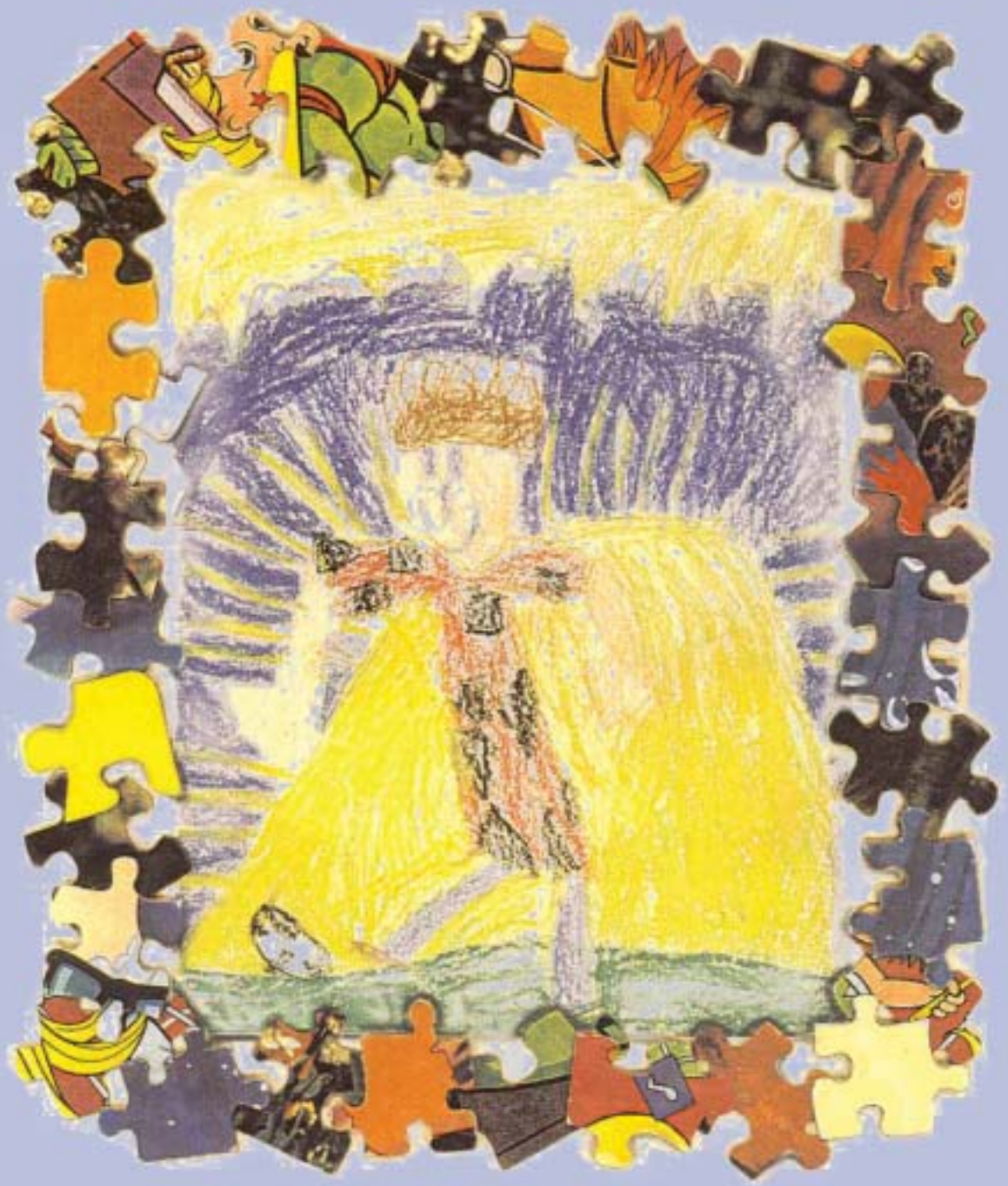
Children For Our Future



Alabama Child Death Review System 2000 Report

DEATHS AMONG CHILDREN IN ALABAMA FOR THE YEAR 2000

ALABAMA CHILD DEATH REVIEW SYSTEM
ANNUAL REPORT

EXECUTIVE SUMMARY

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TABLE OF CONTENTS

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March 15, 2003

The death of any child is a tragedy, but a child death which could have been prevented is even more tragic. The Alabama Child Death Review System (ACDRS) was established by state law on September 11, 1997 to review all unexpected or unexplained child deaths in the State of Alabama. Since that date, the state and local components of ACDRS have been working together to analyze child death trends, identify preventable deaths, and implement prevention strategies. This report briefly summarizes the ACDRS findings and recommendations for the year 2000.

