Children For Our Future

Alabama Child Death Review System
2002 Report

DEATHS AMONG CHILDREN IN ALABAMA FOR THE YEAR 2002

ALABAMA CHILD DEATH REVIEW SYSTEM ANNUAL REPORT

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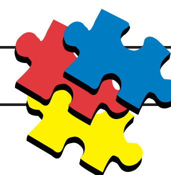

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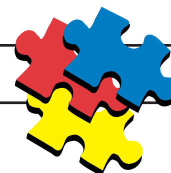


July 1, 2005

Without a doubt, Alabama's most precious resource is her children. The death of even one child represents a tragedy for the child's family, the community, and our entire state. To help prevent or reduce future tragedies, the Alabama Child Death Review System (ACDRS) studies the circumstances of all "unexplained or unexpected" child deaths in Alabama and tries to identify what steps might be taken to prevent the next similar tragedy.

A 1997 Alabama law created the ACDRS, making it a branch of the Alabama Department of Public Health (ADPH) and providing funding from the Children First Trust Fund. For several years prior to the implementation of the ACDRS process, Alabama was ranked 49th among all states in the category of "child death," according to the national "Kids Count" rankings as published by the Annie E. Casey Foundation. Since the birth of the ACDRS, Alabama has improved to 39th. Voices for Alabama's Children, a respected advocacy group focusing specifically on children's issues and related Alabama legislation, attributes much of the aforementioned improvements in ranking to the efforts of the ACDRS.

Each Judicial Circuit in Alabama has at least one Local Child Death Review Team, which is required by law to meet a minimum of once per year. Local Teams review all infant and child deaths that meet the ACDRS review criteria. The findings of these Local Teams are further reviewed by the State Child Death Review Team, a multi-disciplinary team that includes state agency directors and representatives; medical, legal, and law-enforcement professionals; and private citizens appointed by the Governor. This comprehensive review process, which is largely initiated by local community residents, is what has brought this continuing positive trend of reduced infant and child deaths to Alabama.

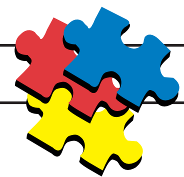
In addition to reporting on team findings and collecting data, the ACDRS is mandated to submit to the Governor periodic recommendations related to preventing child deaths in Alabama. The latest recommendations, detailed herein, include enhanced child death investigation training; the importance of safe infant sleeping practices; the need for proper and consistent use of smoke and carbon monoxide detectors in homes; and improvements in child passenger safety, especially related to all-terrain vehicles, passengers riding in open truck beds, and enhancements to the existing Child Safety Restraint Law.

As you will see, this latest ACDRS Annual Report shows a continuation of the positive trends observed over the past few years. This includes improvements in the ACDRS performance and operations, along with a reduction in preventable child deaths that meet the ACDRS review criteria. The ACDRS staff, State and Local Child Death Review Teams, and our strategic partners remain committed to the prevention of child deaths in Alabama through public awareness, education, and direct prevention efforts. Our goal is simple yet very important: Fewer child deaths in Alabama!

Sincerely,

Donald E. Williamson, MD
State Health Officer

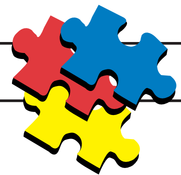
PREFACE



There were 896 children under the age of 18 who died in Alabama in 2002. 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, the ACDRS has been empowered to maintain statistics on child mortality; to identify deaths that may be the result of 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 unexpected/unexplained child injuries and deaths in Alabama.

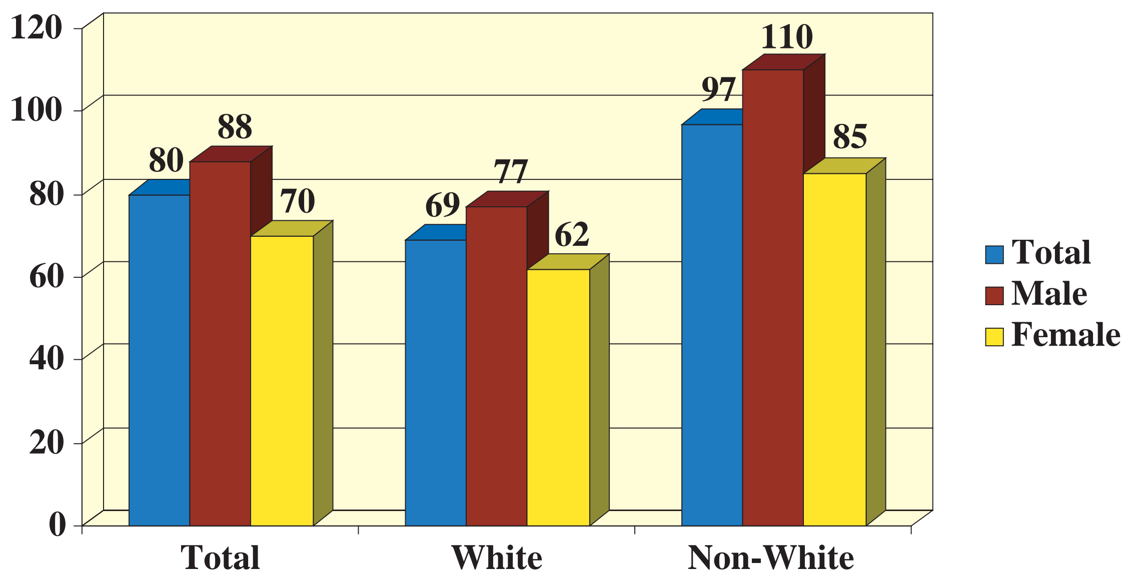
This report is a compilation of findings from Local Child Death Review Teams whose tasks are to: 1) identify factors that put a child at risk of injury or death; 2) share information among agencies that provide services to children and families or that investigate child deaths; 3) improve local investigations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

While this Executive Summary presents key findings from the local review teams and from Alabama child mortality data, it also makes recommendations that can help prevent unexpected/unexplained child deaths. 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 work together to make Alabama a safer and healthier place for children.

