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Alabama Child Death Review System
2003 Annual Report

DEATHS AMONG CHILDREN IN ALABAMA FOR THE YEAR 2003

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT

EXECUTIVE SUMMARY

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The University of Alabama
Institute for Rural Health Research

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STATE TEAM MEMBERS
(As of MAY 1, 2006)

	MEMBER	REPRESENTATIVE
1.	Jefferson Co. Coroner, Medical Examiner Ex Officio	Robert Brissie, MD Coroner/Medical Examiner
2.	State Health Officer Chair Ex Officio	Donald E. Williamson, MD State Health Officer AL Dept. of Public Health
3.	AL Sheriff's Association Appointee Ex Officio	Sheriff Bobby Timmons Executive Director
4.	AL Dept. of Forensic Sciences, Director Ex Officio	Taylor Noggle, Director AL Dept. of Forensic Sciences
5.	AL Dept. of Human Resources, Commissioner Ex Officio (Page Walley)	Shirley Scanlan
6.	AL Dept. of Mental Health and Mental Retardation, Commissioner Ex Officio (John Houston)	Steve Lafreniere Director of Children's Services
7.	AL Dept. of Public Safety, Director Ex Officio (Colonel W.M.Coppage)	Capt. Gerone Grant AL Dept. of Homeland Security
8.	Pediatrician appointed by AL Academy of Pediatrics w/expertise in SIDS	Cheryl Outland, MD Pediatrician
9.	Health professional w/expertise in child abuse/neglect appointed by AL Dept. of Public Health	Sharron Richards Denman Social Work Program Specialist, Children's Rehabilitation Services
10.	Family practice physician appointed by AL Academy of Family Physicians	VACANT
11.	AL Dept of Forensic Sciences Representative	James R. Lauridson, MD
12.	Private citizen appointed by the Governor	Judge Bill English Lee County Probate Judge
13.	Private citizen appointed by the Governor	Senator Gerald Dial
14.	Private citizen appointed by the Governor	Jean Brown

	MEMBER	REPRESENTATIVE
15.	Private citizen appointed by the Governor	Olga White Montgomery Hispanic Coalition
16.	Private citizen appointed by the Governor	District Chief Randy Thomas Montgomery Fire Dept.
17.	Member of Clergy appointed by the Governor	Rev. Jay Wolf First Baptist Church
18.	Private citizen appointed by the Governor	J.R. Sample Chief Investigator Shelby County D.A.
19.	Private citizen appointed by the Governor	Beth Holloway Twitty Mt. Brook, AL
20.	Private citizen appointed by the Governor	Tara Kyser Kinston, AL
21.	AL Coroner's Association Representative	Jim Grigg
22.	AL Network of Children's Advocacy Centers, Representative	Tara Johnson State Coordinator
23.	AL Sheriff's Association Representative	James Hayes Sheriff, Etowah County
24.	AL District Attorney's Association Representative	Mike O'Dell D.A., Cherokee/DeKalb Counties
25.	Pediatric Emergency Medicine Specialist appointed by Medical Assoc. of the State of Alabama	Hoyt A. Childs, Jr., MD Pediatric Emergency Specialist
26.	AL Association of Chiefs of Police Representative	Frank DeGraffenried, Chief Auburn Police Dept.
27.	Chair of Senate Health Committee or designee	Senator Larry Means
28.	Chair of House Health Committee or designee	Rep. Mike Millican

A LETTER FROM THE STATE CHAIRMAN

May 1, 2006

Infant and child deaths are unique in the profound effects that they have upon individuals and communities. They are all tragedies, but those that could have been prevented are particularly tragic. Over the years, there have been many efforts to prevent and reduce accidental and other unexpected child deaths. But, unfortunately, there have always been infant and child deaths that have remained largely unexplained. As with any prevention effort or program, it is not possible to prevent an occurrence until it is understood how and why it occurs in the first place. Therefore, in order to prevent the deaths of children, it is absolutely necessary to understand how and why children die. It is to this task that the **Alabama Child Death Review System (ACDRS)** is dedicated.

The ACDRS was created by State law enacted in 1997. Funded totally by the Children First Trust Fund, it is tasked with studying the circumstances of all "unexplained or unexpected" infant and child deaths in the State and identifying which of these deaths are preventable. Far from just a data-collection agency, the ACDRS reports its findings to officials and the public at large, makes annual recommendations to the Governor based upon these findings, and takes direct action at both the State and local level. In addition, the ACDRS has developed a new and widely-accepted curriculum for training child death scene investigators, developed literature and education programs on a wide variety of child death and injury prevention topics, directly brought about policy changes at the local level, and made State-level recommendations regarding these and many other issues.

The ACDRS is made up of three major components. The **ACDRS State Office**, the directional part of the system, is located in the Alabama Department of Public Health. There is at least one **Local Child Death Review Team** in every Alabama Judicial Circuit. These multidisciplinary teams are the action arms of the system, and are required to meet at least once per year (most meet more frequently) to review resident child death cases. The **State Child Death Review Team**, the advisory part of the system, is also multidisciplinary and meets quarterly to review the findings of all Local Teams, as well as other broader issues related to child deaths in Alabama. Its 28 members include State agency directors and representatives, medical professionals, judicial and law enforcement officials, State legislators, and private citizens appointed by the Governor. The three components work together as a comprehensive system to collect and analyze data to better understand both how and why children die in this State and to act upon the findings.

We are pleased to report several encouraging trends related to the ACDRS and to child deaths in Alabama in general, which you can read about in detail in the "Successes" section of this report. The program itself has grown in scope and participation, while performance has significantly improved.

The ACDRS staff, team members, and strategic partners remain committed to the simple, yet very important, goal of preventing child deaths in Alabama through public awareness, education, and direct prevention efforts. Our mission, when all is said and done, is to ensure **fewer child deaths in Alabama!**

Sincerely,

Donald E. Williamson, M.D.
State Health Officer

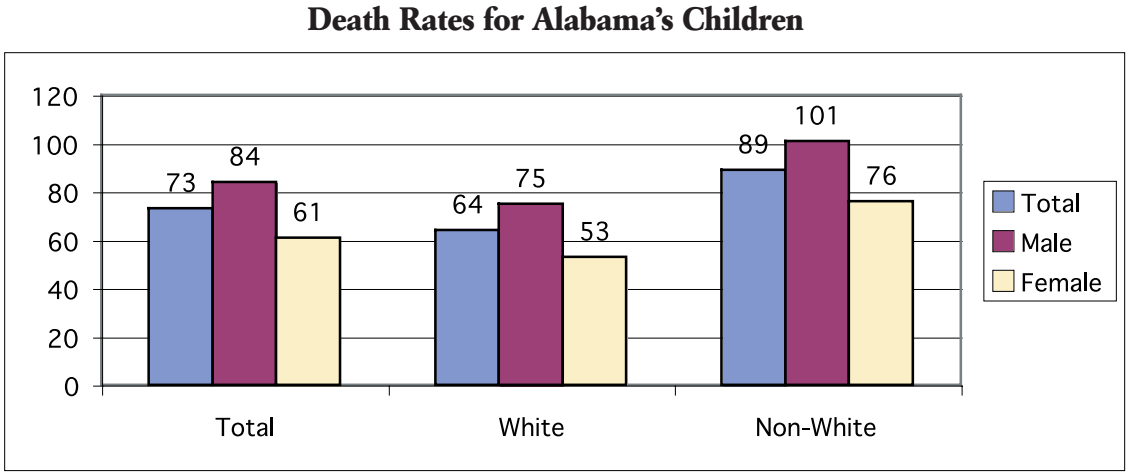
There were 823 children under the age of 18 who died in Alabama in 2003. While each one of these deaths is a tragedy, especially to family and friends, each one also serves as a powerful warning that other children are at risk. To better understand how and why these children died, the ACDRS has been 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.

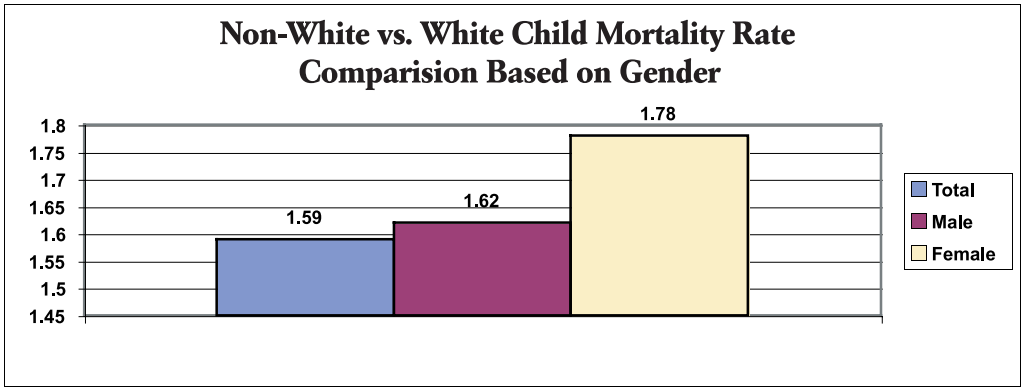
This Executive Summary presents key findings from the local review teams and from Alabama child mortality data. It also makes recommendations that can help prevent unexpected/unexplained child deaths. Thus, this report honors the memory of all those children who have died in Alabama. We hope that it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

KEY FINDINGS

- There were 823 infant/child deaths (those under the age of 18) during 2003. This compares to 896 for 2002, 911 for 2001, and 915 for 2000.
- This represents approximately 73 deaths per 100,000 children.
- Sixty percent of these deaths were to male children.
- Forty-three 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 among specific population groups:

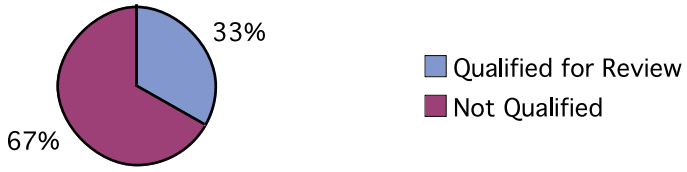


- Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher rates ($p < .05$) than do whites (i.e. non-white males had a child morality rate 1.62 times greater than white males).