Several items in this report indicate that progress is being made. The percentage of qualifying cases completed and returned by the local teams has improved from an initial rate of 64 percent to 74 percent for 2000. The number of cases that qualified for ACDRS review was about 500 per year in both 1998 and 1999 – the two years which we combined for our first report. In 2000, only 386 child deaths met review criteria. While ACDRS obviously cannot claim responsibility for the overall decline in child deaths and cases qualifying for review, we believe that at least some of this decrease is due to our efforts in that regard.

In September of 2000, ACDRS submitted its first-ever set of recommendations to the Governor. Those recommendations, along with the support and efforts of other like-minded agencies, helped to improve daycare standards, secure passage of a new graduated drivers license law, improve child passenger safety requirements, and increase awareness of such issues as Sudden Infant Death Syndrome, Shaken Baby Syndrome, the "Back to Sleep" campaign, and issues regarding safe infant/child bedding and co-sleeping practices.

As long as Alabama children die needlessly, there will be room for improvement. Likewise, this Annual Report also requires improvement. The ACDRS rate of case return must continue to improve. Toward that end, this Annual Report publicly states how each local team is performing. We are making ongoing efforts to improve our performance where needed. In conjunction with this report and in accordance with state law, we are submitting our second set of recommendations to the Governor for his consideration and action. These recommendations are intended to save infant and child lives. Our goal is to protect Alabama's greatest resource - our children!

Sincerely,

Donald Williamson, MD
State Health Officer

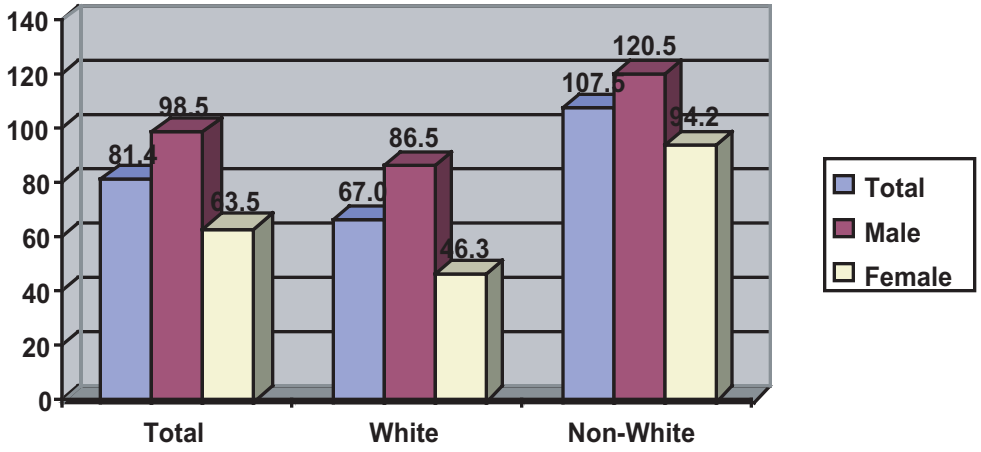
There were 915 children under the age of 18 who died in Alabama in the year 2000. While each one of these deaths is a tragedy, especially to family and friends, each one also serves as a powerful warning that other children are at risk. To better understand how and why these children died in Alabama, the Child Death Review System has been empowered to maintain statistics on child mortality; to identify deaths which may be from abuse, neglect or other preventable causes; and from that information to develop and implement measures to aid in reducing the risk and incidence of future child injury and death in Alabama.

This report is a compilation of findings from Local Child Death Review Teams whose task is to: 1) identify factors that make a child at risk of injury or death, 2) share information among agencies that provide services to children and families or investigate child death, 3) improve local investigations of unexpected/unexplained child deaths by participating agencies, 4) improve existing services and systems while identifying gaps in the community requiring additional services, 5) identify trends relevant to unexpected/unexplained child injury and death, and 6) educate local public regarding incidence and causes of child injury and death while defining their role in helping to prevent such tragedies.

