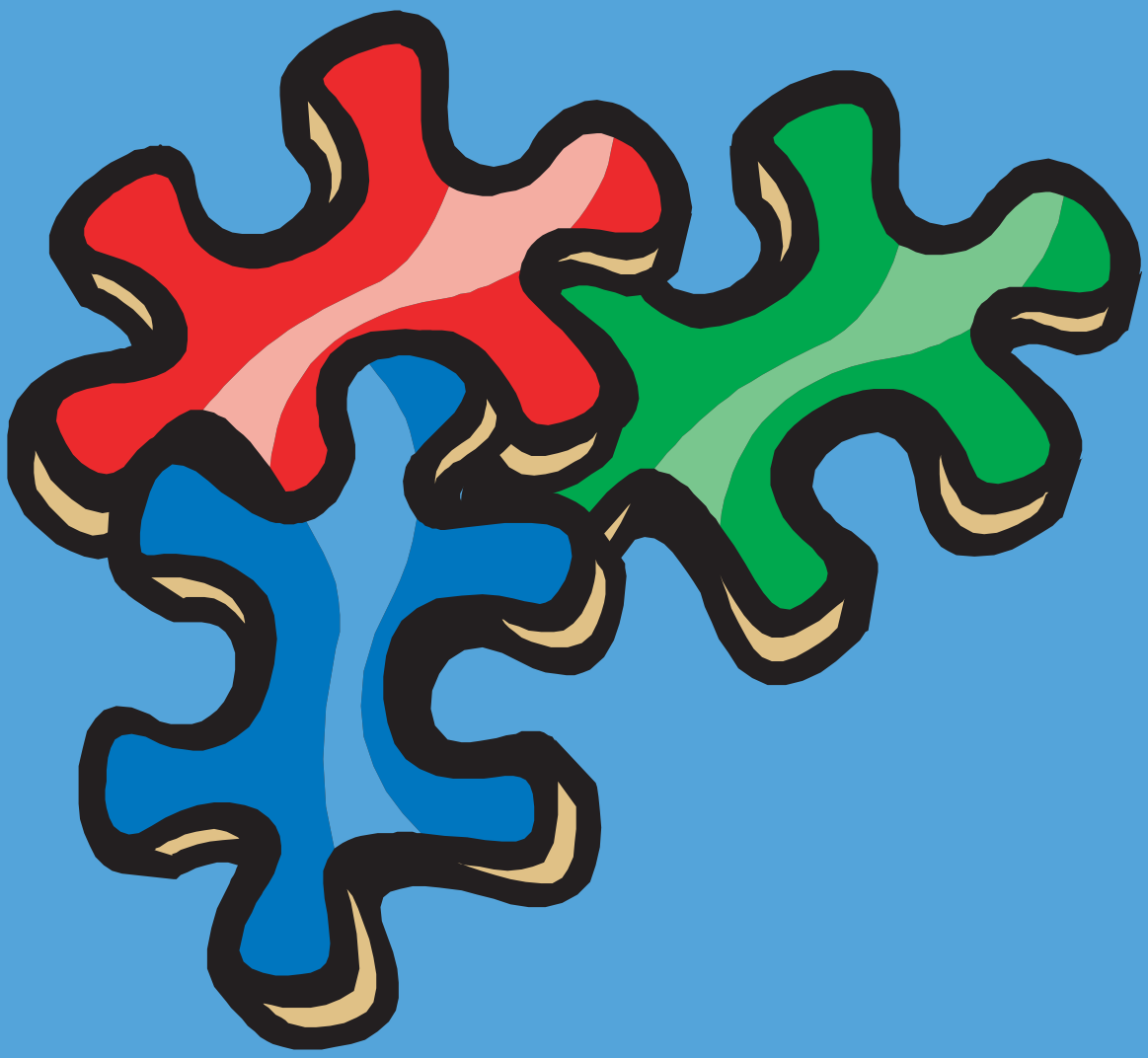
Alabama Child Death Review System Annual Report



Report for Completed 2005 Data

Learning from the Past to protect the Future...

DEATHS AMONG CHILDREN IN ALABAMA

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT - 2005 DATA

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December 1, 2008

The death of a child represents a tragedy for the child's family, the community, and our entire state. There have been many efforts to prevent and reduce accidental, unexpected, and unexplained child deaths. In order to improve prevention efforts, there must be an understanding of how these deaths occur. This is the task that has been given to the Alabama Child Death Review System (ACDRS).

The Child Death Review (CDR) model began years ago with the systematic investigation of child abuse and neglect deaths and grew in scope to include other causes of death. In 1997, the ACDRS was created under state law and is funded primarily by the Children First Trust Fund. The ACDRS studies the circumstances of all non-medical infant and child deaths throughout the state and identifies those deaths that could be considered preventable. The findings are reported to the Governor, other state officials and agencies, and the general public. In addition to collecting data, the ACDRS develops new literature and educational programs on a wide variety of topics including child vehicular safety, safe infant sleeping, and youth homicide and suicide. The data and related findings are used to make recommendations about policy changes at the local and state levels.

The ACDRS comprises the State Office, Local CDR Teams throughout the state, and the State CDR Team. The State Office is responsible for the coordination and efficient operation of the review process and is instrumental in creating strategies to make the public aware of ways to prevent future infant and child deaths. The Local CDR Teams are responsible for analyzing cases assigned to them by the State Office and making recommendations about how to prevent future infant and child deaths. The State CDR Team is comprised of 28 members and meets quarterly. It is a multi-disciplinary team that includes state agency representatives, medical professionals, law enforcement professionals, attorneys, legislators, and private citizens. This team serves as an advisory board and the policy arm of the ACDRS. Those involved with ACDRS at every level remain committed to the task of preventing child deaths in Alabama through education and public awareness.

This report represents the data collected and analyzed related to infant and child deaths in Alabama during 2005. It also includes an updated version of the very informative five-year trend analysis that was first included in last year's report. The trend analysis report covers the years 2001 through 2005 and illustrates trends that are very important to the research and prevention efforts of the ACDRS.

Sincerely,

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

Alabama Child Deaths

2001 – 2005

There were 4,360 children under the age of 18 who died in Alabama during the years 2001 through 2005.

An examination of the deaths on a year-by-year basis reveals that in 2001 there were 911 deaths, in 2002 there were 897 deaths, in 2003 there were 823 deaths, in 2004 there were 853 deaths, and in 2005 there were 876 deaths. This represents approximately 77 deaths per 100,000 children less than 18 years old.

Each of these deaths is a tragedy, especially to family and friends. Each death also serves as a powerful warning that other children are at risk. To better understand how and why these children died, the Alabama Child Death Review System (ACDRS) has been empowered to: maintain statistics on child mortality; identify deaths that may be the result of abuse, neglect, or other preventable causes; and, from that information, develop and implement measures to aid in reducing the risk and incidence of future unexpected and unexplained child deaths in Alabama.

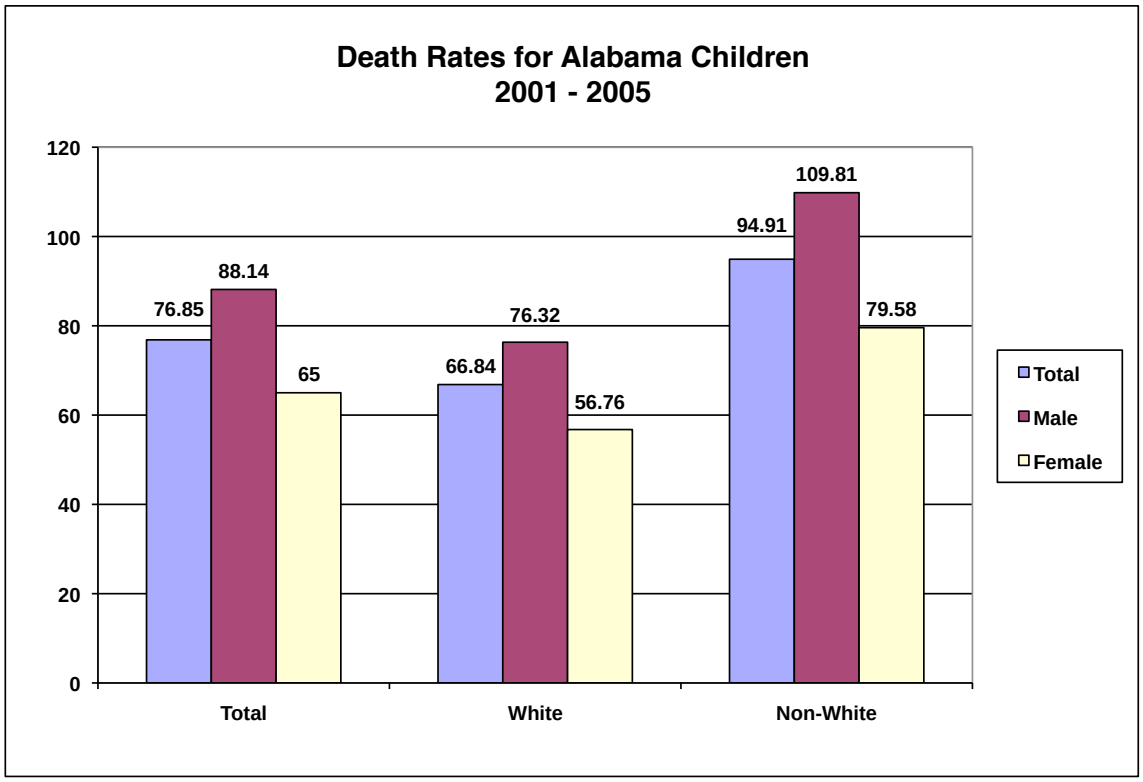
This report is a compilation of findings from Local Child Death Review Teams whose tasks are to: 1) identify factors that put a child at risk of injury or death; 2) share information among agencies that provide services to children and families or that investigate child deaths; 3) improve local investigations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

The ACDRS was created by state law in 1997 and has now been in place long enough to compile and analyze statistics on child deaths during complete five-year periods. What follows is a look at unexpected and unexplained child deaths in Alabama during the years 2001 through 2005, as well as statistics and information about the work of the ACDRS during 2005.

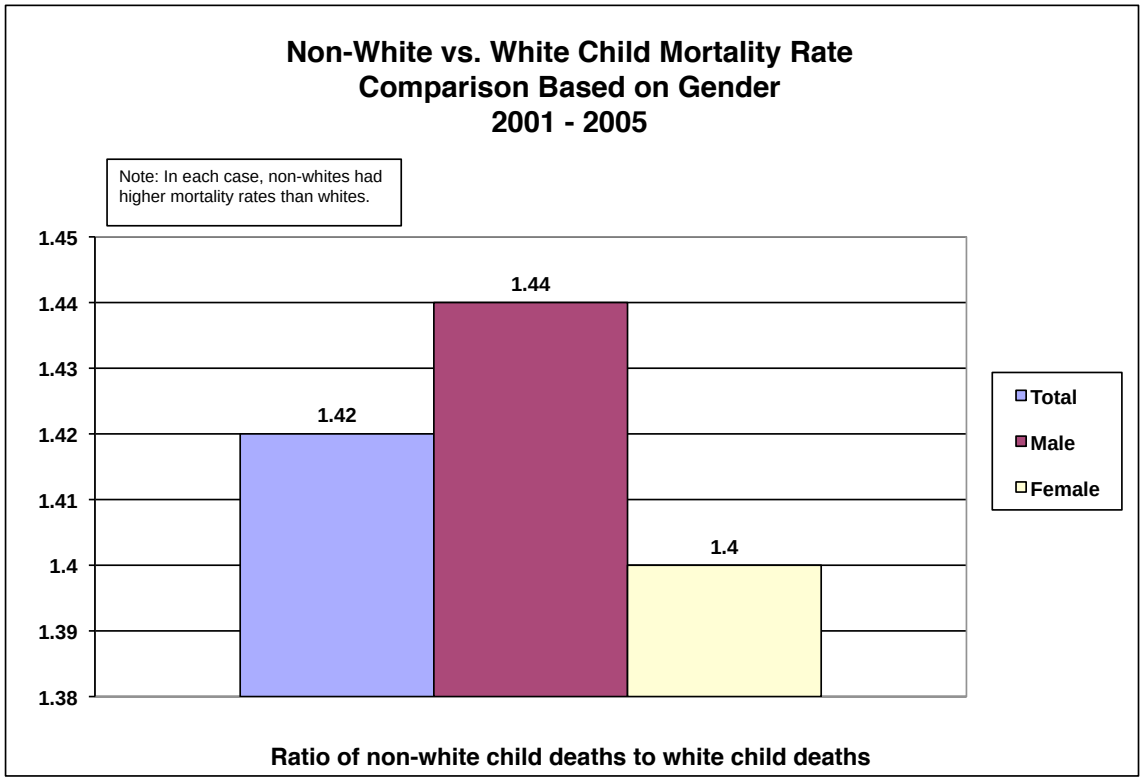
This report seeks to honor the memory of all those children who have died in Alabama. We hope that this report, and the work of the local Child Death Review Teams and the Alabama Child Death Review System, lead to a better understanding of how we can all work together to make Alabama a safer and healthier place for children.