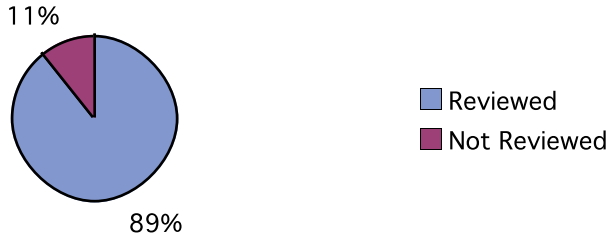


KEY FINDINGS

- As the chart below indicates, of the 823 child deaths in Alabama in 2003, there were 274 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (274), the Local Review Teams reviewed and returned 244 reports (see chart below). This compares to 81 percent reported previously.

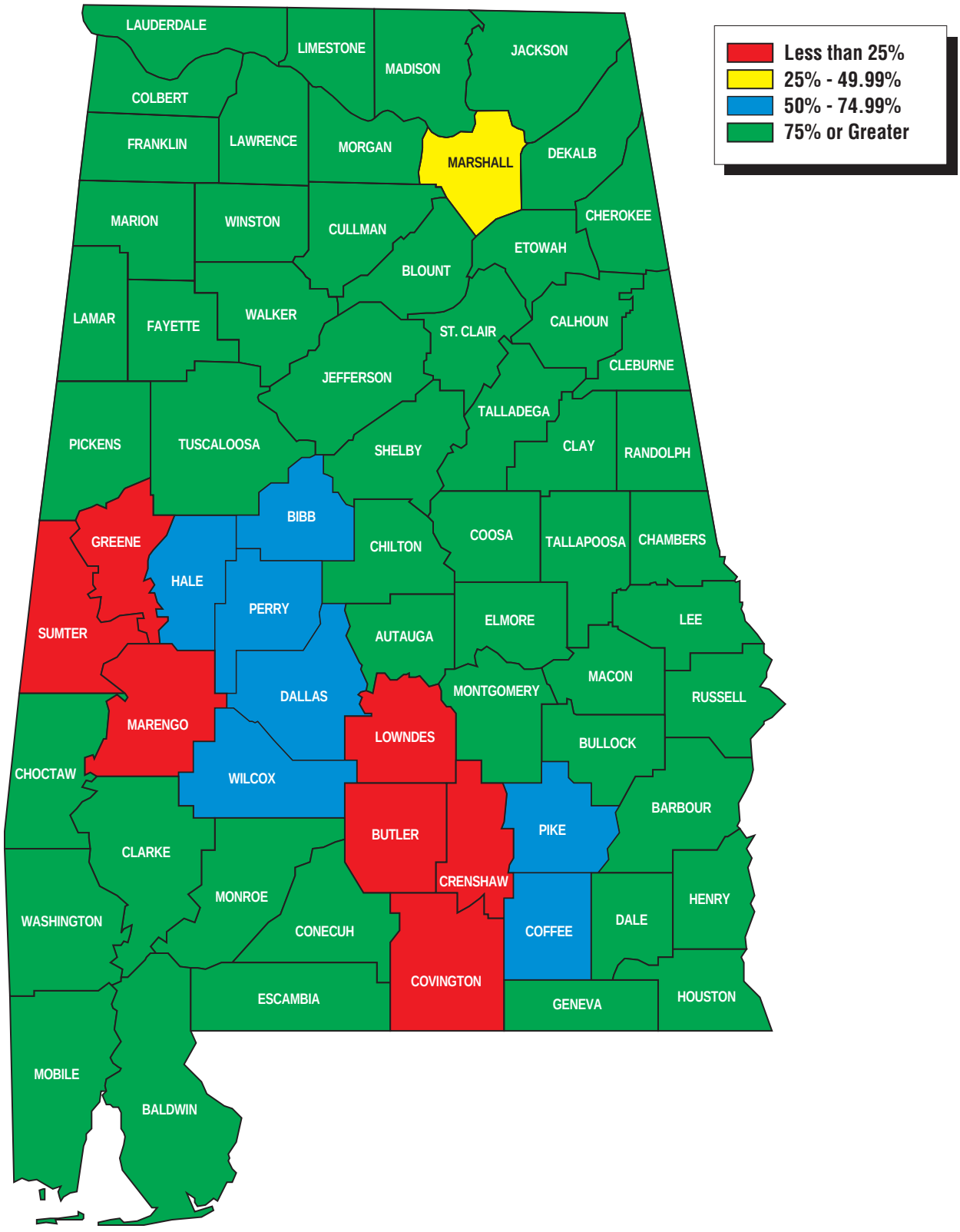


- There were no significant race or gender differences in the proportion of cases reviewed compared to those not reviewed.

- 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	290	6	6	0
28 days - < 1 year	209	72	67	5
1 year - < 5 years	86	44	34	10
5 years - < 10 years	60	26	22	4
10 years - < 16 years	84	51	47	4
16 years - < 18 years	94	75	68	7

- There is a wide variety in the percentage of qualified cases that were reviewed and returned in 2003. 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-three cases were reviewed.
- We do not know the initial sleeping position of 55 percent of the babies whose deaths were reviewed, however 24 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of those cases reviewed, 42 percent of infants were sleeping in adult beds and 48 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge of the deaths where the position of the infant was unknown.
- Only three of the reviewed cases involved families who did not smoke.
- Of all cases reviewed, at least six cases (18 percent) were "rollover" deaths.

RECOMMENDATIONS

1. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
2. Increase public awareness of "Back to Sleep" and "Babies Sleep Safest on Their Backs" programs.
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.
7. Provide increased public education and encourage strict adherence to the 2005 American Academy of Pediatrics guidelines for preventing SIDS and reducing risks associated with infant sleeping environment.
8. Ensure that the death of every child in Alabama is reported to the appropriate medical examiner in accordance with the ACDRS statute, Act #97-893.
9. Increase the number of forensic laboratories available in order to provide investigators with more timely information.
10. Require certification and training for everyone authorized to complete birth and death certificates in Alabama to include the use of standardized definitions used in their completion.

KEY FINDINGS

- Eighty-nine cases were reviewed.
- Twenty-two of these deaths (29 percent) were due to the fault of young drivers (those 16 years of age).
- Eight of these deaths (9 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-two of these deaths (36 percent) were the result of not using lap and shoulder belts or other appropriate safety restraints. Two deaths (2.3 percent) were the result of restraints not being used correctly.
- Additionally, 42 of these deaths (47.2 percent) were due to reckless driving or speeding, with 20 of these deaths (22.5 percent) caused by reckless driving and 22 (24.7 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 to include licensure and mandatory safety equipment.
6. Consider changing the minimum age to acquire a driver's license from 16 to 18-years-old.
7. Pass legislation prohibiting the use of cell phones while driving for drivers under the age of 18 years.
8. Reinstate and restore funding for the "Alabama Child Passenger Safety Program."
9. Adopt a policy of including multiple agencies in the development and implementation of all child safety interventions.

KEY FINDINGS

- Thirteen cases were reviewed.
- In four 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. In three of the cases, or 23 percent, there was no smoke alarm.
- Three of the cases (23 percent) were deaths that occurred in mobile homes, while 46 percent occurred in wood-frame homes and 8 percent in wood/brick 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.
4. Explore the possibility of restricting cigarette retail sales to allow only "fire safe" cigarettes in Alabama.

KEY FINDINGS

- Fourteen cases were reviewed.
- Seven of these deaths (50 percent) occurred in swimming and/or wading pools.
- Twenty-nine percent of these deaths occurred in open water.
- Two deaths (14.3 percent) occurred in bath tubs.
- Of the 14 drowning deaths, 12 (85.7 percent) were reported as not wearing a floatation device.

RECOMMENDATIONS

1. Support public education and awareness campaigns about water safety. Place special emphasis on the need for constant adult supervision, and 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

- Seventeen cases were reviewed.
- At least six of these deaths (35.2 percent) were suspected to be the result of "rollovers" by an adult during a bed sharing situation. (Note: This is not a duplication of rollovers identified in the SIDS section.)
- Seven of these victims (41.2 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.
3. Provide increased public education and encourage strict adherence to the 2005 American Academy of Pediatrics guidelines for reducing risks associated with infant sleep environment.

KEY FINDINGS

- Twenty cases were reviewed.
- Fourteen of these deaths (70 percent) were the result of firearm use, with 11 deaths (55 percent) caused by handgun use and three deaths (15 percent) caused by shotgun use.
- The vast majority of these deaths, 15 (75 percent), were known to be due to an "intent to do harm."
- Only three child deaths (15 percent) reviewed in this category were reported to be the result of playing with firearms, while two (10 percent) were the result of hunting accidents.
- Five of the 20 children (25 percent) were killed by a weapon being handled by a family member.