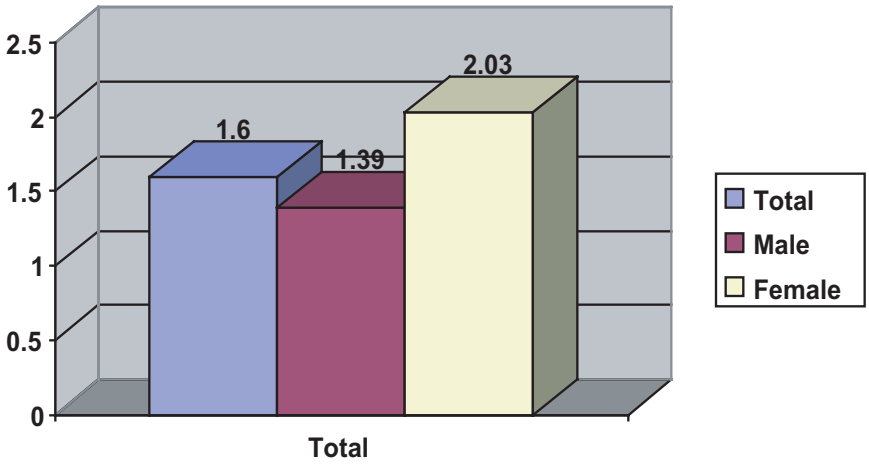
While this Executive Summary presents key findings from the local review teams and from data on Alabama child mortality, it also makes recommendations that can help prevent other deaths to our children. Thus, this report honors the memory of all those children who have died in Alabama. We hope that it leads to further understanding of how we can all make Alabama a safer and healthier place for children.

KEY FINDINGS

- There were 915 deaths to children (i.e., those under the age of 18) during 2000.
- This represents 81.4 deaths per 100,000 children.
- Sixty-two percent of these deaths were to male children.
- Fifty-three percent of these deaths were to white children.
- Below is a graph showing the total, race-specific, and gender-specific death rates (per 100,000 children) among children in Alabama. This allows one to compare death rates while adjusting for population differences:

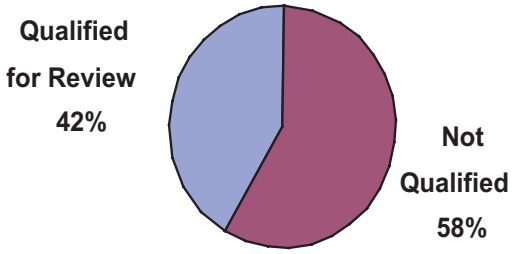


- Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance non-whites have significantly ($p < .05$) higher rates than do whites. For example, non-white female children died at more than twice the rate of white female children.

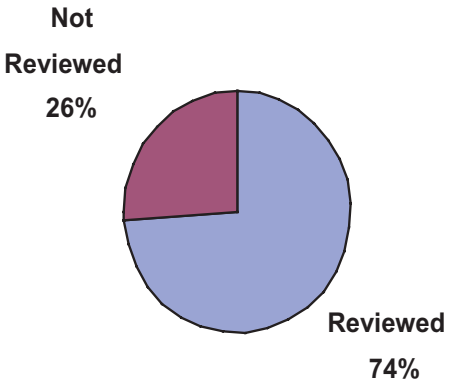


KEY FINDINGS

- As the chart below indicates, of the 915 child deaths in Alabama, there were 386 deaths during the year 2000 that qualified for review under the Alabama Child Death Review System.



- Of those deaths that qualified for review (386), the local review teams reviewed and returned 285 reports (see chart below).

