance for both native born community members and immigrants was not always easy to obtain and left questions on how to get adequate healthcare to the most at risk.

Mental Health And Substance Misuse

Mental health and substance misuse were seen in cases reviewed in 2023 and were in some cases interconnected.

MENTAL HEALTH

- There was a general delay in obtaining mental health care in Davidson County for both mothers and children.
- Maternal depression and anxiety were identified in several cases by the review team. A lack of access to affordable and timely maternal mental health care was noted.
- Students have access to mental health services through Metro Nashville Public Schools (MNPS). MNPS employs approximately 450 mental health professionals and while the students can self refer, parents, teachers and staff can also refer for services. MNPS also provides supplemental support for students who receive insurance based services.

SUBSTANCE MISUSE

- Maternal and parental/caregiver substance misuse was noted during the reviews. While pregnant, some mothers were using substances such as Subutex, Hydrocodone, Cocaine and others.
- Children gained access to and misused substances in the home. This usage could be intentional or unintentional and wasn't always clear. Access to substances was made easier due to a lack of proper substance storage in the home.
- Community exposure to substances was also seen allowing for ease of access for children.
- The team discussed how many of the substance use programs currently available work to address individual needs, however this issue is one that is intergenerational and not only person-specific. A community and family based approach may make a larger impact on treating substance misuse.

Maternal Risk Factors

Maternal health is important before, during and after pregnancy for both the mother and the child. During the reviews the team discussed the importance of adequate maternal healthcare.

HEALTHCARE ACCESS

- Access to care for some mothers has diminished over time as obstetrician (OB) practices have closed and not been replaced.
- The team observed that there are few OB physicians accepting Tenncare.
- With this difficulty in finding a physician some mothers are starting care in the second or third trimester or receiving no prenatal care at all.
- Other mothers have turned to midwifery care which may be unlicensed and present risks.
- Difficulties in transitioning from OB care to regular medical care was identified for mothers with chronic conditions.

MEDICAL RISK FACTORS

During reviews there were risk factors that were common among mothers that experienced infant loss.

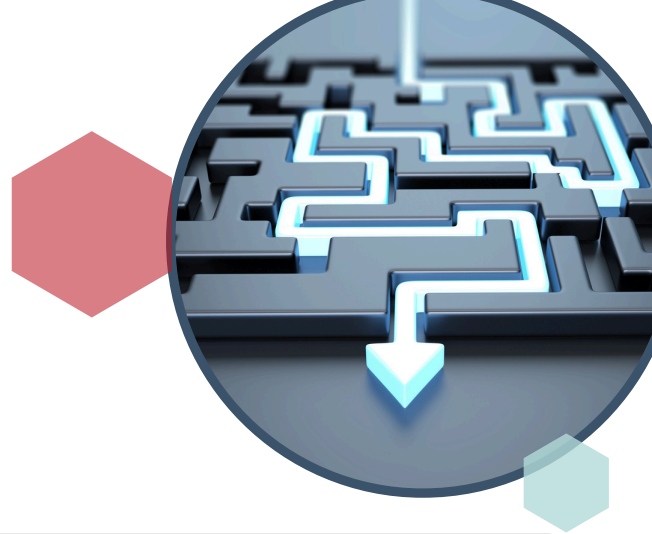
- Instances of previous fetal loss
- Maternal smoking
- Short time periods between one pregnancy and the next
- Substance use among some mothers which could have negative health effects for mother, child and their families
- A high parity (defined as the number of times that a woman has given birth to a fetus with a gestational age of 24 weeks or more, regardless of whether the child was born alive or stillborn) was also noted.[14]

Social Services

Social Services provide important resources to our community. Obtaining these services may not always be easy and can present a challenge for those who need them most.

REFERRALS/SERVICE BARRIERS

- Inadequate service documentation was seen across many of the cases reviewed.
- Home visiting referrals were not made or not documented properly for qualifying mothers.
- Gaps were identified between referrals and provision of home visiting services.
- The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a service that is extremely beneficial to families and there were instances where WIC was either not being utilized or not documented as having been offered to the family.
- Referrals may be made but services may not be obtained due to providers closing and a lack of alternate sources for these families.
- Families were not able to get the care necessary for their children in the home as easily or for as much time as they need because of a shortage of home nursing staff.
- Language barriers were often seen for those that were not native born community members.