RECOMMENDATIONS

1. Encourage gun safety education for youth and parents.
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

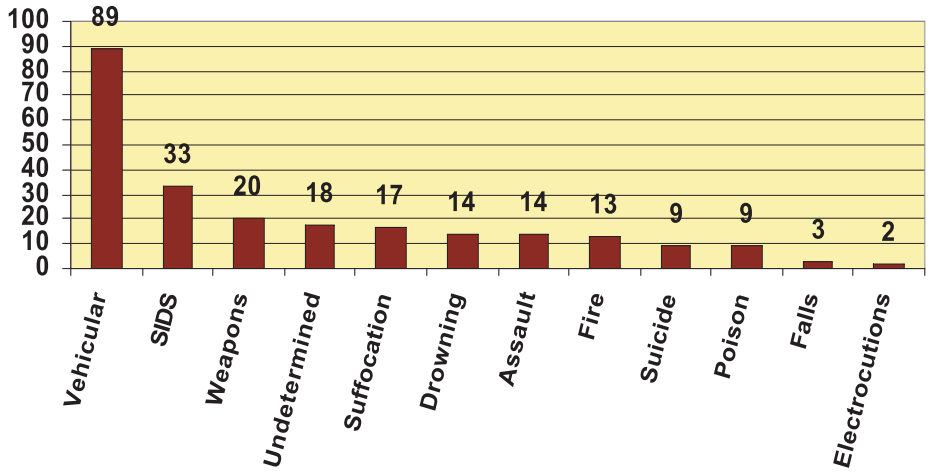
- Nine cases were reviewed.
- Four of these deaths (44 percent) were reported as being unexpected.
- Four of these deaths (44 percent) were the result of hanging while five (56 percent) resulted from the use of firearms.

RECOMMENDATIONS

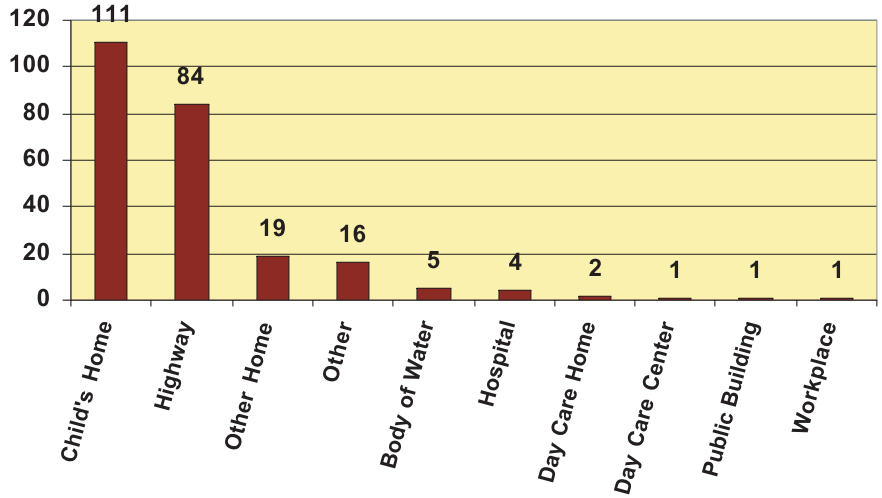
1. Support Statewide efforts to examine all of the issues surrounding adolescent suicide and develop plans for prevention.
2. Institute training for teachers about suicide risk assessment and referral resources.
3. Support a Statewide education and awareness campaign aimed at parents and others about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

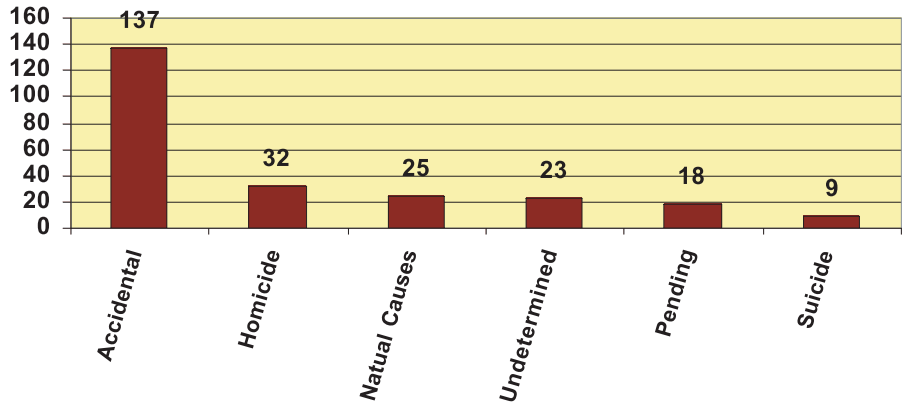
- Motor Vehicle was the most often (40 percent) reviewed cause of child death.



- The child's home was the single most frequent place of death (44 percent).



- Accident was the most frequent (137 cases) manner of death reviewed.



POISON:

- Nine cases were reviewed.
- Seventy-eight percent (7) of the poisoning cases reviewed resulted from prescription or illegal drug use.

ELECTROCUTIONS:

- Two cases were reviewed.
- Both were the result of an electrical appliance/tool.

ASSAULT:

- Fourteen cases were reviewed.
- Of those, seven deaths were caused by the use of hands and fists.
- Parents were responsible for two of the assault deaths. The majority of the remainder of the deaths were caused by parents' friends or significant others.

UNDETERMINED:

- Eighteen cases were reviewed in which the cause of death remained "undetermined."
- In at least four of these cases, infant sleep environment hazards are suspected.

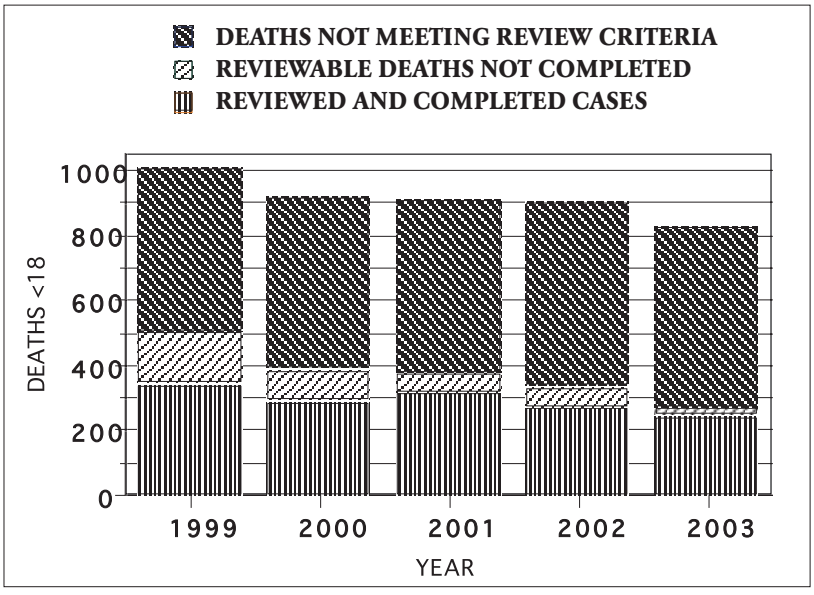
In Chapter 2 of his famous poem, "The Rhyme of the Ancient Mariner," Samuel Taylor Coleridge laments, "…water, water, everywhere, nor any drop to drink…" The Mariner and his crew ponder their fate of being surrounded by water with not one drop of it suitable for drinking. Similarly, we in the ACDRS could wonder, "…data, data, everywhere…SO WHAT?" We have collected boxes and boxes of data. But if we do not use it to achieve significant, positive results, such as reductions in infant and child deaths in Alabama, what indeed is the point?

Thankfully, unlike the troubled "Mariner," we can enjoy the facts and fruits of our labor in some very important ways. Indeed, we are seeing continuing, great results from the efforts of our superb State and Local Teams. Please take a moment to review the details of the following charts:

ACDRS Data CY 1999-CY 2003

Calendar Year	1999	2000	2001	2002	2003	Total
Total Deaths <18	1009	915	911	897	823	4555
Deaths Meeting Review Criteria % of Total Deaths Meeting Criteria	505 50.05%	386 42.19%	380 41.71%	335 37.35%	274 33.29%	1880 41.27%
Cases Reviewed and Completed % of Reviewable Cases Completed	338 66.93%	290 75.13%	313 82.37%	275 82.09%	244 89.05%	1460 77.66%

ACDRS Data CY 1999-CY 2003 - Chart Form



These charts depict some very good news for our State! Notice the steady, decreasing trend in "Total deaths…" within the ACDRS criteria age group (birth to <18 years old). Likewise, note the decreasing trend in numbers of deaths that meet our criteria for ACDRS review (i.e. "Unexpected or Unexplained deaths plus SIDS…"). In CY 2003, we experienced one of our sharpest single-year declines in numbers of "criteria-meeting" deaths since we began keeping records! And, finally, also notice that for the third year in a row, Alabama has exceeded the 80 percent case review rate plateau, a remarkable achievement in itself. Our CY 2003 case review rate has reached an all-time high of nearly 90 percent, and, because our participation rate among all our Teams has reached 96 percent, we expect our review rate trend to continue improving.

With such a dramatic drop in "deaths meeting our criteria for review," we wondered where these drops were occurring. The following chart compares the 13 causes of death reviewed by the ACDRS in CY 2002 and CY 2003.