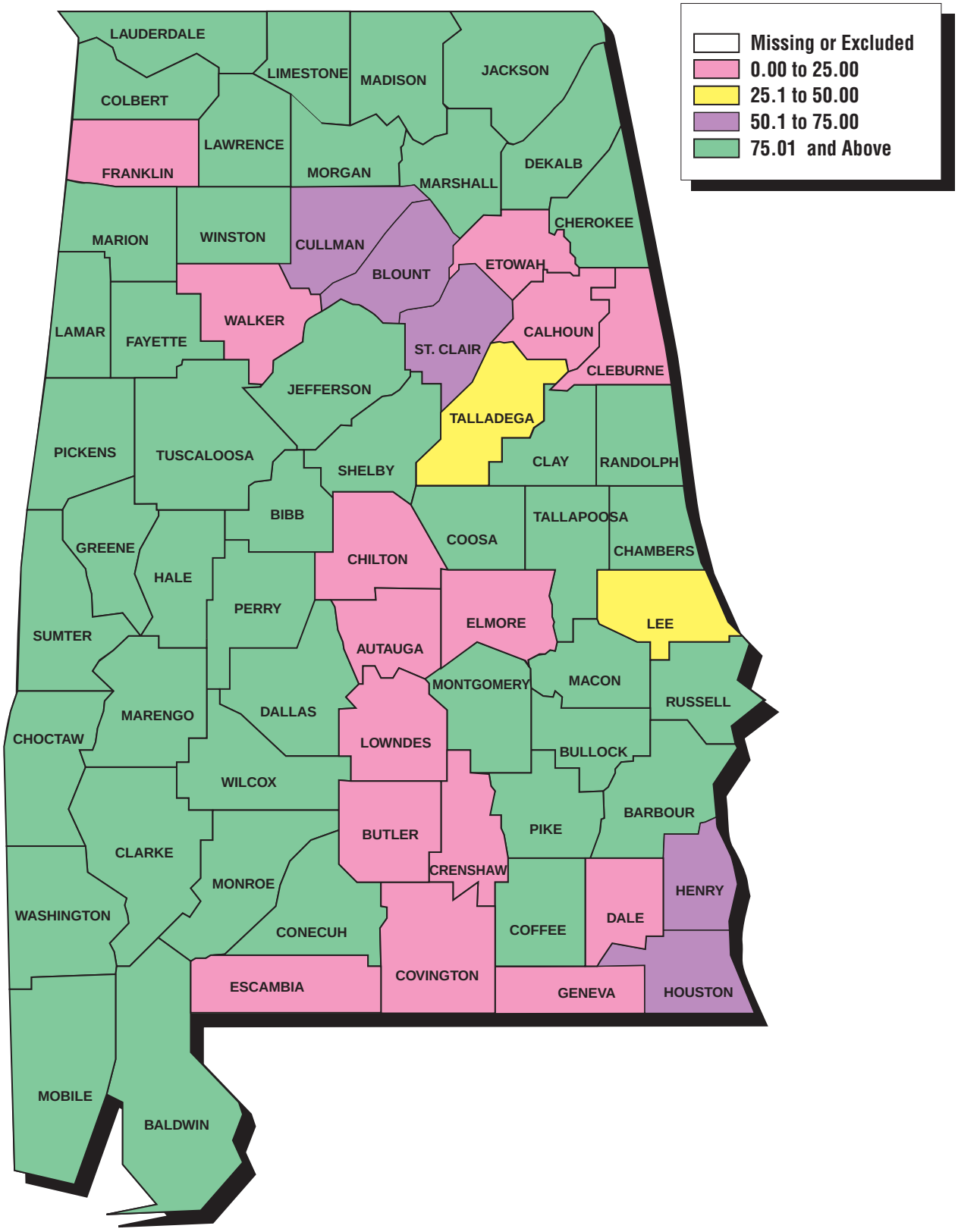


- There were no significant race or gender differences in the proportion of cases reviewed compared to those not reviewed.

- While proportionately fewer neonates (those less than 28 days old) qualified for review than did any other age category, there was no significant age group difference between those who were and those who were not reviewed.

AGE GROUP	ALL	QUALIFIED	REVIEWED	NOT REVIEWED
< 28 days	338	7	3	4
28 – 364 days	226	122	85	37
1 – 4 years	92	64	49	15
5 – 9 years	53	31	22	9
10 – 14 years	100	69	52	17
15 – 17 years	103	93	74	19

■ Unfortunately there is a wide variety in the percentage of qualified cases that were reviewed and returned. The map below indicates the return rate for each Local Child Death Review Team. Our goal is a 100 percent return rate.



