Alabama Child Death Review System Annual Report

Report for Completed 2007 Data

Learning from the Past to Protect the Future…

DEATHS AMONG CHILDREN IN ALABAMA

ALABAMA CHILD DEATH REVIEW SYSTEM

ANNUAL REPORT - 2007 DATA

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A LETTER FROM THE STATE CHAIRMAN

September 1, 2010

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 our 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. ACDRS reviews the circumstances and underlying factors of all infant and child deaths in Alabama in order to identify those deaths that possibly could have been prevented. The findings of these reviews, as well as the recommendations drawn from them, are reported to state officials, state agencies, and to the general public. In addition to collecting and reporting data, ACDRS develops new literature and educational programs on many prevention topics including child vehicular safety, teen driving, safe infant sleeping, and youth suicide. The data and related findings are used to make recommendations about policy changes at the state and local levels.

ACDRS consists of the State Office, Local CDR Teams throughout the state, and the State CDR Team. The State Office is responsible for program coordination and is instrumental in implementing strategies to make the public aware of ways to prevent future infant and child deaths. The Local CDR Teams are responsible for the in-depth analysis of cases assigned to them by the State Office and for making recommendations about how to prevent future infant and child deaths. The State CDR Team is a 28-member multidisciplinary team that meets quarterly and serves as an advisory board. Those involved with ACDRS at every level remain committed to the mission 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 2007, a year for which ACDRS once again reviewed 95 percent or more of all qualifying cases statewide. It includes a five-year trend analysis that covers the years 2003 through 2007 and illustrates some of the trends that are so important to the research, awareness, and prevention efforts. It also highlights some of the past successes, current challenges, and future plans of ACDRS. We hope that you will find this information useful.

Sincerely,

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

Alabama Child Deaths

2003 – 2007

There were 4,387 children under the age of 18 who died in Alabama during the years 2003 through 2007. An examination of the deaths on a year-by-year basis reveals that in 2003 there were 823 deaths, in 2004 there were 852 deaths, in 2005 there were 876 deaths, in 2006 there were 893 deaths, and in 2007 there were 943 deaths. This represents approximately 78.15 deaths per 100,000 children.

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.

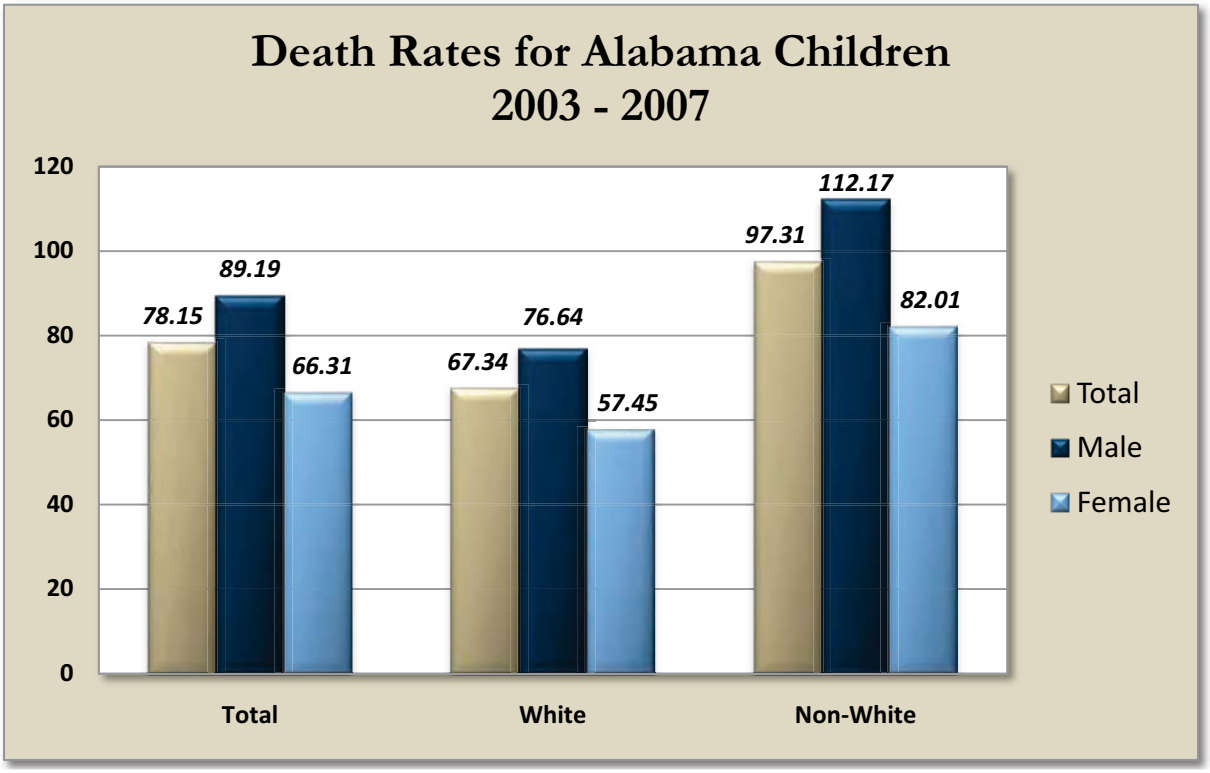
This report is a compilation of findings from Local Child Death Review Teams whose tasks are to: 1) identify factors that put a child at risk of injury or death; 2) share information among agencies that provide services to children and families or that investigate child deaths; 3) improve local investigations 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.