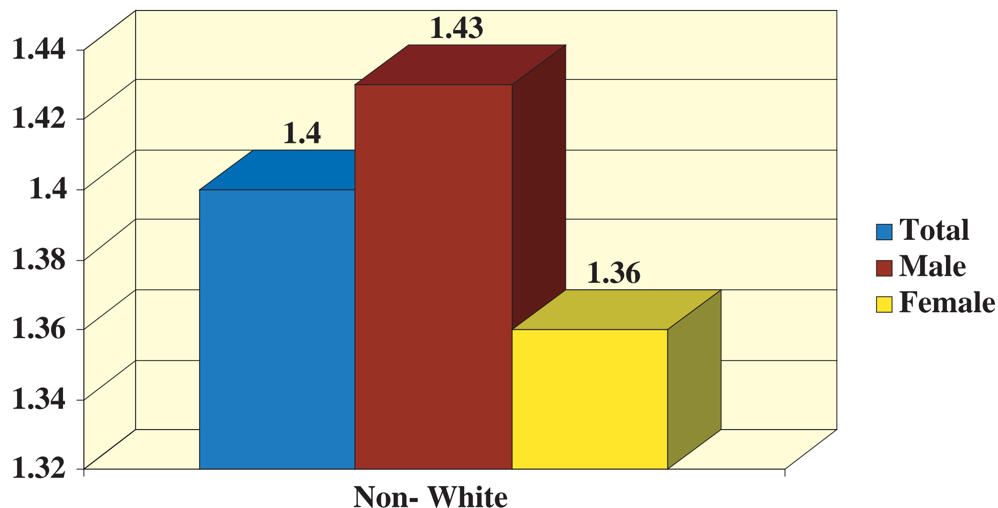


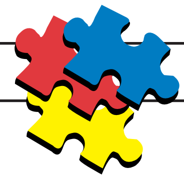
KEY FINDINGS

- There were 896 infant/child deaths (those under the age of 18) during 2002.
- This represents approximately 80 deaths per 100,000 children.
- Fifty-seven percent of these deaths were to male children.
- Forty-two percent of these deaths were to black 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 for comparison of death rates while adjusting for population differences:



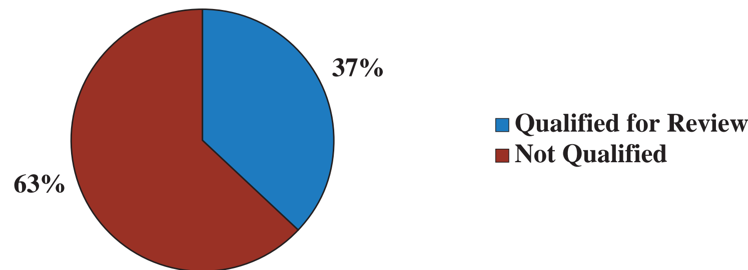
- Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher rates ($p < .05$) than do whites (i.e. non-white males had a child mortality rate 1.43 times greater than white males).



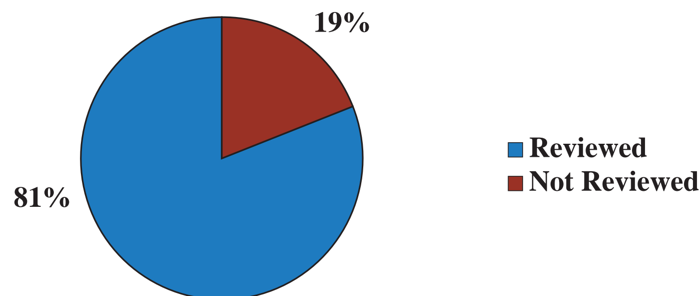


KEY FINDINGS

- As the chart below indicates, of the 896 child deaths in Alabama in 2002, there were 335 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (335), the Local Review Teams reviewed and returned 272 reports (see chart below).



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

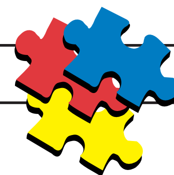
- While proportionately fewer neonates (those less than 28 days old) qualified for review than did any other age category, there were no significant age group differences between those who were and those who were not reviewed.

AGE GROUP	ALL	QUALIFIED	REVIEWED	NOT REVIEWED
< 28 days	325	6	6	0
28 days - < 1 year	184	65	59	6
1 year - < 5 years	95	60	49	11
5 years - < 10 years	58	35	28	7
10 years - < 16 years	117	75	53	22
16 years - < 18 years	117	94	77	17

- Unfortunately, there is a wide variety in the percentage of qualified cases that were reviewed and returned in 2002. The map below indicates the return rate for each Local Child Death Review Team. Our goal is a 100 percent return rate.

Less than 25%
25% - 49.99%
50% - 74.99%
75% or Greater

LAUDERDALE
LIMESTONE
MADISON
JACKSON
COLBERT
FRANKLIN
LAWRENCE
MORGAN
MARSHALL
DEKALB
MARION
WINSTON
CULLMAN
CHEROKEE
ETOWAH
BLOUNT
LAMAR
FAYETTE
WALKER
ST. CLAIR
CALHOUN
JEFFERSON
CLEBURNE
TALLADEGA
PICKENS
TUSCALOOSA
SHELBY
CLAY
RANDOLPH
BIBB
GREENE
CHILTON
COOSA
TALLAPOOSA
CHAMBERS
HALE
PERRY
SUMTER
AUTAUGA
ELMORE
LEE
MACON
DALLAS
MONTGOMERY
RUSSELL
MARENGO
LOWNDES
BULLOCK
CHOCTAW
WILCOX
BARBOUR
BUTLER
PIKE
CLARKE
CRENSHAW
MONROE
HENRY
WASHINGTON
CONECUH
COFFEE
DALE
COVINGTON
ESCAMBIA
GENEVA
HOUSTON
MOBILE
BALDWIN

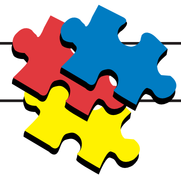


KEY FINDINGS

- Twenty-five cases were reviewed.
- While the position of infants was unknown in most of the reviewed cases (52 percent), 32 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of all the SIDS cases reviewed, only three were known not to have a history of smoking in the household.

RECOMMENDATIONS

1. Increase public awareness of "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs.
2. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
3. 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.
4. Study the merits of mandating autopsies for all sudden and unexplained child deaths.
5. Develop and implement a program to train medical examiners and law enforcement personnel in the thorough investigation of child deaths.
6. Develop and implement a mechanism for notifying the appropriate medical examiner whenever a death certificate is received that 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.

