Children For Our Future

Alabama Child Death Review System
1998/1999 Report

January 15, 2002

Children are not supposed to die. Every death of a child is a tragedy, especially if that death could have been prevented. To better understand how and why children die and take actions to prevent future deaths, we needed a standardized procedure for the in-depth review of all unexpected and unexplained child deaths.

In 1993, the Corporate Foundation for Children partnered with the Alabama Department of Human Resources to sponsor a statewide task force of professionals to examine the child fatality response system in Alabama and make recommendations on how we might better determine the circumstances surrounding a child's death. Representatives from various disciplines, agencies and private interests that work with children on both local and state levels within Alabama came together in a spirit of collaboration. As a result of this extraordinary commitment, legislation to establish the Alabama Child Death Review System was enacted and signed into law on September 11, 1997. This program is housed in the Alabama Department of Public Health.

Alabama's future is contingent upon the survival of its children. We must protect the safety and well being of our children if we are to guarantee their survival. Child Death Review Teams have significant potential to improve service delivery and linkage among systems as Alabama seeks to prevent deaths of its children. We are committed to building a broad review process that addresses all preventable child deaths. By adopting this public health approach, a better understanding and greater awareness of all the causes of child deaths can be realized on the local and state level.

It is with great pleasure that I present the 1998/1999 Alabama Child Death State Advisory Team Annual Report. This is our first effort at such a report, and being our first, we already see areas where we can improve our annual product. Our goal is to prevent the needless infant/child deaths in Alabama. With this first annual report we highlight our efforts toward that end. I encourage you to carefully read this report and to continue to take an active role in promoting the health and safety of our Alabama children.

Sincerely,

Donald E. Williamson, M.D.
State Health Officer
STATE OF ALABAMA

MISSION

To understand how and why children die in Alabama, in order to take action to prevent other child deaths.

Submitted To

Governor Don Siegelman
The Alabama State Legislature
The People of Alabama

Alabama Department of Public Health
Bureau of Family Health Services
Thomas M. Miller, MD, Director

January 2002

Acknowledgements

We wish to acknowledge the dedication and unwavering support of the more than eleven hundred volunteers from throughout Alabama who serve our state and the children of Alabama by participating on Child Death Review Teams. It is an act of courage to acknowledge that the death of a child is a community problem. Their willingness to step outside of their traditional professional roles and examine all of the circumstances that lead to child deaths, and to seriously consider ways to prevent other deaths, has made this report possible.

We want to thank the members of our State Team for their leadership and direction. Most especially, we want to thank each of our state's District Attorneys and their Local Child Death Review Team Coordinators, for volunteering their time to organize, facilitate and report on the findings of their reviews.

The Alabama Department of Public Health, Center for Health Statistics has been especially helpful in providing the child mortality data and in helping us to better understand and interpret the statistics on child deaths.

And finally our special thanks go to Mr. Chris Sellers, ADPH/FHS who did yeoman service for us in analyzing our data and helping us determine what it all meant.

Alabama Child Death Review System
Alabama Department of Public Health

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http://www.alapubhealth.org/CDR

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Part 1: The Data

Preface (Technical Notes)

Comments on the First Two Years Experience and Data Limitations

Periodic field-testing and revision of data collection instruments characterized the first two years of official child death review data collection. Additionally, considerable efforts have been dedicated to the recruitment and implementation of review teams and the operational protocols that guide their performance. During this formative time period, a remarkable network of local death review teams guided by refined, field tested procedures has been established. Indeed, the current operational, data collection and reporting structures should serve the State proudly over the next several years.

The frequent evaluation and remediation of data collection difficulties identified during this formative time has resulted in several data limitations which must be identified for this report:

1. The initial data collection instrument was difficult for review teams to use. The first instrument was not a single questionnaire, but a series of independent questionnaires. Several data elements represented redundant information with respect to data already available on the birth or death certificate.
2. Although a standard set of instructions was presented, several data elements were not sufficiently defined, which compromised the validity of some of the data reported.
3. The role of alcohol or drug abuse was not adequately included for reporting purposes.
4. Limited data pertaining to child abuse was collected.
5. Limited data pertaining to the preventability of various causes of death were collected in a usable form.
6. As a result of the culmination of these data collection problems, the valid and reliable data retrieved for this report represents considerably less than 100% of the qualified, review team cases. This report is comprised of a sample representing 64% of all review team reports. Much of these data were manually reviewed to document the needed level of detail.

Major improvements in data collection, computer management and reporting have been noted for year 2000 and beyond data. We will receive tremendous benefit from the lessons learned in our first two years of data gathering. Nonetheless, current data provided in this report provide an important and useful profile of the unexpected and unexplained deaths of Alabama's children.

Beyond the advances made in child death review data collection, management and computerization, several noteworthy achievements have resulted from the work of the Alabama Child Death Review System. Many of these achievements are highlighted in this report.

A systematic review of qualifying infant/child deaths identified many attributes worthy of detailed study. What follows are data summaries for the years 1998 and 1999. Vital Statistics data from the Alabama Center for Health Statistics provide a statewide source of data that has been useful for comparison with the more specific qualifying infant/child death review data.

1998 Data Summary

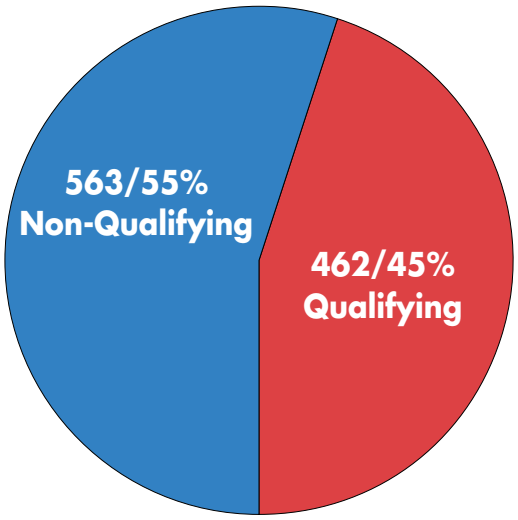
Based on Alabama Department of Public Health, Center for Health Statistics data, there were 1,025 infant and child deaths (birth through <18 years old) in Alabama in 1998. Of those 1,025 deaths, 462 deaths met the criteria for a Child Death Review (CDR) (Criteria = less than 18 years old and death classified as unexpected/unexplained). Of the 462 qualifying deaths, only 294 were actually reviewed by a local team and a CDR report completed and returned to the state headquarters (64% return rate).

1,025 Total Deaths in 1998	
462 Qualified Deaths	**462/1025 = 45% Meet Review Criteria**
294 Cases Reviewed and Returned	**294/462 = 64% Returned Case Rate**
168 Cases Not Returned	**168/462 = 36% Not Returned**

The data that follows is based on the 1998 cases reviewed and returned to state headquarters.

1998 Data Analysis

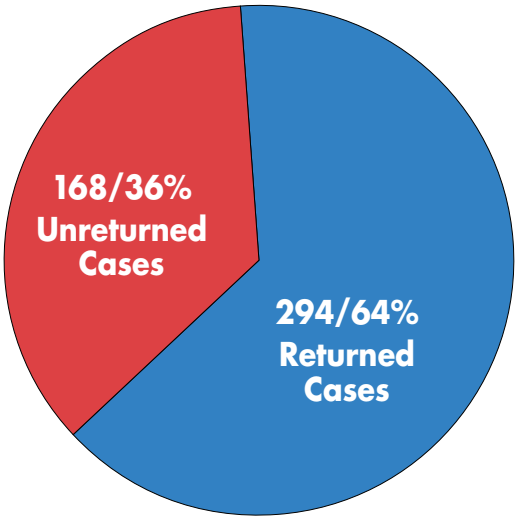
Total Infant/Child Deaths - 1998



Total Deaths = 1025

Of the 1,025 infant/child deaths reported to the Alabama Center for Health Statistics, 462 deaths (45%) met the criteria for system review (See Part 4: Definitions). According to Center figures, these infant/child deaths comprise 2% of the total of 43,905 deaths which occurred in Alabama during 1998.

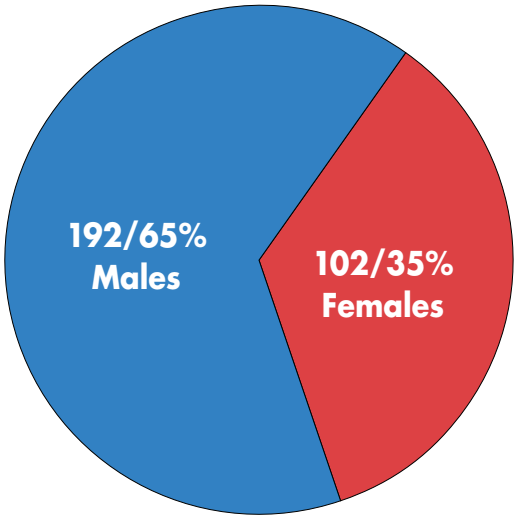
Returned vs. Unreturned Cases - 1998



Total Qualified Cases = 462

Of the infant/child deaths eligible for review (462), the Local Child Death Review Teams completed and returned 294 cases (64%) for analysis.

Deaths by Gender - 1998
Reviewed cases only.