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 2003 through 2007, as well as statistics and information about the work of ACDRS during 2007.

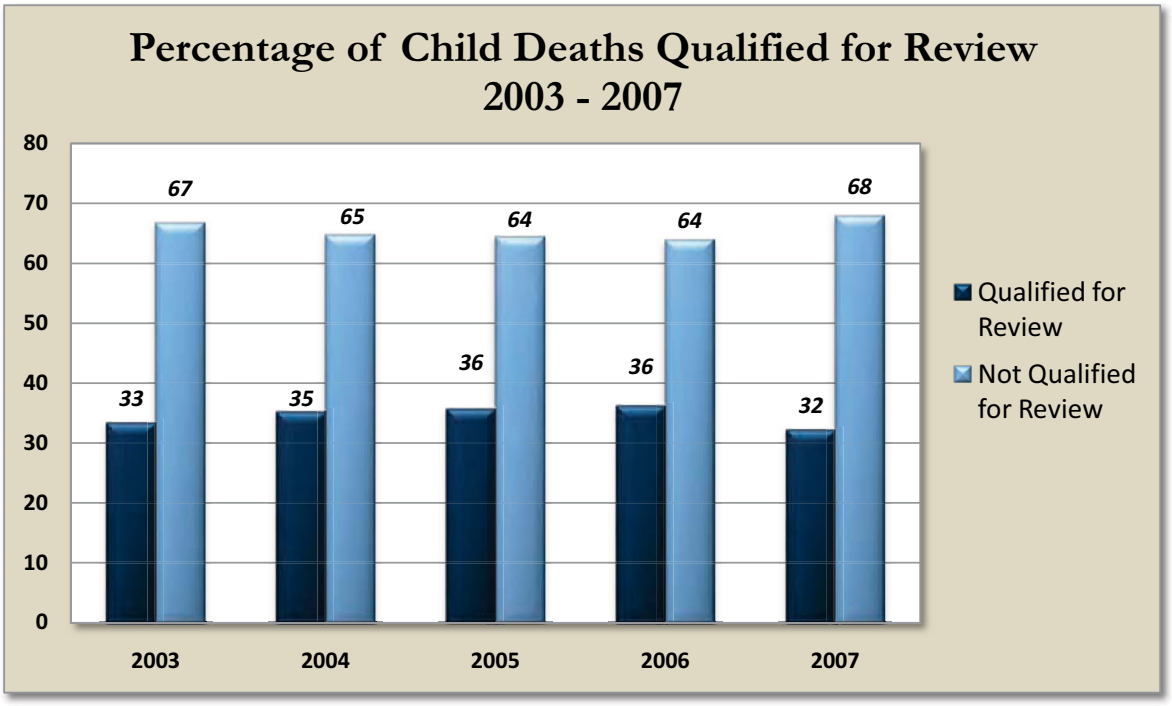
This report seeks to honor the memory of all those children who have died in Alabama. We hope that this report, and the work of the local Child Death Review Teams and the Alabama Child Death Review System, leads to a better understanding of how we can all work together to make Alabama a safer and healthier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