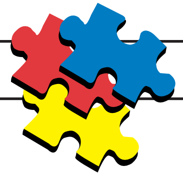


KEY FINDINGS

- One-hundred-and-nine cases were reviewed.
- Twenty-eight of these deaths (25.7 percent) were due to the fault of young drivers (those 16 years of age).
- Twelve of these deaths (11 percent) were due to underage drivers (those under the age of 16).
- Fifteen of the deaths were specifically listed as being due to an inexperienced driver.
- Thirty-six of these deaths (33 percent) were the result of not using lap and shoulder belts or other appropriate safety restraints. Five deaths (4.6 percent) were the result of restraints not being used correctly.
- Additionally, 52 of these deaths (47.7 percent) were due to reckless driving or speeding, with 31 of these deaths (28.4 percent) caused by reckless driving and 21 deaths (19.3 percent) caused by speeding.

RECOMMENDATIONS

1. Encourage the inclusion of information about the dangers of driving at high speeds and expand current education about reckless driving in driver's education courses.
2. 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.
3. Support new legislation to improve child passenger restraint laws.
4. Promote new legislation to restrict passengers in the back of pickup trucks.
5. Encourage new laws to better regulate children on all-terrain vehicles.

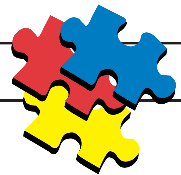


KEY FINDINGS

- Fifteen cases were reviewed.
- In three of these cases, fires were the result of faulty wiring in children's places of residence.
- In only one case was there a smoke alarm in the residence. In 10 of the cases, it was not known whether the residence had a smoke alarm.
- Six of the cases (40 percent) were deaths that occurred in mobile homes.

RECOMMENDATIONS

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

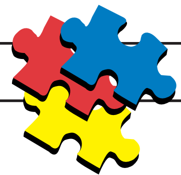


KEY FINDINGS

- Twenty cases were reviewed.
- Thirteen of these deaths occurred in swimming and/or wading pools.
- Twenty percent of these deaths occurred in open water.
- Of the 20 drownings, 80 percent were reported as not wearing a floatation device.

RECOMMENDATIONS

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

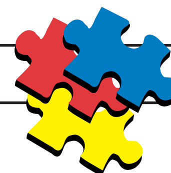


KEY FINDINGS

- Twenty-six cases were reviewed.
- One of these deaths (3.8 percent) was considered intentional.
- Ten of these deaths (38.5 percent) were suspected to be the result of “roll overs” by an adult during a bed sharing situation.
- Eleven of these victims (42.3 percent) were reported to be sleeping in an adult bed when the death occurred.

RECOMMENDATIONS

1. Promote and encourage statewide education and awareness campaigns about safe bedding practices and the dangers of bed sharing.
2. Promote and encourage parenting classes for new and, especially, young parents.

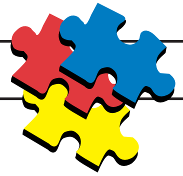


KEY FINDINGS

- Sixteen cases were reviewed.
- Eleven of these deaths (68.6 percent) were the result of handgun use.
- The vast majority of these deaths, 11 of the 16 (68.8 percent), were known to be due to an “intent to do harm.”
- Only two child deaths reviewed in this category were reported to be the result of playing with firearms.
- Four of the 16 children (25 percent) were killed by a weapon being handled by a family member.

RECOMMENDATIONS

1. Encourage youth and parent gun safety education.
2. Support crisis team and victim advocacy for 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.
5. Encourage safe and secure storage of firearms.

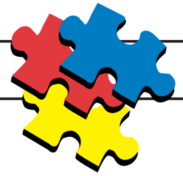


KEY FINDINGS

- Thirteen cases were reviewed.
- Five of these deaths (38.5 percent) were reported as being unexpected.
- Nine of these deaths (69.2 percent) resulted from the use of firearms, followed by three deaths (23.1 percent) that were the result of hanging.

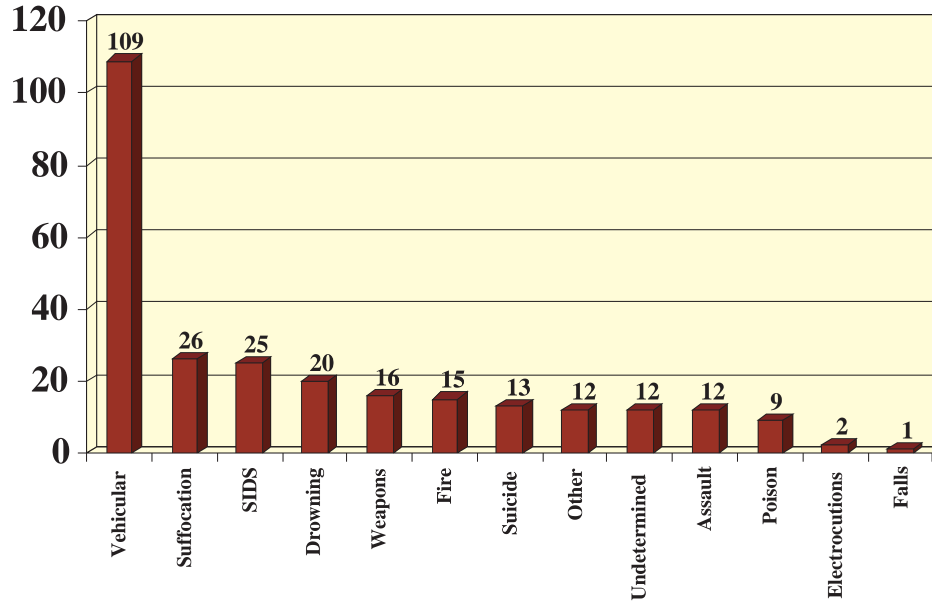
RECOMMENDATIONS

1. Support statewide efforts to examine all of the issues surrounding adolescent suicide and develop plans for prevention.
2. Institute training for teachers about suicide risk assessment and referral resources.
3. Support a statewide education and awareness campaign aimed at parents and others about adolescent suicide risk assessment and assistance resources.
4. Support the Alabama Suicide Prevention Plan of 2004.
5. Encourage safe and secure storage of firearms.