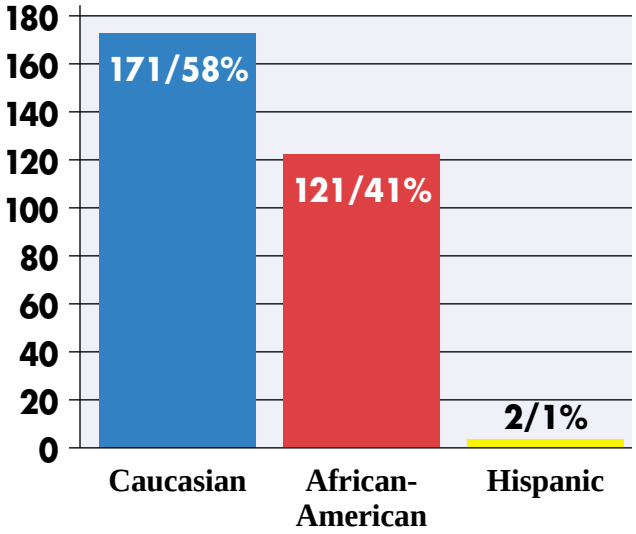
Total Reviewed Deaths = 294

Of the infant/child deaths qualifying for review, males comprised 192 cases (65%) of the total reviewed, while females comprised 102 cases (35%). These results markedly differ from the all ages death data for Alabama where 22,020 males make up 50.2% of the 43,905 deaths and 21,885 females make up 49.8%.

Seemingly, age and unexpected/unexplained death distorts the typical ratios of deaths among genders. In our limited study, male infants/children seem to be at a higher risk of dying from an unexpected/unexplained death than are females.

	Reviewed Deaths		State Deaths	
Male	**192**	**65%**	**22,020**	**50.2%**
Female	**102**	**35%**	**21,885**	**49.8%**
Total	**294**	**100%**	**43,905**	**100%**

Deaths by Race - 1998
Reviewed cases only.



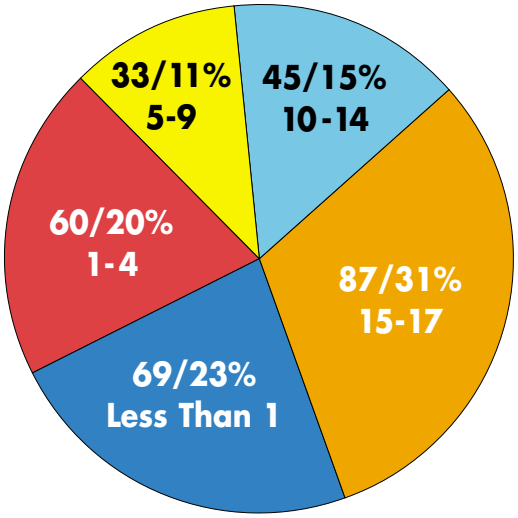
Total Reviewed Deaths = 294

Within our reviewed, eligible cases, our analysis reveals that 171 of our cases (58%) were Caucasian, 121 cases (41%) were African American, and 2 cases (1%) were Hispanic. Data from the ACHS show that deaths across all ages distribute among the races in this manner: 32,987 (75.1%) were Caucasian and 10,918 (24.9%) as other races. Race proportions for infant/child deaths in our qualifying group do not follow race proportions for the state at large. Our study shows that among the unexpected/unexplained deaths in the criteria age group, Alabama's African American infants/children are at higher risk than our all age numbers show. Further, as our Hispanic population grows and becomes more visible, we expect the infant/child deaths among this race to grow as well. These tendencies may be a function of our small sample size…but the trend will be watched closely as our data improves.

	Reviewed Deaths		State Deaths	
Caucasian	**171**	**58%**	**32,987**	**75.1%**
Other	**123**	**42%**	**10,918**	**24.9%**
Total	**294**	**100%**	**43,905**	**100%**

Deaths by Age Group - 1998

Reviewed cases only.



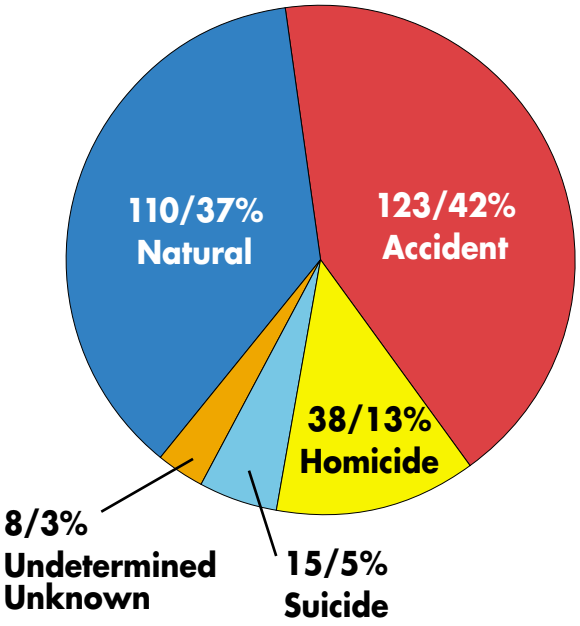
When assessed by age group, 69 cases (23%) fell within the less than 1-year-old group, 60 cases (20%) were in the 1 to 4 year old group, 33 cases (11%) fell into the 5 to 9 year old group, 45 cases (15%) were in the 10 to 14 year group, and 87 cases (31%) were within the 15 to 17 year old group.

As we will see in our Cause of Death analysis, the large number of deaths within the older age groups, particularly the 15 to 17 year old group, seems to be a result of the risks associated with teenaged driving and the increased amount of time Alabama's older children spend on or near the state's highways.

Total Reviewed Deaths = 294

Manner of Death - 1998

Reviewed cases only.



Total Reviewed Deaths = 294

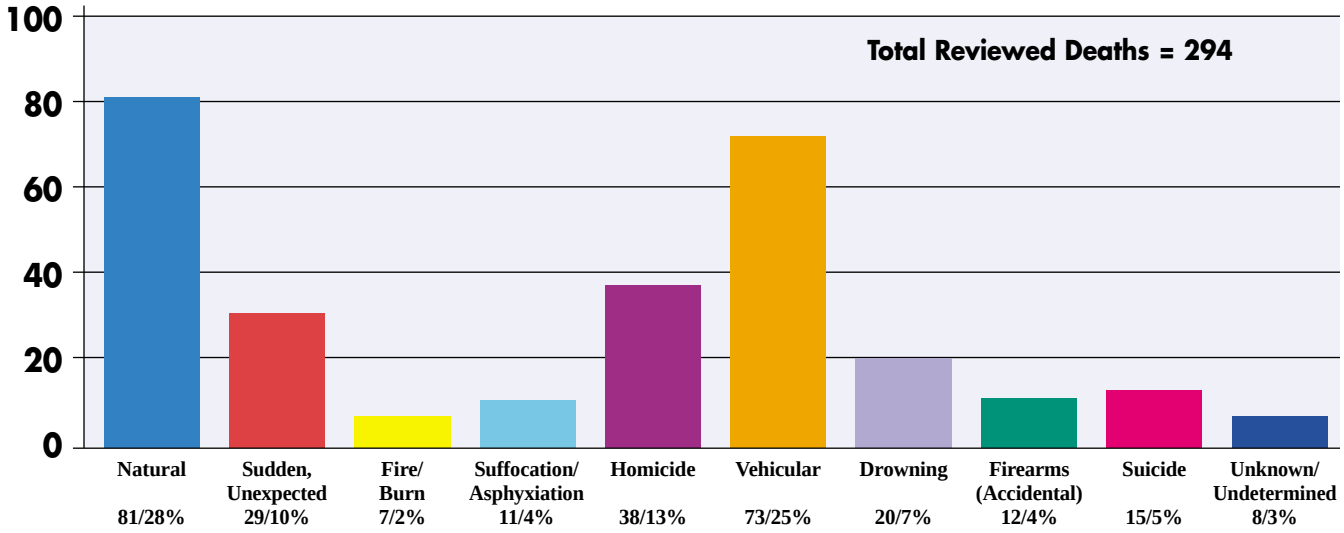
Our analysis revealed that 110 of our qualifying cases (37%) had as the Manner of Death (see Part 4. Definitions) the classification of "Natural", 123 cases (42%) were classified as "Accidents", 38 cases (13%) were "Homicides", 15 cases (5%) were "Suicides", and the remaining 8 cases (3%) remained as "Unknown/Undetermined". Death rates of the state population for all ages regarding the Manner of Death reveal 5.03% are classified as "Accidents" and 1.05% are classified as "Homicides". Even with allowances for the small sample size that has been noted previously, these numbers reflect the increased risk that qualifying children possess over and above the population as a whole. As we will see later, within our returned, qualifying cases, "Suicides" are primarily a white, male, teenaged problem, "Homicide" is primarily a black, teenaged problem, and vehicular deaths are the primary "Accidental" death problem for teenagers in our state.

(Note: Please see Part 4: Definitions for an explanation of "Natural" deaths. These deaths would normally not be reviewed by our teams. However, frequently death certificates are labeled "Unknown" or "Pending" for Manner of Death. To insure that we don't miss a qualifying case, these cases will always be reviewed. Many of these cases eventually result in a "Natural" Manner and/or Cause of Death.)

