**Anomalously warm temperatures are associated with increased injury deaths**

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**Temperatures which deviate from long-term local norm affect human health, and are projected to become more frequent as the global climate changes. There is limited data on how such deviations affect deaths from different injuries. Here, we used data on mortality and temperature over a 38-year period (1980-2017) in the entire contiguous USA and formulated a Bayesian spatio-temporal model to quantify how anomalous temperatures, defined as deviations of monthly temperature from the local average monthly temperature over the entire analysis period, affect deaths from different unintentional (transport, falls and drownings) and intentional (assault and suicide) injuries, by age group and sex. We found that a 2°C anomalously warm year would be associated with an estimated 2,135 (95% credible interval 1,906-2,368) additional injury deaths in the contiguous USA. 84% of these additional deaths would occur in males, concentrated mostly in adolescent to middle ages. These deaths would comprise of increases in deaths from drownings, transport, assault and suicide, offset partly by an overall decline in deaths from falls in older ages. The findings demonstrate the need for targeted public health interventions against injuries during periods of anomalously high temperatures, especially as these episodes increase with global climate change.**

Anomalously warm and cold weather events are an important public health concern in today's world, and one of the key drivers for seeking adaptation measures against anthropogenic climate change.[1–3] Current assessments of the health effects of weather and climate, and by extension of global climate change, largely focus on parasitic and infectious diseases and cardiorespiratory and other chronic diseases.[1–6] Less research has been conducted on injuries,[7–9] especially in a consistent way across injury types and demographic subgroups of the population. There are two reasons to investigate a potential role for temperature anomalies on injury mortality: First death rates from injuries vary seasonally and the seasonality varies by age group,[10,11] which motivates investigating whether temperature may play a role in their pathogenesis. Second, there are plausible behavioural and physiological pathways for a relationship between temperature and injury – for example changes in driving patterns and performance,[12–21] alcohol drinking,[22] and levels of anger[23–25] – which motivates testing whether injury deaths are affected by temperature anomalies. Our aim was to evaluate how deaths from various injuries in the USA may be affected by anomalously warm and temperatures that occur today and are expected to become increasingly common as a result of global climate change.

We used vital registration data on all injury deaths in the contiguous USA (i.e., excluding Alaska and Hawaii) from 1980 to 2017, with information on sex, age at death, underlying cause of death and county and state of residence. From 1980 to 2017, 4,145,963 boys and men and 1,825,817 girls and women died from an injury in the contiguous USA, accounting for 9.3% and 4.2% of all male and female deaths respectively. 95.7% of male injury deaths and 94% of female injury deaths were in those aged 15 years and older, and over half (52.3%) of male injury deaths were in those aged 15-44 years (Figure 1). In contrast with males, there was less of an age gradient in females after 15 years of age.

Injuries from transport, falls, drownings, assault, and suicide accounted for 78.6% of injury deaths in males and 71.8% in females. The remainder were from a heterogeneous group of "other injuries" (Figure 1), within which the composition of injuries that led to death varied by sex and age group. Transport was the leading injury cause of death in women younger than 75 years and men younger than 35 years. Between 35 and 74 years of age, more men died of suicide than any other injury. Above 75 years of age, falls were the largest cause of death in both men and women.

There was a decline in age-standardised death rates of three out of five major injuries (transport, drownings and assault) from 1980 to 2017, although assault deaths have more recently (since 2014) increased (Figure 2). In contrast, age-standardised death rates from falls increased over time while those from suicide initially decreased followed by an increase to surpass 1980 levels. The largest overall decline over time was for transport deaths in both sexes and for deaths from drownings in men, which declined by over 50% from 1980 to 2017. Age-standardised death rates for transport injuries and drownings peaked in summer months but deaths from other major injuries did not have clear seasonal patterns.

We defined a measure of anomalous temperature for each county and month, which represents the deviation from the county's average temperature in that month over the entire analysis period (Supplementary Figure 1). County-level anomalies were aggregated to state level with use of population weights. Average size of anomaly over the study period (1980-2017), a measure of how variable temperatures are around their state-month long-term average, ranged from 0.4°C for Florida in September, to 3.4°C for North Dakota in February (Figure 3). The average size of anomaly had a median value of 1.2°C across all states and months (Figure 3). Temperature anomalies were largest in January and December and smallest in August and September. They were larger in northern and central states than in southern and coastal ones.

We analysed the association of monthly injury death rates with anomalous temperature using a Bayesian spatio-temporal model, described in detail in Methods. We used the resultant risk estimates and the age-sex-specific death rates from each injury in 2017, to estimate additional deaths if each month in each state were +2°C above its long-term average, consistent with the upper bound of the Paris Climate Agreement. Based on this analysis, we estimated that there would be an estimated 2,135 (95% credible interval 1,906-2,368) excess injury deaths, equivalent to 1.0% of all injury deaths in 2017, in each year in which each month in each state was +2°C warmer than its long-term average (Figure 4). Deaths from drowning, transport, assault and suicide would increase, partly offset by a decline in deaths from falls in middle and older ages and in winter months (Figure 4). Most excess deaths would be from transport injuries (985; 866-1,085) followed closely by suicide (720; 593-841). 84% of the excess deaths would occur in males and 16% in females. 92% of all male excess deaths would occur in those aged 15-64 years, who have higher rates of deaths from transport and suicide. In those aged 85 years and older, there would be an estimated decline in injury deaths, because deaths from falls are expected to decline in a warmer year.

Proportionally, deaths from drownings are estimated to increase more than those of other injury types, by as much 18.3% (16.6, 20.2) for a +2°C anomaly in men aged 15-24 years (Figure 5). The smallest proportional increase was that of assault and suicide (less than 4% in all age and sex groups). There was a larger percent increase in transport deaths for males than for females, especially in young and middle-ages (e.g., 2.7% (2.1, 3.4) for 25-34 year old men versus 0.7% (-0.4, 1.9) for women of the same age) (Figure 5).