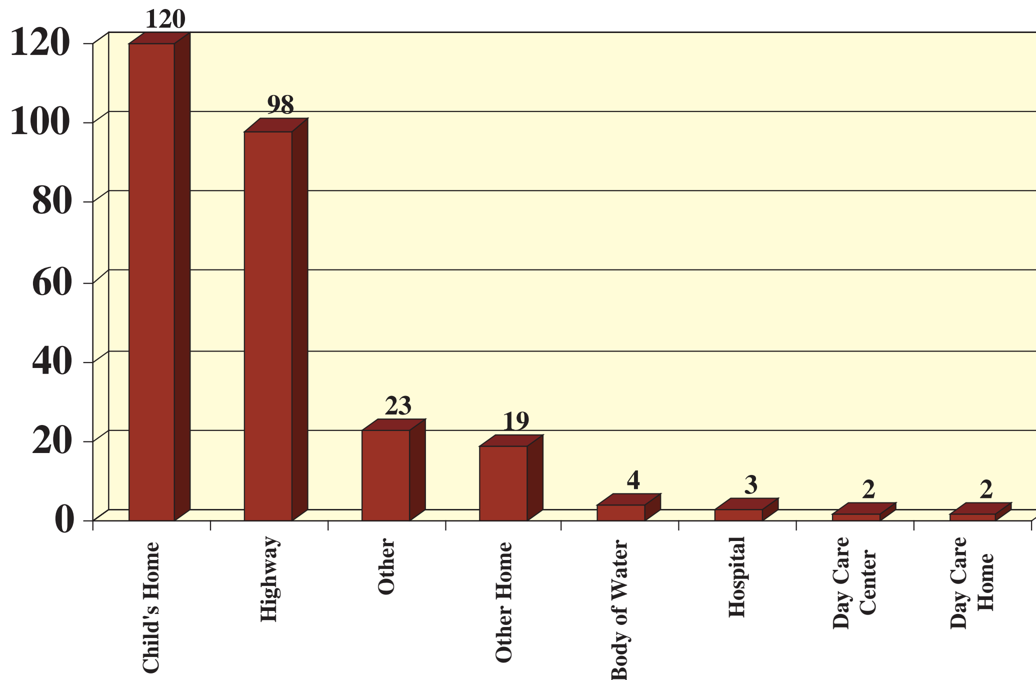


REVIEWED CASES ONLY

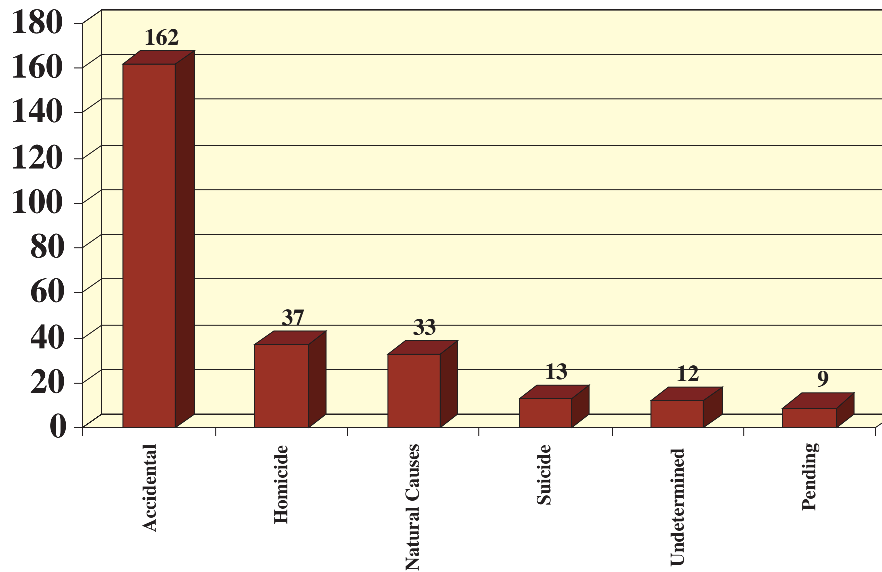
- Motor Vehicle was the most often (40 percent) reviewed cause of child death.



- As can be seen from the graph below, the single most frequent place of death (44 percent) was the child's home.



- Accident was the most frequent (162 cases) manner of death reviewed.



POISON:

- Nine cases were reviewed.

- Two-thirds of poisoning cases reviewed resulted from prescription or illegal drug use.

ELECTROCUTIONS:

- Two cases were reviewed.

- Both were the result of lightning.

ASSAULT:

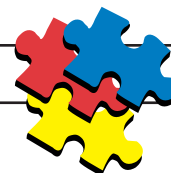
- Twelve cases were reviewed.

- Of those, six deaths were caused by the use of hands and fists.

- Parents were responsible for one-third of the assault deaths. The majority of the remainder of the deaths were caused by the parents' friends or significant others.

UNDETERMINED:

- Twelve cases were reviewed.



Frequently we are asked, "How many lives is the ACDRS saving each year?" This is a difficult question to answer. However, we know our Teams are being successful because we are able to show a very positive trend in the decreasing number of cases that are meeting our criteria for review each year. Please take a look at the following chart:

ACDRS 1998 - 2002
Final Statistics

1998	Number	Percentage
Deaths meeting ACDRS criteria	462	45.07%
Deaths NOT meeting ACDRS criteria	563	54.93%
Total child deaths	1025	100.00%

1998	Number	Percentage
Cases reviewed/completed	294	63.64%
Cases still outstanding	168	36.36%
All cases meeting ACDRS criteria	462	100.00%

1999	Number	Percentage
Deaths meeting ACDRS criteria	505	50.05%
Deaths NOT meeting ACDRS criteria	504	49.95%
Total child deaths	1009	100.00%

1999	Number	Percentage
Cases reviewed/completed	338	66.93%
Cases still outstanding	167	33.07%
All cases meeting ACDRS criteria	505	100.00%

2000	Number	Percentage
Deaths meeting ACDRS criteria	386	42.23%
Deaths NOT meeting ACDRS criteria	528	57.77%
Total child deaths	914	100.00%

2000	Number	Percentage
Cases reviewed/completed	290	75.13%
Cases still outstanding	96	24.87%
All cases meeting ACDRS criteria	386	100.00%

2001	Number	Percentage
Deaths meeting ACDRS criteria	380	41.71%
Deaths NOT meeting ACDRS criteria	531	58.29%
Total child deaths	911	100.00%