	Reviewed Deaths		State Deaths	
Accident	**123**	**42%**	**2,209**	**5.03%**
Homicide	**38**	**13%**	**463**	**1.05%**
Suicide	**15**	**5%**	**567**	**1.29%**
Other	**118**	**40%**	**40,666**	**92.63%**
Totals	**294**	**100%**	**43,905**	**100%**

Causes of Death - 1998

Reviewed cases only.



Our analysis indicates that the Cause of Death (see Part 4: Definitions) for 81 of the reviewed, qualifying cases (28%) was "Natural", for 29 cases (10%) was "Sudden/Unexpected", for 7 cases (2%) was "Fire/Burn", for 11 cases (4%) was "Suffocation/Asphyxiation", for 38 cases (13%) was "Homicide", for 73 cases (25%) was "Vehicular", for 20 cases (7%) was "Drowning", for 12 cases (4%) was "Accidental Firearm", for 15 cases (5%) was "Suicide", and for 8 cases (3%) was "Unknown/Undetermined".

Further, with regard to "Accidental" deaths, our analysis shows that infant/children within our criteria group, succumb to "Accidental" deaths at a rate at least twice as high as the rate for the population as a whole. And in particular, the incidence of teenaged vehicular deaths occurs at an alarming rate when a teenaged driver is combined with several passengers and almost any outside distraction…such as darkness, poor weather, excessive speed, cell phone usage, and/or fatigue.

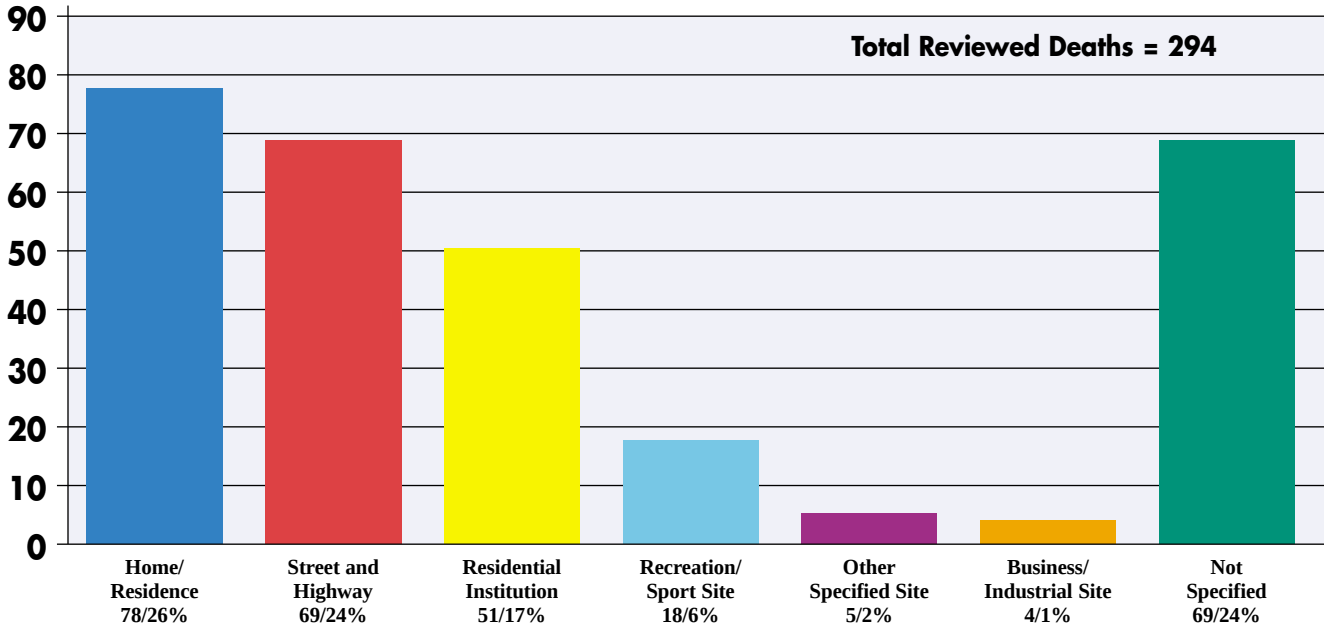
(Note: The presence of "Natural" Causes of Death occurs for the same reason as noted in "Manner of Death" in the previous section.)

Accident Category ÷ Population Totals

	Reviewed Deaths		State Deaths	
Fire	7	0.70%	85	0.19%
Suffocation	11	1.10%	127	0.29%
Firearms	12	1.20%	432	0.98%
Vehicular	73	7.10%	1,146	2.61%
Drowning	20	2.00%	108	0.25%
Other			311	0.71%
Total Accidents	123	12.10%	2,209	5.03%
Population Totals	1,025	0 < 18	43,905	All Ages

Place of Death - 1998

Reviewed cases only.



Our analysis of the 294 reviewed, qualifying cases revealed that 78 cases (26%) occurred at home, 69 cases (24%) took place on a street, road or highway, 51 cases (17%) occurred at a residential institution (usually this means a hospital…), 18 cases (6%) occurred at a recreation or sports site, 5 cases (2%) occurred at another specified site, 4 cases (1%) took place at a business/industrial site, and 69 cases (24%) occurred at an unnamed/unspecified location.

The large number of "Natural" deaths account for most of the deaths that occurred at home and in residential institutions. This is quite understandable in cases of perinatal, neonatal, and post neonatal/infant deaths. Because of the delicate, young age, most of these will occur either at home or in a hospital. But the large percentage of qualifying deaths that occur on streets/roads/highways gives even more evidence to the fact that vehicular deaths should be of major concern for all of us who are interested in the welfare of Alabama's children.

1999 Data Summary

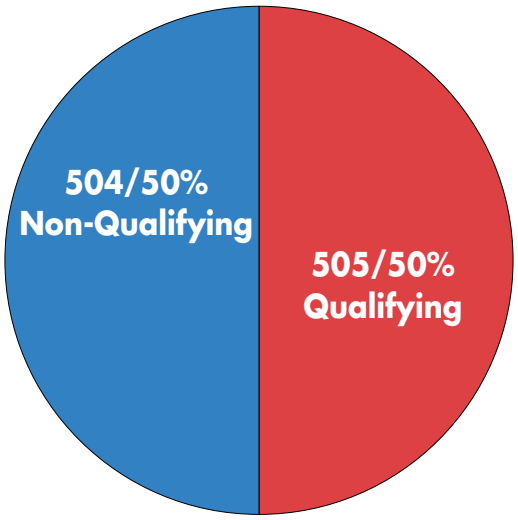
Based on Alabama Department of Public Health, Center for Health Statistics data…there were 1,009 infant and child deaths (birth through <18 years old) in Alabama in 1999. Of those 1,009 deaths, 505 deaths met the criteria for a Child Death Review (CDR) (Criteria = less than 18 years old and death classified as unexpected/unexplained). Of the 505 qualifying deaths, only 338 were actually reviewed by a local team and a CDR report completed and returned to the state headquarters (67% return rate).

1,009 Total Deaths in 1999	
505 Qualified Deaths	**505/1009 = 50% Meet Review Criteria**
338 Cases Reviewed and Returned	**338/505 = 67% Returned Case Rate**
167 Cases Not Returned	**167/505 = 33% Not Returned**

The data that follows is based on the 1999 cases reviewed and returned to state headquarters.

1999 Data Analysis

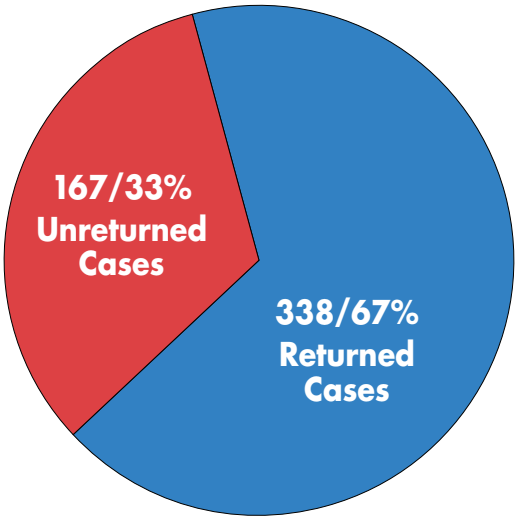
Total Infant/Child Deaths - 1999



Total Deaths = 1009

Of the 1,009 infant/child deaths reported to the Alabama Center for Health Statistics, 505 child deaths (50%) met criteria for system review (See Part 4: Definitions). According to Center figures, these infant/child deaths comprise 2% of the 44,720 citizens who died in 1999.

Returned vs. Unreturned Cases - 1999

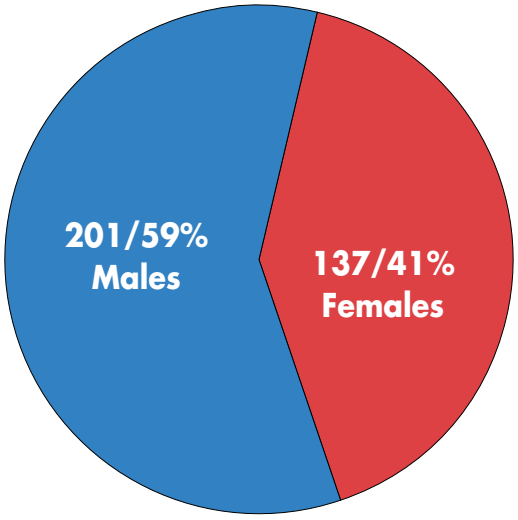


Total Qualified Cases = 505

Of the infant/child deaths eligible for review, the Local Child Death Review Teams completed and returned 338 cases (67%) for analysis.