That anomalously warm temperature influences deaths from drowning, although not previously quantified, is highly plausible because swimming is likely to be more common when temperature is higher. The higher relative and absolute impacts on men compared with women may reflect differences in their behaviours. For example, over half of swimming deaths for males occur in natural water, compared to about one quarter for females.[26] The former may rise more in warmer weather. Similarly, deaths from falls declined more in older ages because falls in the elderly are more likely to be due to slipping on ice than those in younger people.[27–29]

The pathways from anomalous temperature to transport injury are more varied. Firstly, driving performance deteriorates at higher temperatures.[16–19] Further, alcohol consumption increases in warm temperatures,[22] which also provides an explanation for why teenagers, who are more likely than other age groups to crash while intoxicated,[30] experience a larger proportional rise in deaths from transport when temperatures are anomalously warm than older adults. Lastly, warmer temperatures generally increase road traffic in North America;[12–15,20,21] coupled with more people outdoors in warmer weather,[31] this increase could lead to more fatal collisions.

Pathways linking anomalously high temperatures and deaths from assault and suicide are less established. One hypothesis is that, more time spent outdoors in anomalously warmer temperatures leads to an increased number of face-to-face interactions, and hence arguments, confrontations, and ultimately assaults.[32,33] These effects could be compounded by the greater anger levels linked to higher temperatures.[23–25] However, further research on the association of temperature and assault, and the factors mediating it, is needed.[34] Regarding suicide, it has been hypothesised that higher temperature is associated with higher levels of distress in younger people.[35] Nonetheless, the mechanisms for the links between temperature and mental health requires further investigation, including whether the relationship varies by age and sex, as indicated by our results. Future research should also investigate the extent to which the increased risk of injury death as a result of anomalous temperature depends on community characteristics such as poverty and deprivation, quality of roads and housing, emergency response, and social services.

Our work highlights how deaths from injuries are currently susceptible to temperature anomalies and could also be modified by rising temperatures resulting from climate change, unless countered by social and health system interventions that mitigate these impacts. Though absolute impacts on mortality are modest, some groups, especially men in young to middle-ages, will experience larger impacts. Therefore, a combination of public health interventions that broadly target injuries in these groups – for example targeted messaging for younger males on the risks of transport injury and drowning – and those that trigger in relation to forecasted high temperature periods – for example more targeted blood alcohol level checks – should be a public health priority.

## Methods

### *Data sources*

We used data on deaths by sex, age, underlying cause of death and state of residence in the contiguous USA from 1980 to 2017 through the National Center for Health Statistics (NCHS) (https://www.cdc.gov/nchs/nvss/dvs_data_release.htm) and on population from the NCHS bridged-race dataset for 1990 to 2017 (https://www.cdc.gov/nchs/nvss/bridged_race.htm) and from the US Census Bureau prior to 1990 (https://www.census.gov/data/tables/time-series/demo/popest/1980s-county.html). We did not include Alaska and Hawaii, (which together made up 0.5% of the US population in 2017) because their climates and environment are distinct from other states due to their substantial physical distance. We calculated monthly population counts through linear interpolation, assigning each yearly count to July.

The underlying cause of death was coded according to the international classification of diseases (ICD) system (9$^{th}$ revision from 1980 to 1998 and 10$^{th}$ revision thereafter). The 6 million injury deaths fell into six categories: transport, falls, drownings, assault, suicide and an aggregate set of other injuries. We report the results of all of these categories except other injuries (1,402,941 deaths or 23% of total injury deaths during 1980-2017), because the composition of this aggregate group varies by sex, age group, state and time.

We obtained data on temperature from ERA5, which uses measurement data from global in-situ and satellite measurements to generate a worldwide meteorological dataset, with full space and time coverage over our analysis period.[36] We used gridded four-times-daily estimates at a resolution of 30 km to generate monthly temperatures by county and following population-weighting, monthly temperatures by state throughout the analysis period.

*Anomalous temperature metric*

With few exceptions,[7,37] current climate change risk assessments extrapolate from associations of daily mortality with daily temperature.[5,6,38–40] Climate change, however, will fundamentally modify weather, including seasonal weather patterns, compared to long-term averages, and hence can disrupt existing forms of adaptation. To mimic the conditions that may arise with global climate change, we developed methodology to examine how deviations from long-term average temperature may impact injury death rates.

We first defined a measure of anomalous temperature for each county and month, which represents the deviation from the average temperature of the county in that month over the entire analysis period (Supplementary Figure 1). To calculate the magnitude of temperature anomaly, we first calculated average temperatures for each month in each county over the entire 38 years of analysis. We subtracted these long-term average temperatures from respective monthly temperature values to generate a temperature anomaly time series for each month and year in each county (Supplementary Figure 1). The temperature anomaly metric measures the extent that temperature experienced in a specific month, year and county is warmer or cooler than the long-term average to which the population has acclimatised. These values can be different for different months in the same county, and different counties in the same month. Further, a county with higher, but more stable, temperature in a specific month has smaller anomalies than one with lower but more inter-annually variable temperature. County-level anomalies were aggregated to state level with use of population weights for analysing their associations with mortality.