(**Note:** Some numbers in the five-year trend section might be different from earlier reports because more data is now available.)

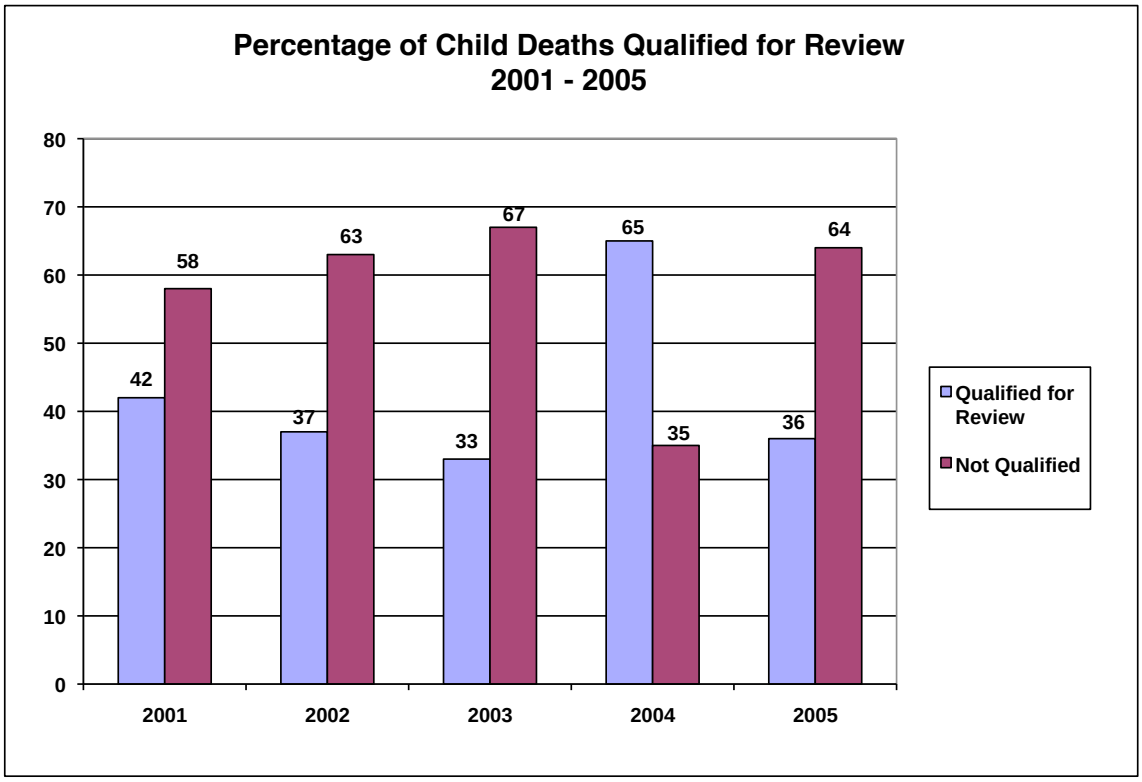
- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama from 2001 to 2005. This allows for comparison of death rates among specific population groups.



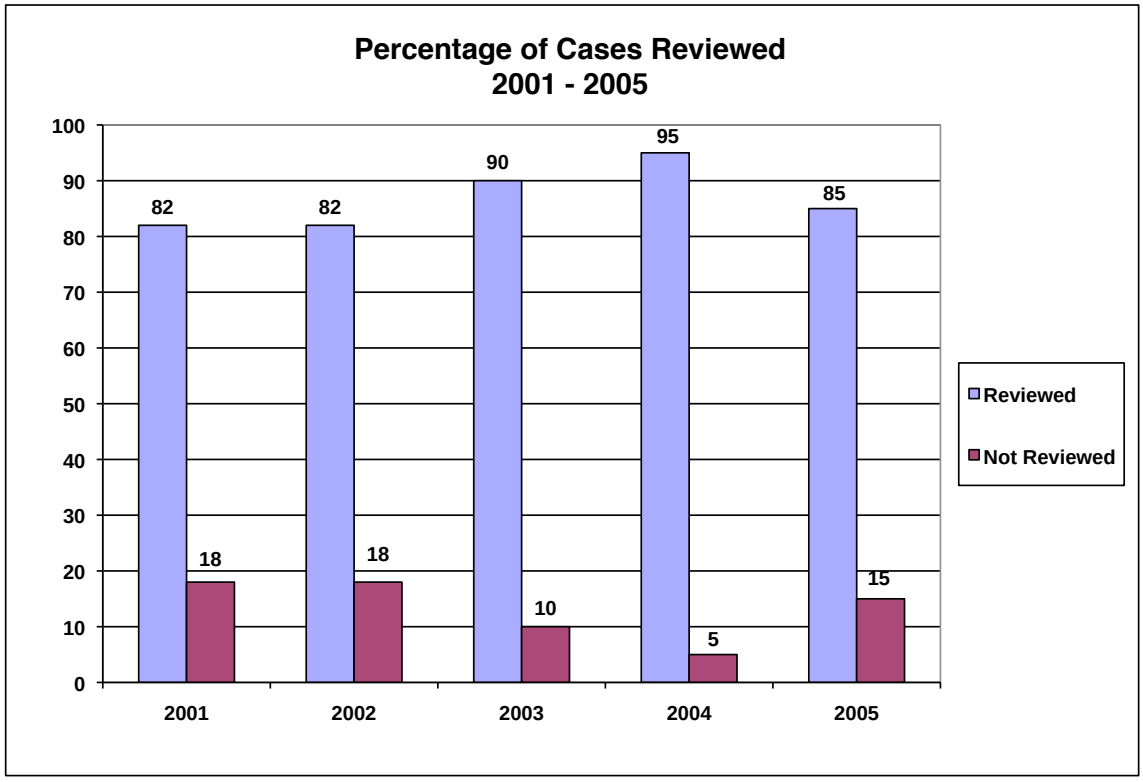
- Racial comparisons of the above rates are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher mortality rates ($p < .05$) than do whites (i.e. non-white males had a child mortality rate 1.44 times greater than white males).



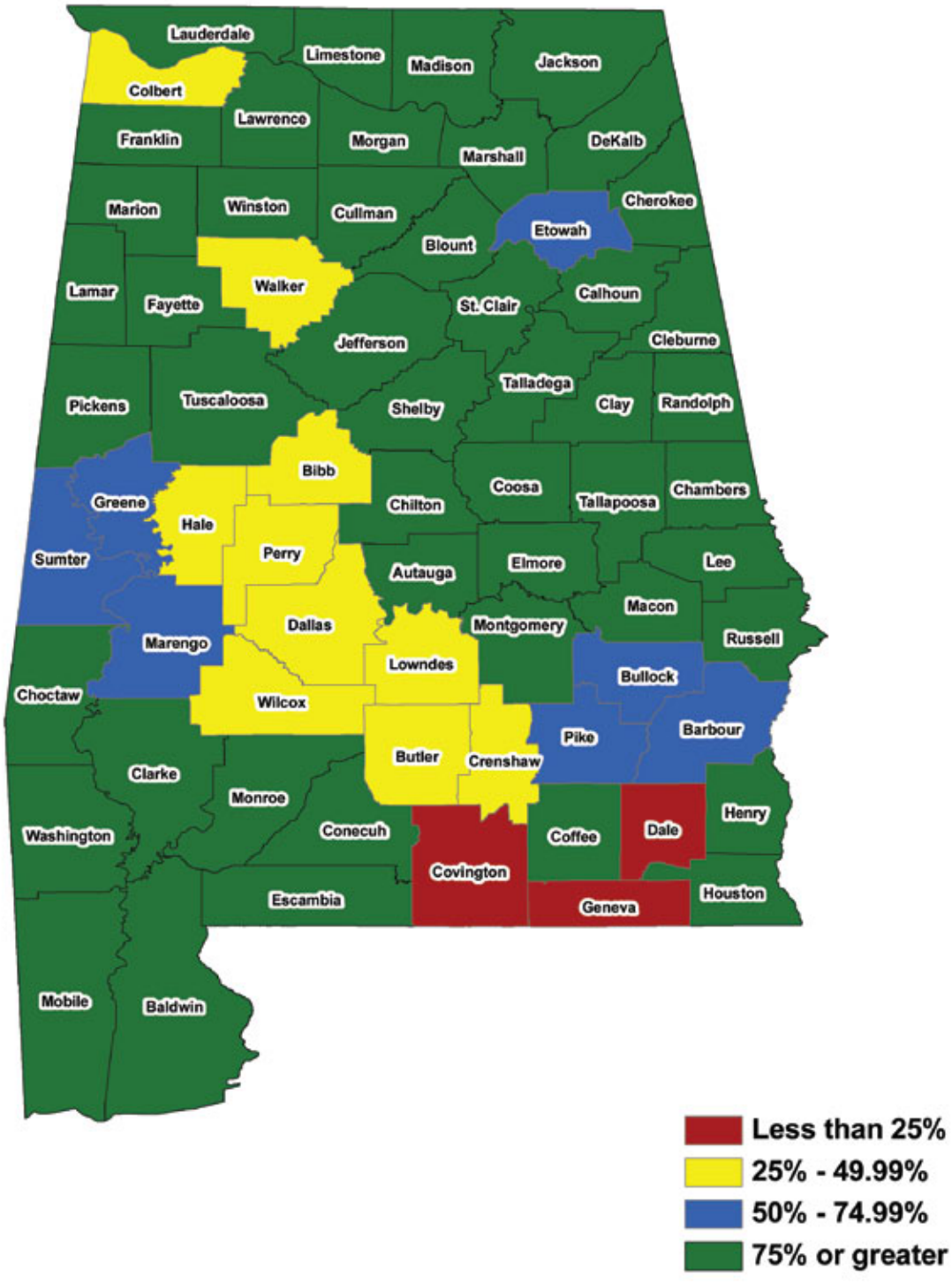
- Of the 4,360 child deaths that occurred during the years 2001 through 2005, those that qualified for review under the Alabama Child Death Review System totaled 1,600 (37 percent). The percentage of child deaths that have qualified for review has remained fairly constant over the five-year period.



- Of the total number of deaths that qualified for review during the years 2001 through 2005, the Local Child Death Review Teams reviewed and returned 1,384 cases (87 percent). The percentage of cases that qualified for review and were in fact reviewed has increased over the five-year period.

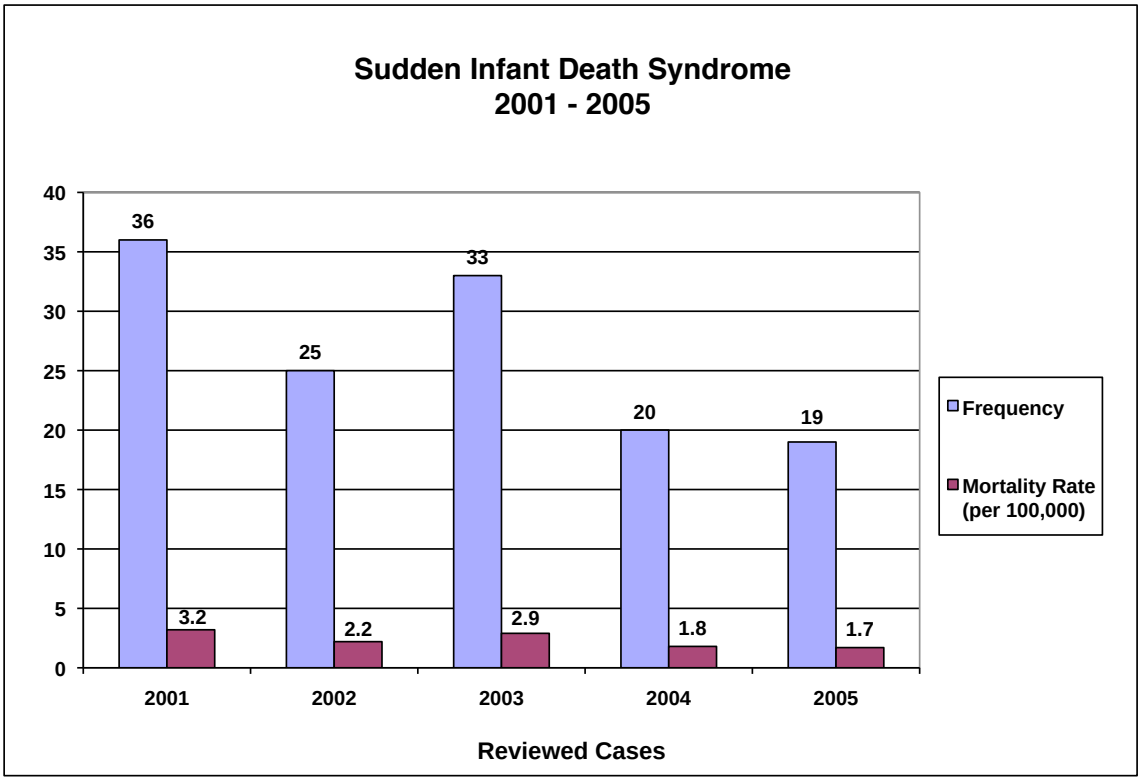


- The map below shows the case return rate of each Local Child Death Review Team for the years 2001 to 2005. While there are areas that can improve on the rate of review, all review teams should be commended for their efforts.