Deaths by Gender - 1999

Reviewed cases only.



Total Reviewed Deaths = 338

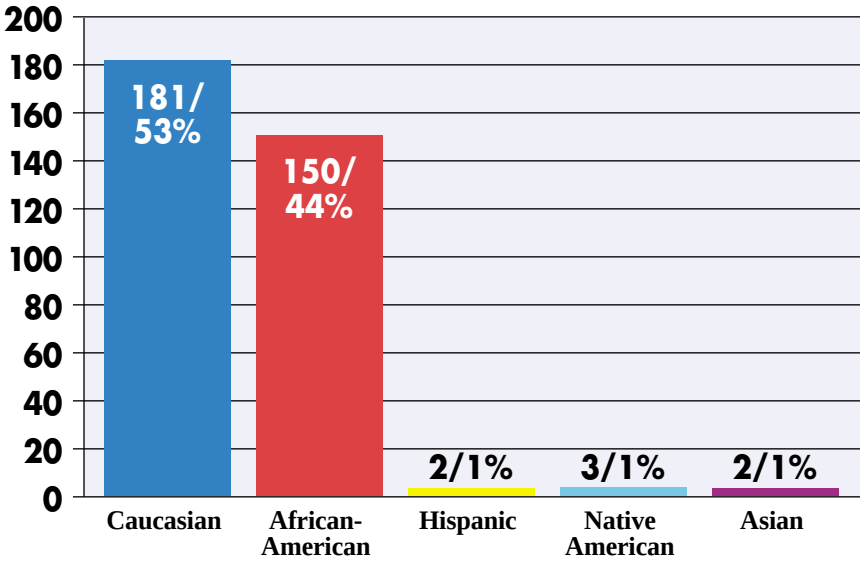
Among the infant/child deaths qualifying for review, males comprised 201 cases (59%) of the total reviewed while females comprised 137 cases (41%.) These results markedly differ from all ages death data for Alabama where 22,132 males make up 49.5% of the 44,720 deaths and 22,588 females make up 50.5%.

As with our 1998 data, age and unnatural/unexpected death appears to distort the typical ratios of deaths among genders. In both 1998 and 1999 male infants/children seem to be at a higher risk of dying from an unexpected/unexplained death than are females.

	Reviewed Deaths		State Deaths	
Male	201	59%	22,132	49.5%
Female	137	41%	22,588	50.5%
Total	338	100%	44,720	100%

Deaths by Race - 1999

Reviewed cases only.



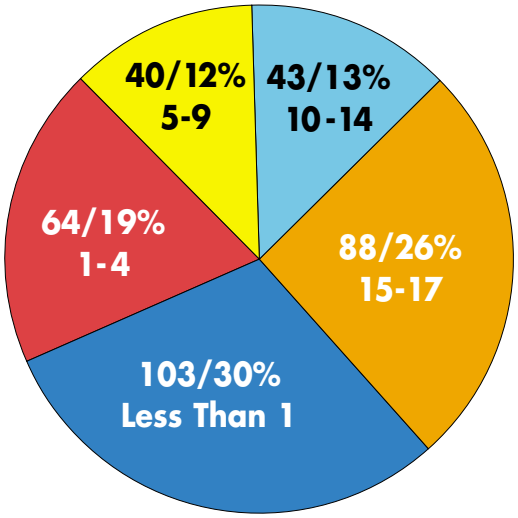
Total Reviewed Deaths = 338

	Reviewed Deaths		State Deaths	
Caucasian	181	53%	33,588	75.11%
Other	157	47%	11,132	24.89%
Total	338	100%	44,720	100%

Death distribution among Alabama's races follow: 181 cases (53%) as Caucasian, 150 cases (44%) as African American, 2 cases (1%) as Hispanic, 3 cases (1%) as Native American and 2 cases (1%) as Asian. Data from the ACHS show that deaths across all ages distribute among the races as 33,588 (75.11%) as Caucasian and 11,132 (24.89%) as other races. Our 1999 data follows the same pattern that our 1998 data followed. Deaths within our criteria group do not follow the race proportions for deaths among the state at large. Unexpected/unexplained deaths among the 0 to 17 age group seem to occur within Alabama's African American race at a much higher rate than deaths within the all ages grouping.

Deaths by Age Group - 1999

Reviewed cases only.



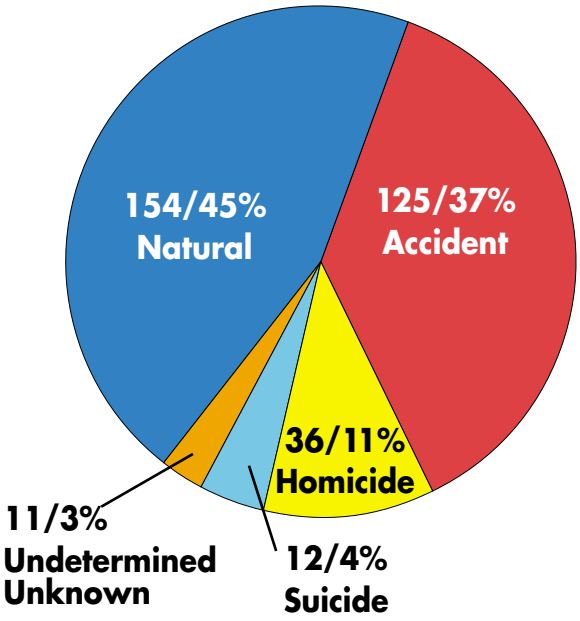
When assessed by age group, our analysis revealed 103 cases (30%) were in the less than 1 year old group, 64 cases (19%) fell in the 1 to 4 year old group, 40 cases (12%) were in the 5 to 9 year old group, 43 cases (13%) were in the 10 to 14 year old group, and 88 cases (26%) were in the 15 to 17 year old group.

As with our 1998 analysis, our 1999 data again points to the dangers of teenaged drivers and the risks to our older children because of their frequent use of Alabama's highways.

Total Reviewed Deaths = 338

Manner of Death - 1999

Reviewed cases only.



Total Reviewed Deaths = 294

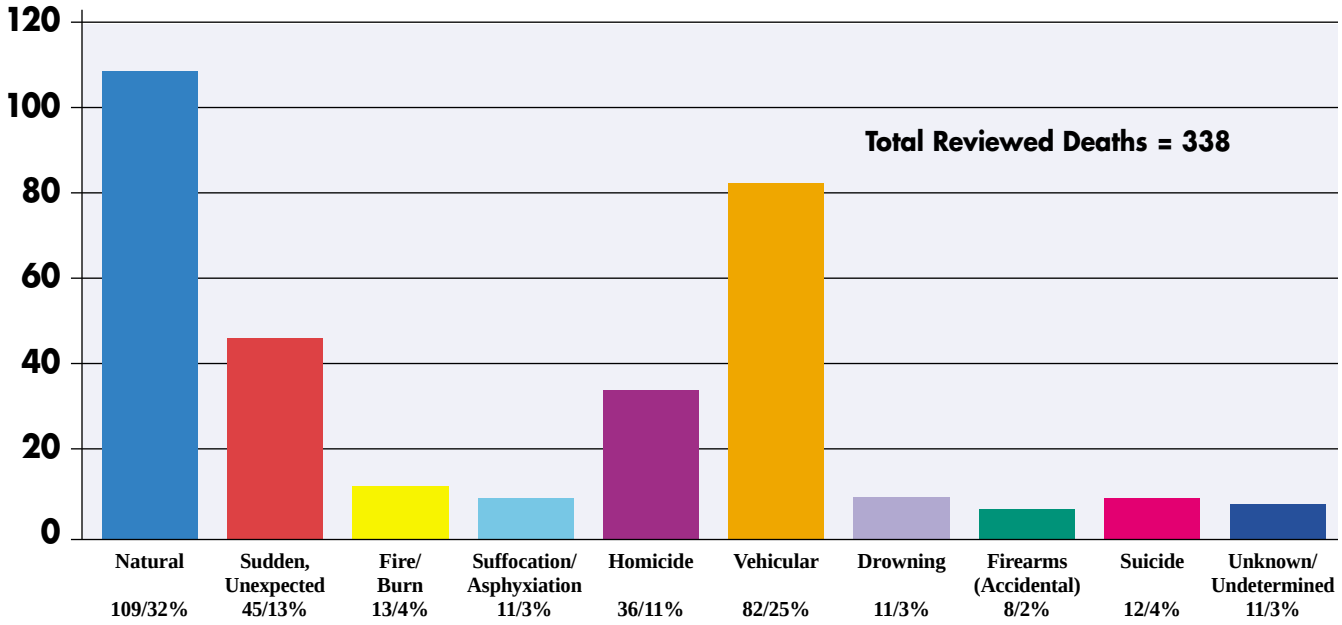
Review determined the manner of death for 154 cases (45%) as natural, 125 cases (37%) as accidental, 36 cases (11%) as homicide, 12 cases (4%) as suicide and 11 cases (3%) as unknown or undetermined. Death rates of the state population regarding manner of death for accidents (5.10%) and homicides (1.08%) demonstrate how much more risk children qualifying for review possess than the population as a whole. Death rates of the state population for all ages regarding the Manner of Death reveal 5.10% are classified as "Accidents" and 1.08% are classified as "Homicides". As with our 1998 data, even with allowances for the small sample size that has been noted previously, these numbers reflect the increased risk that qualifying children possess over and above the population as a whole. We continue to see in 1999, within our returned, qualifying cases, "Suicides" are primarily a white, male, teenaged problem, "Homicide" is primarily a black, teenaged problem, and vehicular deaths are the primary "Accidental" death problem for teenagers in our state.