ACDRS REVIEWED CASES
2002-2003, by Cause of Death

(In order of 2003 prevalence)

COD	2002	2003
Vehicular	111	87
SIDS	25	33
Weapons	16	20
Undetermined	12	18
Suffocation	26	17
Drowning	20	14
Assault	13	14
Fire	15	13
Suicide	13	9
Poison	9	9
Other	12	5
Falls	1	3
Electrocution	2	2
TOTALS	275	244

While we can easily see in this chart that the decrease in the number of vehicular deaths in CY 2003 accounted for the single largest annual death reduction (24), we can also see that a total of six of the 13 categories experienced a decline as well. This means that CY 2003 was a good year for Alabama in many ways and our positive trend was spread across a fairly wide spectrum of causes.

We are delighted to report significant progress in all of our special interest programs, as well as in our statistics. In our last annual report, we reported that our new "Cribs for Kids" program was on the verge of becoming a reality. We are happy to report that this program is doing very well. In August 2005, we partnered with the "Gift of Life Foundation" (GOL) and started a pilot program in Montgomery County.

To date, GOL has placed almost 30 portable cribs with families who could not afford to purchase them on their own. We are already receiving inquiries from groups in other counties in our State who want to start the program in their communities. We are confident that this is going to be a well received program throughout our State and will save countless infant lives from the dangers of "bed sharing."

Our ACDRS data shows that, since 1998, Alabama has suffered the loss of slightly more than one child per month to youth suicide. This is a terrible, terrible loss of life and one that can be prevented. The ACDRS has partnered with the Alabama Suicide Prevention Task Force to develop an effective State-wide Youth Suicide Prevention Program. This new program highlights the danger or warning signs that might identify children thinking of suicide, describes appropriate actions to take when the warning signs are identified, and then provides the location of resources where help might be obtained. Our Youth Suicide Prevention Program includes: the Alabama Suicide Prevention Plan; an educational brochure (20,000 English copies were distributed in the first month and the brochure will soon be available in Spanish as well); a website for useful information (http://www.adph.org/suicideprevention); and a Speaker's Bureau of experts available to discuss pertinent suicide issues. A third printing of the English version of the brochure has already been ordered.

The ACDRS has also developed a new All-Terrain Vehicle (ATV) Safety Brochure. The brochure will be the center point of our new campaign to reduce injuries and deaths caused by these dangerous vehicles. A forthcoming Press Release and several appropriate Public Service Announcements will signal the start of this new Statewide campaign.

We have highlighted only a few of the successes we are seeing. Many others are identified throughout this report.

The Alabama Child Death Review System is a grass-roots program driven by local citizens for the express purpose of saving the lives of as many of Alabama's infants and children as possible. Unlike the mournful "Mariner" of poetry fame that began this report, we are not surrounded by assets and resources that we cannot or will not use. We are making use of our resources to achieve meaningful results. However, even though our very effective State and Local Teams have contributed significantly to a more than 40 percent reduction in preventable child deaths since the ACDRS began, we recognize that every death is more than just a statistic to Alabama families and other fellow citizens. Every single infant and child death is a terrible personal tragedy. We are dedicated to reducing these tragedies as much as possible.

ALABAMA CHILD DEATH REVIEW SYSTEM - FREQUENTLY ASKED QUESTIONS

1. **What is the ACDRS?**
   - Alabama is one of 49 States that have Child Death Review.
   - 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 Division 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 collection 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 any 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 (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?

- Members assisted in getting the following legislation passed into law:
  - "Safe Haven" Law (2000)
  - Graduated Driver's License (2002)
  - "Baby Douglas" Day Care Medication (2004)
  - Enhanced Child Safety Restraint Law (2006)
  - "Brody Parker" Unborn Child Crime Law (2006)
  - Prevention of Exposure to Drug Labs Law (2006)

- Legislation pending:
  - Additional All-Terrain Vehicle regulations
  - Passengers prohibited in open truck beds
- Trends since ACDRS was established:
  - Fewer total child deaths (from 1,000 to fewer than 850)
  - Fewer deaths meeting criteria (from 500 a year to fewer than 275)
  - Improved case review and completion rate (from 64 percent to more than 85 percent)
  - Participation rate among Local Teams has now reached 96 percent
- Education Programs (English/Spanish)
  - "Shaken Baby Syndrome"
  - "Safety for Sleeping Babies"
  - "Back to Sleep"
  - Improved Infant/Child Death Investigations
  - "Child Suicide Prevention"
  - "Cribs for Kids"
  - "Dangers of Children on ATVs" (Pending)

11. What is Alabama's greatest resource?

OUR CHILDREN!!!

ALABAMA CHILD DEATH REVIEW SYSTEM - TIMELINE OF ACTION (AN EXAMPLE)

- Infant/child death occurs on September 1, 2003.
- Death certificate received at the ACDRS State Office on September 15, 2003. (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, 2003. 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, 2004. (By law, each Local Team is required to meet only once per calendar year.)
- The ACDRS State Office receives the last of the 2003 death certificates by July 2004.
- September 1, 2005, is the deadline by which the ACDRS State Office is to receive all 2003 cases that have been reviewed by LCDRTs.
- The ACDRS 2003 Annual Report is published and distributed in the Spring 2006.

The Alabama Child Death Review System supported the following bills considered by the Alabama Legislature during the 2006 regular session:

Enhanced child safety restraints: Existing law requires that child passenger restraints be used for children under the age of six years. Children who are four or five-years old are permitted to be restrained by adult, lap-shoulder belts. A bill before the Legislature would eliminate references to age as the sole criteria for child passenger restraints and would instead require appropriate restraint systems based on weight or age. The measure would increase fines from $10 to $25 for each violation, provide a point system for violations that could lead to suspension of a driver's license, and allow dismissal of the charges upon proof of acquisition of an appropriate passenger child restraint. A portion of the fines would be given to the Alabama Head Injury Foundation. (**Governor Bob Riley has signed this legislation into law.**)

Riding in truck beds: A bill before the Legislature would prohibit operators of pickup trucks from allowing people under the age of 18 to ride in the truck bed on a paved highway. (**Did not pass but is covered in above legislation.**)

Registration of all-terrain vehicles: Currently, operators of ll-terrain vehicles are not required to register their vehicles or have a certificate of title. A measure under consideration by lawmakers would require that operators of all off-road vehicles, beginning with the 2007 model year, register their vehicles and obtain a certificate of title from the Department of Conservation and Natural Resources. The Alabama Child Death Review System has proposed that regulations governing the use of atvs be further strengthened by requiring that all atv operators be licensed, that atv operators wear safety equipment, and that passengers not be allowed on atvs. (**Did not pass.**)

Prohibit teen drivers from using cell phones while driving: Any person 17 years of age or younger would be prohibited from operating a motor vehicle on a public street, road, or highway while also communicating on a cell or wireless phone under a bill before the Legislature. Supporters say the legislation would save lives because young drivers are inexperienced and must devote full attention to the road. (**Did not pass.**)

Funding for children's advocacy programs: A bill before the Legislature would provide $840,600 in funding for Children's Advocacy Centers and the Alabama Network of Children's Advocacy Center, Inc. The funding for the 2007 fiscal year would come from the State General Fund. The advocacy centers provide various services to children throughout Alabama. (**Governor Bob Riley has signed this legislation into law.**)

Drugs and child abuse: A measure under consideration by lawmakers would make it a crime to expose a child to an environment in which controlled substances are produced or distributed. Exposing a child to such an environment would be defined as child abuse under the bill. (**Governor Bob Riley has signed this legislation into law.**)

Crimes against unborn children: Under existing law, a person commits criminal homicide if he or she intentionally, knowingly, recklessly, or with criminal negligence causes the death of another person. A bill before the Legislature would include an unborn child in the definition of person. The measure would not apply to a legal abortion or otherwise make an abortion legal. (**Governor Bob Riley has signed this legislation into law.**)

Tobacco funds for the Children First Trust Fund: A bill before the Legislature would appropriate nearly $42 million in tobacco settlement funds to the Children First Trust Fund for the fiscal year ending September 30, 2007, as well as an additional $48 million from other tobacco settlement funds. The money would be used to help fund a variety of agencies and programs that assist children, including the Department of Children's Affairs, the Alabama Medicaid Agency, the Juvenile Probation Services Fund, the State Multiple Needs Children's Fund, the Department of Youth Services, the Department of Rehabilitation Services, as well as the Alabama Child Death Review System. (**Governor Bob Riley has signed this legislation into law.**)

The Alabama Child Death Review System also supports these initiatives:

Sudden Infant Death Syndrome Education: Under existing law, hospitals and birthing centers are not required to provide new parents with information about the dangers of unsafe sleep for infants. The Alabama Child Death Review System supports an initiative that would require hospitals and birthing centers to provide written and verbal information to parents about Sudden Infant Death Syndrome (SIDS) and other sleep-associated deaths of infancy, including: asphyxia due to prone position (sleeping on stomach) or entrapment; suffocation due to bed sharing rollover, pillows and soft sleep surfaces, loose bedding, and soft toys; second hand smoke exposure; and overheating during sleep.

Infant and child death investigations: The Alabama Child Death Review System supports strengthening the Alabama infant and child death investigation process and would like to see legislation that would: standardize death investigations Statewide; provide an adequate number of State laboratories to reduce the delay in obtaining forensic results; require certification and training for everyone authorized to complete birth and death certificates in Alabama and standardize both how certificates are to be completed and the definitions used to complete them; and provide the necessary resources to operate such an all-encompassing infant and child death investigation system.