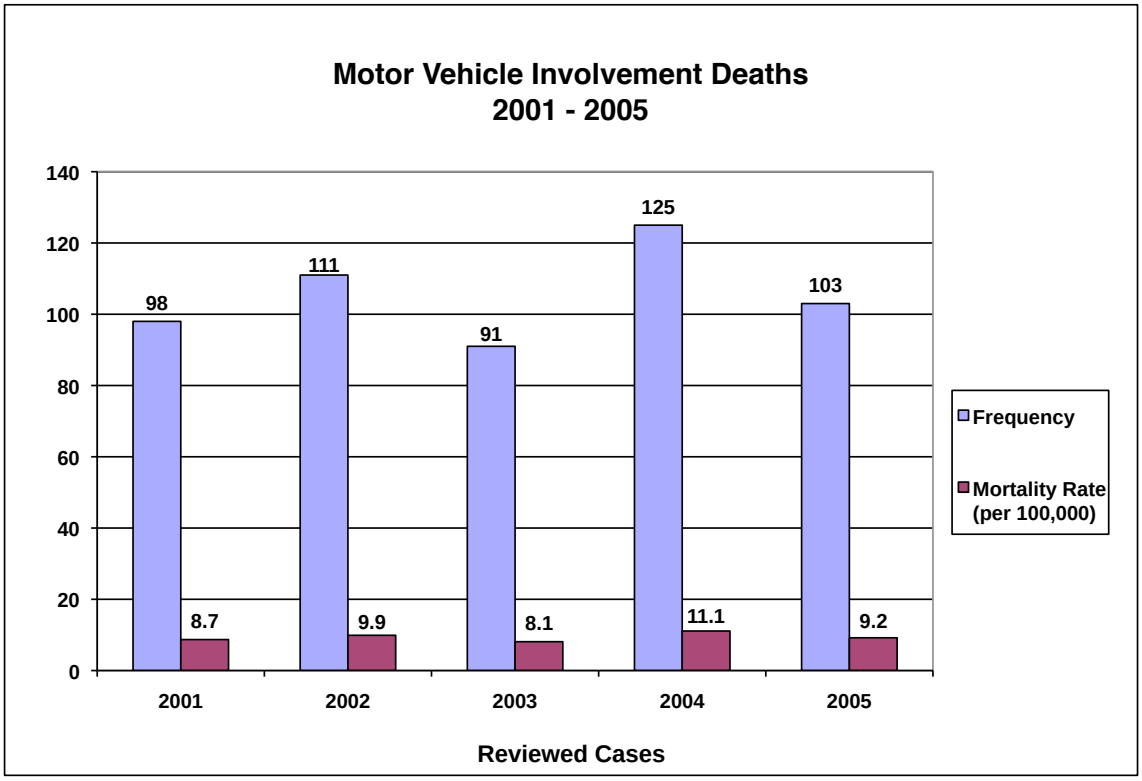


ALABAMA CHILD DEATHS

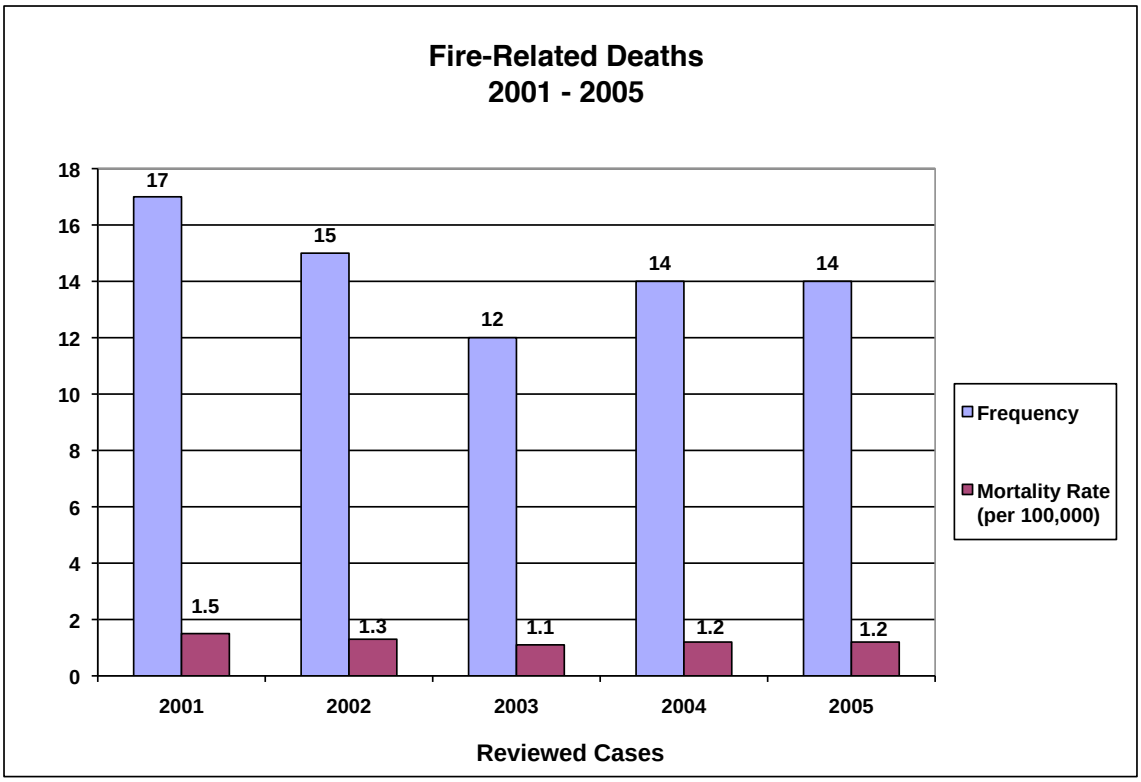
2001 – 2005



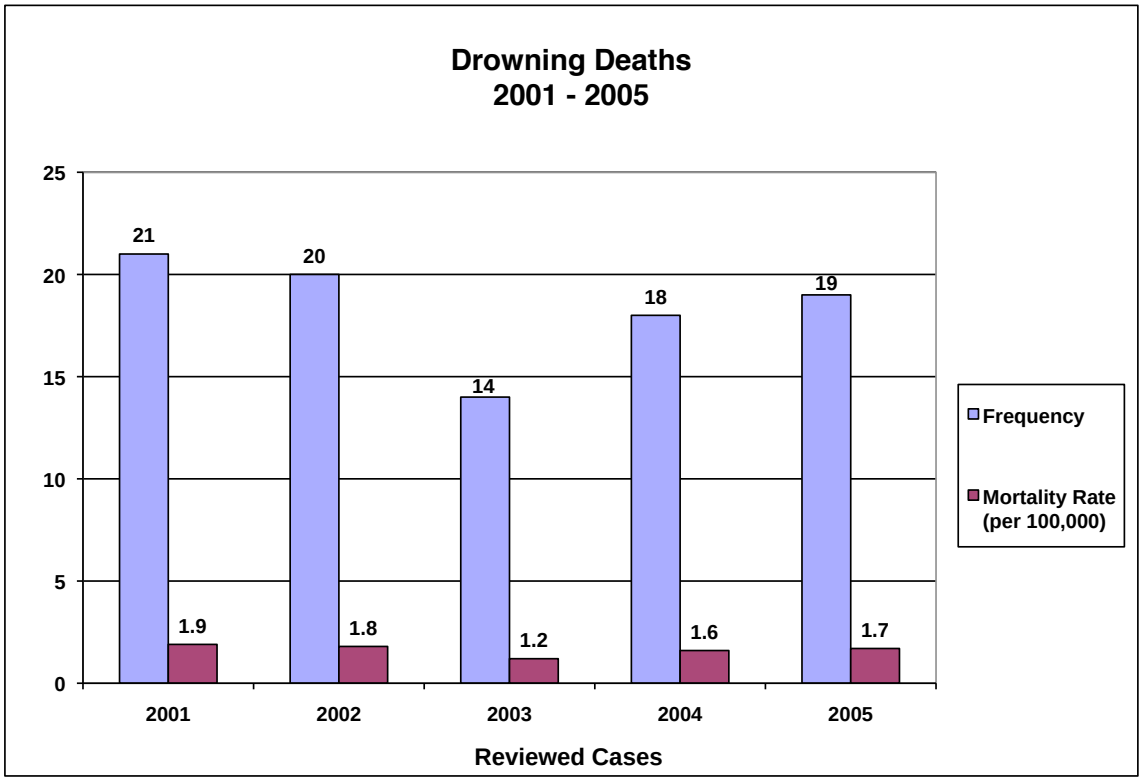
- While more data is needed, there does appear to be a general decline in Sudden Infant Death Syndrome mortality during this period.



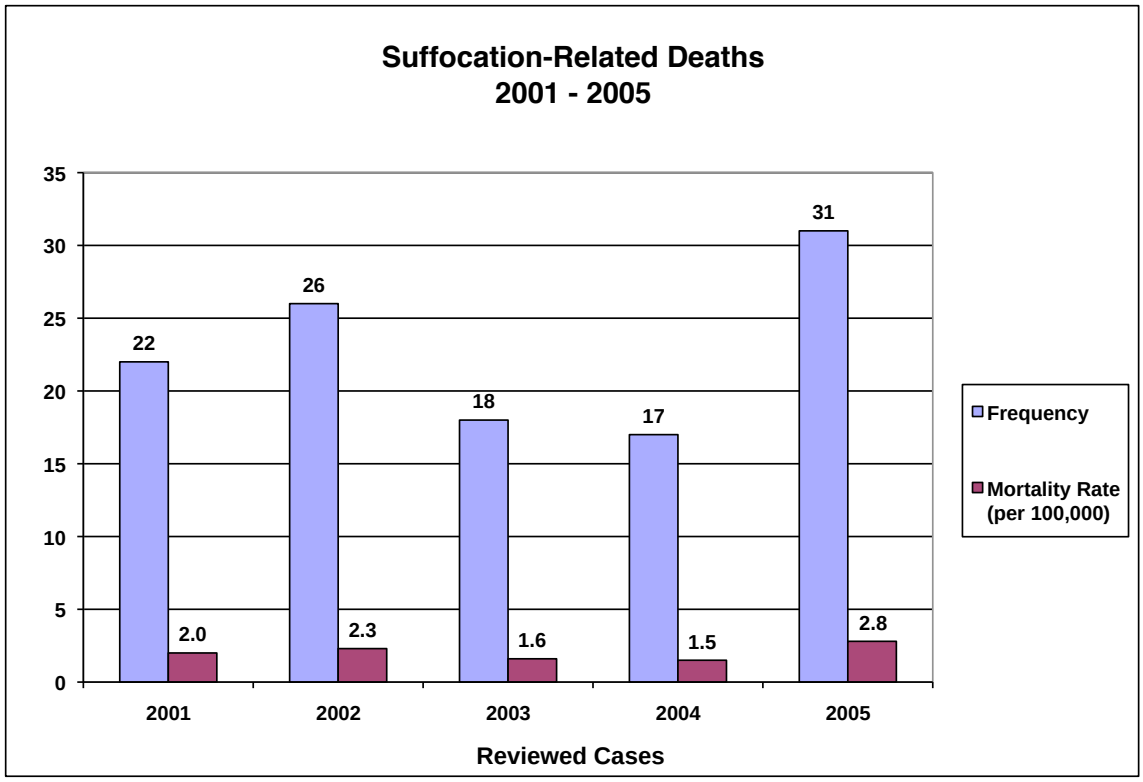
- Of the cases reviewed, the mortality rate has varied slightly over the five years reviewed.