(Note: Please see Part 4: Definitions for an explanation of "Natural" deaths. These deaths would normally not be reviewed by our teams. However, frequently death certificates are labeled "Unknown" or "Pending" for Manner of Death. To insure that we don't miss a qualifying case, these cases will always be reviewed. Many of these cases eventually result in a "Natural" Manner and/or Cause of Death.)

	Reviewed Deaths		State Deaths	
Accident	**125**	**37%**	**2,284**	**5.10%**
Homicide	**36**	**11%**	**483**	**1.08%**
Suicide	**12**	**4%**	**560**	**1.25%**
Other	**165**	**48%**	**41,393**	**92.57%**
Totals	**238**	**100%**	**44,720**	**100%**

Causes of Death - 1999

Reviewed cases only.



Review indicated the Cause of Death for 109 cases (32%) as "Natural", 45 cases (13%) as "Sudden/Unexpected", 13 cases (4%) as "Fire/Burn", 11 cases (3%) as "Suffocation/ Asphyxiation", 36 cases (11%) as "Homicide", 82 cases (25%) as "Vehicular", 11 cases (3%) as "Drowning", 8 cases (2%) as "Accidental Firearm", 12 cases (4%) as "Suicide", and 11 cases (3%) as "Unknown/Undetermined".

Further, as in 1998, with regard to "Accidental" deaths, our analysis shows that infants/children within our criteria group, succumb to "Accidental" deaths at a rate at least twice as high as the rate for the population as a whole. And in particular, the incidence of teenaged vehicular deaths occurs at an alarming rate when a teenaged driver is combined with several passengers and almost any outside distraction…such as darkness, poor weather, excessive speed, cell phone usage, and/or fatigue.

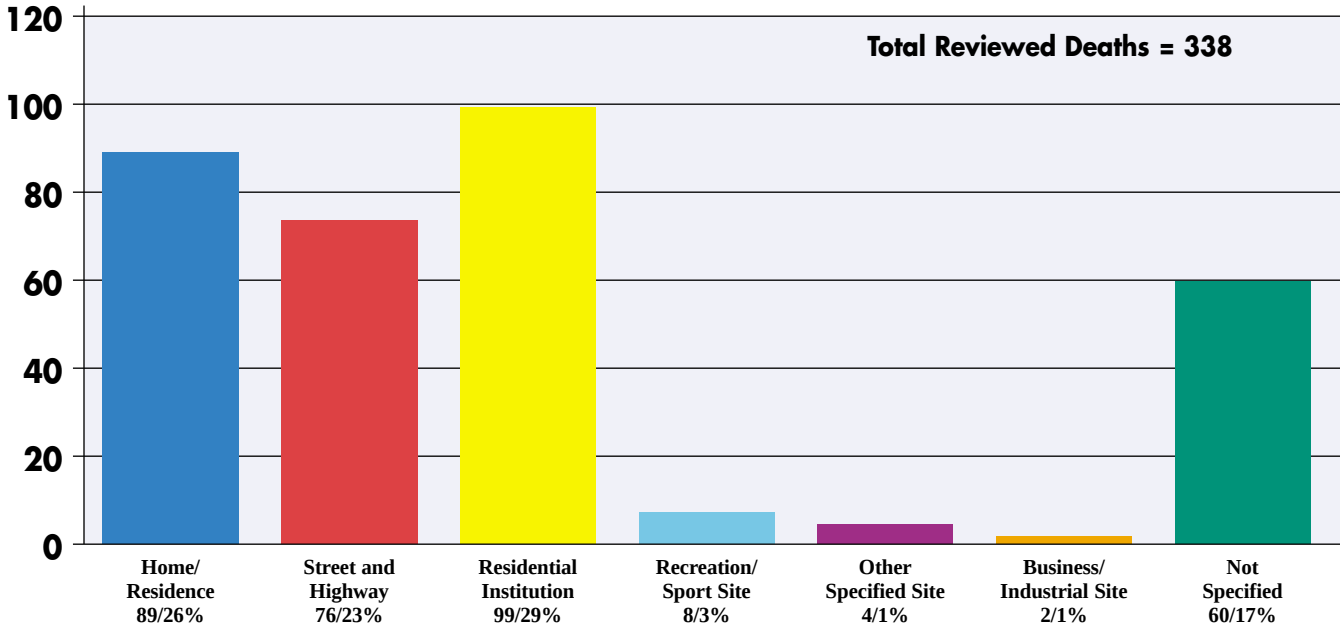
(Note: The presence of "Natural" Causes of Death occurs for the same reason as noted in "Manner of Death" in the previous section.)

Accident Category ÷ Population Totals

	Reviewed Deaths		State Deaths	
Fire	13	1.3%	126	0.28%
Suffocation	11	1.1%	152	0.34%
Firearms	8	0.8%	47	0.11%
Vehicular	82	8.1%	1,132	2.53%
Drowning	11	1.1%	74	0.17%
Other			753	1.68%
Total Accidents	125	12.4%	2,284	5.11%
Population Totals	1,009	0 <18	44,720	All Ages

Place of Death - 1999

Reviewed cases only.



Our analysis of the 338 reviewed, qualifying cases revealed that 89 cases (26%) occurred at home, 76 cases (23%) took place on a street, road or highway, 99 cases (29%) occurred at a residential institution (usually this means a hospital…), 8 cases (3%) occurred at a recreation or sports site, 4 cases (1%) occurred at another specified site, 2 cases (1%) took place at a business/industrial site, and 60 cases (17%) occurred at an unnamed/unspecified location.

The 1999 data is very similar to 1998. The large number of "Natural" deaths account for most of the deaths that occurred at home and in residential institutions. This is quite understandable in cases of perinatal, neonatal, and post neonatal/ infant deaths. Because of the delicate, young age, most of these will occur either at home or in a hospital. But the large percentage of qualifying deaths that occur on streets/roads/highways gives even more evidence to the fact that vehicular deaths should be of major concern for all of us who are interested the welfare of Alabama's children.

1998/1999 Comments and Conclusions

State law 97-893 requires that the State Child Death Review Team undertake a series of important duties. One of these duties is…"providing the Governor and the Legislature with an annual written report which shall include, but not be limited to, the State Team's findings and recommendations for each of its (14) duties; and providing copies of such report to the public…". The contents of this first report satisfy the requirements of the stated portion of the law.

The State Team has actively pursued the accomplishment of each of its duties. A list of these duties may be found in Section 4 of Part 2, Annex H of this report. Although the outcome of each duty is not in final form as yet, we are well on our way to a cooperative agreement on how to deal/accomplish each task.

The Alabama Child Death Review System is a newcomer to its role in the Child Death Review community. However, we are fast becoming a model for other states to follow. We are one of the very few states in America to have every county covered by a Child Death Review Team. And, as noted in the following comments on Data Limitations, even though we are not satisfied on the return rate for our qualifying cases…we must get close to 100% of our cases returned to be able to have reliable data analysis…we are happy that in Alabama it will now be relatively difficult for the death of a child to go unnoticed or overlooked.

Findings and Recommendations

Findings:

- The 1998/1999 return rates for qualifying Alabama infant/child deaths was not sufficient.
- Analysis of 1998/1999 data indicates that the age and the unexpected/unexplained criteria for our review groups, distorts the typical ratios of deaths among genders and races.
- Vehicular deaths are by far the leading problem area for teenaged children in Alabama.
- Homicide is more of a problem for African American infant/children than for any other race in the qualifying group.
- Infant and children succumb to accidental deaths at a rate more than twice that of the population as a whole.

Recommendations:

- Public education programs in the areas of Shaken Baby Syndrome and Safeplace for Newborns be a continuing project of the Alabama Child Death Review Program. Other programs should be added to this list as they are discovered.
- The Alabama Child Death Review System should continue to champion and support the adoption and passage of a Graduated Driver's License Law/Program in Alabama.
- Day Care should be a continuing interest item for our State Team and new recommendations for Day Care operations improvement continue to be made as conditions warrant.

Data Limitations

Several limitations place barriers to developing a meaningful statistical analysis of the data for years 1998 and 1999. Most damaging are the 64% (1998) and 67% (1999) reporting rates. With a third of the potential data still in committee, analysis only speculates the true phenomena occurring among child deaths. Additionally, analysis regarding a particular relationship among variables often presents sample sizes too small (i.e. count under 30) for conclusive statistics. However, the data does present a meaningful assessment of the nature of child deaths in the state. Particular focus may compare the distribution of death features across demographics among the children of our study and the deaths recorded in the state as a whole. (Note: In some instances, rounding errors of the data present totals not summing to 100%.)