2001	Number	Percentage
Cases reviewed/completed	313	82.37%
Cases still outstanding	67	17.63%
All cases meeting ACDRS criteria	380	100.00%

2002	Number	Percentage
Deaths meeting ACDRS criteria	335	37.40%
Deaths NOT meeting ACDRS criteria	561	62.60%
Total child deaths	896	100.00%

2002	Number	Percentage
Cases reviewed/completed	272	81.19%
Cases still outstanding	63	18.81%
All cases meeting ACDRS criteria	335	100.00%

This chart shows very positive trends in the data we are collecting. Except for a brief aberration between 1998 and 1999, from 1998 to 2002 the number of infant and child deaths in Alabama that meet our criteria for review is showing a definite reduction. This reduction is evident both in the number of deaths that meet criteria for review, the number of total infant and child deaths, and the percentage of total deaths that meet criteria for review. These are just a few of the successes we are seeing.

In addition, during this past year, the ACDRS enjoyed other very positive results. In August, we completed our first ACDRS Training Conference. The conference, which was held in Mobile, Ala., served two purposes: First, we held our quarterly ACDRS State Team Meeting for our 28-member State Team; second, we combined this meeting with a Training Conference for all of our Local Team Coordinators and Chairpersons. The conference was a great success with more than 60 Team members in attendance, all of whom gave the conference a very high evaluation.

Further items of note include the fact that for the second year in a row, we exceeded 80 percent in our case review and return rate! While this is a marked improvement, it is still not good enough. We are continuing to try new ways to achieve our ultimate goal of 100 percent.

The ACDRS continues to follow the guidelines set out in state law that require us to provide public education on topics that pertain to saving infant and child lives. We have updated many of our educational brochures to include Spanish language versions for our ever-growing, Spanish-speaking population. In addition, we are working with the Alabama Suicide Prevention Task Force to develop a Youth Suicide Awareness and Prevention brochure to be distributed statewide. Likewise, we are working with the Alabama Injury Prevention Task Force to develop an All-Terrain Vehicle (ATV) Safety/Awareness Program for our state.

We also observe with satisfaction and pride the great work that continues to be done by the Jefferson County and Mobile County Hospital-Based Shaken Baby Syndrome Parent Education Programs, which we helped start. We hope these two programs will serve as examples, or seedlings, for the creation of similar programs in hospitals and counties throughout Alabama. We have other new programs, such as “Cribs for Kids,” which provides portable baby cribs to families that cannot afford them. We hope to start this program within the next few months.

Because of the results we are seeing and the work we are doing, the ACDRS is becoming much better known throughout our state. The media is aware of us now and we regularly take part in newspaper, radio, and television interviews across Alabama. The previous chart shows that since 1998, we have enjoyed approximately a 30 percent decrease in the number of infant and child deaths that meet our criteria for review. This is great news and we are thankful for the trend. But it is not good enough. A 30 percent reduction is significant, but the death of even one child is one too many. Our goal continues to be to prevent as many infant and child deaths as we can, and to prevent these deaths as often as we can!

1. What is the ACDRS?

- Alabama is one of 49 states that have Child Death Review Systems.
- Alabama state law signed on September 11, 1997, created the ACDRS State Office and both Local and State CDR Teams.
- The ACDRS is tasked to review, evaluate, and prevent cases of unexpected/unexplained child deaths.

2. What is the "Mission" of the ACDRS?

- To understand how and why children die in Alabama in order to prevent future child deaths.

3. What is the primary focus of the ACDRS?

- The primary purpose of the ACDRS is prevention, not prosecution. This is done through statistical analysis, education and advocacy efforts, and local community involvement.
- "Preventability" refers to the ability of an individual or community to reasonably have done something to alter the conditions that led to the child's death, thereby preventing the child's death, or to reasonably do something now to reduce the likelihood of future similar deaths.

4. How is the ACDRS organized?

- The ACDRS is comprised of three major components:
  - — The ACDRS **State Office** is located in the Alabama Department of Public Health, within the Women & Children's Health Branch of the Bureau of Family Health Services. There are three full-time staff members — Director, Assistant Director, and Administrative Assistant.
  - — State Law requires each District Attorney to form at least one **Local Child Death Review Team (LCDRT)** in each Alabama Judicial Circuit. LCDRTs are multi-disciplinary and are required to meet at least once per year (most meet more frequently).
  - — The **State Child Death Review Team (SCDRT)**, chaired by the State Health Officer (Director of ADPH), is also multi-disciplinary and meets quarterly. Its 28 members include various state agency directors and representatives, medical professionals, judicial and law-enforcement officials, state legislators, and private citizens appointed by the Governor.
- Because of these components the ACDRS considers itself a "system."

5. How is the ACDRS funded?

- Funding originates in Alabama's portion of the National Tobacco Settlement (NTS) through the Children First Trust Fund (CFTF).
- The amount will equal 1/2 percent of the total CFTF portion of the NTS, not to exceed $300,000.

6. What does the ACDRS do?

- Analyzes the deaths of Alabama's children
- Makes recommendations to the Governor
- Recommends and supports legislation
- Helps create policy and procedures
- Educates the public
- Helps to reduce infant and child deaths in Alabama

7. How does the ACDRS operate?

- The State Office receives a copy of all death certificates issued to Alabama residents less than 18 years of age. Each certificate is reviewed to determine whether it meets the ACDRS review criteria. Copies of those meeting the criteria are then mailed out to the LCDRT in the decedent's county of residence.
- The LCDRT reviews the individual cases and, based on their findings, fills out the appropriate data col-

lection forms and submits the information to the ACDRS State Office. The Local Team then takes action as allowed and/or required in the community to prevent additional deaths and makes recommendations to the State Team for statewide consideration and action.

- The ACDRS State Office enters the information submitted by the LCDRT into a master database. The information in the database is then used to answer requests for specific data and to generate annual reports.
- The State Child Death Review Team meets quarterly to discuss CDR issues, review the State Office data, consider LCDRT recommendations and performance, and conduct general ACDRS business. The SCDRT makes periodic recommendations to the Governor and takes action on issues related to CDR (including educational programs, informational publications, and other efforts).