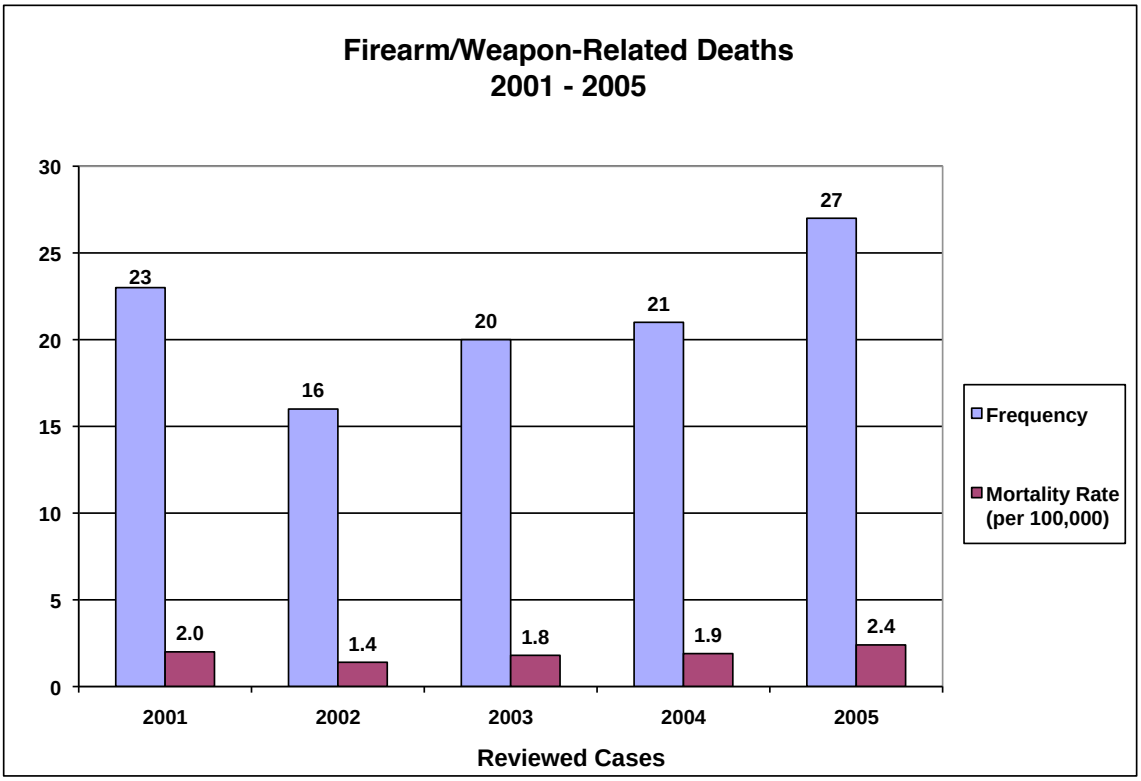
- Fire-related deaths have remained fairly constant for the five-year period.



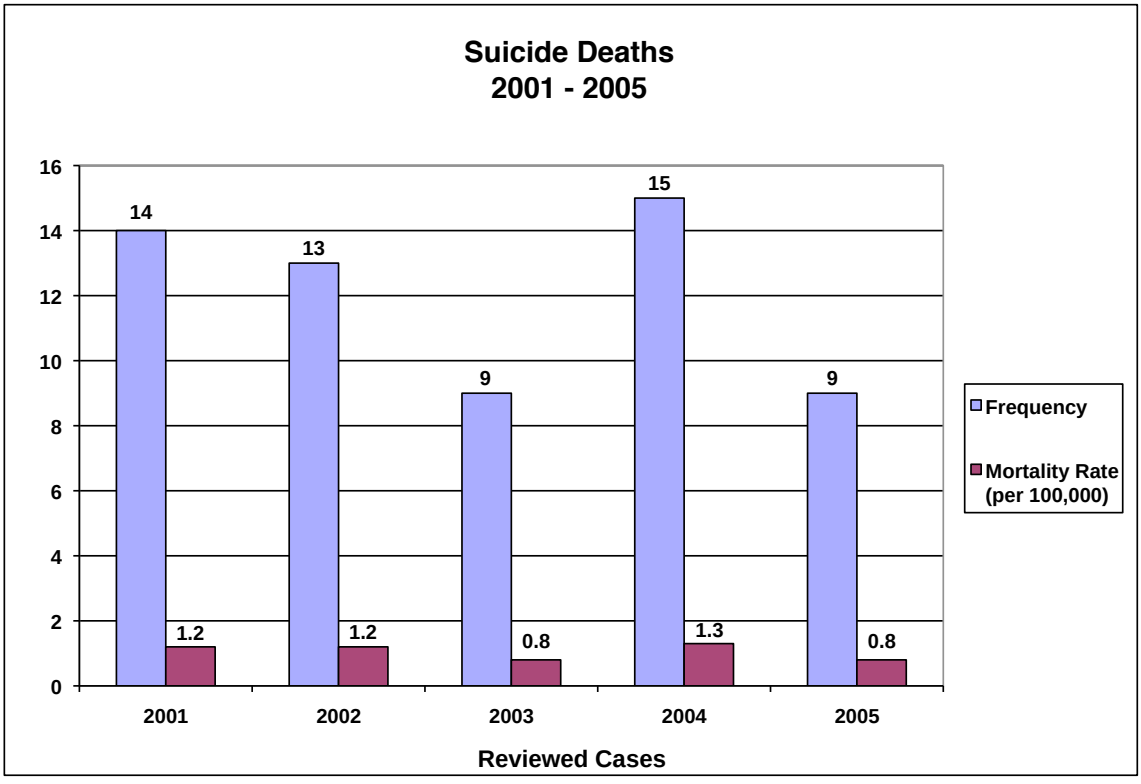
- With the exception of 2003, death rates due to drowning have been fairly constant.



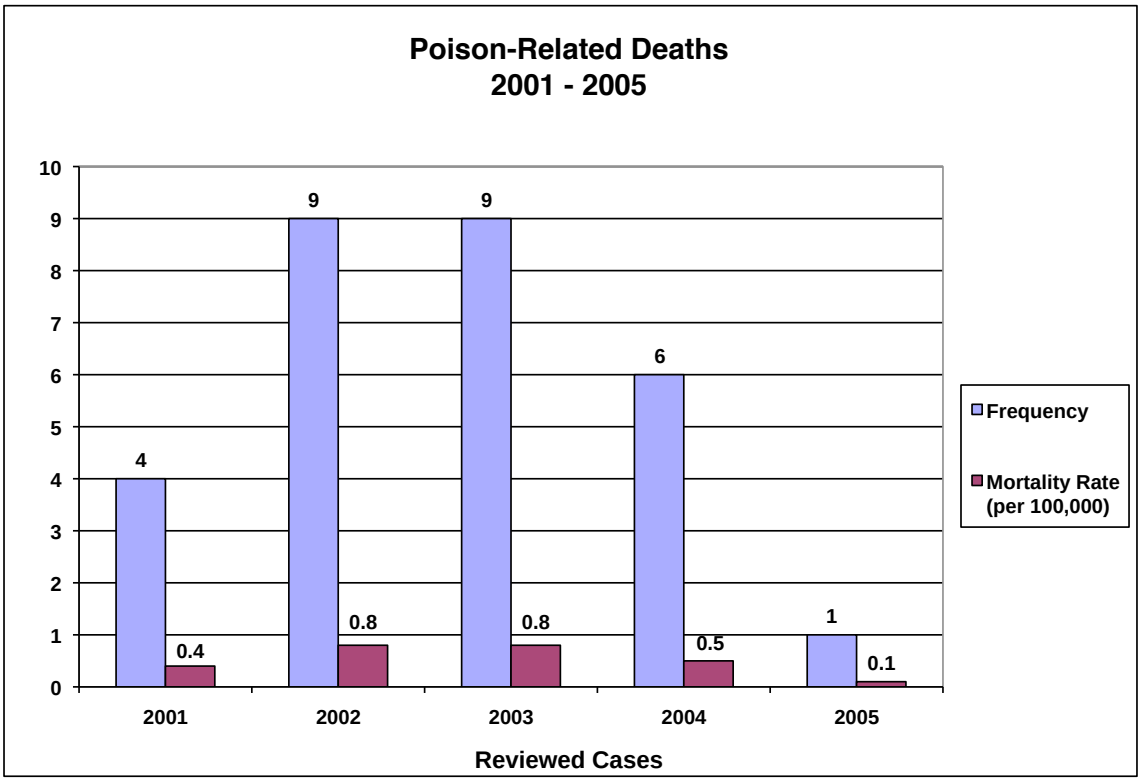
- Suffocation-related deaths appear to be on the decline with the exception of 2005, when an unexpected number of cases were collected.



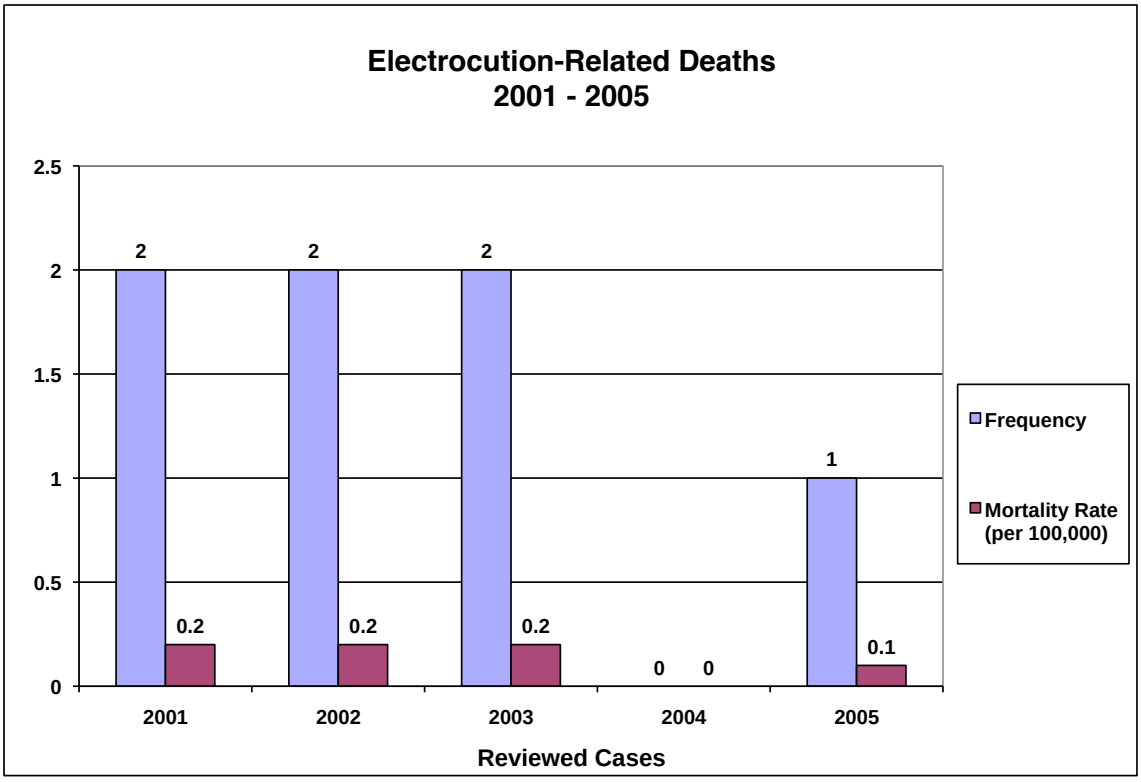
- While there has been some fluctuation in these death rates, overall they appear to be on the rise.