*Statistical methods*

We analysed the association of monthly injury death rates with anomalous temperature using a Bayesian spatio-temporal model, which leveraged variations over space and time to infer associations. We modelled the number of deaths in each month in each year as following a Poisson distribution:

$$deaths_{state-time} \sim Poisson(death\,rate_{state-time} \,.\, population_{state-time})$$

with log-transformed death rates modelled as a sum of components that depend on location (state) of death, month of year, overall time (in months) and temperature anomaly:

$$\begin{aligned}
\log(deaths_{state-time}) = \\
\alpha_0 + \beta_0 \cdot time + \\
\alpha_{state} + \beta_{state} \cdot time + \\
\alpha_{month} + \beta_{month} \cdot time + \\
\zeta_{state-month} + \\
\psi_{state-month} \,.\, time + \\
\nu_{time} + \\
\gamma_{month} \cdot Anomaly_{state-time} + \\
\varepsilon_{state-time}
\end{aligned}$$

The model contained terms that represent the national level and trend in mortality, with $\alpha_0$ as the common intercept and $\beta_0$ the common slope with overall time. Death rates also vary by month, which may be partly related to temperature and partly due to other monthly factors; monthly variations tend to be smooth across adjacent months.[10] Therefore, we allowed each month of the year to systematically have a different mortality level and trend, with $\alpha_{month}$ the month-specific intercept and $\beta_{month}$ the month-specific slope with overall time. We used a first-order random walk prior for the monthly random intercepts and slopes, widely used to characterise smoothly varying trends.[41] The random walk had a cyclic structure, so that December was adjacent to January.

We also included state random intercepts and slopes for death rates, with $\alpha_{state}$ as the state-specific intercept and $\beta_{state}$ the state-specific slope with overall time. These terms measure deviations of each state from national values, and allow variation in level and trend in mortality by state. We modelled the state-level random intercepts and slopes using the Besag, York, and Mollie (BYM) spatial model,[42] which includes both spatially-structured random effects with an intrinsic Conditional Autoregressive (ICAR) prior and spatially-unstructured independent and identically distributed (IID) Gaussian random effects. The extent to which information is shared between neighbouring states depends on the uncertainty of death rates in a state and the empirical similarity of death rates in neighbouring states. We also included state-month interactions for intercepts and slopes ($\zeta_{state-month}$ and $\psi_{state-month}$), to allow variation in mortality levels and trends in a particular state for different months and vice-versa. These state-month interactions were modelled as IID and therefore were of Type I space-time interactions.[43] Non-linear change over overall time (in months) was captured by a first-order random walk, $\nu_{time}$.[41] In order to ensure identifiability each set of random walk terms or state random effects was constrained to sum to zero.

Finally, we included a term that relates log-transformed death rate to the above-defined state-month temperature anomaly, $\gamma_{month} \cdot Anomaly_{state-time}$. The coefficients of $\gamma_{month}$ represent the logarithm of the monthly death rate ratio per 1°C increase in anomaly. There was a separate coefficient for each month which means that an anomaly of the same magnitude could have different associations with injury mortality in different months. As with the month-specific intercepts and trends, we used a cyclic first-order random walk to smooth the coefficient of the temperature anomaly across months. An over-dispersion term ($\varepsilon_{state-time}$) captured the variation unaccounted for by other terms in the model, modelled as $N(0,\sigma_{\epsilon}^{2})$. We used weakly informative priors so that parameter estimation was driven by the data. As in previous analyses,[44,45] hyper-priors were defined on the logarithm of the precisions of the random effects, in other words on $\log(1/\sigma^2)$. These were modelled as logGamma($\theta$, $\boldsymbol{\delta}$) distributions with shape $\theta$ = 1 and rate $\boldsymbol{\delta}$ = 0.001. The same hyper-priors were used for all precision parameters of the random effects in the model. For the common slope, we used $N(0, 1000)$ and for the common intercept a flat prior.

In addition to representing the spatial (across states) and temporal (across months and years) patterns of mortality, the intercept terms ($\alpha_{month}$, $\alpha_{state}$, $\zeta_{state-month}$) in our statistical model implicitly adjust for unobserved factors that influence mortality at the state, month and state-month level; the slope terms ($\beta_{month}$, $\beta_{state}$, $\psi_{state-month}$) do so for changes in these factors over time.[44] This means that the only confounding factors would be those that have the same state-month anomaly as temperature.

We fitted the models using integrated nested Laplace approximation (INLA), using the R-INLA software, which offers orders of computational efficiency improvement in Bayesian inference compared to traditional MCMC.[46] The uncertainty in our results were obtained from 5000 draws from the posterior marginal of each month's excess relative risk. The reported 95% credible intervals are the 2.5$^{th}$ to 97.5$^{th}$ percentiles of the sampled values.

Analyses were done separately by injury type, because different injuries can have differing associations with anomalously warm and cold temperature. Analyses were also done separately by sex and age group (0-4 years, 10-year age groups from 5 to 84 years, and 85+ years) because injury death rates vary by age group and sex, as might their associations with temperature. We used the resultant risk estimates and the age-sex-specific death rates from each injury in 2017, to calculate additional deaths if each month in each state were +2°C above its long-term average, not only realistic in our lifetimes under current projections of global climate change but an agreed upper bound chosen under the Paris Climate Agreement.[47] +2°C is also within the range of anomaly size experienced by some states (Figure 3). For this calculation, we multiplied the actual death counts for each month, sex, state and age group in 2017 by the corresponding excess relative risk, which was calculated as the exponential of the coefficient of the temperature anomaly term from the above analysis.

*Sensitivity analyses*

We conducted sensitivity analyses to assess how much our results might depend on the temperature metric used to generate anomalous temperature. First, instead of building our monthly temperature anomalies based on daily mean temperatures, we used daily maxima and minima. These measures were strongly correlated to those generated from daily means (Supplementary Table 3), and therefore we did not run models using these alternatives.