Alabama Child Death Review Successes

Legislation creating the Alabama Child Death Review System was enacted in 1997 and has a mandate to review all unexpected/unexplained deaths of children in Alabama from birth to 18 years (HB.26, 97-893). Reviews include children who die from a vehicle accident, drowning, fire, SIDS, child abuse, asthma, infections, etc. These teams do not review deaths from prematurity, birth defects, or terminal illnesses. The purpose of these reviews is to identify trends in such deaths, educate the public about the incidence and causes of these deaths, and engage the public in efforts to reduce the risk of such injuries and deaths.

Child Death Review Teams (CDRT)

Lack of funding stability for FY 1998-99 hindered the program's ability to hire appropriate staff. In the interim, a retired, U.S. Air Force colonel volunteered his time and expertise. He worked closely with the ACDRS Director and the UAB School of Public Health's Department of Health Services Administration to develop a new database, identify the type of software and hardware needed to meet the needs of the evolving program, and do whatever else was necessary to keep the program moving forward. In July 1999, this volunteer was hired as a full time assistant to the program and among other things is responsible for the data entry and analysis for both child death and fetal/infant death reviews.

As of March 24, 2000, 28 Judicial Circuits have ongoing active local review teams, 10 circuits have identified team members and have a scheduled first review meeting date, leaving three circuits with no plan for team development. Under the direction of the State Team, an attempt will be made in these areas to identify the local public health representative to initiate a meeting. Local teams continue to review unexpected/unexplained child deaths. To date, 967 (462/1998 + 505/1999) child death certificates have been sent to local teams, with 632 (294/1998 + 338/1999) cases (65%) reviewed, data forms returned, and entered into the ACDRS database. The lag in obtaining completed reports has created a problem in producing an annual report. Our program numbers will continue to be updated as reporting forms are returned. Without exception local teams have applauded the review process and commented on how ACDR efforts have helped to: change agency policy/procedures; distinguish intentional deaths from accidental; and develop new programs that might prevent child deaths.

The following are a few examples:

- The Mobile area identified a large number of newborn infants along the Gulf Coast who had been abandoned or left to die. Frustrated with the horror of "dumpster babies", the Child Death Review Chairperson partnered with the local media and built a program called "Safeplace". The program allows mothers to leave newborns less than 72 hours old at hospital emergency department with no questions asked. The hospital will offer medical care to the mother and infant if needed and then call child protection services to take custody of the newborn. Police are not called (as long as it has been determined the baby has not been abused) and there is no threat of prosecution. The program is working! Five babies have entered the program, five babies that now have a chance for a good life. The concept has taken off all over the country. The reporter and district attorney who came up with the idea have been on Good Morning America, The Today Show, and numerous other news programs to share their ideas. Numerous states, including Florida, Texas and Minnesota, have already passed legislation for similar programs. Legislation for Alabama's program is currently being sent through the legislature. Legislators are "enthusiastically supporting this great work" (HB.115 Public Law #00-760 was passed into Alabama law in May 2000!).
- The Bessemer ACDR Team sites a case that before review was thought to be death by natural causes. As a result of the timely review process, information shared began to build suspicions as to the true cause of death. Additional

Alabama Child Death Review Successes Continued

investigation found strong evidence that the child had been murdered and the perpetrator was convicted for her acts. Law enforcement directly contributes the break in the case to the work of the ACDR team members. The four surviving siblings have all been placed in foster care and will receive mental health services to deal with the emotional turmoil suffered.

- Similarly, a child death in DeKalb County was listed as "...death by natural causes, aspiration". But, as a direct result of the local team's review, the child was found to have a lethal dose of drugs and the criminal investigation was re-opened.
- Because of local reviews, many other specific examples of case outcomes being changed could be highlighted. Here is a summary of the consequences found to date:

  19 cases were re-opened for additional investigations

  24 reviews resulted in changes to agency policies or procedures

  21 reviews resulted in new prevention activities being initiated
- In keeping with the ACDRS mission to help educate team members, a grant was obtained enabling six medical examiners from the Alabama Department of Forensic Sciences to attend a national meeting which focused on pediatric forensic issues. The feedback from the physicians was extremely positive and they all have agreed to share what they learned with other members of their child death review teams.
- ACDR has worked with seven other southeastern states to offer the Southeastern Conference on Child Fatalities to be held in May 2000 in South Carolina. This first of its kind conference offered pediatric forensic professionals from the eight southern states to share their expertise. Several Alabama speakers were chosen to present. Included on the program also were parents who have lost children. Hopefully, insight on their personal experiences will make us more sensitive to support grieving parents.
- ACDRS is currently working with the Department of Human Resources to establish a statewide quality assurance effort that will critically review every child death with whom the agency has had child welfare contact within the prior 12 months.
- ACDRS has agreed to work with the Medicaid Maternity Providers in compiling separate statistics of perinatal infant deaths enrolled in their care. A collaboration with a UAB researcher concerned with maternal deaths is being considered.
- ACDRS continues to serve on the National Child Fatality Review Advisory Committee. As a result of this effort, a national teleconference on child fatalities was downloaded across the country. This conference was hosted by Dr. Michael Durfee from California. He is credited with designing the original multi-disciplinary child death review concept created as a result of a horrific child death in the Los Angeles area.

Even though ACDRS has only been in existence for two years, it has been used as a model by several other states to help in the building of their programs. The successes of our program speak for themselves.

The review of child deaths from motor vehicle crashes by the Local Child Death Review Teams has identified the inexperienced first year driver to be at higher risk for a fatal traffic accident. Any one variable, such as rain, darkness, drinking, horseplay, etc. added to their driving inexperience has been found in cases reviewed. These findings have supported legislation currently being introduced calling for graduated vehicle licensure. This legislation will put restrictions on teenage drivers to help better prepare them to be a safe driver. (As of January 2002 this bill is still not law, but is again on the agenda for consideration.)

Alabama Child Death Review Successes Continued

2000 Goals

- Secure funding
- Increase local child death review team participation to 100%
- Work with State Team to identify priority areas and produce report
- Collaborate with other agencies and legislature to advocate for children's issues
- Support SPAC regional fetal/infant death review teams
- Continue to support training opportunities for local team members
- Work closely with Alabama Department of Forensic Sciences and law enforcement to develop guidelines for child death investigation
- Work with hospitals and mental health agencies to offer support services to all parents who suffer the loss of an infant or child
- REDUCE FETAL/INFANT/CHILD DEATHS IN ALABAMA.

Frequently, we are asked to identify the number of lives we have saved through our reviews of past death cases. We are not sophisticated enough to be able to do that yet. We may never be that sophisticated, but we are certain we have saved at least one life and, if that's true, our efforts are **more than rewarded!**

Significant Milestone

On September 28, 2000 the State Child Death Review Team delivered its first set of recommendations to the Governor of Alabama. These recommendations were helpful in achieving improved standards of care for Alabama's Day Care Centers and Homes. Additional recommendations were made in the areas of: child care for "undocumented" children; public education and awareness programs on behalf of children; support for graduated driver's license legislation; standardized protocols for infant/child death investigation; and increased attention to the reduction of Alabama's infant mortality rate. The delivery of these recommendations was a milestone event for the Alabama Child Death Review System!

Part 3: Center for Heath Statistics Data

1998 Data

DEATHS BY LEADING CAUSES AND DEATH RATES FOR ALL RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1998

CAUSE OF DEATH (ICD-9 CODES)	TOTAL		MALE		FEMALE	
	NUMBER	RATE[1]	NUMBER	RATE[1]	NUMBER	RATE[1]
LESS THAN 1 YEAR						
ACCIDENTS (800-949)	13	21.3	10	32.1	3	10.1
SIDS (798.0)	57	93.6	31	99.4	26	87.4
HOMICIDE (960-978)	1	1.6	1	3.2	0	0.0
1-4 YEARS						
ACCIDENTS (800-949)	47	19.3	35	28.1	12	10.1
HOMICIDE (960-978)	12	4.9	6	4.8	6	5.0
5-9 YEARS						
ACCIDENTS (800-949)	39	13.2	28	18.5	11	7.7
HOMICIDE (960-978)	3	1.0	3	2.0	0	0.0
10-14 YEARS						
ACCIDENTS (800-949)	46	15.8	32	21.4	14	9.9
HOMICIDE (960-978)	3	1.0	2	1.3	1	0.7
SUICIDE (950-959)[2]	5	1.7	5	3.3	0	0.0
15-17 YEARS						
ACCIDENTS (800-949)	90	50.5	56	61.8	34	38.9
HOMICIDE (960-978)	19	10.7	18	19.9	1	1.1
SUICIDE (950-959)	15	8.4	15	16.5	0	0.0
0-17 YEARS						
ACCIDENTS (800-949)	235	22.0	161	29.4	74	14.2
SIDS (798.0)	57	5.3	31	5.7	26	5.0
HOMICIDE (960-978)	38	3.6	30	5.5	8	1.5
SUICIDE (950-959)	20	1.9	20	3.7	0	0.0

[1] Rate is per 100,000 population.