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

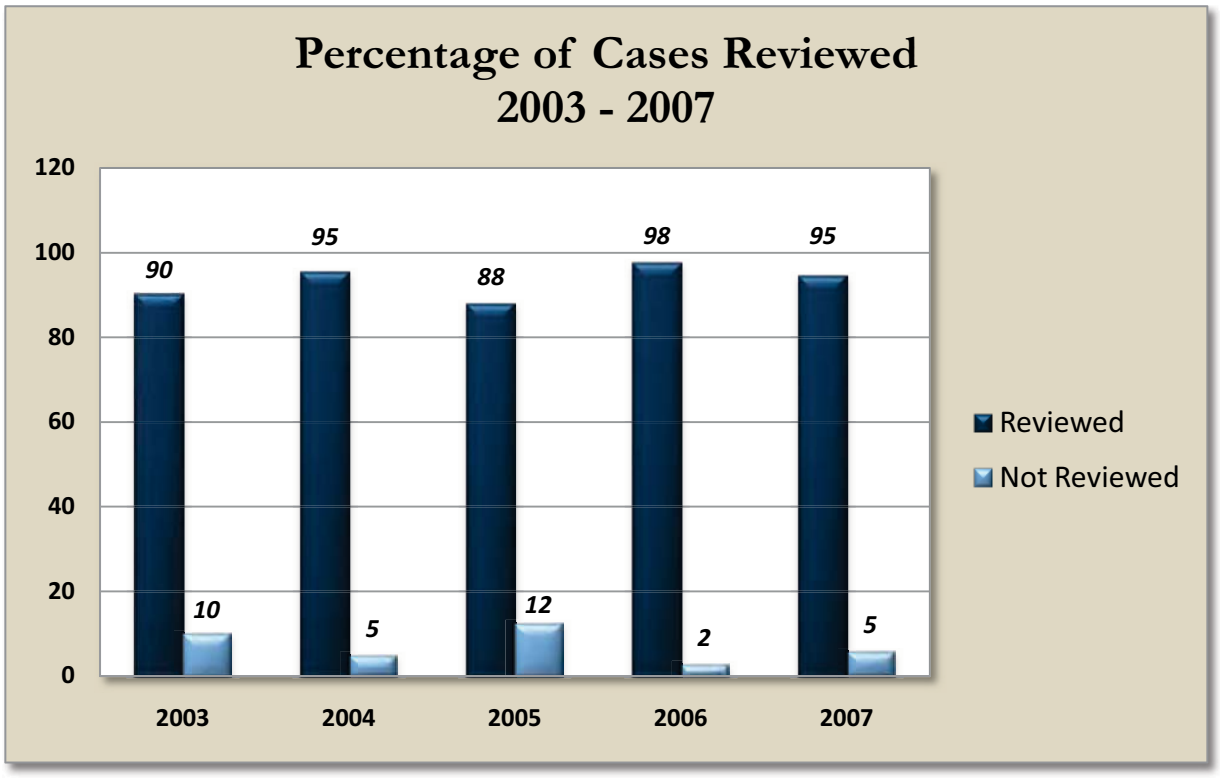
- Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama from 2003 through 2007. This allows for comparison of death rates among specific population groups.