Second, together with temperature anomaly based on daily mean temperatures, we also included a second measure of anomaly in the model. The additional measures were related to more extreme anomalous situations which may be relevant if the impacts on injuries are related to more extreme temperatures and how frequent they are in each month:

- temperature anomaly calculated based on 90$^{th}$ percentile (°C) of daily mean temperatures within a month, compared to the average of 90$^{th}$ percentiles for each state and month
- number of days in a month above the long-term 90$^{th}$ percentile of average temperature for each state and month (adjusted for length of month)
- number of 3+ day episodes above the long-term 90$^{th}$ percentile of average temperature for each state and month (adjusted for length of month)

The correlations among these variables and anomaly based on mean were between 0.60 and 0.89 (Supplementary Table 4). The estimated rate ratios of temperature anomaly based on daily means (i.e., the anomaly measure used in the main analysis) were robust to the addition of alternative measures of anomaly, while the coefficients of the additional measures were generally not significant and with large credible intervals. Therefore, we did not include the alternative additional measures of extreme anomalous temperature in the main analysis.

*Comparison with prior studies*

While there are no previous studies of how deviations of monthly temperature from long-term average are associated with injury mortality, our results are broadly in agreement with those that have analysed associations with absolute temperature and for specific injury types. A study of suicide in US counties over 37 years (1968-2004) estimated that 1°C higher monthly temperature would lead to a 0.7% rise in suicides,[7] compared to our findings of 0.9-2% in males and 0.6-3.9% in females in different ages for a +2°C anomaly. A cross-sectional analysis in 100 US counties found that a 1°C higher temperature would lead to a 1.3% increase in death rates from road traffic injuries,[21] compared to our finding of 0.8-4.1% in males and 0.6-2.7% in females for a +2°C anomaly. In a study of six French heatwaves during 1971-2003, mortality from unintentional injuries rose by up to 4% during a heatwave period compared to a nonheatwave baseline.[8] A study of daily mortality from all injuries from Estonia found a 1.24% increase in mortality when daily maximum temperature went from the $75^{th}$ to $99^{th}$ percentile of long-term distribution.[9]

*Strengths and limitations*

The major strength of our study is that we have comprehensively modelled the association of temperature anomaly with injury by type of injury, month, age group and sex. Our measure of temperature anomaly internalises long-term historical experience of each state, and is closer to what climate change may bring about than solely examining daily episodes, or average temperature to which people have adapted. To utilise this metric, we integrated two large disparate national datasets on mortality (US vital statistics) and meteorology (ERA5), and developed a bespoke Bayesian spatio-temporal model. A limitation of our study is that, like all observation studies, we cannot rule out confounding of results due to other factors. As described above, our statistical model by design adjusts for factors related to month, state and state-month that are either invariant over time or that change linearly. Rather, the confounding factors would be those with anomalies that are similar to those of monthly temperature in each state, such as air pollution. However, to our knowledge, there is currently no evidence of an association between air pollution and injury mortality.

## Data availability

ERA5 temperature data are downloadable from https://www.ecmwf.int/en/forecasts/datasets/reanalysis-datasets/era5. Vital statistics files with geographical information can be requested through submission of a proposal to NCHS (https://www.cdc.gov/nchs/nvss/nvss-restricted-data.htm).

## Code availability

The computer code for the Bayesian model used in this work will be available at www.globalenvhealth.org/code-data-download upon publication of the paper.

## Supplementary information

This file contains Supplementary Figure 1, Supplementary Table 1, Supplementary Table 2, Supplementary Table 3 and Supplementary Table 4.

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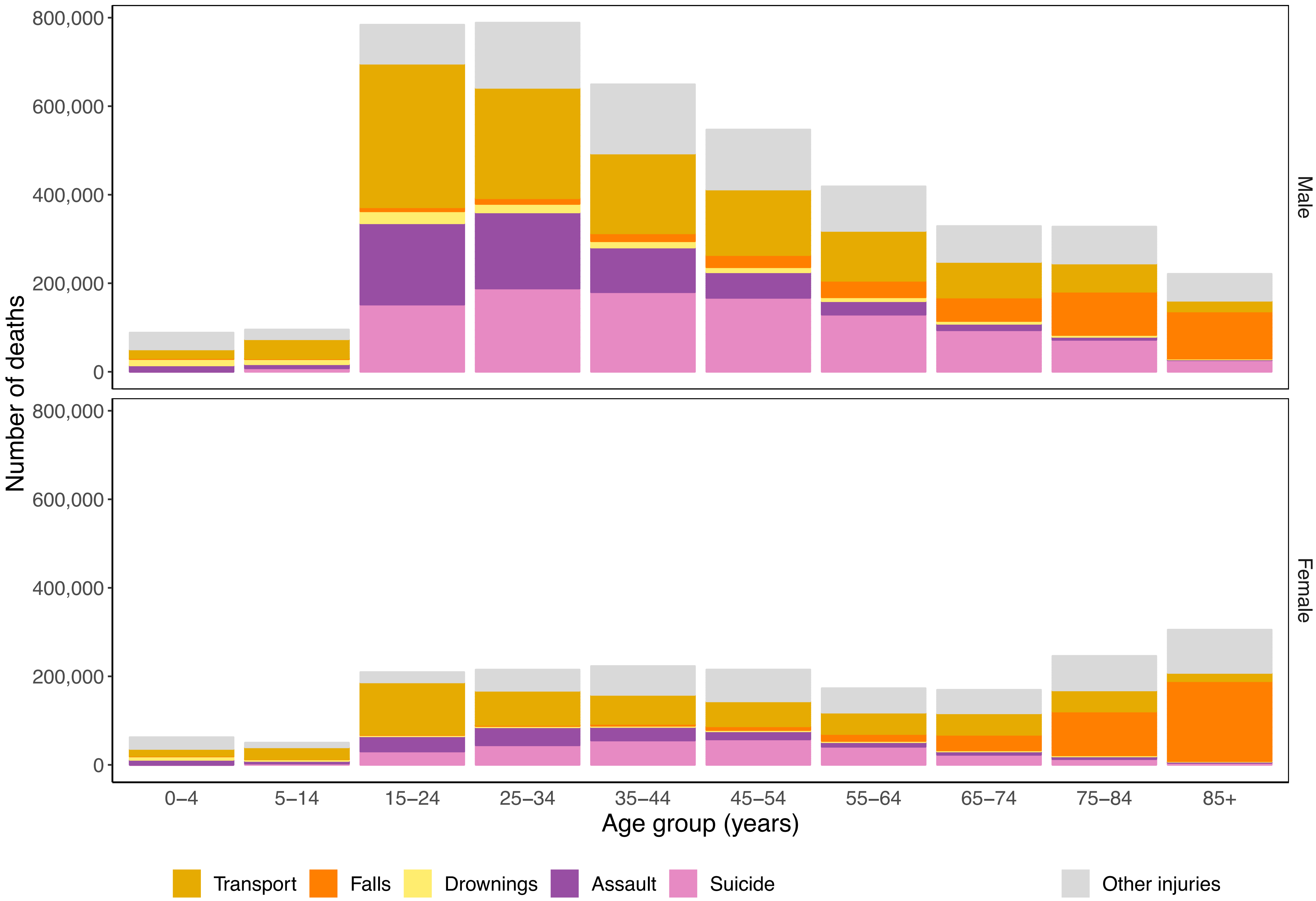
## Author contributions