8. What is included within the ACDRS case review criteria?

- Deceased must be a resident of Alabama
- Deceased must be within the age range of birth to less than 18 years of age
- Deceased cause of death must be non-natural or SIDS

9. What are the ACDRS goals?

- All child deaths considered
- All eligible deaths reviewed
- High completion rate
- Meaningful research and recommendations
- Reduce preventable infant and child deaths in Alabama

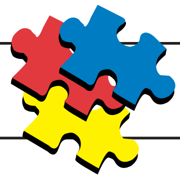
10. What are some of ACDRS' successes?

- Assisted in getting the following legislation passed into law:
  - — "Safe Place" Law (2000)
  - — Graduated Driver's License (2002)
  - — "Baby Douglas" Day Care Medication (2004)

  Legislation pending:
  - — Additional All-Terrain Vehicle regulations
  - — Passengers prohibited in open truck beds
  - — Enhanced Child Safety Restraint Law
- Trends since ACDRS was established:
  - — Fewer total child deaths (from 1,000 a year to less than 850 per year)
  - — Fewer deaths meeting criteria (from 500 a year to less than 350 per year)
  - — Improved case review and completion rate (from 64 percent to more than 80 percent)
- Education Programs (English/Spanish)
  - — "Shaken Baby Syndrome"
  - — "Safety for Sleeping Babies"
  - — "Back to Sleep"
  - — Improved Infant/Child Death Investigations
  - — "Child Suicide Prevention" (Pending)
  - — "Dangers of Children on ATVs" (Pending)
  - — "Cribs for Kids" (Pending)

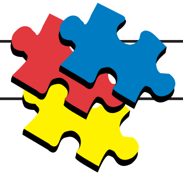
11. What is Alabama's greatest resource?

OUR CHILDREN!!!



ALABAMA CHILD DEATH REVIEW SYSTEM - CASE REVIEW TIMELINE (AN EXAMPLE)

- Infant/child death occurs on September 1, 2002.
- Death certificate received at the Alabama Child Death Review System State Office on September 15, 2002. (The ACDRS State Office normally receives death certificates within 60 days of when they are issued.)
- Death certificate sent to the Local Child Death Review Team (LCDRT) on September 22, 2002. The ACDRS State Office continues to send additional death certificates that it receives to the Local Team within one to two weeks of receipt of the documents.
- The LCDRT meets to review this specific case and others on March 1, 2003. (By law, each Local Team is required to meet once per calendar year.)
- The ACDRS State Office receives the last of the 2002 death certificates by July 2003.
- September 1, 2004, is the deadline by which the ACDRS State Office is to receive all 2002 cases that have been reviewed by LCDRTs.
- The ACDRS 2002 Annual Report is published and distributed in the Spring of 2005.



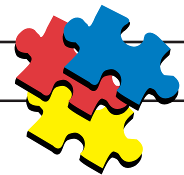
The Alabama Child Death Review System supports the following:

- Enhanced child safety restraints: A bill before the state Legislature would require child passenger restraints for children up to the age of 12 when they are traveling in cars and other vehicles on Alabama roads, streets, and highways. A $25 fine would be imposed for each violation, and a portion of that money would be distributed to the Alabama Head Injury Foundation so that the organization can assist families at or below the federal poverty level in obtaining car seats, booster seats, and other appropriate restraint systems. In addition, a driver would receive one point toward a driver's license suspension for a first violation and two points for every subsequent violation. A license can be suspended for 60 days if a driver gets 12 points over two years. Specifically, the measure requires that children be placed in rear-facing safety seats until they are 1-year-old or 20 pounds; in forward-facing safety seats until they are 5-years-old or 40 pounds; and in booster seats until they are 12-years-old or 80 pounds. Under existing law, children 3-years-old or younger must ride in a child safety seat, and children ages 4 and 5 must ride in a child safety seat or be fastened in a vehicle seat belt. There is a $10 fine for each violation.

The ACDRS also supports these initiatives:

- Prohibit operators of pickup trucks from allowing people under the age of 18 to ride in the truck bed.

- Strengthen regulations governing children and the use of All-Terrain Vehicles. Currently, neither an operator's license nor safety courses are required prior to operating an ATV in Alabama. Since January 2000, the ACDRS has reviewed at least 20 ATV-related infant and child deaths. Of these, 16 of the deaths involved operators who were 16-years-old or younger; and at least four deaths occurred to a passenger on the ATV, and those fatalities included victims between the ages of 2 years and 10 years.



The Alabama Child Death Review System created a Child Death Investigation Task Force to develop an unexpected/unexplained child death investigation training initiative, as well as a child death scene investigation protocol in an effort to promote conformity statewide in how these deaths are investigated. The following details those efforts and their outcome.

For many years in Alabama, law enforcement officials did not receive training specific to the investigation of unexpected/unexplained infant and child deaths, and there was not a standard way to probe these fatalities. The ACDRS is working to change that.

With 67 counties in Alabama, "There might be 67 different ways that things were being done," says J.R. Sample, an investigator with the Shelby County District Attorney's Office and coordinator of that county's Local Child Death Review Team. "The goal is to get everyone from border to border doing something of the same semblance."

The ACDRS was created by state statute in 1997 with the aim of ensuring that all child deaths in Alabama are fully investigated and that any unexpected/unexplained deaths are further reviewed so that causes can be found and such future deaths prevented. As part of those efforts, the ACDRS created a Child Death Investigation Task Force, which was charged with developing a child death investigation training initiative, as well as a child death scene investigation protocol so that there could be some conformity statewide in how unexpected/unexplained infant and child deaths are investigated.

"The law creating the ACDRS said there had to be some changes — that there had to be a standardized way to investigate unexplained infant and child deaths," says Dennis Trammell, who, like Sample, was a member of the Child Death Investigation Task Force and who now works for a child advocacy group in Cleburne and Calhoun Counties.

"The goal of the task force was to try and standardize the way child deaths are investigated so that whether it's a large police department or a two-man department, there are protocols as to how things should be investigated so that things don't get overlooked," Trammell says.

Today, law enforcement officers, both new recruits and veterans, can receive special training in how to investigate unexpected/unexplained infant and child deaths. Officers also have access to and are encouraged to use a "Death Scene Assessment Tool" created by the Child Death Investigation Task Force — a checklist of questions to ask and information to gather at infant and child death scenes.