KEY FINDINGS

- Thirty-five cases were reviewed.
- In only five cases were the infants known to be in a crib by themselves and put to sleep on their back as is recommended.
- African American babies are at higher risk of SIDS than are white babies.
- Of all the SIDS deaths reviewed, only two were known **not** to have a history of smoking in the household.

RECOMMENDATIONS

1. Teach the use of standard protocols for the investigation of all unexpected and unexplained child deaths, including autopsy, scene investigation and review of medical history.
2. Study the merits of mandating autopsies for all sudden and unexplained deaths.
3. Develop and implement a program to train medical examiners and law enforcement personnel in the thorough investigation of child deaths.
4. Develop and implement a mechanism for notifying the appropriate medical examiner whenever a death certificate is received which shows SIDS as the cause of death, but for which no autopsy was done, and/or the medical examiner had not been involved in the case.
5. Increase public awareness of "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs.

KEY FINDINGS

- Eighty-eight deaths were reviewed.
- Twenty-three of these child deaths (26.1 percent) were due to young drivers (16 years of age) at fault.
- Nine child deaths (10.2 percent) in this category were due to underage driving.
- In only 14.8 percent of these cases were safety restraints reported as being used correctly.
- Additionally, of these deaths involving motor vehicles, 27.3 percent were due to reckless driving or speeding.

RECOMMENDATIONS

1. Encourage the inclusion of information about the dangers of driving at high speeds on gravel roads or in other poor road conditions, and expand current education on reckless driving in driver's education courses.
2. Promote the adoption of legislation that would make it illegal under certain conditions to ride in the back of a pickup truck on public roads.
3. Encourage auto dealerships to provide point-of-sale information resources about proper installation and usage of child safety seats and booster seats when selling new or used vehicles.
4. Promote and encourage public education and safety training programs for child operators of ATVs.
5. Modify existing legislation to increase the child age requirement for seat restraints from less than 5 years of age to less than 16 years of age.

KEY FINDINGS

- Sixteen deaths were reviewed.
- The vast majority (62.5 percent) of fire related deaths to children occurred to individuals who resided in mobile homes.
- None of the cases were known to have a smoke alarm in their residence or other place of death.

RECOMMENDATIONS

1. Encourage enforcement of laws governing smoke detector installation, testing and inspection in new and used manufactured homes.
2. Support local fire departments in developing, expanding and implementing fire education activities, particularly for elementary schools and other childcare facilities.
3. Encourage community education efforts regarding the need for installation and periodic testing of smoke detectors in homes, businesses, and places of worship.

KEY FINDINGS

- Twenty-one deaths were reviewed.
- All of the children who drowned in open bodies of water were reported as **not** wearing a floatation device.

RECOMMENDATIONS

1. Support public education and awareness campaigns on water safety with a special emphasis on the need for constant adult supervision and a focus on open bodies of water, pools and bathtubs.
2. Encourage enforcement of ordinances regarding pool fencing and signage.
3. Encourage communities to seek ways to make swimming lessons and water safety classes more readily available to children and adults.
4. Promote the use of floatation devices while swimming in open bodies of water.

KEY FINDINGS

- Twenty-four cases were reviewed.
- Twenty-five percent of these deaths to children due to suffocation were considered intentional.
- Another 25 percent of the deaths were considered unintentional "roll over" by an adult.

RECOMMENDATIONS

1. Promote and encourage statewide education and awareness campaigns regarding safe bedding practices and the dangers of co-sleeping.
2. Promote and encourage parenting classes for new and especially young parents.

KEY FINDINGS

- Fifteen cases were reviewed.
- Sixty percent of these deaths to children were known to be the result of handgun use.
- The vast majority (73.3 percent) of these deaths were known to be due to an "intent to do harm."
- Only two child deaths reviewed in this category were reported as the result of playing with firearms.

RECOMMENDATIONS

1. Encourage youth and parent gun safety education.
2. Support crisis team and victim advocacy to children who witness violence.
3. Support after-school and evening education and recreation programs for high-risk youth.
4. Encourage community based violence prevention programs.