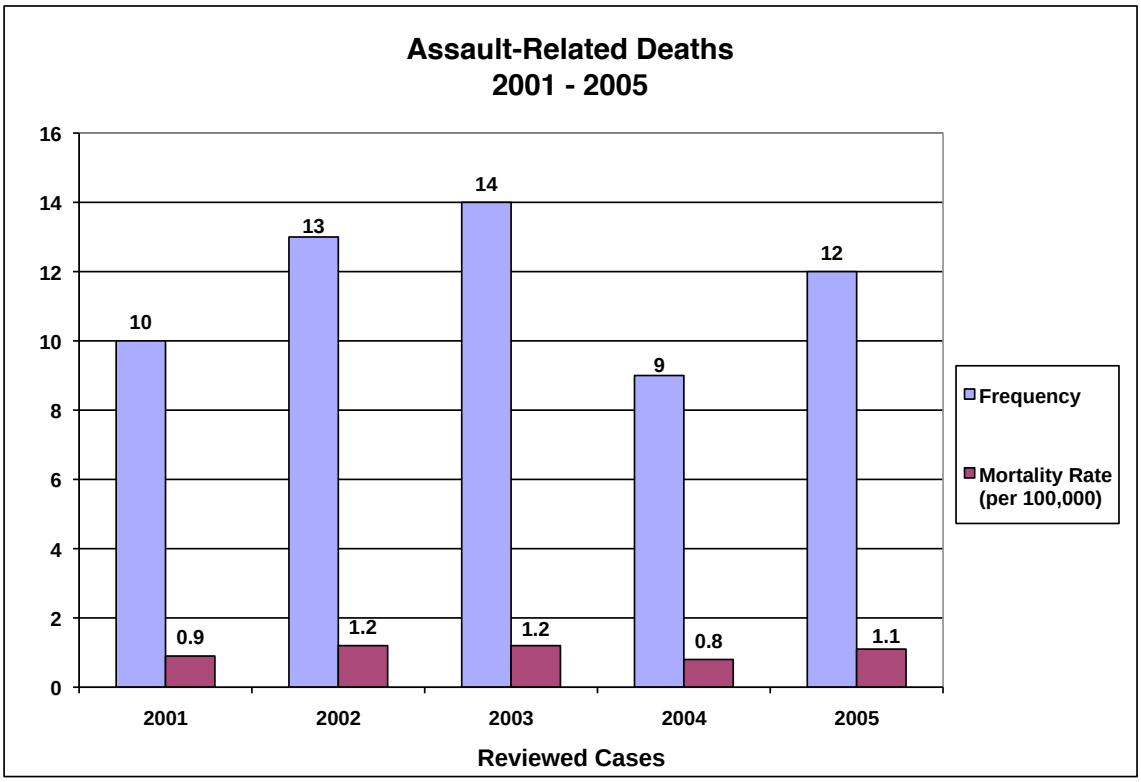
- The suicide death rates have fluctuated slightly over the five-year period.



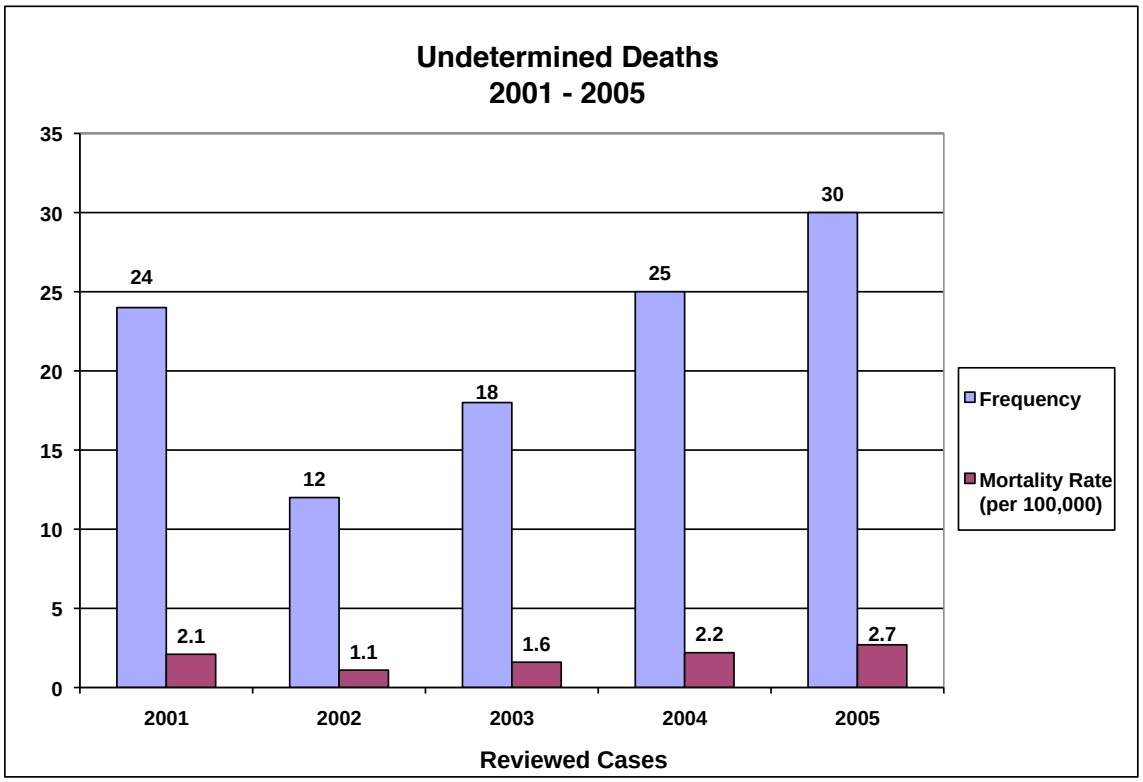
- There appears to be a possible spike in cases during 2002 and 2003, but these numbers are of insufficient size to document a trend.



- Electrocution-related deaths appear to be fairly consistent over time.

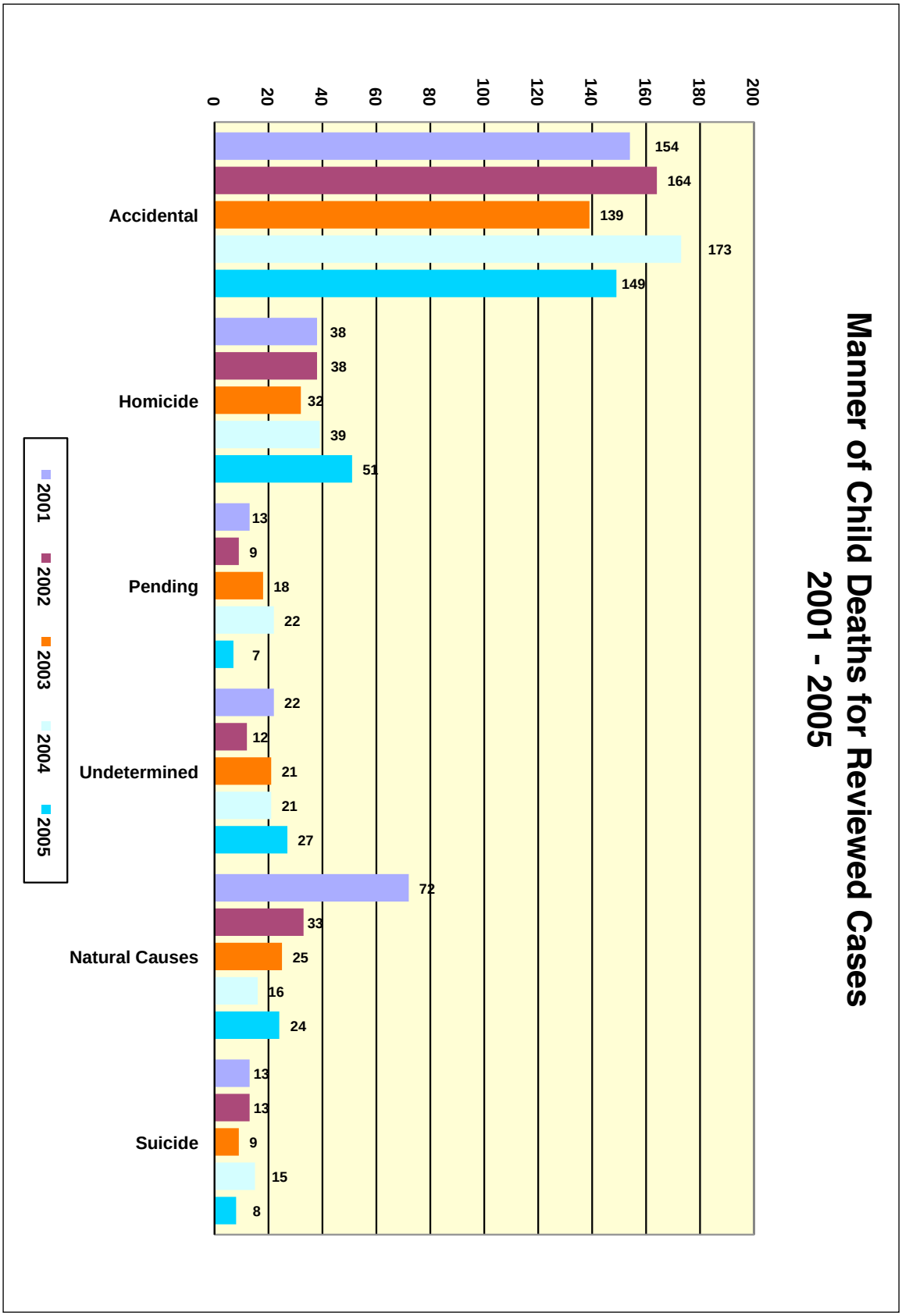


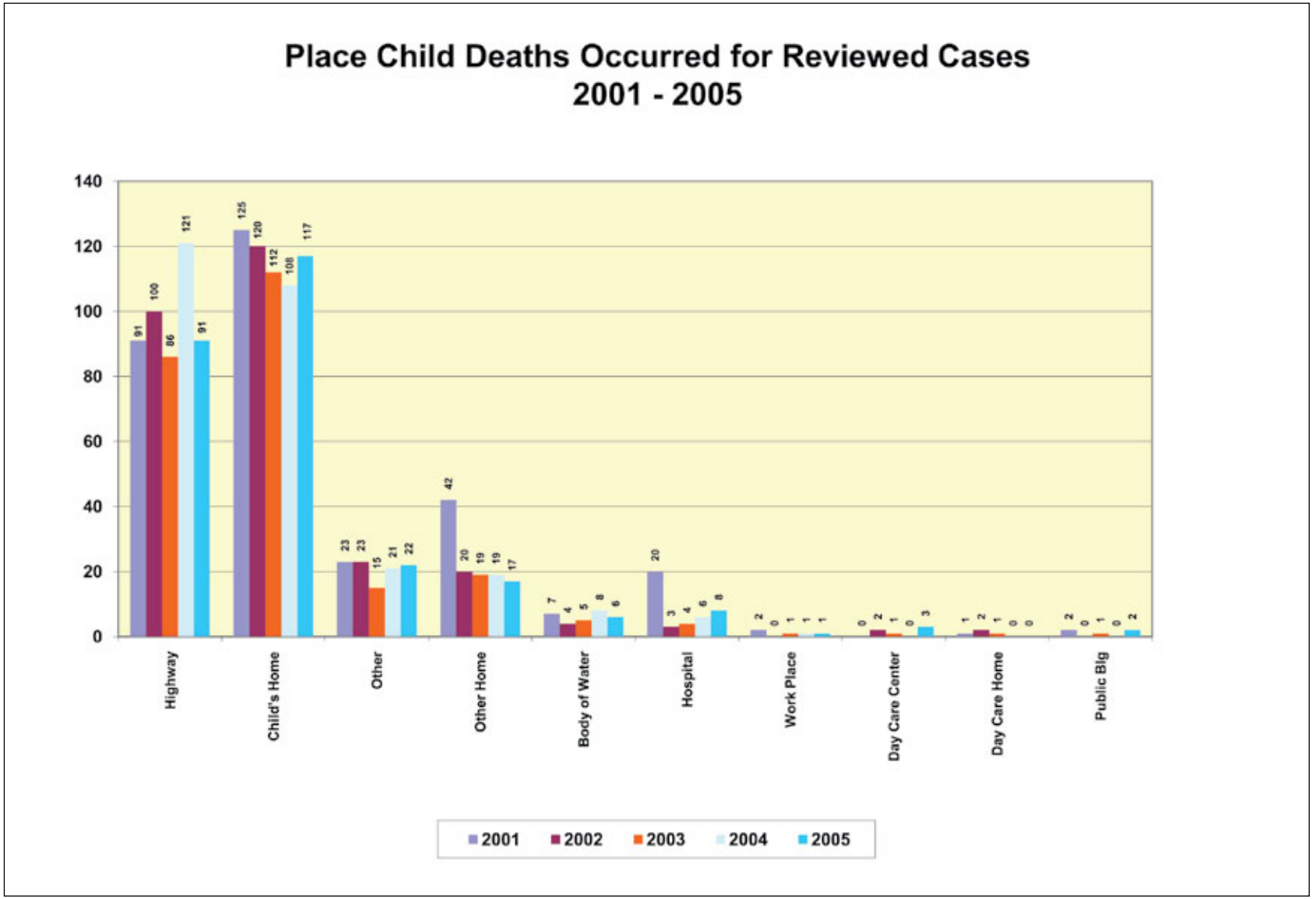
- Child assault-related deaths appear to be somewhat variable. However, the number of cases is of insufficient size to provide strong evidence for any implications.



- The number of undetermined deaths dropped in 2002 before rising in 2003 to 2005.