All authors contributed to study concept and interpretation of results. RP, GD and ME collated and organised temperature and mortality files. RP, JEB, VK and ME developed statistical model, which was implemented by RP, JEB and VK. RP performed the analysis, with input from other authors. RP and ME wrote the first draft of the paper; other authors contributed to revising and finalizing the paper.

**Competing interests statement**

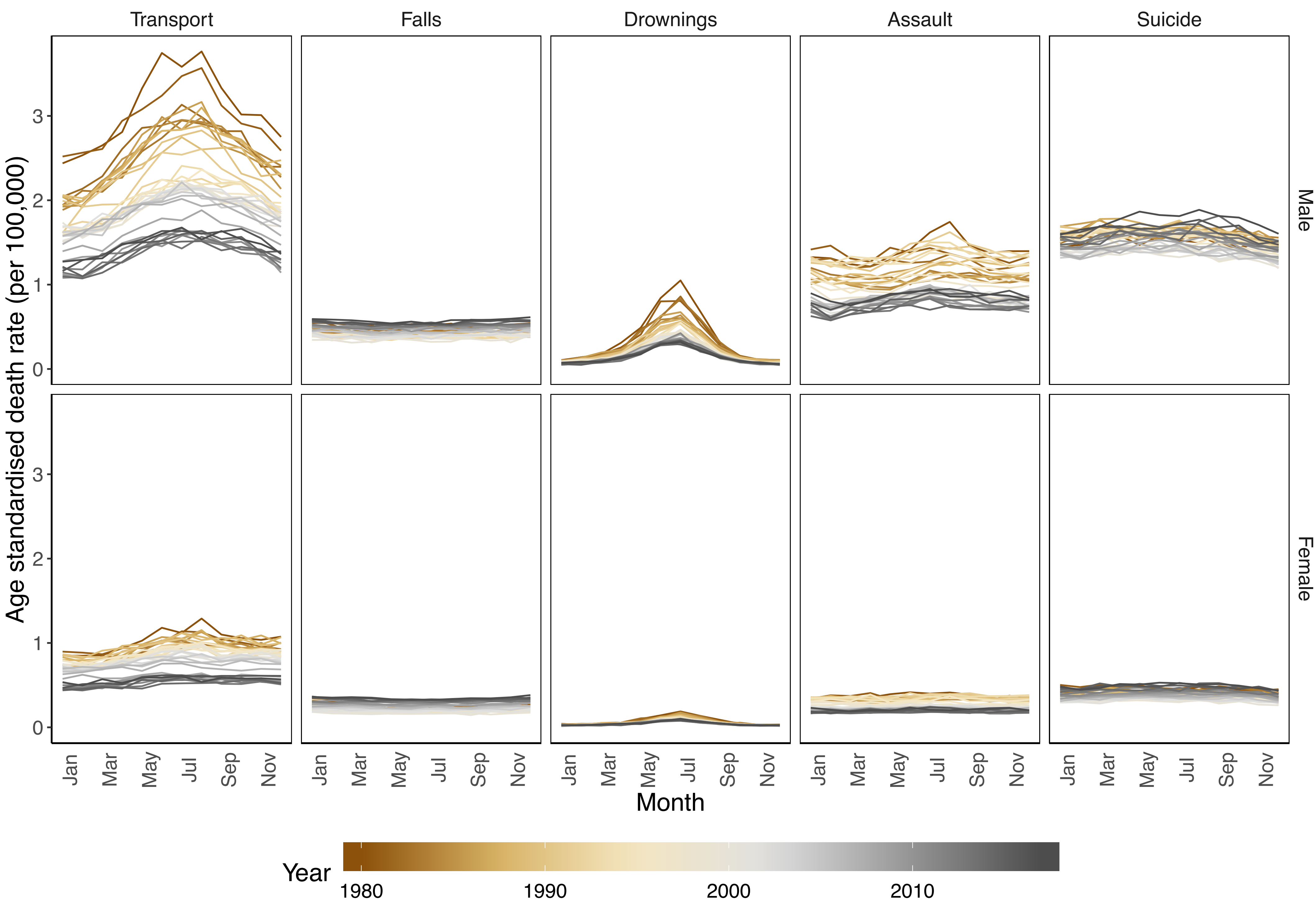
ME reports a charitable grant from AstraZeneca Young Health Programme, and personal fees from Prudential, Scor, and Third Bridge, all outside the submitted work; all other authors declare no competing interests.

**Figure 1.** Number of injury deaths, by type of unintentional (transport, falls, drownings, and other) and intentional (assault and suicide) injury, by sex and age group in the contiguous USA for 1980-2017.