The Child Death Investigation Task Force was created in 2002 and included nearly 20 members who represented law enforcement, the State Department of Human Resources, and various other child advocacy organizations. "There was a smattering of representatives from all kinds of groups that might be involved in child death investigations," Sample says. Task force members attended several training sessions, and went to work in 2003. Their mission: create a training program and a death scene assessment tool that could provide a consistency statewide in how infant and child deaths are investigated.

"For law enforcement, this is always a touchy area — child abuse and death cases. It takes a special person with special training," says Trammell, who worked for the Alabama Bureau of Investigation during the time he served as a task force member. "It's not an area where there was a lot of expertise. Training and investigative tools were needed."

Members of the Child Death Investigation Task Force decided to tackle training first. They recommended that Alabama police academies add a block of instruction to their existing "Death Investigation" syllabus and training courses devoted to

the basics associated with investigating child deaths, as well as unexpected/unexplained child deaths.
While the training would be part of the curriculum and, therefore, mandatory for new recruits, the task force suggested that continuing education credit be offered to veteran law enforcement officers who also participated in the training. "We decided police academies should take a portion of their death investigating training time and focus on child death investigations," Sample says. "There was no specific training for investigating child deaths before this. Police academies provided training on death investigations, but child deaths were not covered."

Sample says focusing a portion of death investigation training on child deaths is important because those investigations are often much different than adult death investigations. "A death is a death be it a child or an adult," Sample says. "But while there are general aspects of the scene for both children and adults that might be similar, there's a stigma associated with a child death. A child is not supposed to die."

Sample says when an infant or child dies, a parent, for example, might grab the child and run through the house, or go next door with the child to get help from neighbors, thereby spreading the death scene in many different directions. "That's one of the biggest differences working a child death scene. You have to go back and recreate your scene," Sample says.

Trammell adds that with infant and child deaths, particularly those that are not readily explainable, "you are going into a situation where you have to be very diplomatic with a parent or a caregiver. You may not know if the cause of death is SIDS (Sudden Infant Death Syndrome) or abuse. You have to be careful how you ask questions. With an adult death, it's often more obvious what the cause is. There are a lot of differences in how you approach an unexplained child death."

The Child Death Investigation Task Force also developed a sort of checklist, what members titled a "Death Scene Assessment Tool," using information gleaned from similar task forces in other states. Use of the assessment tool is optional, and Sample says law enforcement officers can add questions and modify it to better suit their needs and the needs of their jurisdictions. "With the assessment tool we're saying, 'Here is what we want you to think about,'" says Sample, whose current work sometimes includes investigating infant and child deaths. "I have that list and I take it with me. That way I have a checklist in front of me to remind me what to ask."

In addition to more standard questions, the Death Scene Assessment Tool also asks:

- Where the infant or child was found, whether it was a crib or bassinet, stroller, play pen, couch or sofa, a child bed, adult bed, or a mattress on the floor.
- The condition of the bed, if the infant or child was found there.
- The bedding or material the infant or child was sleeping on, including its thickness, whether the material was covering the infant or child or his or her head, whether there were side cushions in the bed, and what other items were in the bed.
- Whether the infant or child was put to sleep on his or her back, stomach, or side, whether the infant or child was capable of rolling over, and whether the parent(s) or caregiver(s) had knowledge of recommended sleep positions.
- Whether the infant or child was sleeping with anyone at the time of death.

The ACDRS approved the recommendations of the Child Death Investigation Task Force in late 2003 and, with its work complete, the Task Force disbanded shortly thereafter. The ACDRS implemented the Task Force suggestions in January 2004.

Both Sample and Trammell say that many police academies have enacted the infant and child death investigation training recommended by the Task Force, and many law enforcement officers are using the Death Scene Assessment Tool. Sample says he is beginning to see some conformity and consistency in the way unexpected/unexplained infant and child deaths are now investigated in Alabama.

"People are starting to get on the same page," he says. "Instead of people thinking in 67 different ways, people are beginning to think in a more uniform way." (A copy of the "Infant/Child Death Scene Investigation Assessment Tool" can be seen/downloaded from the "Downloads" section of the ACDRS web site at: http://www.adph.org/cdr .)

HOSPITAL-BASED SHAKEN BABY SYNDROME PARENT EDUCATION PROGRAMS

During the past year, hospital-based Shaken Baby Syndrome Parent Education Programs were started in Mobile and Jefferson Counties. Funding for the initial year was provided by the ACDRS and Healthy Start, a national initiative that provides in-home assistance and services for new parents. The ACDRS is hopeful that similar Shaken Baby Syndrome Parent Education Programs can be started in other Alabama counties.

Mobile County:

The Healthy Start: Never Shake A Baby program in Mobile County is little more than a year old but already has reached nearly 3,000 new parents with information about the dangers of shaking a baby.

"For many parents, this is new information. They have heard about Shaken Baby Syndrome, but they may have only a vague idea of what it is all about," says Lydia Pettijohn, the program's Executive Director. "We've gotten a very positive response from parents and hospital staff."

The Mobile program began in November 2003, about five months after Ms. Pettijohn was first contacted by the ACDRS and asked to create a shaken-baby education program. Ms. Pettijohn believed the best way to reach new parents was shortly after they delivered their babies, while they were still in the hospital. She wrote a proposal that called for hospital-based, one-on-one sessions with new parents to talk about the warning signs and dangers associated with Shaken Baby Syndrome, as well as ways to manage the stress that comes with being the parent of a newborn. She received $42,000 from the ACDRS and Healthy Start to launch the program.

Ms. Pettijohn met with administrators and nurses at four Mobile hospitals. "They were very receptive to the program," she says. Healthy Start: Never Shake A Baby is a voluntary program that today operates within the University of South Alabama Women's and Children's Hospital, Providence Hospital, and Springhill Memorial Hospital. While the hospitals encourage new parents to participate, the decision ultimately belongs to the parents who must sign up if they want to take part. Expectant parents are asked whether they want to participate when they first arrive at the hospital. Program instructors also visit the rooms of new parents to ask if they are interested.