KEY FINDINGS

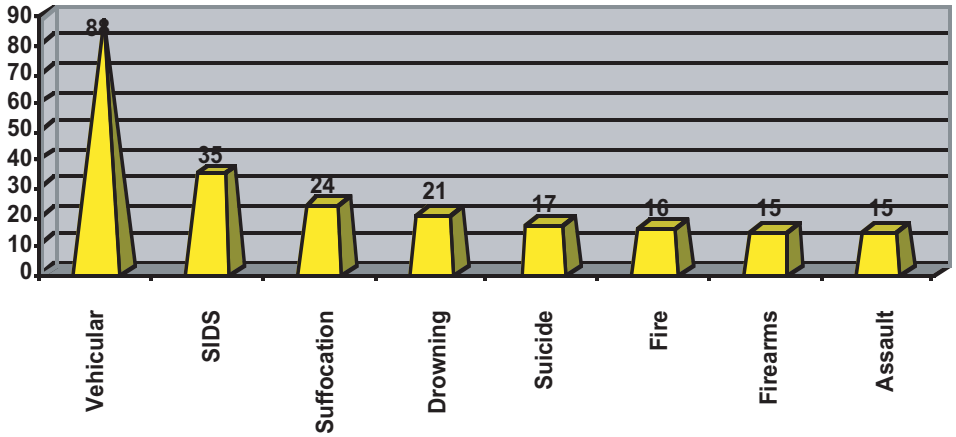
- Seventeen cases were reviewed.
- Eight (47.1 percent) of these deaths were reported as being completely unexpected.
- Most (41.2 percent) were classified as hangings, followed by use of firearms (35.3 percent).

RECOMMENDATIONS

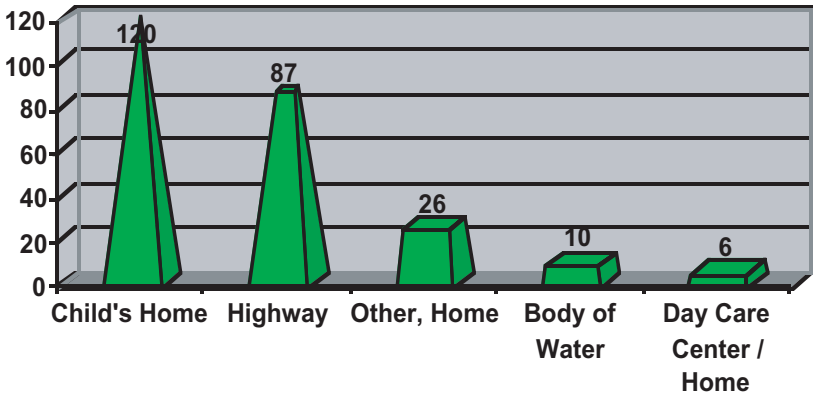
1. Support statewide efforts to examine all of the issues surrounding adolescent suicide and develop plans for prevention.
2. Institute training for teachers concerning suicide risk assessment and awareness of referral resources.
3. Support statewide education and awareness campaign aimed at parents and others regarding suicide risk assessment and assistance resources.

REVIEWED CASES ONLY

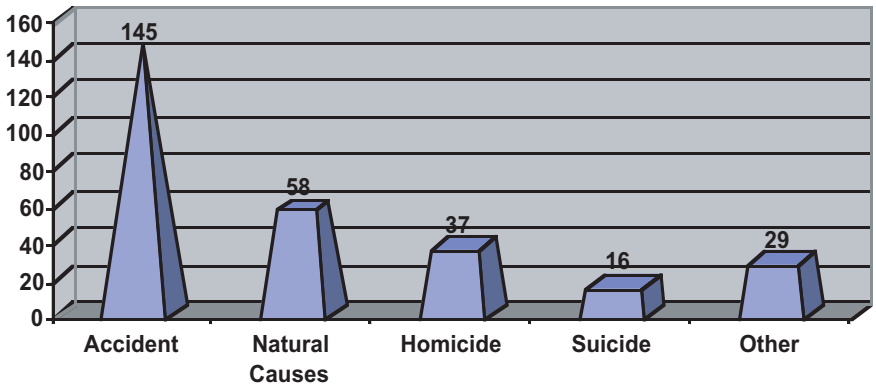
■ Motor Vehicle was the most often (34.4 percent) reviewed cause of child death.