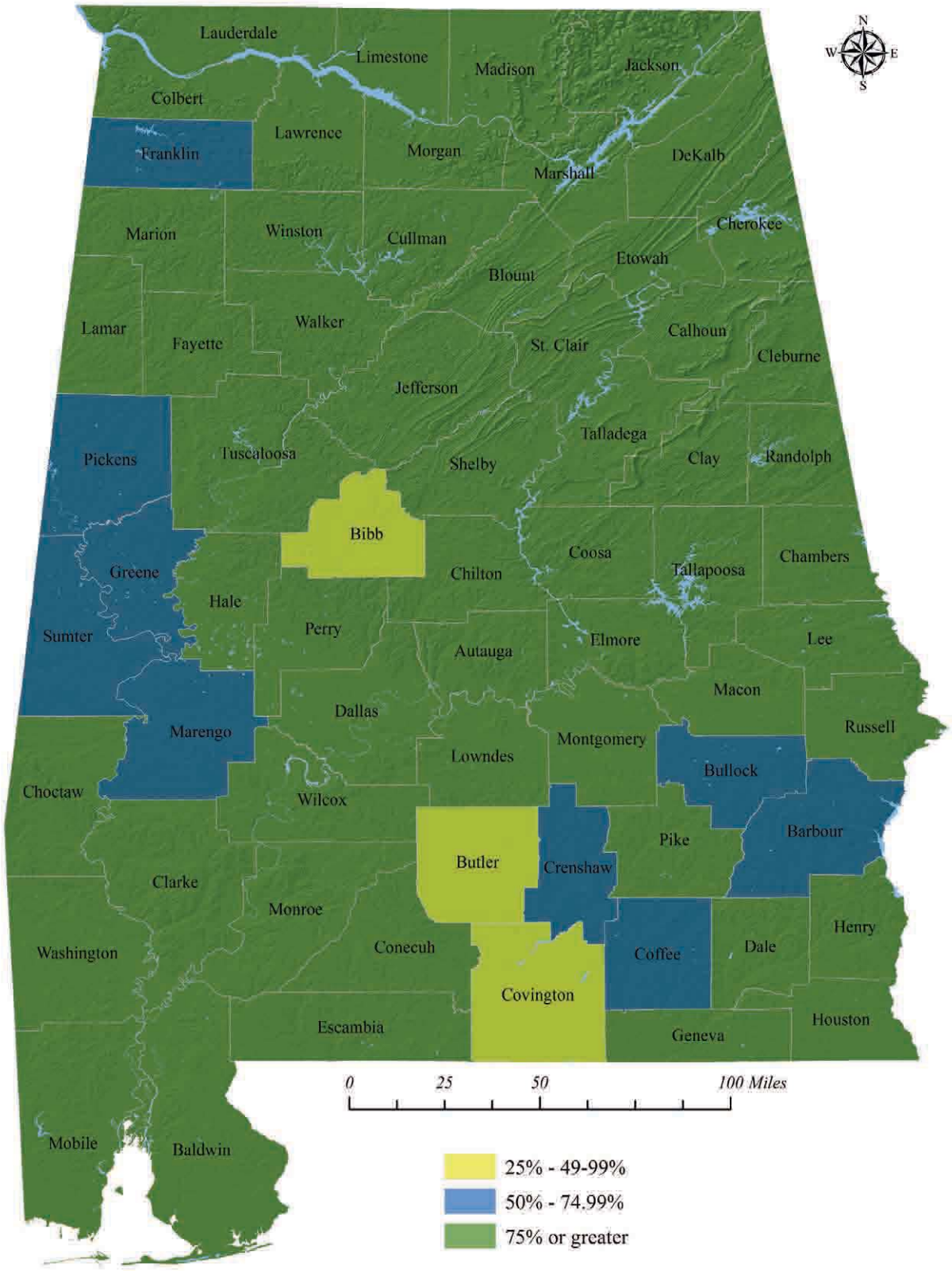
- Of the 4,387 child deaths that occurred during the years 2003 through 2007, those that qualified for review under ACDRS totaled 1,512 (35 percent). The percentage of child deaths that have qualified for review has remained fairly constant over the five-year period.



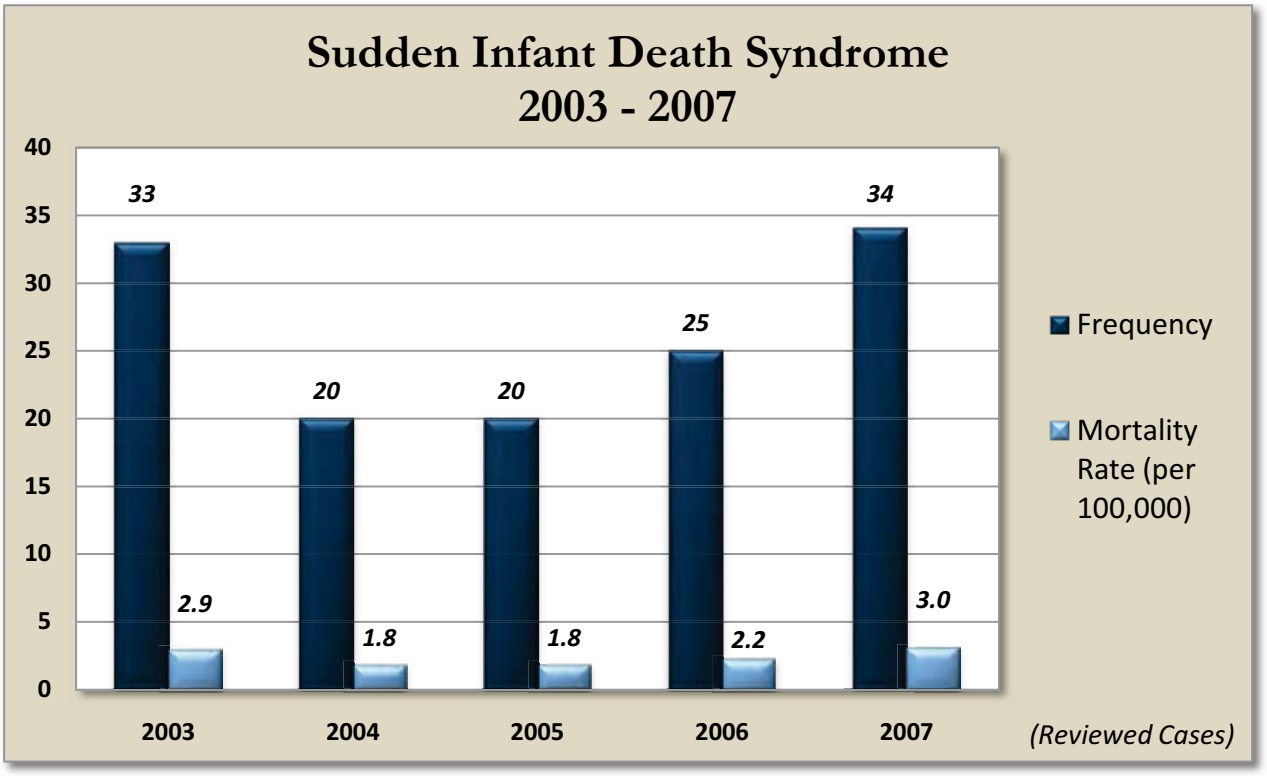
- Of the total number of deaths that qualified for review during the years 2003 through 2007, the Local Child Death Review Teams reviewed and returned 1,408 cases (93.1 percent). The percentage of cases that qualified for review and were in fact reviewed has increased slightly over the five-year period.