If new parents choose to participate, an instructor from Ms. Pettijohn's staff meets with the new mother in her hospital room. Fathers and extended family members are also welcome to attend. The one-on-one session lasts about an hour. "We start off providing information about new baby care," Ms. Pettijohn says. "We talk about how new babies cry a lot and that there are ways to calm them. We introduce parents to Dr. Harvey Karp's '5 S's' — swaddling, side-laying in a parent's arms, shushing in the ear, swinging gently, and sucking. If the babies are awake, we have the parents try this with the babies." Ms. Pettijohn says the first three S's simulate the sounds and feel of the womb, and babies typically stop crying at the third S (shushing in the ear).

"We also go over stress management issues and tell parents how to take care of themselves — to get enough sleep, to let the housework go, that it's O.K. to let the baby cry for a bit if you need to walk out of the room for a minute to relax or make a telephone call to talk to someone," Ms. Pettijohn says.

New parents are also shown a video, "Portrait of Promise," which illustrates the lives of three children who are the victims of Shaken Baby Syndrome. One child dies, and two are severely injured. Afterward, parents must sign an affidavit (a sworn statement that can be used in court) saying they understand the dangers associated with shaking a baby. At the end of the session, new parents are provided with brochures and other written information about Shaken Baby Syndrome, as well as a magnet that shows her employer's phone number (the Exchange Club Family Center) to call for support and for answers

to any questions they may have.
Ms. Pettijohn says while she has no quantitative data, she believes that Healthy Start: Never Shake A Baby is working and that it has helped reduce the number of Shaken Baby Syndrome injuries and deaths in Mobile County.

Unfortunately, the initial funding provided by the ACDRS and Healthy Start has run out. The program continues to operate with money Ms. Pettijohn has received from several grants she has been awarded, and she is currently looking for additional financial support.

In the meantime, she is training senior volunteers and trying to recruit health education and nursing students at the University of South Alabama to serve as instructors. She is working with RSVP, short for Retired Senior Volunteer Program, and already half a dozen RSVP members who are retired nurses have completed a Healthy Start: Never Shake A Baby orientation program. One retired nurse is already working as a staff volunteer for the program. "The hospitals really want this program." Ms. Pettijohn says. "It is making a difference."

"New mom and big sister receive shaken baby training from the Mobile County Shaken Baby Syndrome Parent Education Program.

Jefferson County:

Strong response to UAB's Shaken Baby Prevention Program has prompted program officials to try and expand the initiative to other hospitals in Jefferson County.

"New parents have been very receptive," says Erin Mayfield, coordinator of the program, which currently operates only at UAB Hospital in Birmingham. "Most of the parents we have worked with are very intrigued and want to learn all they can about Shaken Baby Syndrome. For the most part, those that don't know about it want to learn, and those that do know about it are receptive to more information and respect what we are doing."

UAB's Shaken Baby Prevention Program has been in operation for about a year. Initial funding for the program came from the Alabama Child Death Review System, although the majority now comes from a grant awarded by the Alabama Children First Trust Fund. The program has also received donations.

Like a similar program in Mobile County, UAB's Shaken Baby Prevention Program is hospital-based, voluntary, and consists of one-on-one sessions with new parents. Ms. Mayfield and a program staff member visit UAB Hospital almost daily where they speak with new parents to see if those parents are interested in participating in a one-on-one education session about Shaken Baby Syndrome. If parents are interested, Ms. Mayfield or a staff member meets with them in their hospital room, usually the day after the birth of their baby.

"We start out congratulating them on the birth of their child, and then we ask them if they have ever heard of Shaken Baby Syndrome," Mayfield says. "We explain the seriousness of it, but we make sure it doesn't come across like finger pointing. And, we explain that Shaken Baby Syndrome can involve caregivers other than the parents." New parents are shown the video "Portrait of Promise," which depicts the lives of three victims of Shaken Baby Syndrome. "We tell parents it's O.K. to leave a crying child for a moment and walk out of the room and take a deep breath or call someone. We tell them, 'When you are stressed, put the baby down, leave the room, regain yourself,'" Mayfield says.

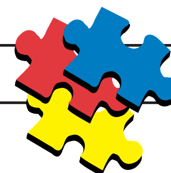
A brochure titled "Never Ever Shake a Baby," which contains information about the warning signs and dangers associated with Shaken Baby Syndrome, is given to new parents. Parents also receive magnets with a 1-800 number to call when they need help, as well as a phone number for the Exchange Club Family Skills Center in Birmingham, which offers parenting education classes. The materials are offered in both English and Spanish.

UAB's Shaken Baby Prevention Program also includes a follow-up component. Staff members check in by telephone with the parents they visited in the hospital when their babies are one-month and four-months-old "to see how everyone is doing. We make sure there is someone parents can call if they are stressed and need help," Ms. Mayfield says. Newsletters are sent to parents when their babies are one-month, two-months, four-months, six-months, and nine-months old letting parents know what to expect developmentally from their babies at these ages and how parents can assist in that development.

The UAB Program currently has a staff of two — Ms. Mayfield and another instructor who is fluent in Spanish. In a typical day, the pair might conduct one-on-one sessions with anywhere from two to 15 new mothers. Since the program started, they have met with just over 2,000 new mothers. Fathers and extended family members are also welcome at the sessions.

Ms. Mayfield hopes the program can be expanded to Birmingham's Brookwood Hospital and St. Vincent's Hospital, but funding is an issue. She continues to search for additional resources. "We still have enough money to keep the current program going, but we're trying to find grants and other money sources to expand and reach even more new parents," she says.

"Bedside discussions with parents about infant crying hallmark the SBS Prevention Program. Mother, baby, and UAB parent coach Amy Young review useful and dangerous parent responses.



- Cases That Meet the Criteria for Review — These are cases involving the deaths of Alabama resident infants and children from birth to less than 18 years of age whose deaths are considered unexpected or unexplained.

- Cause of Death — As used in this report, the term "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 — This term includes those cases that were reviewed by a Local Child Death Review Team and added to the ACDRS database.

- Manner of Death — This is one of six general categories (Accident, Homicide, Suicide, Undetermined Circumstances, Pending Investigation, or Natural Causes) that is found in Item #49 on an Alabama Death Certificate.

- 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 ACDRS normally will not review such cases. However, many cases in which the cause of death is initially classified as "Pending" or "Undetermined/Unknown" are later discovered to have been 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 of death, but 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 and 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, this category includes all deaths which, prior to investigation, appear possibly to have been caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or SIDS.

...we're all part of the solution

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