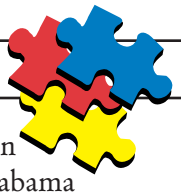


■ As can be seen from the graph below, the single most frequent place of death (42.1 percent) was the child's home.



■ Accident was the most frequent (145) manner of death reviewed.





Legislation creating the Alabama Child Death Review (ACDRS) System was enacted in 1997 and has a mandate to review all unexpected/unexplained deaths of children in Alabama from birth to 18 years. 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.

ACDRS is now fully funded and staffed at the state level. The State Team has been identified and meets quarterly. Local Child Death Review Teams (LCDRTs) have been established in every judicial circuit in Alabama, and most are active and in full compliance with state law. Seventy-four percent of qualifying cases were completed and returned by the LCDRTs in 2000 – a significant improvement from the 64 percent return rate for 1998-9. Probably our most significant statistic is this - the number of cases that qualified for ACDRS review (about 500 per year in 1998-9) dropped to 386 in 2000!

ACDRS submitted its first-ever set of recommendations to the Governor in September of 2000. Those recommendations were taken very seriously and helped lead to new legislative action and increased public awareness. Several policy/practice changes and prevention activities occurred which were at least partly due to ACDRS recommendations. Some specific recommendations and their subsequent outcomes include:

- Recommendations to improve the quality and, especially, safety of day care settings in Alabama contributed to the adoption of new minimum standards, including training related to "Back to Sleep," safe bedding practices, CPR, and first aid; on-site safety assessment of play areas and playground equipment; periodic "spot checks" for hazardous conditions which can lead to immediate closure; and more stringent licensing requirement and accountability.

- Recommendations for statewide public education and general injury prevention awareness campaigns in several areas led to such efforts in the areas of Shaken Baby Syndrome, "Back to Sleep," and Child Passenger Safety.

- The recommendation for the development and subsequent passage of legislation supporting graduated drivers licenses was adopted and such legislation was passed into state law and went into effect October 1, 2002.

- The recommendation that all professionals responsible for child death investigations in Alabama receive training in a standardized set of protocols has led to the development of the Child Death Investigation Curriculum Task Force and its current, ongoing efforts to develop a standardized Child Death Investigation Curriculum to be taught to all future police officers receiving Alabama Peace Officers Standards and Training (APOST) certification.

These recommendations resulted partly from the recommendations and activities of our LCDRTs. Our teams routinely report improvements to community investigation procedures and prevention activities, as well as, the occasional reopening of criminal investigations as a result of their case reviews. Our successes can materialize as any one of a number of forms.

ACDRS will soon (March 2003) submit our second set of recommendations to the Governor. These recommendations encourage:

- New legislative restrictions upon child ATV operation and child transportation in truck beds, and modification of child passenger restraint requirements;

- New considerations for safety signage, fencing, and flotation device usage related to children swimming in public/private pools and open water areas;

- Further statewide public education and awareness programs related to the dangers of co-sleeping with an infant, including safe bedding practices, and the continuing promotion of the "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs; and...

- Greater emphasis on the importance of smoke and carbon monoxide alarms, particularly in mobile homes.

As reported earlier, the number of preventable infant and child deaths in Alabama has been reduced. It is our hope that through continuing ACDRS activities, including our recommendations, this number will continue to decrease.

Fewer preventable infant and child deaths in Alabama – that has been the result of ACDRS activities and their subsequent effects on our state and local communities. This is the goal and continuing mission of the ACDRS.

DEFINITIONS

- Cases Which Meet the Criteria for Review- Cases involving the deaths of Alabama 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 met the criteria for review, were sent to the appropriate Local Team for review, were reviewed, and for which reports were completed, returned and the data subsequently added to the master database.

- Manner of Death- Item #49 on a Death Certificate that 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.

- Unexpected/Unexplained- For the purposes of Child Death Review...in referring to a child's death, includes all deaths that, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, or other agents or SIDS.

...we're all part of the solution

ALABAMA DEPARTMENT OF PUBLIC HEALTH

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Informational materials
in alternative formats
will be made available
upon request.