THE CRIBS FOR KIDS PROGRAM

Martha Jinright, Director
The Gift of Life Foundation
Mongtomery, Alabama

The Gift of Life Foundation is a non-profit entity created in 1988 to address issues contributing to the high infant mortality rate and increasing teen pregnancy rates in Autauga, Elmore, Lowndes, and Montgomery counties in central Alabama. For the past 17 years, through both public and private partnerships, the Foundation has provided to low-income women in this area access to a comprehensive and coordinated system of obstetrical care and education.

While infant mortality and teen pregnancy rates have dropped significantly since the Foundation's inception, over the past few years that downward trend has stagnated, raising awareness of the need for new and innovative approaches to further reduce these rates. When Gift of Life was approached by the Alabama Child Death Review System to implement a pilot "Cribs for Kids" program in Montgomery County, both the idea and the partnership seemed a natural fit.

The Alabama Child Death Review System had already looked to other states to see what they were doing to reduce preventable infant deaths and found that the Cribs for Kids program originating in Pittsburgh, Pennsylvania, was enjoying resounding success in the prevention of Sudden Infant Death Syndrome and rollover deaths, showing a 50 percent decrease in such deaths over the last 10 years.

In August 2005, the Gift of Life Foundation launched the Cribs for Kids pilot program in Montgomery County. The program works this way: Prior to each Gift of Life mother's delivery, her assigned Gift of Life care coordinator provides information about SIDS prevention and safe sleeping habits, including information about the "Back to Sleep" program, which encourages parents to place infants on their backs to sleep. The care coordinator then assesses each mother for risk factors using a psychosocial assessment tool. Women who meet one or more of the risk criteria are enrolled in the Cribs for Kids pilot program. Participants in the program take part in a comprehensive informational session about the what, why, and how of reducing incidents of suffocation, SIDS, and rollovers. After a review of each session topic, both the care coordinator and the participant initial a document showing their acknowledgment and understanding of the information.

Upon completion of the enrollment and informational session, the participant receives a voucher for a portable crib supplied by the Alabama Child Death Review System and distributed through The Gift of Life administrative office. At pickup, the participant is shown how to set up the crib and take it down, and receives training on when and how the crib is to be used. The Gift of Life also provides follow up services, gathering information from each mother 60 days after she receives a crib to ensure that the crib is being used properly and that the mother understands and is complying with safe sleep habits for her infant.

We are hopeful that we will see the same results experienced by Cribs for Kids programs in other states and communities. The Gift of Life is proud to be a part of the Cribs for Kids initiative with the Alabama Child Death Review System. This partnership has given The Gift of Life the opportunity to empower our mothers with new information so that they can make healthy decisions for their children, to provide at-risk families with a much-needed resource, and to give the next generation a safe sleeping environment in which to begin their future.

Judith A. Harrington, Ph.D.
Private Practice
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In Alabama, the third leading cause of death for youths between the ages of 15 and 24 is suicide. This fact is consistent with national statistics; only accidents and injuries more frequently end the lives of young people. In a survey of Alabama youths, 8 percent reported attempting suicide, and 12 percent had made plans to try and do so. Nationally, a young person dies from suicide at a rate of every two hours. According to the experts (Maris, Berman & Silverman, 2000), depressive illness occurs with great frequency across the lifespan, but the most dramatic increase is between the ages of 9 and 19. Depression is widely considered to be one of the most highly correlated predictors of suicide.

Many well-meaning individuals believe that when people (especially children) exhibit suicidal gestures or messages they are "attention-seeking." Teens' "help-seeking" through risky behavior or suicidal statements have been minimized through such euphemisms as "she is a drama queen," "he just needs better limits," or "it's just a call for help" as if it is normal or healthy for a teen to write in his or her English classes about morbid death wishes, or "doodle" in a notebook startling images of death, or to inflict self-injury alongside verbal messages of hopelessness. Indeed, it is a call for help that must be taken seriously by parents, friends, teachers, counselors, and all persons to whom children in despair turn. Fisher, Kleinman, and Morishima (1992, in Maris, Berman, & Silverman, 2000) indicate through their research that one-third of 119 completed adolescent suicides had a previous attempt (girls 48 percent and boys 27 percent).

Dr. Frank Campbell, Director of the Baton Rouge Crisis Information Center and former President of the American Association of Suicidology, presented a model at a recent training (2005) that classifies the seriousness of intent for all who might be in a position to provide intervention. Adapted here, it is:

	INTENT IS TO DIE	**INTENT IS TO LIVE**
OUTCOME: **THE INDIVIDUAL DIES**	**I. Virulent Risk** Suicide risk is very high. He or she chooses very lethal and/or secretive means and intervention is difficult.	**II. Attempt Gone Awry** Suicidal person wants the pain to end but does not want to die. He or she hopes that help will arrive, but the attempt goes awry when help is too late
OUTCOME: **THE INDIVIDUAL LIVES**	**III. Intervention is Successful** Suicidal person is ambivalent about dying. May attempt through less risky means, hoping that help arrives. Intervention is possible if warning signs are detected early enough.	**IV. Parasuicide** Suicidal person does not want to die, but uses risky behavior to get help with difficulties. Helpers misread the risk, mislabel warning signs, and misdiagnose the risk. The parasuicidal person is 40 percent more likely to become a "Suicide Attempt Gone Awry."

While youths who contemplate suicide can be found in all four quadrants in this table, it is perhaps Quadrant IV that is most disturbing for suicide prevention advocates. We have much work to do to prepare helpers in all sectors to accurately recognize suicide warning signs and to develop a new way of thinking about the so-called "drama queens" or "attention seekers." We owe it to children and their families to respond to the call, thus placing our communities in a better position to help children to alleviate or manage their depression, hopelessness, and difficulties with the hopes of a productive life beyond their painful episode. It is widely understood that with proper recognition of suicidality as a psychiatric emergency with social, cultural, emotional, and resource-access themes, risk can subside and suicidal persons can learn to respond to life's challenges without resorting to suicide as an "option."

One such initiative to educate Alabamians about youth suicide risk comes from the Alabama Child Death Review System. Among the many representatives from public health, mental health, community agencies, private mental health agencies, and the academic community, the Alabama Child Death Review System has been vigorously reaching out to many sectors in an effort to educate Alabamians about the incidence of, warning signs of, and methods for intervening with suicidal youth. In 2005, the Alabama Child Death Review System, along with help from the Suicide Prevention Task Force, developed for widespread circulation an easy to read and highly informative brochure enumerating warning signs about what concerned persons can do. In one month alone, more than 20,000 of these brochures were distributed to counselors, parents, and students in school settings, and to crisis centers, youth agencies, legal representatives who investigate deaths, and many more. (Note: this brochure has been translated and will soon be available in Spanish as well as in English.) To order copies of this brochure, visit http://www.adph.org/cdr, or write bhinds@adph.State.al.us or call 334-206-2938. For more information about the work of the Alabama Task Force on Suicide Prevention, visit www.adph.org/suicideprevention.

It is my hope that all Alabamians will be well informed enough to know and recognize suicidal warning signs so that we can link arms and surround suicidal children with proper help. I hope that the obvious helpers, such as school counselors, social workers, counselors, psychologists, and psychiatrists will continue their careful assessment and response to suicidal risk, but also that the neighbor next door, the soccer mom, the lunch room lady, the art teacher, the little league coach, the youth minister, and the friend will all be armed with accurate empathy and tools to assist a child in despair.

Michael A. Taylor, M.D.
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The University of Alabama School of Medicine, Tuscaloosa Campus

I have had the honor of participating in the Alabama Child Death Review System (ACDRS) for several years since its inception in 1997, both as a member of the State Team and the local team in the county where I reside. The local team consists of a number of professionals from the community: the District Attorney's office, police, Department of Human Resources workers, hospital officials, the medical examiner, school officials, the health department, physicians, the local children's advocacy center, and many others. All are professionals dedicated to caring for children and who take time out of their busy professional schedules four times a year in order to spend a morning going over the grim details of the untimely deaths of a number of local children. It is serious and depressing work for everyone. The State team brings together an even larger number and mix of professionals who travel from all over the State to Montgomery four times a year in order to review statistics, facts, figures, and recommendations that are compiled from the information returned from the local teams from across the State. The State ACDRS team must then decide on recommendations to give to the Governor and the Legislature on ways to prevent as many deaths as is possible.

On both teams, all members are very cognizant that with each of the cases reviewed, we are discussing the unexpected death of a child; someone's son or daughter, someone's grandchild, someone's niece or nephew, someone's student, and someone's friend, who has prematurely lost his or her life, often due to unfortunate and, in many cases, preventable accidents.

I am willing to serve on these important teams performing this grim task because in contradistinction to the name, the focus of the Alabama Child Death Review System is not about death, but life. The hope is that by examining the details of the deaths of these children, we may discover ways to prevent the untimely accidental deaths of many other children. I have been profoundly touched by the dedication of my fellow team members and the staff of the ACDRS over the past decade. Everyone seems to know just how important the job is and the potential for prevention of needless loss of life to our youngest fellow citizens. I think that I can speak for most, if not all, of my team colleagues when I say that if our efforts have led to the prevention of even one child's death, it is more than worth the time, money, and effort spent.

I am proud to say that there have already been some successes. In 1999, there were 505 children whose deaths met the criteria for review by the ACDRS. That number has decreased steadily each year since so that in 2003, the most recent year for which we have all of the figures in, that number had dropped to 274, a 45 percent decrease. At the same time, the population of children in Alabama had increased slightly, not decreased. Prior to the establishment of the ACDRS in 1997, the annual death rate had been steadily increasing along with the population and I have to believe that a large part of the decrease in deaths we have witnessed is due to the awareness and prevention efforts that have been implemented as a result of recommendations that have come from the local and State teams.