Data to Action

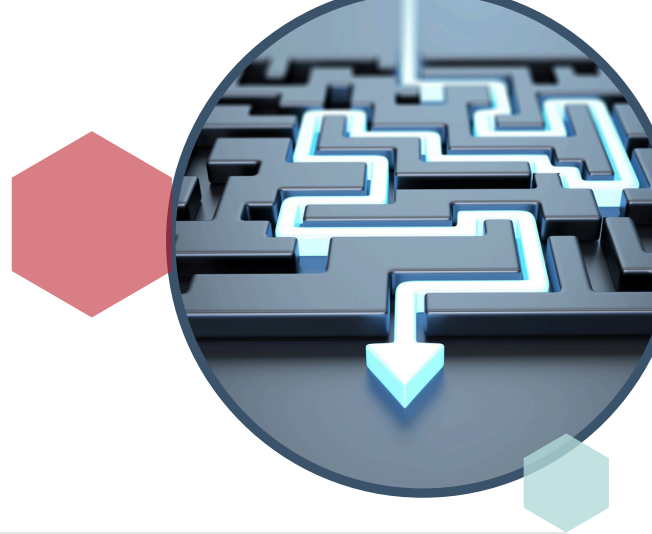
There were two workgroups established by the review team to tackle topics that needed more time and discussion.

ORDER OF PROTECTION WORKGROUP

There was a lack of support and advocacy services noted for order of protection petitioners who file at night court. The Metro Office of Family Safety (OFS) received permission from both of the clerks offices and Metro Legal to follow-up with high risk petitioners. There is a staff member that reviews hundreds of handwritten petitions each month and flags those with high risk factors. OFS has also contracted with an agency to provide services at their facility overnight, on weekends and holidays.

WIC AND SUBSTANCE USE WORKGROUP

The WIC staff screens for substance use at every certification appointment and can provide Narcan through the health department and referrals as needed. However, there was a lack of educational resources for staff. The workgroup reviewed WIC processes, identified gaps and barriers, and recommended solutions. This workgroup was still in process at the time these cases were reviewed. As of the writing of this report over 50 members of the WIC team have received Narcan training and training to identify the signs of a possible overdose. WIC is exploring funding options to provide “lock boxes” to be handed out at the client’s request for storage of supplies, such as prescriptions or tobacco/nicotine products.



Data to Action

During reviews recommendations may be made based on the identification of system gaps. These recommendations are then tailored for and directed to specific organizations to help drive their work.

FOSTER CARE/ ADOPTION RECORDS AND THE MEDICAL EXMANIER

During a review there was discussion about how difficult it can be for the Medical Examiner to obtain sealed records for deaths with foster care and adoption history. Without these records it can be difficult to make a determination of homicide without the pertinent history of child abuse. A recommendation was sent to the State CDR team to ease the sharing of information.

GUN LOCKS

The Metro Public Health Department and its home visiting program offers gun locks for safe firearm storage. These gun locks are offered free of charge and may be used to store many different types of firearms.

WIC AND SAFE SLEEP

The WIC staff discovered that the safe sleep education flag had been removed from the WIC online charting system. Without that flag, opportunities for WIC staff to provide safe sleep education to their clients could have been missed. The State WIC team is working on a formal way to return this education to the online charting system and has a contingency plan for the interim.

Note from our team

This report is dedicated to the 108 children whose lives were lost in 2023.

Their stories ground our work, reminding us that behind every data point is a child deeply loved, a family forever changed, and a future that could have been. We are humbled by the privilege of listening to their stories.

The Child Death Review Team honors their lives, and we remain committed to the work that ensures their stories lead to meaningful change.

Technical Notes

Data collected by the CDRT highlight extreme outcomes in children and youth, and it is important to exercise caution when applying these findings to the general population. Nonetheless, these findings shed light on areas where community systems, policies, and practices may fall short in safeguarding children effectively. This valuable information serves as evidence to advocate for systemic changes.

The data in this report are sourced from various agency records and discrepancies are occasionally rectified during the child death review process. Therefore, the results presented here may differ from those in other publications.