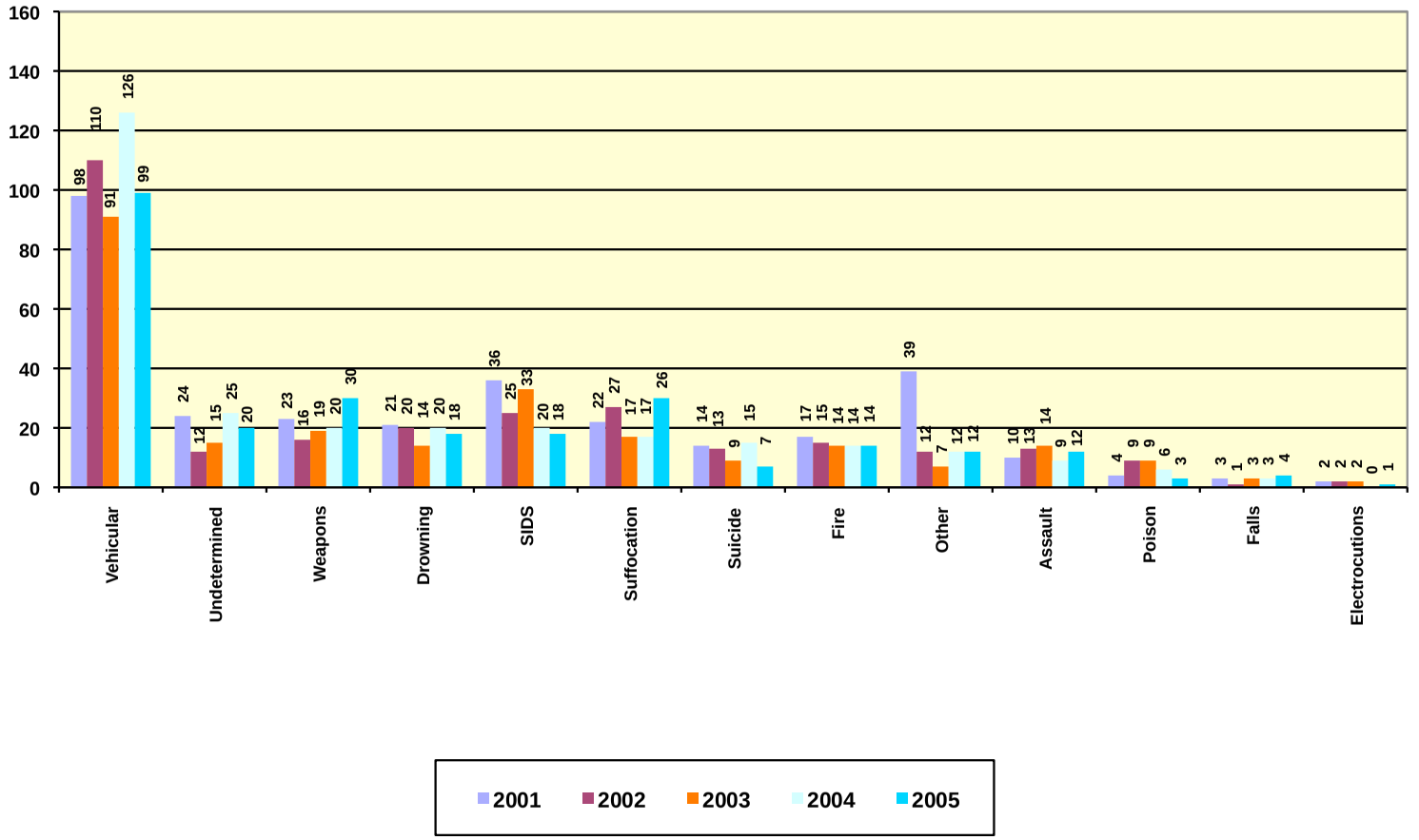
- While this chart does represent some fluctuation by year, natural causes represents a considerable decrease from 2001.





- There does seem to be fluctuation in some locales, such as the highway, but deaths are relatively consistent in other locales.

Causes of Child Deaths for Reviewed Cases
2001 - 2005

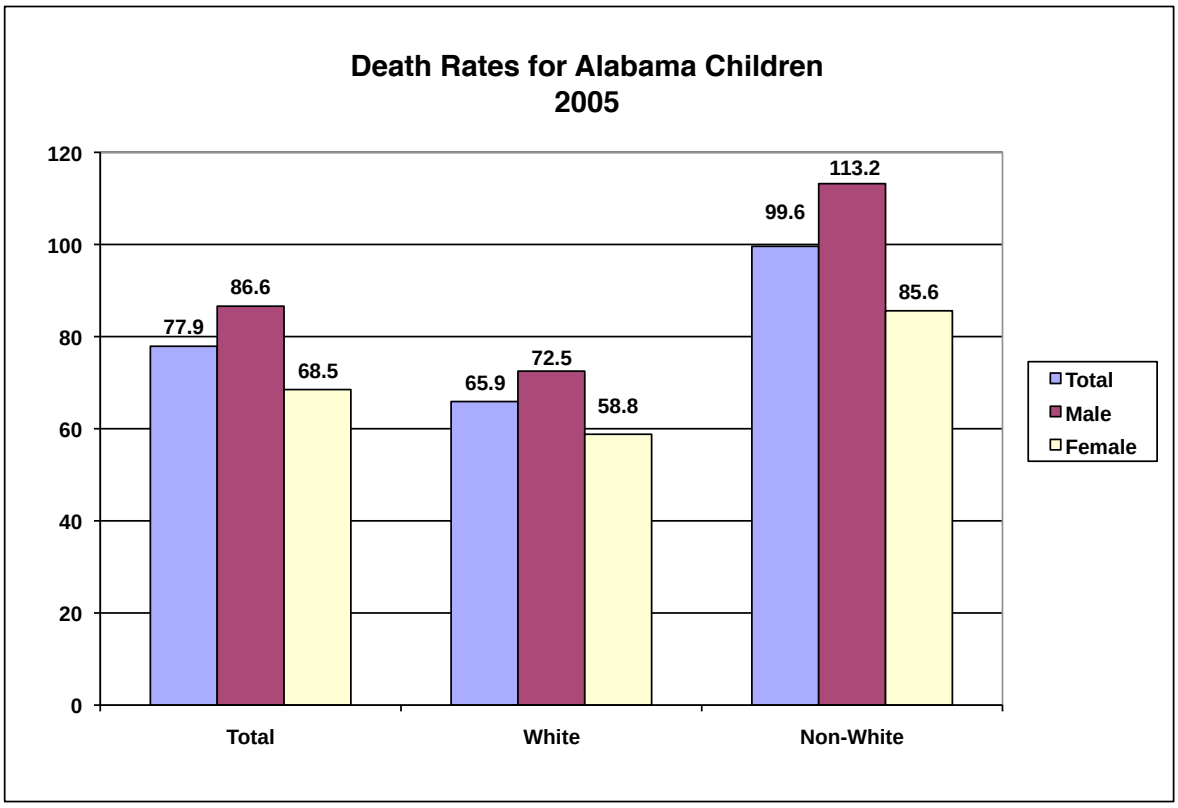


- With the exception of fire and electrocutions, causes of child deaths have shown no consistent trends over the five-year period.

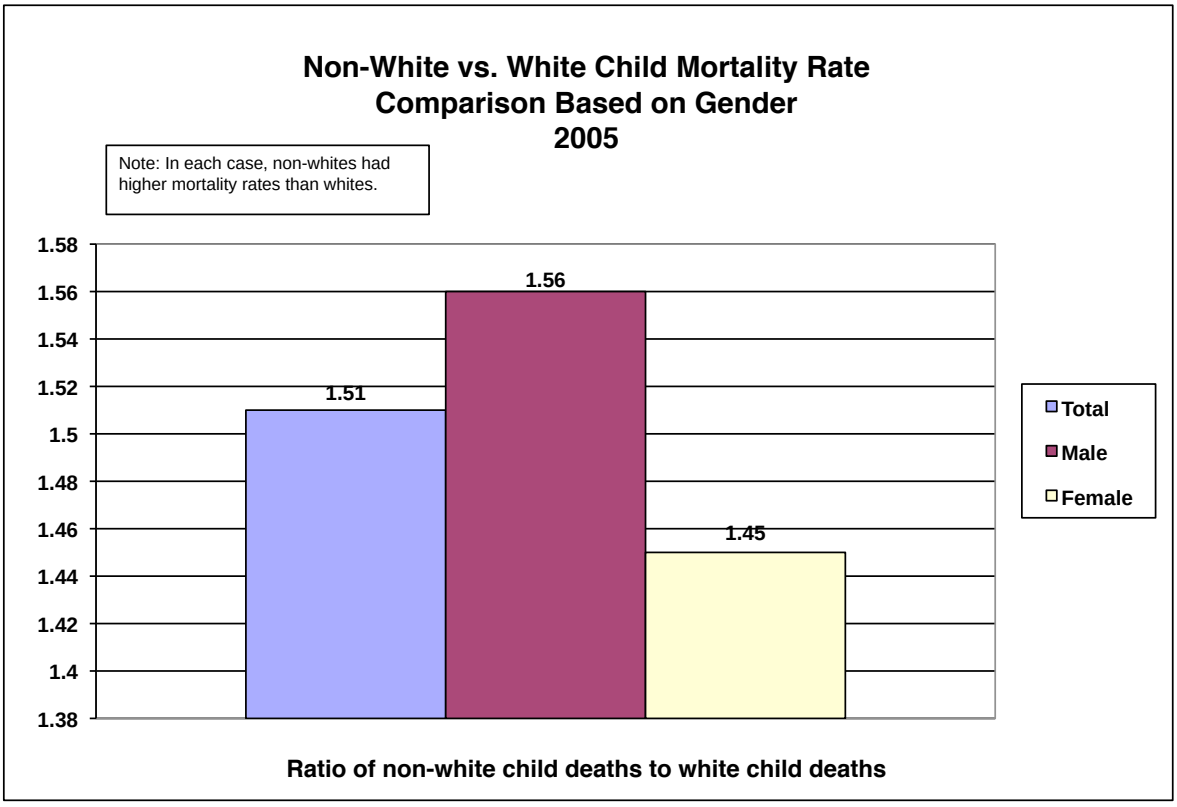
KEY FINDINGS

- There were 876 infant and child deaths (those under the age of 18) during 2005.
- The 2005 findings represent approximately 78 deaths per 100,000 children.
- Fifty-seven percent of child deaths in 2005 were to male children.
- Forty-six percent of child deaths in 2005 were to non-white children.

Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2005. The graph allows for comparison of death rates among specific population groups.

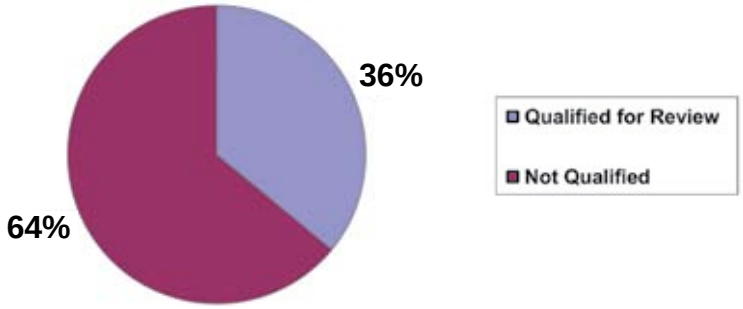


- Racial comparisons of the death rates of Alabama children are shown in the graph below. It should be noted that in each instance, non-whites have significantly higher rates ($p < .05$) than do whites (i.e. non-white males had a child mortality rate 1.56 times greater than white males).

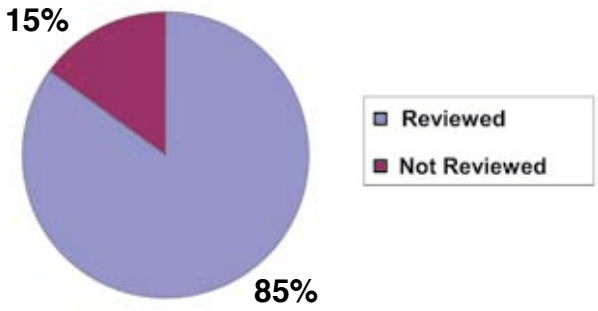


KEY FINDINGS

- As the chart below indicates, of the 876 child deaths in Alabama in 2005, there were 311 deaths that year that qualified for review under the Alabama Child Death Review System.



- Of the deaths that qualified for review (311), the Local Child Death Review Teams reviewed and returned 264 reports (see chart below). This compares to 92 percent reported for 2004.

