TENNESSEE
DEPARTMENT OF CHILDREN'S SERVICES

CHILD DEATH REVIEW
ANNUAL REPORT 2013
ADDENDUM

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Introduction

The following report is an addendum to the 2013 Child Death Review Annual Report. The Child Death Review (CDR) process outlined in the 2013 annual report was not fully implemented until August 29, 2013. All child death and near death cases which have arisen since that time are subject to the full process. There were 109 deaths and near deaths reviewed and included in the 2013 annual report. Of the 109 cases, 94 occurred between January 1, 2013 and August 29th, 2013. Those child death and near death cases which arose between January 1, 2013 and August 29th, 2013 have been subject to a modified review process[1]. This addendum encompasses the findings derived from the reviews of children subject to the modified review process which were not included in the 2013 Child Death Review Annual Report, due to not being confirmed as meeting CDR criteria at the time the annual report was published. These additional cases represent in full all remaining cases reviewed with the modified process.

Cases Reviewed

For this addendum, a total of 53 deaths and near deaths were reviewed. This includes: 37 non-custody deaths, 13 non-custody near deaths, 2 custody deaths, and 1 custody near death. Cases are reviewed contingent upon meeting criteria for review. Cases are given priority for review by the order in which they meet criteria.

Number of Deaths and Near Deaths Reviewed in 2013 by CDR Regional Group

Region 1	Region 2	Region 3	Region 4
19	7	13	14

Demographics of Child Death Cases Reviewed

Gender	Male: 20	Female: 19
Previous DCS History	Yes: 32	No: 7
DCS Custody	Yes: 2	No: 0

Demographics of Child Near Death Cases Reviewed

Gender	Male: 7	Female: 7
Previous History	Yes: 9	No: 5
Custody	Yes: 1	No: 13

All elements designated by the Child Abuse Prevention and Treatment Act (CAPTA) for the child death and near death cases included in this report can be found at the DCS website[2] at the following link http://www.tn.gov/youth/childsafety/publicnotifications.html. In addition, a summary of child death and near death data for 2013 is available at the same link.

[1] The modified review process consists of a full TFACTS case file review, which informs the development of a report for each child death or near death. These reports are then presented to the DCS Office of Child Health Leadership team.

[2] When the Child Death Review process was developed, the Department did not envision providing CAPTA case information online. By providing this information online, the Department is able to more completely and quickly provide the public this information than would be available in an annual report.

Findings

Learning and improving DCS's systems are a primary focus of the Child Death Review. DCS conducts reviews in order to understand how children and families can be better supported to eliminate or reduce the likelihood of these tragic outcomes. Through this understanding, the Department learns how it can support children and families in the future to keep children safe, healthy and ensure they are back on track. Through the review of deaths and near deaths in this review period, findings were consistent with the 2013 annual report in the following areas: Workload Demands, Safe Sleep, and Mental Health and Substance Abuse Assessment.