[2] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1998 Data Continued

DEATHS BY LEADING CAUSES AND DEATH RATES FOR WHITE RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1998

CAUSE OF DEATH (ICD-9 CODES)	TOTAL		MALE		FEMALE	
	NUMBER	RATE[1]	NUMBER	RATE[1]	NUMBER	RATE[1]
LESS THAN 1 YEAR						
ACCIDENTS (800-949)	7	17.9	6	29.8	1	5.3
SIDS (798.0)	46	117.7	24	119.2	22	116.1
HOMICIDE (960-978)	1	2.6	1	5.0	0	0.0
1-4 YEARS						
ACCIDENTS (800-949)	23	14.7	17	21.1	6	7.9
HOMICIDE (960-978)	7	4.5	4	5.0	3	4.0
5-9 YEARS						
ACCIDENTS (800-949)	25	12.7	19	18.8	6	6.3
HOMICIDE (960-978)	0	0.0	0	0.0	0	0.0
10-14 YEARS						
ACCIDENTS (800-949)	31	15.9	20	19.9	11	11.7
HOMICIDE (960-978)	1	0.5	0	0.0	1	1.1
SUICIDE (950-959)[2]	3	1.5	3	3.0	0	0.0
15-17 YEARS						
ACCIDENTS (800-949)	75	64.0	43	71.4	32	56.2
HOMICIDE (960-978)	3	2.6	2	3.3	1	1.8
SUICIDE (950-959)	13	11.1	13	21.6	0	0.0
0-17 YEARS						
ACCIDENTS (800-949)	161	22.9	105	28.9	56	16.4
SIDS (798.0)	46	6.5	24	6.6	22	6.5
HOMICIDE (960-978)	12	1.7	7	1.9	5	1.5
SUICIDE (950-959)	16	2.3	16	4.4	0	0.0

[1] Rate is per 100,000 population.

[2] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1998 Data Continued

DEATHS BY LEADING CAUSES AND DEATH RATES FOR BLACK AND OTHER RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1998

CAUSE OF DEATH (ICD-9 CODES)	TOTAL		MALE		FEMALE	
	NUMBER	RATE[1]	NUMBER	RATE[1]	NUMBER	RATE[1]
LESS THAN 1 YEAR						
ACCIDENTS (800-949)	6	27.5	4	36.2	2	18.5
SIDS (798.0)	11	50.4	7	63.4	4	37.1
HOMICIDE (960-978)	0	0.0	0	0.0	0	0.0
1-4 YEARS						
ACCIDENTS (800-949)	24	27.5	18	40.8	6	13.9
HOMICIDE (960-978)	5	5.7	2	4.5	3	7.0
5-9 YEARS						
ACCIDENTS (800-949)	14	14.3	9	18.1	5	10.3
HOMICIDE (960-978)	3	3.1	3	6.0	0	0.0
10-14 YEARS						
ACCIDENTS (800-949)	15	15.6	12	24.6	3	6.3
HOMICIDE (960-978)	2	2.1	2	4.1	0	0.0
SUICIDE (950-959)[2]	2	2.1	2	4.1	0	0.0
15-17 YEARS						
ACCIDENTS (800-949)	15	24.6	13	42.7	2	6.6
HOMICIDE (960-978)	16	26.3	16	52.6	0	0.0
SUICIDE (950-959)	2	3.3	2	6.6	0	0.0
0-17 YEARS						
ACCIDENTS (800-949)	74	20.3	56	30.4	18	10.0
SIDS (798.0)	11	3.0	7	3.8	4	2.2
HOMICIDE (960-978)	26	7.1	23	12.5	3	1.7
SUICIDE (950-959)	4	1.1	4	2.2	0	0.0

[1] Rate is per 100,000 population.

[2] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1998 Data Continued

ACCIDENTAL DEATHS AND RATES BY TYPE OF ACCIDENT, RACE AND AGE GROUP FOR RESIDENTS AGED 0-17 YEARS, ALABAMA, 1998

CAUSE OF DEATH (ICD-9 CODES)	AGE 0-17 TOTAL NUMBER	AGE 0-17 TOTAL RATE[1]	AGE 0-17 WHITE NUMBER	AGE 0-17 WHITE RATE[1]	AGE 0-17 BLACK AND OTHER NUMBER	AGE 0-17 BLACK AND OTHER RATE[1]
Motor Vehicle Accidents (810-825)	150	14.0	111	15.8	39	10.7
Drowning (830, 832, 910)	31	2.9	20	2.8	11	3.0
Fire and Flames (890-899)	12	1.1	4	0.6	8	2.2
Firearms (922)	8	0.7	4	0.6	4	1.1
Suffocation (911-913)	6	0.6	4	0.6	2	0.5

WHITE MALE

CAUSE OF DEATH	LESS THAN 1 YEAR NUMBER	LESS THAN 1 YEAR RATE[1]	1-4 YEARS NUMBER	1-4 YEARS RATE[1]	5-14 YEARS NUMBER	5-14 YEARS RATE[1]	15-17 YEARS NUMBER	15-17 YEARS RATE[1]
Motor Vehicle Accidents (810-825)	3	14.9	4	5.0	25	12.4	32	53.1
Drowning (830, 832, 910)	1	5.0	5	6.2	5	2.5	6	10.0
Fire and Flames (890-899)	0	0.0	1	1.2	2	1.0	0	0.0
Firearms (922)	0	0.0	1	1.2	2	1.0	1	1.7
Suffocation (911-913)	1	5.0	1	1.2	1	0.5	0	0.0

BLACK AND OTHER MALE

CAUSE OF DEATH	LESS THAN 1 YEAR NUMBER	LESS THAN 1 YEAR RATE[1]	1-4 YEARS NUMBER	1-4 YEARS RATE[1]	5-14 YEARS NUMBER	5-14 YEARS RATE[1]	15-17 YEARS NUMBER	15-17 YEARS RATE[1]
Motor Vehicle Accidents (810-825)	1	9.1	10	22.7	9	9.1	10	32.9
Drowning (830, 832, 910)	2	18.1	1	2.3	4	4.1	1	3.3
Fire and Flames (890-899)	0	0.0	5	11.3	1	1.0	0	0.0
Firearms (922)	0	0.0	1	2.3	2	2.0	0	0.0

WHITE FEMALE

CAUSE OF DEATH	LESS THAN 1 YEAR NUMBER	LESS THAN 1 YEAR RATE[1]	1-4 YEARS NUMBER	1-4 YEARS RATE[1]	5-14 YEARS NUMBER	5-14 YEARS RATE[1]	15-17 YEARS NUMBER	15-17 YEARS RATE[1]
Motor Vehicle Accidents (810-825)	0	0.0	5	6.6	12	6.3	30	52.7
Drowning (830, 832, 910)	1	5.3	0	0.0	2	1.1	0	0.0
Fire and Flames (890-899)	0	0.0	1	1.3	0	0.0	0	0.0
Poisoning (850-869)	0	0.0	0	0.0	0	0.0	1	1.8
Suffocation (911-913)	0	0.0	0	0.0	1	0.5	0	0.0

BLACK AND OTHER FEMALE

CAUSE OF DEATH	LESS THAN 1 YEAR NUMBER	LESS THAN 1 YEAR RATE[1]	1-4 YEARS NUMBER	1-4 YEARS RATE[1]	5-14 YEARS NUMBER	5-14 YEARS RATE[1]	15-17 YEARS NUMBER	15-17 YEARS RATE[1]
Motor Vehicle Accidents (810-825)	0	0.0	3	7.0	6	6.2	0	0.0
Drowning (830, 832, 910)	0	0.0	2	4.6	1	1.0	0	0.0
Fire and Flames (890-899)	0	0.0	1	2.3	1	1.0	0	0.0
Firearms (922)	0	0.0	0	0.0	0	0.0	1	3.3
Suffocation (911-913)	2	18.5	0	0.0	0	0.0	0	0.0

[1] Rate is per 100,000 population.

Center for Health Statistics, Statistical Analysis Division

1999 Data

DEATHS BY LEADING CAUSES AND DEATH RATES FOR ALL RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1999

CAUSE OF DEATH (ICD-10 CODES)[1]	TOTAL		MALE		FEMALE	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
LESS THAN 1 YEAR						
ACCIDENTS (V01-X59, Y85-Y86)	24	39.7	16	51.7	8	27.1
SIDS (R95)	53	87.6	34	109.9	19	64.4
HOMICIDE (X85-Y09, Y871)	6	9.9	4	12.9	2	6.8
1-4 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	50	20.7	27	21.8	23	19.5
HOMICIDE (X85-Y09, Y871)	10	4.1	5	4.0	5	4.2
5-9 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	44	14.7	20	13.1	24	16.5
HOMICIDE (X85-Y09, Y871)	2	0.7	2	1.3	0	0.0
10-14 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	46	15.9	29	19.5	17	12.1
HOMICIDE (X85-Y09, Y871)	5	1.7	2	1.3	3	2.1
SUICIDE (X60-X84, Y870)[3]	1	0.3	1	0.7	0	0.0
15-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	93	52.3	51	56.2	42	48.2
HOMICIDE (X85-Y09, Y871)	23	12.9	18	19.9	5	5.7
SUICIDE (X60-X84, Y870)	14	7.9	13	14.3	1	1.1
0-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	257	24.0	143	26.1	114	21.9
SIDS (R95)	53	5.0	34	6.2	19	3.6
HOMICIDE (X85-Y09, Y871)	46	4.3	31	5.7	15	2.9
SUICIDE (X60-X84, Y870)	15	1.4	14	2.6	1	0.2

[1] Deaths by cause may not be directly comparable to prior years because of a change in coding due to a revision of the International Classification of Diseases.