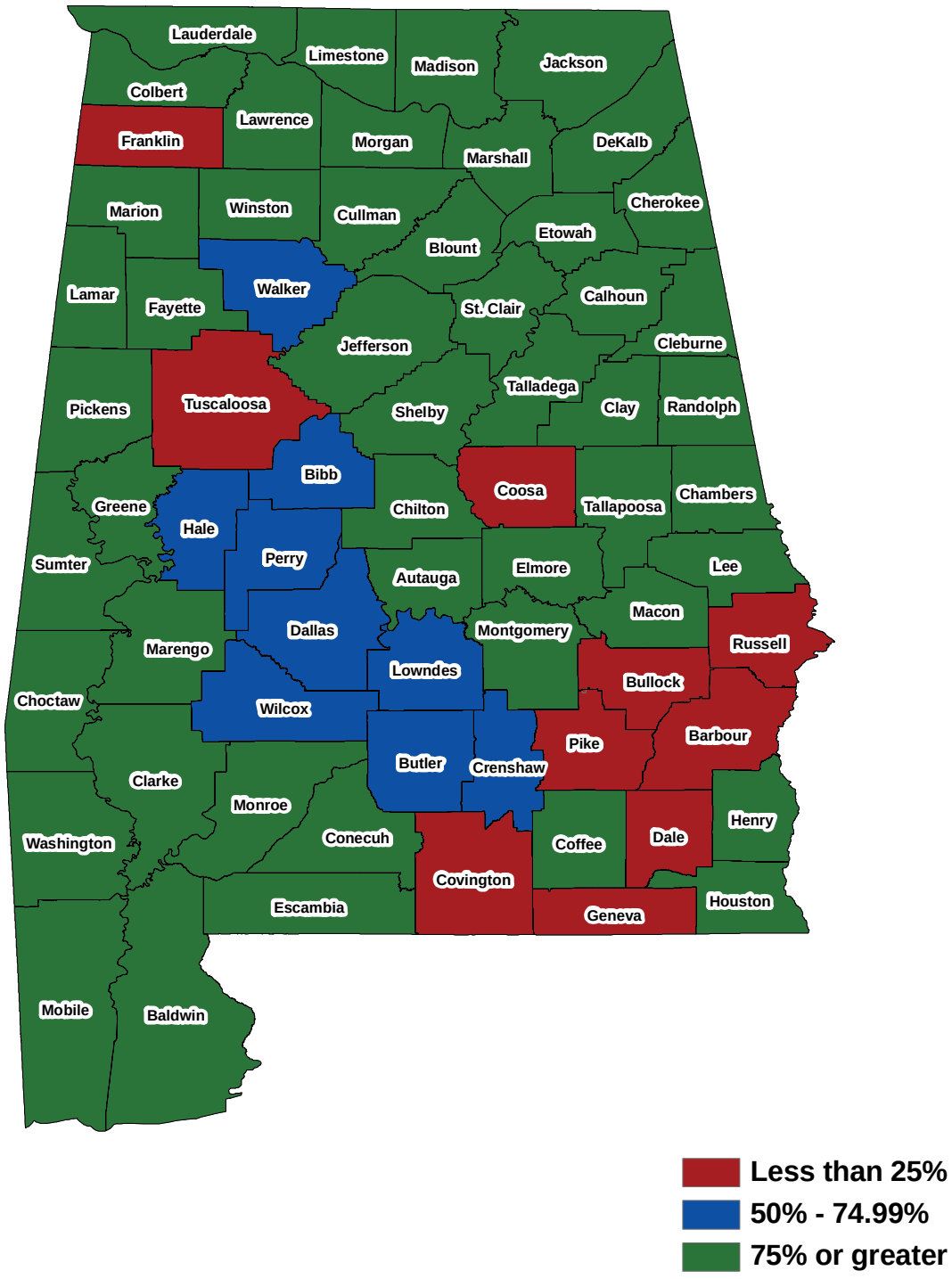


- In 2005, there were no significant race or gender differences in the proportion of cases reviewed compared to those cases not reviewed.

- While proportionately fewer neonates (those less than 28 days old) qualified for review in 2005 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	327	16	15	1
28 days - < 1 year	214	72	67	5
1 year - < 5 years	84	53	41	12
5 years - < 10 years	46	28	22	6
10 years - < 16 years	100	62	51	11
16 years - < 18 years	105	90	68	12

- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2005. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



KEY FINDINGS

- Nineteen suspected cases of Sudden Infant Death Syndrome (SIDS) were reviewed.
- The initial sleeping position of 32 percent of the babies whose deaths were reviewed is unknown; however 16 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of those cases reviewed, 32 percent of infants were sleeping in adult beds and 37 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge of the deaths in cases where the position of the infant was unknown.
- Only two of the reviewed cases involved families that did not smoke.
- Of all cases reviewed, at least three cases (16 percent) were classified as "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.

KEY FINDINGS

- A total of 103 cases were reviewed in 2005.
- Seventeen of these deaths (17 percent) involved young drivers (those 16 years of age).
- Nine of these deaths (9 percent) involved underage drivers (those under the age of 16).
- Fifteen of the deaths (15 percent) were listed as being due to an inexperienced driver.
- Twenty-five of these deaths (24 percent) were the result of not using lap and shoulder belts or other appropriate safety restraints. Two deaths (2 percent) were the result of restraints not being used correctly.
- Additionally, 47 of these deaths (46 percent) were due to reckless driving and/or speeding, with 16 of these deaths (15 percent) classified as reckless driving, 31 deaths (30 percent) classified as speeding, and 10 deaths (10 percent) classified as both reckless driving and 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 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. Encourage new laws to better regulate children on All-Terrain Vehicles to include licensure and mandatory safety equipment.
4. Encourage legislation prohibiting the use of cell phones while driving for drivers under the age of 18.
5. Reinstate and restore funding for the "Alabama Child Passenger Safety Program."
6. Adopt a policy of including multiple agencies in the development and implementation of all child safety interventions.

KEY FINDINGS

- Fourteen cases were reviewed in 2005.
- In three of these cases, fires were the result of faulty wiring in the child's place of residence.
- In five of the cases (36 percent), it was not known whether the residence had a smoke alarm. In six of the cases (43 percent), there was no smoke alarm.
- Four of the cases (29 percent) were deaths that occurred in mobile homes, while three cases (21 percent) occurred in brick-frame homes and one case (7 percent) occurred in a wood- and brick-mix home.

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 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

- Nineteen cases were reviewed in 2005.
- Eight of these deaths (42 percent) occurred in swimming and/or wading pools.
- Three of these deaths (16 percent) occurred in open water.
- Two deaths (11 percent) occurred in bath tubs.
- Of the 19 drowning deaths, 15 of these deaths (79 percent) were reported as not wearing a flotation 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 flotation devices when swimming in open bodies of water.

KEY FINDINGS

- Thirty-one cases were reviewed in 2005.
- At least 11 of these deaths (36 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 Sudden Infant Death Syndrome section.)
- Sixteen of these victims (52 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 sleeping 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-seven cases were reviewed in 2005.
- Twenty-five of these deaths (93 percent) were the result of firearm use, with 20 deaths (74 percent) caused by handgun use and five deaths (19 percent) caused by rifle/shotgun use.
- The vast majority of these deaths, 18 (67 percent), were known to be due to an "intent to do harm."
- Only six child deaths (22 percent) reviewed in this category were reported to be the result of playing with firearms.
- Four of the 27 children (15 percent) were killed by a weapon being handled by a family member.

RECOMMENDATIONS

1. Encourage gun safety education for children 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

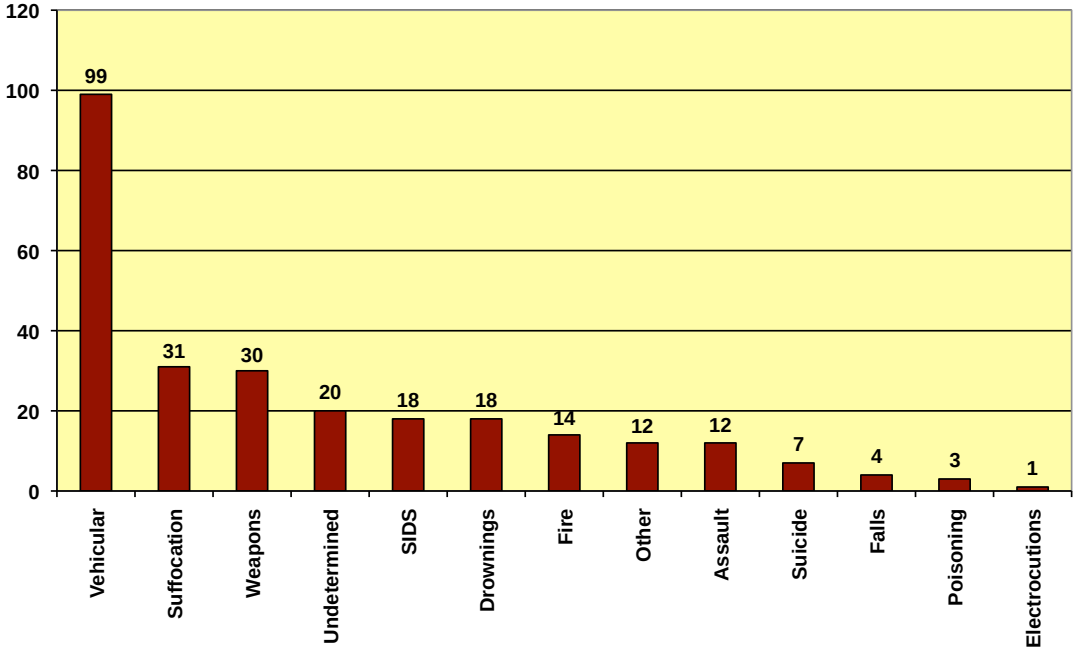
- Nine cases were reviewed in 2005.
- Four of these deaths (44 percent) were reported as being unexpected.
- Four of these deaths (44 percent) were the result of hanging while three deaths (33 percent) resulted from the use of firearms.

RECOMMENDATIONS

1. Support statewide efforts to examine 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 (37 percent) reviewed cause of child death in 2005.



POISON:

- One case was reviewed in 2005.
- The case resulted from illegal drug use.

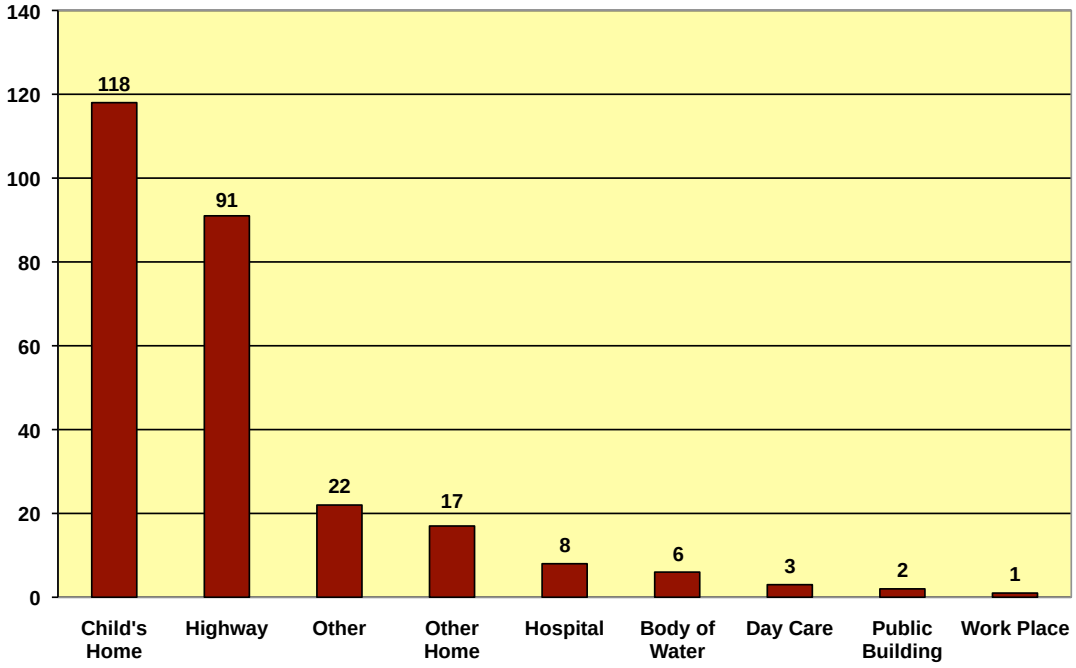
ASSAULT:

- Twelve cases were reviewed in 2005.
- Of those, five deaths (42 percent) were caused by the use of hands and fists.
- Parents were responsible for seven (58 percent) of the assault deaths.