One of the successful prevention efforts initiated by the ACDRS has been to implement a number of "Back to Sleep" awareness campaigns and trainings across the State in an effort to reduce the incidence of Sudden Infant Death Syndrome (SIDS), or the sudden, unexplained death of a previously healthy infant (one to 12 months of age). The American Academy of Pediatrics (AAP) first published a series of recommendation for the prevention of SIDS in 1992 after reviewing research results from several studies over a number of years. The AAP subsequently updated its recom-

mendations in 1996, 2000, and in 2005 as more research information became available. The first recommendations were to position infants in a non-prone position (not on their stomach) when lying them down to sleep, either by placing them on their back or their side. For several decades prior to 1992, pediatricians had recommended the prone sleep position (on their stomachs) for infants due to concerns about spitting up and choking if they slept on their stomachs. In 1996, the AAP changed the recommendation slightly to emphasize a preference for placing infants on their back to sleep, but if they were positioned on their side, to be careful of the arm position. The incidence of SIDS was 1.2 per 1,000 children in 1992 (one for every 833 children born), but after national, State, and local "Back to Sleep" educational campaigns since 1994, that figure dropped to 0.57 per 1,000 children in 2002 (one in 1,754 children), a 50 percent reduction. In 1992, when the first guidelines were released, 70 percent of infants were being placed on their stomachs to sleep (prone position) and that decreased to 11.3 percent in 2002, which correlates directly to the reduction in SIDS incidence.

In the course of reviewing the remaining SIDS deaths, it became apparent that although many parents knew to position their infant on their back to sleep, many daycare workers, relatives, and other substitute child caretakers were not aware and many of the remaining SIDS deaths were occurring while the infant was sleeping in the care of those substitute providers. Efforts were then directed to informing these important child caretakers of the sleep positioning recommendations.

The most recent update from the American Academy of Pediatrics, published in November 2005, included several new recommendations:

- **Back to sleep:** Infants should be placed for sleep in a supine (wholly on back) for every sleep.
- **Use a firm sleep surface:** A firm crib mattress, covered by a sheet, is the recommended sleeping surface.
- **Keep soft objects and loose bedding out of the crib:** Pillows, quilts, comforters, sheepskins, stuffed toys, and other soft objects should be kept out of an infant's sleeping environment.
- **Do not smoke during pregnancy:** Also avoiding an infant's exposure to second-hand smoke is advisable for numerous reasons in addition to SIDS risk.
- **A separate but proximate sleeping environment is recommended, such as a separate crib in the parent's bedroom.** Bed sharing during sleep is not recommended.
- **Consider offering a pacifier at nap time and bed time:** The pacifier should be used when placing infant down for sleep and not be reinserted once the infant falls asleep.
- **Avoid overheating:** The infant should be lightly clothed for sleep, and the bedroom temperature should be kept comfortable for a lightly clothed adult.
- **Avoid commercial devices marketed to reduce the risk of SIDS:** Although various devices have been developed to maintain sleep position or reduce the risk of rebreathing, none have been tested sufficiently to show efficacy or safety.
- **Do not use home monitors as a strategy to reduce the risk of SIDS:** There is no evidence that use of such home monitors decreases the risk of SIDS.
- **Avoid development of positional plagiocephaly (flat back of head):** Encourage "tummy time." Avoid having the infant spend excessive time in car-seat carriers and "bouncers." Place the infant to sleep with the head to one side for a week and then change to the other side.
- **Assure that others caring for the infant (child care provider, relative, friend, babysitter) are aware of these recommendations.**

Of these new recommendations, the two most controversial are avoiding bed sharing (including sleeping with an adult) and promoting the use of pacifiers as the infant goes to sleep. Many parents and professionals, including many breastfeeding supporters, feel strongly that bed sharing, especially with the mother and infant, leads to increased parent-infant bonding and a higher success rate for breastfeeding. There are also many who believe that the use of pacifiers in infants who are being breast fed will decrease the number who are successfully breast fed long term, even though there has not been any research to substantiate that belief. But the evidence for the increased risk for SIDS with bed sharing is compelling and the evidence for reduced SIDS risk with the use of pacifiers is equally strong.

As I reflect back to 1992, I remember how strongly many pediatricians (including me) felt about the importance of infants sleeping on their stomach for their safety and because of that strong belief, there was a similar reluctance to embrace the then new recommendation of positioning infants on their back or side. As I observed the rate of SIDS drop by half over the next decade, it became very apparent that our old beliefs, however strong, were misguided and based on anecdote, not on sound research. I can only hope that as professionals, scientists, parents, elected representatives, and people who are concerned with and responsible for the welfare of our children, we will remain open to all possibilities and be willing to implement any proven method of reducing preventable death and disability in our children.

Even before the newest guidelines were released, the Alabama Child Death Review System had already taken a lead role in initiating efforts to increase awareness of the risk of bed sharing and improper bedding among parents, professionals, and the public at large. And over the coming months, the ACDRS will be developing strategies to expand those efforts while incorporating the other recommendations into ongoing awareness campaigns, as well as exploring new options for expanding successful prevention efforts throughout Alabama.

The work of the ACDRS is far from over; I suspect that it has only just begun. For as long as there are any of Alabama's children dying needlessly from preventable causes, we must be willing to continue to investigate, analyze, report, and compile the details of each of these deaths in order to develop successful strategies to prevent the loss of our most important resource, our children.

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All-terrain vehicles (ATVs) first appeared on the American market in 1971 as convenient tools for work and transportation on farms, ranches, and rural back-roads. In the 1970s and 1980s, the use of ATVs grew into a hobby and a widely popular recreational sport, especially among children and adolescents. After the observation of an alarming rate of injuries from such vehicles and an investigative report by the U.S. Consumer Product Safety Commission, the sale of new three-wheeled ATVs was prohibited. (1,2) Since the 1980s, severe injury and death during ATV use continued to be a great public health concern, especially among riders and drivers below the age of 16.

Alabama requires a certificate of title for all purchasers of ATVs, but has no laws specifying an age limit or requiring helmets or the completion of a safety course. (3) In the areas of Alabama with the highest injury rates, 211 ATV-related injuries were seen at Children's Hospital in Birmingham over an eight-year period, with six resulting in death. From these areas of the State alone, 148 of the injuries were among children less than 14-years-old, and the injuries included 110 fractures and 59 brain injuries. Trauma score severities did not differ significantly between those wearing a helmet and those without a helmet, but Pediatric Trauma Severity scores were significantly lower among younger patients. (4)

Children in states like Pennsylvania, which has legislation requiring helmets, age restrictions, and training certificates, are at a lower risk for fatal injuries using ATVs than children in states without such laws. (5) Still, half of ATV-related injuries and more than 35 percent of ATV-related deaths nationwide are among children 16 years of age or younger, with some states reporting that more than 90 percent of ATV crash-related injuries occur among this age group. (6) Injuries involving ATVs have doubled in recent years and emergency room visits have increased as well, according to the U.S. Consumer Product Safety Commission. (7) Data from 2001 indicated that the number of ATV drivers increased 36 percent, driving hours increased by 50 percent, and the number of ATVs increased 40 percent, resulting in more than 630 ATV-associated crashes. (7) Head and spinal cord injuries are common in these crashes and often result in severe, permanent disability. Studies have been drawing attention to the impulsiveness and lack of maturity of children and adolescents as a risk factor for injury, supporting the calls for legislation.

The American Academy of Pediatrics (AAP) and the U.S. Consumer Product Safety Commission guidelines have been consistent in advocating legislation that prohibits the use of ATVs by children under the age of 16, requires a driver's license for operation on public lands by legal drivers, introduces safety measures, such as seat belts or roll bars in manufacturing, and bans carrying passengers on ATVs. (7,8)

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Alabama ATV Safety Comments

The Alabama Child Death Review System has reviewed 27 child deaths resulting from all-terrain vehicles since 2000 (2004 and 2005 cases are still outstanding), from the upper age limit of 17 years of age all the way down to 2 years of age.

Nine of those 27 children were passengers, riding with someone else. Four of those children were 10 years of age or younger.

Helmet use was documented in only two of the 27 case reviews.

The Southeast Child Safety Institute recommends that children not be allowed to operate an ATV until they are at least 16-years-old. Yet, of the 18 child ATV driver deaths reviewed, 14 children were under 15 years of age, and the three youngest ones were all 11-years-old.

It is against the law in Alabama to operate ATVs on public roads … but that is the only legal restriction in Alabama! There currently are no State requirements regarding safety training or the use of safety equipment, age restrictions, or licensing. Hopefully, this will change in the near future.

ALL-TERRAIN VEHICLE (ATV) CHILD (<18) DEATHS IN ALABAMA

(Cases reviewed and completed by ACDRS; this does not include all of the ATV deaths in the State.)

YEAR	DEATHS	DRIVERS' AGES	PASSENGERS' AGES
2000	4	11, 12, 14	8
2001	8	12, 13, 13, 14, 16	10, 14, 16
2002	5	11, 15, 17	4, 14
2003	4	12, 14, 16	17
2004*	5	11, 12, 14	2, 13
2005*	1	14	
TOTAL	**27**	**Range: 11 - 17 years old**	**Range: 2 - 17 years old**

* Incomplete - There are still 2004 and 2005 cases outstanding.