800,000
600,000
400,000
200,000
0
Number of deaths
Male
Female
0–4
5–14
15–24
25–34
35–44
45–54
55–64
65–74
75–84
85+
Age group (years)
Transport
Falls
Drownings
Assault
Suicide
Other injuries

**Figure 2.** National age-standardised death rates from 1980 to 2017, by type of injury, sex and month.



Transport
Falls
Drownings
Assault
Suicide
Male
Female
Age standardised death rate (per 100,000)
0
1
2
3
Jan
Mar
May
Jul
Sep
Nov
Month
Year
1980
1990
2000
2010

**Figure 3.** Average size of temperature anomaly (°C) from 1980 to 2017, by state and month. The value for each state and month is the mean of the absolute size of anomaly, be it cold or warm, and hence gives an indication of the scale of anomalies around the local average temperatures.

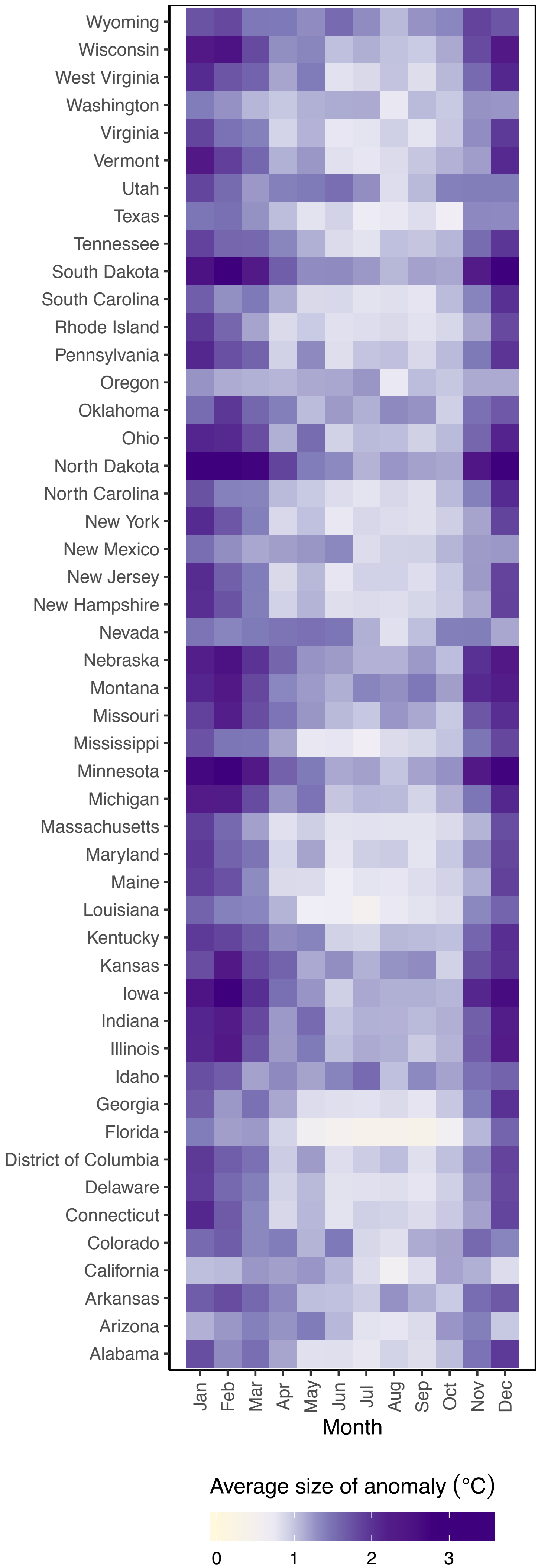
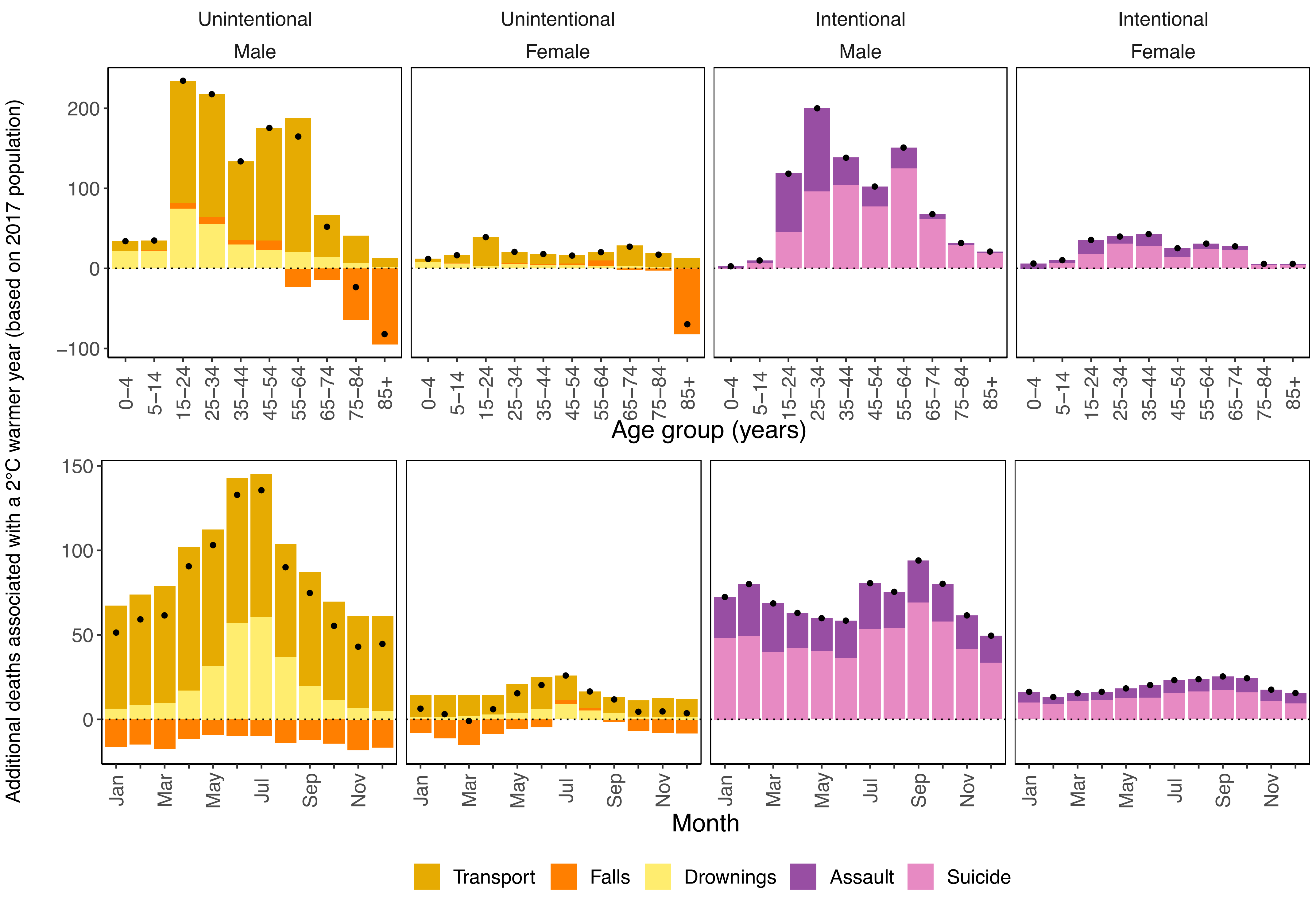
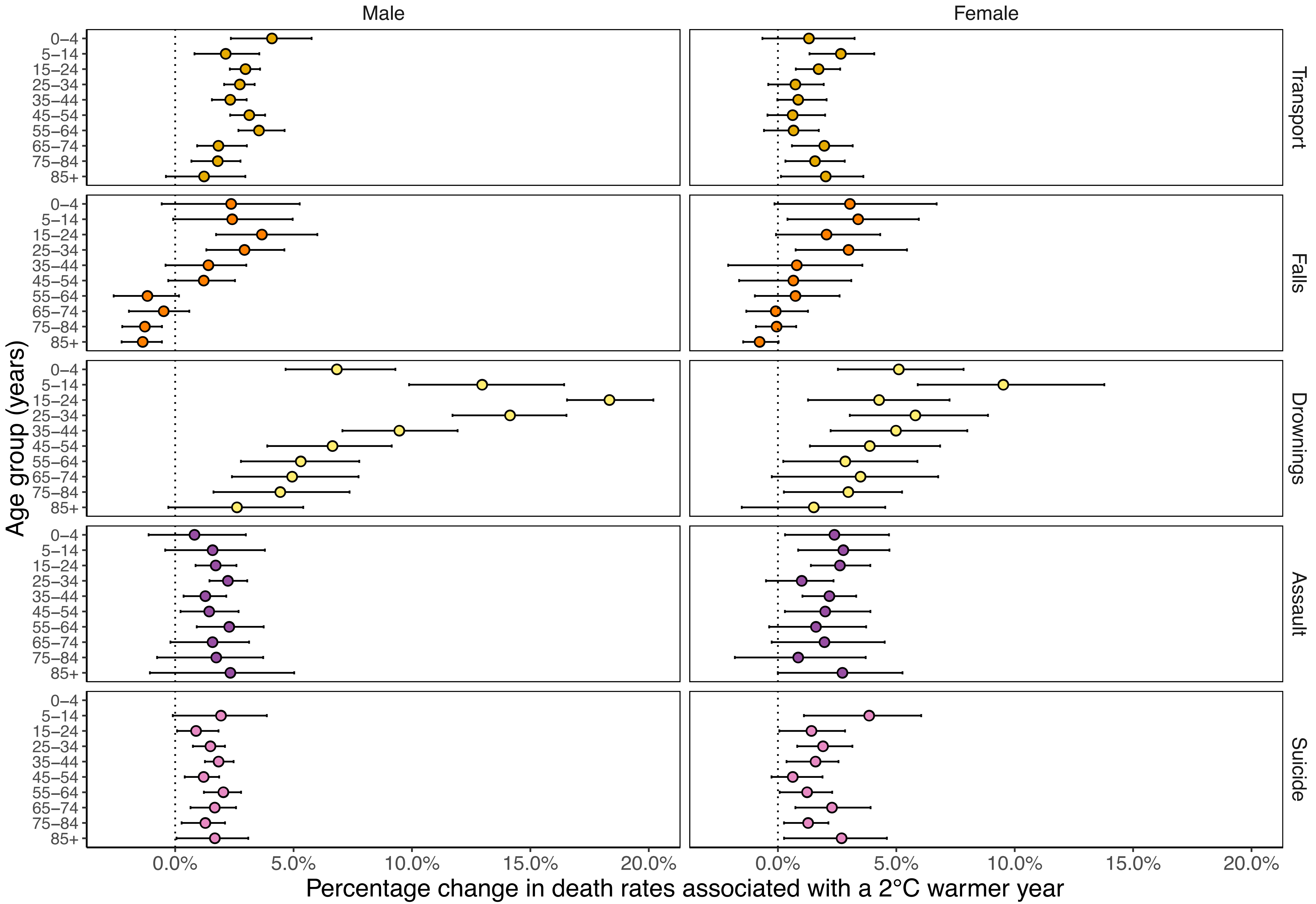

Wyoming
Wisconsin
West Virginia
Washington
Virginia
Vermont
Utah
Texas
Tennessee
South Dakota
South Carolina
Rhode Island
Pennsylvania
Oregon
Oklahoma
Ohio
North Dakota
North Carolina
New York
New Mexico
New Jersey
New Hampshire
Nevada
Nebraska
Montana
Missouri
Mississippi
Minnesota
Michigan
Massachusetts
Maryland
Maine
Louisiana
Kentucky
Kansas
Iowa
Indiana
Illinois
Idaho
Georgia
Florida
District of Columbia
Delaware
Connecticut
Colorado
California
Arkansas
Arizona
Alabama
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Month
Average size of anomaly (°C)
0
1
2
3

**Figure 4.** Additional annual injury deaths for the 2017 US population in year in which each month was +2°C warmer compared with 1980-2017 average temperatures. The top row shows breakdown by type of injury, sex and age group. The bottom row shows the break down by type of injury, sex and month. Black dots represent net changes in deaths for each set of bars.