[2] Rate is per 100,000 population.

[3] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1999 Data Continued

DEATHS BY LEADING CAUSES AND DEATH RATES FOR WHITE RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1999

CAUSE OF DEATH (ICD-10 CODES)[1]	TOTAL		MALE		FEMALE	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
LESS THAN 1 YEAR						
ACCIDENTS (V01-X59, Y85-Y86)	12	31.0	8	40.1	4	21.3
SIDS (R95)	33	85.2	21	105.3	12	63.9
HOMICIDE (X85-Y09, Y871)	2	5.2	2	10.0	0	0.0
1-4 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	25	16.1	13	16.3	12	16.0
HOMICIDE (X85-Y09, Y871)	4	2.6	2	2.5	2	2.7
5-9 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	18	9.1	9	8.8	9	9.4
HOMICIDE (X85-Y09, Y871)	0	0.0	0	0.0	0	0.0
10-14 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	34	17.5	21	20.8	13	13.8
HOMICIDE (X85-Y09, Y871)	3	1.5	2	2.0	1	1.1
SUICIDE (X60-X84, Y870)[3]	1	0.5	1	1.0	0	0.0
15-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	73	62.2	38	62.9	35	61.4
HOMICIDE (X85-Y09. Y871)	8	6.8	3	5.0	5	8.8
SUICIDE (X60-X84, Y870)	9	7.7	8	13.2	1	1.8
0-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	162	23.0	89	24.5	73	21.4
SIDS (R95)	33	4.7	21	5.8	12	3.5
HOMICIDE (X85-Y09, Y871)	17	2.4	9	2.5	8	2.3
SUICIDE (X60-X84, Y870)	10	1.4	9	2.5	1	0.3

[1] Deaths by cause may not be directly comparable to prior years because of a change in coding due to a revision of the International Classification of Diseases.

[2] Rate is per 100,000 population.

[3] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1999 Data Continued

DEATHS BY LEADING CAUSES AND DEATH RATES FOR BLACK AND OTHER RESIDENTS AGED 0-17 YEARS BY AGE GROUP AND SEX, ALABAMA, 1999

CAUSE OF DEATH (ICD-10 CODES)	TOTAL		MALE		FEMALE	
	NUMBER	RATE[1]	NUMBER	RATE[1]	NUMBER	RATE[1]
LESS THAN 1 YEAR						
ACCIDENTS (V01-X59, Y85-Y86)	12	55.2	8	72.7	4	37.2
SIDS (R95)	20	92.0	13	118.2	7	65.1
HOMICIDE (X85-Y09, Y871)	4	18.4	2	18.2	2	18.6
1-4 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	25	28.7	14	31.8	11	25.6
HOMICIDE (X85-Y09, Y871)	6	6.9	3	6.8	3	7.0
5-9 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	26	25.7	11	21.5	15	30.0
HOMICIDE (X85-Y09, Y871)	2	2.0	2	3.9	0	0.0
10-14 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	12	12.6	8	16.6	4	8.5
HOMICIDE (X85-Y09, Y871)	2	2.1	0	0.0	2	4.3
SUICIDE (X60-X84, Y870)[2]	0	0.0	0	0.0	0	0.0
15-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	20	33.1	13	43.0	7	23.2
HOMICIDE (X85-Y09, Y871)	15	24.8	15	49.6	0	0.0
SUICIDE (X60-X84, Y870)	5	8.3	5	16.5	0	0.0
0-17 YEARS						
ACCIDENTS (V01-X59, Y85-Y86)	95	26.0	54	29.3	41	22.7
SIDS (R95)	20	5.5	13	7.0	7	3.9
HOMICIDE (X85-Y09, Y871)	29	7.9	22	11.9	7	3.9
SUICIDE (X60-X84, Y870)	5	1.4	5	2.7	0	0.0

[1] Rate is per 100,000 population.

[2] Suicide can not be listed as a cause of death for children under age 10 according to the National Center for Health Statistics.

Center for Health Statistics, Statistical Analysis Division

1999 Data Continued

ACCIDENTAL DEATHS AND RATES BY TYPE OF ACCIDENT, RACE AND AGE GROUP FOR RESIDENTS AGED 0-17 YEARS, ALABAMA, 1999

CAUSE OF DEATH (ICD-10 [illegible])[1]	AGE 0-17							
	TOTAL		WHITE		BLACK AND OTHER			
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]		
Motor Vehicle Accidents[3]	154	14.4	110	15.6	44	12.0		
Drowning (W65-W74)	25	2.3	16	2.3	9	2.5		
Smoke, Fire and Flames (X00-X09)	24	2.2	8	1.1	16	4.4		
Firearms (W32-W34)	5	0.5	2	0.3	3	0.8		
Poisoning (X40-X49)	3	0.3	1	0.1	2	0.5		

WHITE MALE

CAUSE OF DEATH	LESS THAN 1 YEAR		1-4 YEARS		5-14 YEARS		15-17 YEARS	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
Motor Vehicle Accidents[3]	3	15.0	3	3.8	16	7.9	34	56.3
Drowning (W65-W74)	0	0.0	8	10.0	2	1.0	1	1.7
Smoke, Fire and Flames (X00-X09)	0	0.0	0	0.0	6	3.0	0	0.0
Firearms (W32-W34)	0	0.0	0	0.0	1	0.5	1	1.7

BLACK AND OTHER MALE

CAUSE OF DEATH	LESS THAN 1 YEAR		1-4 YEARS		5-14 YEARS		15-17 YEARS	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
Motor Vehicle Accidents[3]	1	9.1	4	9.1	9	9.1	9	29.8
Drowning (W65-W74)	0	0.0	0	0.0	3	3.0	1	3.3
Smoke, Fire and Flames (X00-X09)	1	9.1	7	15.9	2	2.0	0	0.0
Firearms (W32-W34)	0	0.0	0	0.0	0	0.0	2	6.6

WHITE FEMALE

CAUSE OF DEATH	LESS THAN 1 YEAR		1-4 YEARS		5-14 YEARS		15-17 YEARS	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
Motor Vehicle Accidents[3]	2	10.7	5	6.7	15	7.9	32	56.1
Drowning (W65-W74)	0	0.0	3	4.0	1	0.5	1	1.8
Smoke, Fire and Flames (X00-X09)	0	0.0	1	1.3	1	0.5	0	0.0
Poisoning (X40-X49)	0	0.0	0	0.0	0	0.0	1	1.8

BLACK AND OTHER FEMALE

CAUSE OF DEATH	LESS THAN 1 YEAR		1-4 YEARS		5-14 YEARS		15-17 YEARS	
	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]	NUMBER	RATE[2]
Motor Vehicle Accidents[3]	0	0.0	3	7.0	12	12.4	6	19.9
Drowning (W65-W74)	0	0.0	3	7.0	2	2.1	0	0.0
Smoke, Fire and Flames (X00-X09)	1	9.3	3	7.0	2	2.1	0	0.0
Firearms (W32-W34)	0	0.0	0	0.0	1	1.0	0	0.0
Poisoning (X40-X49)	0	0.0	1	2.3	0	0.0	1	3.3

[1] Deaths by cause may not be directly comparable to prior years because of a change in coding due to a revision of the International Classification of Diseases.

[2] Rate is per 100,000 population.

[3] ICD-10 Codes for Motor Vehicle Accidents are V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0 -V87.8, V88.0-V88.8, V89.0, V89.2.

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Part 4: Definitions

- **Cases Which Meet the Criteria for Review –** Cases involving the deaths of resident infants and children from birth to less than 18 years old whose deaths are unexpected/unexplained.

- **Cause of Death –** As used in this report, cause of death refers to the "underlying" cause of death. The underlying cause of death is the disease or injury/action initiating the sequence of events that leads directly to death or the circumstances of the accident or violence that produced the fatal injury.

- **Reviewed Cases –** Cases which meet the criteria for review, were sent to a Local Team for review, were reviewed, a data report was completed, and were returned and added to the master database.

- **Manner of Death –** Item #49 on a Death Certificate which categorizes the death into one of six general categories (types/kinds): Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes.

- **Natural Causes –** A manner or cause of death by other than external means (the expected outcome of a disease, birth defect, or congenital anomaly). The CDR normally will not review such cases. However, frequently, manner and/or cause of death are classified as "Pending" or "Undetermined/Unknown" at the time of case review by our teams. Frequently these cases are discovered to be in fact death by Natural Causes. This is why there are so many in this category included in our data. Sudden Infant Death Syndrome (SIDS) is considered a natural cause death. Even so, our teams are required by law to review all SIDS deaths.

- **Residential Institutions –** As used in this report, this is a term used to identify a place of death. Included in this classification are hospitals/emergency rooms. The number of deaths that occur in this category is usually fairly high because frequently victims survive long enough to reach the hospital…but not much longer. This does not necessarily mean that hospitals are dangerous places, but it does show that hospitals face frequent life or death situations.

- **Unexpected/Unexplained –** In referring to a child's death, includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents or SIDS.

Note: For additional definitions please see Annex H. Alabama Law, Section 2, pages 2-3.