IMPACT OF THE ALABAMA CHILD DEATH REVIEW SYSTEM - LAUDERDALE COUNTY

Diane M. Grice
Child Death Review Coordinator
Lauderdale County

Let me start by saying that it has been an honor to serve on the Alabama Child Death Review Team for Lauderdale County. When District Attorney Steve Graham asked me to serve as chairperson of this committee several years ago, I had no idea of the journey I was about to take. But with the support and guidance of the State Alabama Child Death Review Team in Montgomery, I was off and running. The State team helped me avoid several unnecessary detours and kept me on the path to having a successful local team. The commitment and love for our children that was expressed by the State team members was not only contagious, but every time I spoke with any member of the State team staff I felt that this program could really make a difference in Lauderdale County and that it would benefit children throughout the State of Alabama. Kathy Graham, Bob Hinds, Tarina Moores, and Richard Burleson have always been there for me and our committee whenever we had a question or a problem that we could not solve. With the support of newly elected District Attorney Chris Connolly, our team has been able to continue with its commitment to do what it takes to protect our children in Lauderdale County. Under the direction of DA Connolly, we review child deaths in our county in a timely fashion. It has been a privilege to serve in the same capacity with a district attorney who holds children in such high regard. This program is one of his top priorities. I regret that there is a need for our county to meet regarding the loss of even one precious child. Every member of this committee feels the same. Their commitment and dedication is remarkable.

Every person who serves on this committee has a similar agenda. We all want to prevent the loss of another child, if possible. If we have a part in saving even one child, then we are a successful team. Our primary goal is to get whatever information is available to the different agencies involved in investigating and trying to prevent child deaths. This may include prevention, education, or a change of policy. We recently were informed that the sheriff's office completely changed its policy regarding the review of all child deaths in our county due to the participation of this committee. Since deputies serve the community and the children of our community, we are proud and fortunate to have them on our team. Every member of the Lauderdale County Sheriff's Department eagerly adopted the Infant/Child Death Investigation Assessment Tool Guide. The policy change could help save children because it allows for more thoroughness in investigations. I am proud to say that the Florence Police Department has also adopted the format of the Child Death Review State Team. The department's assessment tool is posted on its website. We are fortunate in this county to have experienced and caring police officers. The Florence Police Department might have had to write the manual for the assessment tool guide regarding the investigations of child deaths, but, fortunately, the department did not have to. A big thanks goes to the Alabama Department of Public Health and the Alabama Child Death Review Team for providing this tool guide. Their thoroughness and participation is always greatly appreciated.

As we painstakingly review each case, we have seen a pattern in our own county, a pattern that must be changed. We have had several deaths resulting from possible infant rollovers. ECM Hospital has always had excellent training for new parents, and has aggressively implemented additional training regarding rollovers and child safety for new parents leaving the hospital for the first time with their bundle of joy. But let's face it. This common-sense approach can change quickly after a few sleepless nights. We are trying to determine if more training is needed. Perhaps this training could take place before the birth of a child, maybe during child-birth classes, before excitement and exhaustion take over. Maybe more children could be saved. We are working on a solution to this problem. There is no such thing as too much training when it comes to trying to prevent child deaths resulting from rollovers or Shaken Baby Syndrome. We will

leave no stone unturned until we have a solution.

We have also lost several children in car accidents involving student drivers arriving at or leaving school functions. Even though policy changes have taken place in local schools, we fear more accidents could happen. Again, we will work together with all agencies involved to try and resolve this situation in our county. We will find a solution to protect our children.

Again, let me say that what has impressed me the most is the commitment of each and every member of our local team. It is like they cannot do enough to ensure the safety of each and every child in our community. Their eagerness to prevent another loss is heartfelt and admirable. A special thanks goes out to all who have served, including: Coroner Myron Crunk; Kathy Shelton and Donna Ross from ECM Hospital; Kathryn Watson from the Department of Human Resources; Janice Wittscheck and Melanie Wisdom from the Lauderdale County Health Department; Dr. Richard Davy from the Northwest Alabama Children's Advocacy Center; the Lauderdale County District Attorney's Office; Florence Police Department Officer John Hamm and Investigators Suzanna Taylor and Keith Johnson; Kelly Munstan of the Lauderdale County Sheriff's Department and Chief Investigator Travis Clemmons; Alabama State Troopers James Howard, Corporal Britt Bishop, and Lieutenant Randy Keenum; and Dr. Adam Craig. We are pleased to have Selwyn Jones from our local forensic lab as a new member of our team, as well as Dr. Wayne Melvin, a local pediatrician, and Chief Agustin Hendershot from Lexington. The expertise of these individuals will be greatly appreciated.

The Lauderdale County Child Death Review team and the children of Lauderdale County thank all of you who have served. Together we will strive to reduce child deaths in Lauderdale County.

IMPACT OF THE ALABAMA CHILD DEATH REVIEW SYSTEM - DEKALB/CHEROKEE COUNTIES

Robert F. Johnston, Jr.
Assistant District Attorney
Child Abuse Prosecutor
DeKalb, Cherokee Counties

In one of our recent meeting, members of our local Child Death Review Team discovered that there was a dangerous intersection where a number of children had been killed in recent years. We sent a letter to the Director of Transportation asking that measures be taken to mitigate risk in this area. We asked for further inquiry in the form of a traffic homicide investigation. While recommendations of this sort have been helpful, we have discovered that the greatest number of preventable child deaths result from bed sharing.

In nearly every local team meeting, we have to review the death of an infant who suffocated because he or she was sleeping in bed with his or her parents. Despite the argument from some groups that advocate bed sharing, we believe that the risks can no longer be ignored. After a recent State Team meeting of the Alabama Child Death Review System, I returned to my local team with recommendations from the American Academy of Pediatrics. The AAP has begun discouraging the practice of bed sharing. "A separate but proximate sleeping environment is recommended, such as a separate crib in the parents' bedroom. Bed sharing during sleep is not recommended."

One of our local team members, Margaret Stephens, is a nurse practitioner in Fort Payne, Alabama. After observing the dangers associated with bed sharing for years, Margaret was finally armed with the information she needed. The following is Margaret's story:

One of the saddest stories I have heard involves the death of a three-month-old infant. The dad had been consoling his baby and had fallen asleep in his bed with the baby on his chest. When mom went to bed she thought the two looked so comfortable that she chose not to disturb them. Several hours later, mom awoke and realized the baby had slept through the 2 a.m. feeding. She rolled over to check on the baby. Much to her horror, she found the baby dead. Apparently, the baby had slipped off his dad's chest and into the crease formed by the dad's chest and arm. Obviously the family was devastated. Both parents felt guilt and remorse about the loss of the child.

The American Academy of Pediatrics has recommended placing your infant on his back in his crib for sleeping. In general, bed sharing is never recommended. During the first year of life, it can be harmful to sleep with one's baby. There are approximately 100 deaths per year in the United States that are the result of parents accidentally lying on and suffocating their children while sleeping. I have often advised parents about the increased risks of sleeping with their babies only to receive excuses like, "He doesn't sleep well in his own bed," or "I'm afraid that he will need me and I won't hear him," or "I don't sleep that soundly anyway and will know if he moves."

Now I feel that I am able to counteract almost all arguments expressed by bed sharing parents. I have obtained a pamphlet provided by the Alabama Child Death Review System titled, "Safety for Sleeping Babies." I provide this pamphlet to my parents at their child's first check-up and anytime after that if I discover they are sharing a bed. I can only hope that this helps prevent suffocation accidents. There are many accidents and deaths that cannot be prevented, but this particular type of death can certainly be prevented.

Let's not suffocate our babies with love.

Mary L. Murphy, Coordinator
Child Death Review System Local Team
Jefferson County, Alabama
Executive Director, Prescott House
Birmingham, Alabama

It is always sad to find the name of a child you recognize as you prepare for a Local Child Death Review Team meeting. The realization that your path has crossed with this child is always such a shock. It may be the child of an acquaintance, a child from your neighborhood, or a child to whom you or one of your team members has provided services.

Our Local Child Death Review Team serves the largest population area in the State of Alabama - the city of Birmingham in Jefferson County. The county is comprised of multiple law enforcement jurisdictions, and there are five separate Department of Human Resources regions, each of which serves an area the size of most counties in Alabama. Our local team works with four of these DHR regions.

Our local team is a wonderful example of the value of the multidisciplinary approach to investigation. Team meetings take place at our Children's Advocacy Center, Prescott House, and our District Attorney, the Honorable David Barber, chairs the team. We have utilized the multidisciplinary approach for the investigation of child physical and sexual abuse for many years, so it is familiar to us. Our meetings reflect the professional relationships forged over the years as various disciplines once again come together to discuss cases, not of abuse but of child death. There is usually a spirited but serious conversation around the conference room as we review cases. The team is comprised of professionals from our District Attorney's Office, Medical Examiner's Office, local law enforcement, the Department of Human Resources, the local Health Department office, Children's Hospital, and the Prescott House Child Advocacy Center.

The value of the local team is that it serves as a tool to re-charge our members in their daily professions so that we can strive to prevent child deaths. Not just as individuals, but as a team.