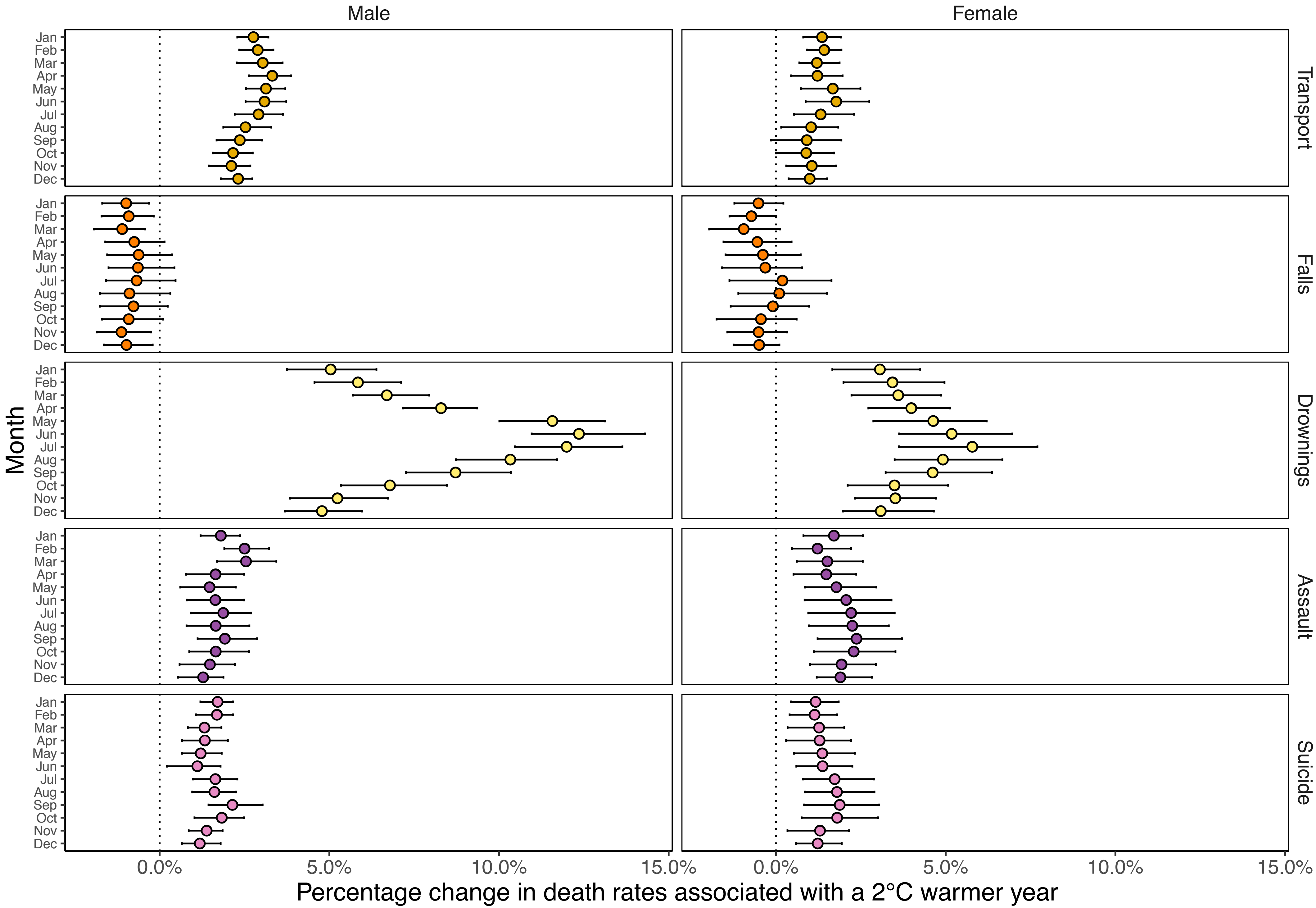


Unintentional
Male
Unintentional
Female
Intentional
Male
Intentional
Female
Additional deaths associated with a 2°C warmer year (based on 2017 population)
200
100
0
−100
0–4
5–14
15–24
25–34
35–44
45–54
55–64
65–74
75–84
85+
Age group (years)
150
100
50
0
Jan
Mar
May
Jul
Sep
Nov
Month
Transport
Falls
Drownings
Assault
Suicide

**Figure 5.** Percent change in death rates in year in which each month was +2°C compared with 1980-2017 average temperatures by type of injury, sex and (A) age group or (B) month.



Male
Female
Transport
Falls
Drownings
Assault
Suicide
Age group (years)
0–4
5–14
15–24
25–34
35–44
45–54
55–64
65–74
75–84
85+
0.0%
5.0%
10.0%
15.0%
20.0%
Percentage change in death rates associated with a 2°C warmer year



Male
Female
Transport
Falls
Drownings
Assault
Suicide
Month
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
0.0%
5.0%
10.0%
15.0%
Percentage change in death rates associated with a 2°C warmer year

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