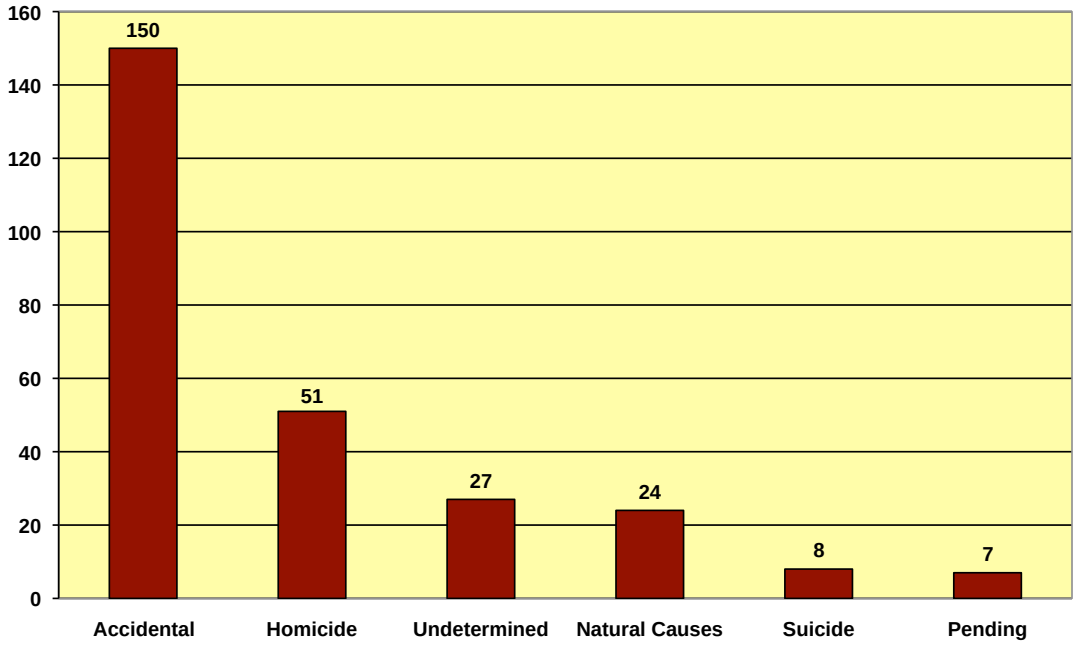
UNDETERMINED:

- Thirty cases were reviewed in 2005 in which the cause of death was undetermined.
- In eight of the cases (27 percent), the infant was not sleeping alone.
- In three of the cases (10 percent), rollover was suspected.
- In 18 of the cases (60 percent), infants were found in an adult bed, on an easy chair, or on the floor.

- The child's home was the single most frequent place of death (44 percent), followed by the highway (34 percent).



- Accident was the most frequent manner of death reviewed (56 percent).



ALABAMA CHILD DEATH REVIEW SYSTEM SUCCESSES - 2005

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. Our very effective State and Local Teams have contributed significantly to a reduction in preventable child deaths since the ACDRS began, and we continue to see new efforts and great results from their hard work. We are delighted to report significant progress in both our data collection and our special interest programs.

Local Child Death Review Teams

The Alabama Child Death Review System is proud that all counties in Alabama now have a Local Child Death Review Team (LCDRT) with a Coordinator in place. This is an amazing goal that most other states with similar programs are striving to reach. After a brief reduction in our completed case rates, we are making every effort to reinvigorate and assist with LCDRT involvement and participation. We are greatly pleased with the impressive efforts of our Local Teams.

ACDRS Training

Many Local Team Coordinators and others participated in training that was made available at our 2008 ACDRS Statewide Training Conference. Coordinators learned how to effectively coordinate and conduct LCDRT meetings and gained insight into the operations of the program at the state level. The conference included not only an Alabama multi-team discussion, but also a multi-state panel discussion so attendees could learn how similar programs operate in other states.

Alabama SUIDI Team

The Centers for Disease Control and Prevention has established standardized tools and protocols for Sudden Unexplained Infant Death Investigations (SUIDI), which are being adopted nationwide. The ACDRS Director is proud to be one of the five members of the Alabama SUIDI Team, which has developed a formal SUIDI training course for Alabama. The Team recently established and trained a cadre of trainers to teach the SUIDI curriculum to first responders statewide. The dissemination of this important information should greatly improve infant death scene investigations, the accuracy of infant death diagnoses, and the overall usefulness of the information the ACDRS collects regarding infant deaths.

The Alabama Cribs for Kids Program

The Cribs for Kids Program in Alabama began in Montgomery as a pilot program. Cribs have been given to many qualifying families in the Montgomery County area with the help of the Gift of Life Foundation. After experiencing success with the program there, Gift of Life and the ACDRS decided to expand the program to other counties in the state. Talladega and Escambia counties have already been added and we hope to expand our efforts with the Cribs for Kids Program to even more Alabama counties in the near future.

Booster Seat Advocacy Program

The Booster Seat Advocacy Program is a joint effort of the ACDRS, Children's Hospital Child Safety Institute, the UAB Department of Pediatrics, and the Alabama Department of Public Health's Injury Prevention Division. The program was initiated after the passage of the enhanced child restraint amendment in Alabama. Booster seats are provided to families throughout Alabama to ensure that children who are too large for infant seats but too small to be adequately protected by seat belts alone are protected while riding in passenger vehicles.

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

1. What is the ACDRS?

- Alabama state law signed on September 11, 1997, created the ACDRS State Office and both Local and State Child Death Review Teams.
- Alabama is one of 49 States that has Child Death Review (CDR).
- 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 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 the Alabama Department of Public Health), 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 equals one-half of 1 percent of the total CFTF portion of the NTS not to exceed $300,000.
- The Alabama Medicaid Agency now also provides some supplemental funding to the ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

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 ACDRS State Office receives a copy of all death certificates issued to Alabama decedents less than 18 years of age. Each certificate is reviewed to determine whether it meets the ACDRS review criteria. Cases meeting the criteria are then assigned to the appropriate LCDRT on a case-by-case basis.
- The LCDRT reviews each case individually and, based upon its findings, completes 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/or makes recommendations to the State Team for consideration and action.
- The ACDRS State Office collects and analyzes the information submitted by the LCDRTs. This information is then used to answer requests for specific data and to generate reports.
- The State Child Death Review Team meets quarterly to discuss Child Death Review (CDR) issues, review the statewide 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).
- All formal recommendations and prevention efforts are evidence-based and goal-oriented.

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

- The deceased must have died in Alabama.
- The deceased must have been born alive (ACDRS does not review fetal deaths).
- The deceased must be less than 18 years of age.
- The cause of death must be non-medical, unexplained, and/or unexpected.

9. What are the ACDRS goals?

- All Alabama death certificates assessed for review criteria
- All eligible cases reviewed at the local level by the appropriate LCDRT
- High participation and completion rates by LCDRTs
- Meaningful research and recommendations
- Reductions in preventable infant and child deaths in Alabama

10. What is Alabama's greatest resource?

OUR CHILDREN!!!

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

- An infant or child death occurs on September 1, 2005.
- The death certificate is received at the ACDRS State Office by November 1, 2005, barring delays.
- The case is assigned to the appropriate Local Child Death Review Team (LCDRT) by November 15, 2005.
- The LCDRT meets to review this specific case and others by December 31, 2006. (LCDRTs meet as often as needed, based upon caseload, but must meet at least once per calendar year by law. Many meet several times per year.)
- The ACDRS State Office receives the last of the 2005 death certificates by July 2006.
- September 1, 2008, is the deadline by which the ACDRS State Office is to receive all 2005 cases that have been reviewed by LCDRTs.
- The ACDRS Annual Report on 2005 data is completed by the end of 2008.

ALABAMA SUDDEN UNEXPLAINED INFANT DEATH INVESTIGATION TEAM

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Sudden Infant Death Syndrome (SIDS) describes a very specific type of natural cause of death in infants from one month to one year of age in which all external contributing causes are eliminated through complete autopsy and toxicology, review of the clinical history, and thorough death scene investigation. Sudden Unexplained Infant Death (SUID) is a much broader term used to describe sudden infant deaths from a variety of both internal and external causes. SIDS is a very specific type of SUID and it has become increasingly evident that the majority of infant deaths diagnosed as SIDS in recent years would have been more appropriately diagnosed as SUID cases.

In 2005, the Centers for Disease Control and Prevention (CDC) established a comprehensive, unified approach to the investigation of SUIDs. This approach to investigating SUID was then developed into a universal data collection form and a corresponding training course that was given across the United States. The individuals who received the initial training were selected from each state and were tasked with taking the training back to their home state. This effort is known as the CDC Sudden Unexplained Infant Death Investigation (SUIDI) Initiative.

The current Alabama SUIDI Team, which includes both the Alabama Child Death Review System (ACDRS) Director and myself, has developed a one-day training course based on the CDC SUIDI curriculum. The course is designed to cover the different types of SUIDs. Additional subjects include infant growth and development, interviewing techniques, scene investigation and photography relating to sleeping environment, and doll re-enactment. The doll re-enactment is used for the caregiver to give a more accurate demonstration of how the infant is placed to sleep and then discovered.

In 2008, the Team recruited 14 individuals from across the state to serve as regional trainers and trained them to deliver the entire course. The trainers will provide the one-day course to individuals and agencies that are involved in the investigation of infant deaths. The goal of the state SUIDI Team and trainers is to give as many as 80 sessions during 2009. Our hope is that, as first responders throughout the state are trained in the SUIDI protocols and the use of the SUIDI Form, infant death scene investigations and the information collected will greatly improve. This will lead to more accurate death diagnoses that, in turn, will more effectively inform prevention efforts such as those initiated or supported by the ACDRS.

We are proud to be involved in this important effort.

Dale Wisely, Ph.D.
Director of Student Services and Community Education
Mountain Brook Schools
Mountain Brook, Alabama

In the United States and in Alabama, more teenagers die in motor vehicle accidents than from any other cause. More teenagers die in car wrecks than any other age group. Nationwide, approximately 5,500 teenagers lose their lives in car wrecks every year. In Alabama each year, we lose about 170 teenagers to car wrecks. In 2006, the last year for which data was analyzed, Alabama ranked No. 2 in the nation for the number of teenage driver-related fatalities.

Research points to a number of critical factors that seem to be contributing to these fatal accidents. Teenagers are new drivers and often inexperienced at the highly complex set of skills required for safe driving. We fail to adequately train many of these young drivers. Usually, teenagers are taught to drive by their parents, who are both amateur drivers and amateur educators.

Driving is risky and many drivers, including teenagers, drive under conditions that greatly increase the risk of accidents. Although drinking and driving is, of course, a killer at any age, it appears to be true that teenagers are even more impaired when they drink than are adult drivers. Teenagers are less likely than other age groups to wear their seat belts. Teenagers, who research shows are chronically sleep-deprived, have the highest rate of accidents related to falling asleep at the wheel.

As parents who pay their teenagers' cell phone bills know, each year's crop of teenagers appears more dependent on cell phones and text messaging than the last. Add to this their fondness for other hand-held electronic devices such as MP3 players. We now know that many drivers, and perhaps particularly teenagers, are prone to use these devices when driving, greatly increasing the risk of a crash.

Perhaps the most striking risk factor for teenage drivers is the presence of other teenage passengers. Much, if not most, of the added risk of car wrecks among teenagers can be accounted for by the presence of teenage passengers in the vehicle with those young drivers. The rate of crashes rises sharply when the number of passengers increases. And, of course, the more occupants in a vehicle the more possible victims if there is an accident.

Alabama does not have to lose, as it does now, 170 teenagers annually in car accidents. The Alabama Child Death Review System (ACDRS) is helping to develop a set of educational materials, directed at both teenage drivers and their parents, to raise awareness of the terrible risk of car crashes and to provide concrete tools and suggestions for reducing that risk. The ACDRS also hopes to provide consultation to legislators in their efforts to review, and perhaps strengthen, legislation related to the youngest and most vulnerable drivers.

- **Cases That Meet the Criteria for Review** - These are cases involving the deaths in Alabama of infants and children from live 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 Alabama Child Death Review System 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 the data. Sudden Infant Death Syndrome is considered a natural cause of death, but Local Child Death Review 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 then expire there.

- **Sudden Infant Death Syndrome (SIDS)** - This is a very specific type of SUID (see below) in infants from one month to one year of age in which all external contributing causes are eliminated through complete autopsy and toxicology, review of the clinical history, and thorough death scene investigation.

- **Sudden Unexplained Infant Death (SUID)** - This is a broad term used to describe sudden infant death from a variety of both internal and external causes.

- **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.

KEY DATES FOR 2009

- **January 5, 2009** - Implementation of the new web-based reporting system
- **January 22, 2009** - State Team Meeting
- **April 1, 2009** - Deadline for submission of all calendar year 2006 case reviews
- **April 23, 2009** - State Team Meeting
- **July 23, 2009** - State Team Meeting
- **October 22, 2009** - State Team Meeting

...We are all part of the solution

ADPH

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