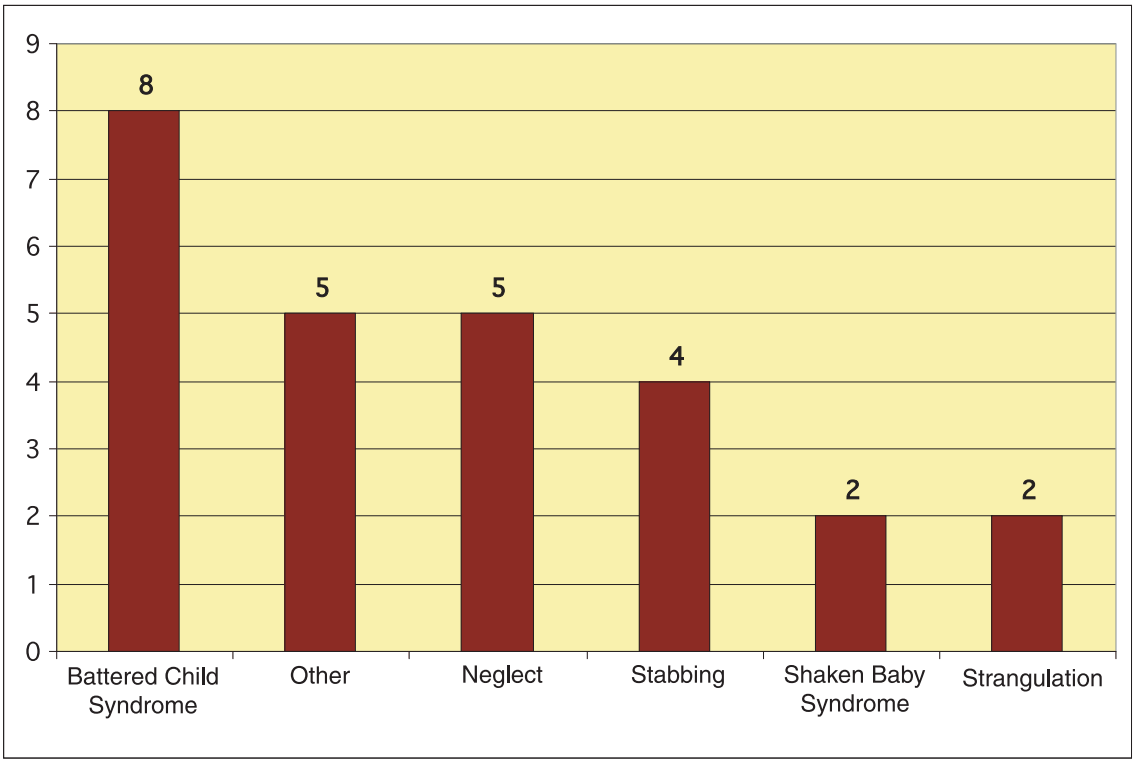
TEN REASONS TO PREVENT CHILD ABUSE

Dr. Deborah Daro
Director of Research
Prevent Child Abuse America
Chicago, IL

1) **Child abuse can be fatal.** Each year an average of three children a day are fatal victims of maltreatment. The vast majority of these children are under the age of one. (See Alabama statistics at the end of this article…)
2) **Child abuse stymies a child's normal growth and development.** The emotional and physical damage children suffer from abuse and neglect is extensive. Documented consequences of abuse include chronic health problems, cognitive and language disorders, and socio-emotional problems, such as low self-esteem, lack of trust, and poor relationships with adults and peers.
3) **Child abuse is costly for many social institutions.** Remediation of the immediate consequences of serious physical abuse alone costs child welfare agencies, hospitals, and rehabilitation facilities millions of dollars annually.
4) **Child abuse costs continue to multiply over time.** For example, children killed as a result of abuse or neglect never have the opportunity to contribute to society. In the past five years, these deaths cost more than $3 billion in lost future productivity.
5) **Child abuse victims often repeat the violent acts that they experienced on their own children.** Although some victims can overcome the scars of their abuse, child abuse victims are six times more likely to become abusive parents than non-abused children are.
6) **Treatment services, while critical, are often ineffective in permanently altering parental behaviors.** Program evaluations have found that even sophisticated clinical demonstration projects, often consisting of weekly contact for 12 to 18 months, only eliminate the future likelihood for physical abuse or neglect for less than half of clients.
7) **Prevention programs targeted at parents before they become abusive or neglectful reduce the likelihood for future maltreatment.** Home visitor programs for new parents have consistently demonstrated the most positive outcomes. Specific gains include improved mother-infant bonding, enhanced parenting skills, and more consistent use of health care services. Recipients of these services also have demonstrated a reduced rate of child abuse when compared to comparable groups of parents not receiving services.
8) **Prevention programs targeted at children can improve a child's awareness of how best to avoid child abuse and other unsafe practices.** Repeated reviews of numerous evaluations of these programs indicate that such efforts can result in increased knowledge for children about safety rules and what they should do if they are being abused. Further, the programs create an environment in which children can more easily disclose prior or ongoing maltreatment.
9) **Child abuse prevention efforts serve as a way to combat other social problems of concern to the public and to policy makers.** Research has found a strong correlation between a history of abuse and a variety of adult problem behaviors, including substance abuse, juvenile and adult crime, and poor social adjustment. The consistent expansion of prevention services may well lead to the eventual reduction of these problems.
10) **Child abuse prevention creates a more compassionate society, one which places a high value on the welfare of children.** Ensuring the safe and secure rearing of the next generation requires the efforts of all policy makers and all citizens. To the extent all are involved in the battle to prevent child abuse, all are made more aware of the need to nurture human potential in all that we do.

CHILD ABUSE IN ALABAMA:

- In CY 2003, of the 244 cases reviewed in Alabama, 26 of the deaths (12 percent) could be classified as the result of child abuse.



- A review of the following chart shows that the problem of child abuse has been with us for a long time.

CY 2000-2005 ACDRS DATA
CHILD ABUSE

YEAR	Total Deaths	Criteria Deaths	Cases Reviewed	Child Abuse
2000	915	386	290	32
2001	911	380	313	24
2002	897	335	275	28
2003	823	274	244	26
2004*	853	299	241	24
2005*	618	231	47	13

*Incomplete Data

(Note #1: Data is based on reviewed CDR cases within the range of birth to less than 18 years old only…)

(Note #2: Criteria deaths are those deaths that fall within the ACDRS criteria for review…i.e.….unexpected/unexplained…)

Child abuse is a terrible thing and is a problem throughout or country as well as our State. As citizens of our great State we need to fight this horrible danger wherever and however we find it. Two good ways would be to comply with and promote both the "Educator's Resource Manual on Child Abuse" (See link…) (http://www.ctf.State.al.us/CTF%20Documents/educatorsresource.pdf); and Alabama's official State prevention plan, "A Plan for the Prevention of Child Abuse and Neglect in Alabama." (See link…) (http://www.ctf.State.al.us/Complete%20Plan.pdf).

We can never do too much to protect our children!

ACDRS CASES REVIEWED BY COUNTY 2000-2003

CIRCUIT	COUNTY	2000	2001	2002	2003
01	Choctaw	4	1	0	2
	Clarke	3	3	1	0
	Washington	4	2	0	0
02	Butler	0	0	0	1
	Crenshaw	0	0	0	0
	Lowndes	0	0	0	0
03	Barbour	3	2	1	2
	Bullock	1	2	2	0
04	Bibb	0	0	0	0
	Dallas	0	0	0	6
	Hale	0	0	0	1
	Perry	1	0	0	0
	Wilcox	2	0	0	2
05	Chambers	3	5	3	2
	Macon	1	5	0	3
	Randolph	4	0	1	0
	Tallapoosa	2	1	2	0
06	Tuscaloosa	9	15	15	10
07	Calhoun	0	9	4	4
	Cleburne	0	1	3	3
08	Morgan	12	9	9	4
09	Cherokee	3	1	1	0
	DeKalb	7	7	5	4
10	Jefferson	36	46	40	36
	Bessemer	8	9	9	5
11	Lauderdale	10	5	5	5
12	Coffee	8	2	2	0
	Pike	3	3	0	3
13	Mobile	35	43	38	21
14	Walker	0	0	0	3
15	Montgomery	17	20	17	8
16	Etowah	0	0	0	18
17	Greene	3	3	0	0
	Marengo	3	4	0	0
	Sumter	2	0	1	0
18	Shelby	6	5	9	6
19	Autauga	1	2	3	3
	Chilton	2	1	7	4
	Elmore	0	0	0	5
20	Henry	0	1	0	1
	Houston	3	7	5	5
21	Escambia	0	1	0	1

CIRCUIT	COUNTY	2000	2001	2002	2003
01	Choctaw	4	1	0	2
22	Covington	0	0	0	0
23	Madison	23	16	26	15
24	Fayette	3	1	0	0
	Lamar	1	3	0	0
	Pickens	0	1	1	0
25	Marion	5	7	4	3
	Winston	0	3	1	1
26	Russell	3	1	4	3
27	Marshall	10	8	5	1
28	Baldwin	12	4	11	5
29	Talladega	2	8	6	6
30	St. Clair	10	17	5	2
31	Colbert	3	0	0	3
32	Cullman	3	4	5	2
33	Dale	0	0	0	1
	Geneva	0	0	0	2
34	Franklin	0	0	1	2
35	Conecuh	1	0	2	0
	Monroe	6	3	0	4
36	Lawrence	3	2	4	5
37	Lee	2	8	4	5
38	Jackson	2	5	2	7
39	Limestone	4	6	3	4
40	Clay	1	1	1	1
	Coosa	0	0	1	1
41	Blount	0	2	6	3
Total		**290**	**315**	**275**	**244**

(As of December 2005)

DEFINITIONS

- **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.

CALENDAR OF EVENTS - 2006

- August 14 - State Team Meeting (In conjunction with Local Team Training Conference August 14 - 16, 2006)
- September 1 - Deadline for completion of CY 2004 cases
- November 16 - State Team Meeting

(Note: Dates, times, and locations are subject to change)

...we're all part of the solution

ADPH

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