Information from the review process is compiled into a standardized data collection form and then input into a database managed by The National Center for Fatality Review and Prevention.

National and state data are gathered from the National Vital Statistics System Database, CDC WONDER, and reports from the Tennessee Child Fatality Review Team.

Child and infant mortality rates were computed using Davidson County vital records, except for 2023, which was gathered from CDC WONDER. These calculations account for deaths not reviewed by CDRT. Population estimates are sourced from the American Community Survey (ACS), with single-year estimates utilized for child mortality rate calculations. In 2020, ACS estimates were unavailable, so bridged-race population estimates from the National Center for Health Statistics (NCHS) were used.

References

1 Centers for Disease Control and Prevention. (n.d.). Infant Mortality. Retrieved December 11, 2025, from https://www.cdc.gov/maternal-infant-health/infant-mortality/index.html.

2 Johns Hopkins Medicine. (n.d.). News & Publications. The ABCs of Safe Sleep. Retrieved December 30, 2025, from https://www.hopkinsmedicine.org/news/articles/2022/10/the-abcs-of-safe-sleep.

3 Centers for Disease Control and Prevention. (n.d.).WISQARS Glossary. Injury Intents. Retrieved December 11, 2025, from https://wisqars.cdc.gov/glossary/.

4 Children's Safety Network. (n.d.). Poisoning Prevention. Retrieved December 11, 2025, from https://childrenssafetynetwork.org/child-safety-topics/poison-prevention. (last retrieved 12/11/2025)

5 Children's Safety Network. (n.d.). Drowning Prevention. Retrieved December 11, 2025, from https://childrenssafetynetwork.org/child-safety-topics/poison-prevention.

6 Children's Safety Network. (n.d.). Teen Driving Safety. Retrieved December 11, 2025, from https://www.childrenssafetynetwork.org/child-safety-topics/teen-driving-safety.

7 The National Child Traumatic Stress Network. (n.d.). Trauma-Informed Schools for Children in K-12: A System Framework. Retrieved December 11, 2025, from https://www.nctsn.org/sites/default/files/resources/fact-sheet/trauma_informed_schools_for_children_in_k-12_a_systems_framework.pdf.

References

8 Keppens G, Spruyt B. (2020). The Impact of Interventions to Prevent Truancy: A Review of the Research Literature. *Studies in Educational Evaluation* (Vol. 65). Retrieved December 11, 2025, from https://www.sciencedirect.com/science/article/pii/S0191491X19303979.

9 Roben C, Costello A. (2022). Increasing Support for Home Visiting Innovation is Critical for Young Children and Their Families. Society for Research in Child Development: Child Evidence Brief (No. 13). Retrieved December 11, 2025, from https://www.srcd.org/sites/default/files/resources/SRCD%20CEB-Home%20Visiting.pdf.

10 Metropolitan Development and Housing Agency. (n.d.). 2025-2026 Annual Update for Program Year Three to the 2023-2028 Consolidated Plan for Housing and Community Development. Retrieved December 11, 2025, from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.nashville-mdha.org/wp-content/uploads/2025/06/2025-Action-Plan-FINAL-with-Public-Comments.pdf

11 Centers for Disease Control and Prevention. (n.d.). Community Violence Prevention. Retrieved December 11, 2025, from https://www.cdc.gov/community-violence/about/index.html.

12 Office on Violence Against Women. (n.d.). Domestic Violence. Retrieved December 11, 2025, from https://www.justice.gov/ovw/domestic-violence.

13 National Gang Center. (n.d.). About Gangs. Retrieved December 11, 2025, from https://nationalgangcenter.ojp.gov/faqs#0-0.

14 Gaillard, Romy, et al. "Maternal parity, fetal and childhood growth, and cardiometabolic risk factors." Hypertension, vol. 64, no. 2, Aug. 2014, pp. 266–274, https://doi.org/10.1161/hypertensionaha.114.03492.

Contact Us

www.nashville.gov

Team Director:
Brook McKelvey, MPH, MA
brook.mckelvey@nashville.gov

Team Coordinator:
Autumn Ganis, BSPH
autumn.ganis@nashville.gov

Maternal and Child Health Epidemiologist:
Christopher Johnson, MPH
christopher.johnson@nashville.gov

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health