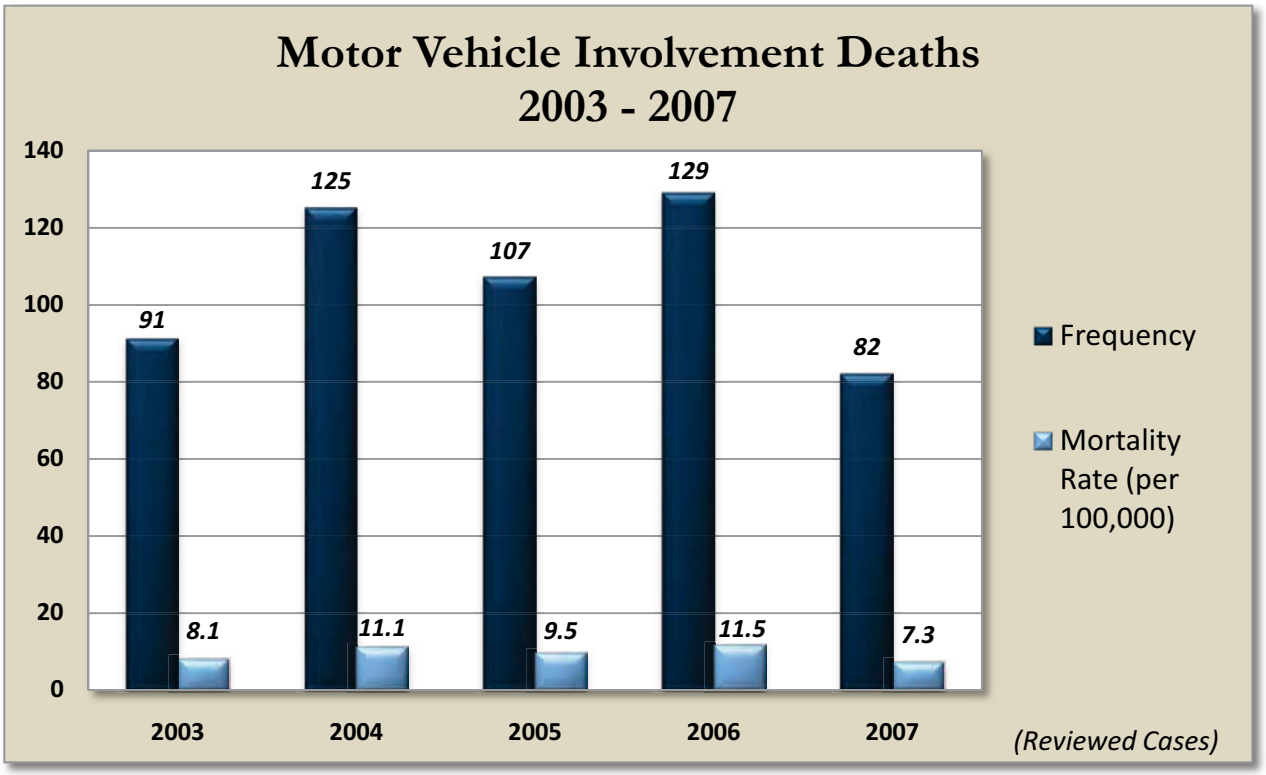
- The map below shows the case return rate of each Local Child Death Review Team for the years 2003 through 2007. While there are areas that can improve on the rate of review, all review teams should be commended for their efforts.



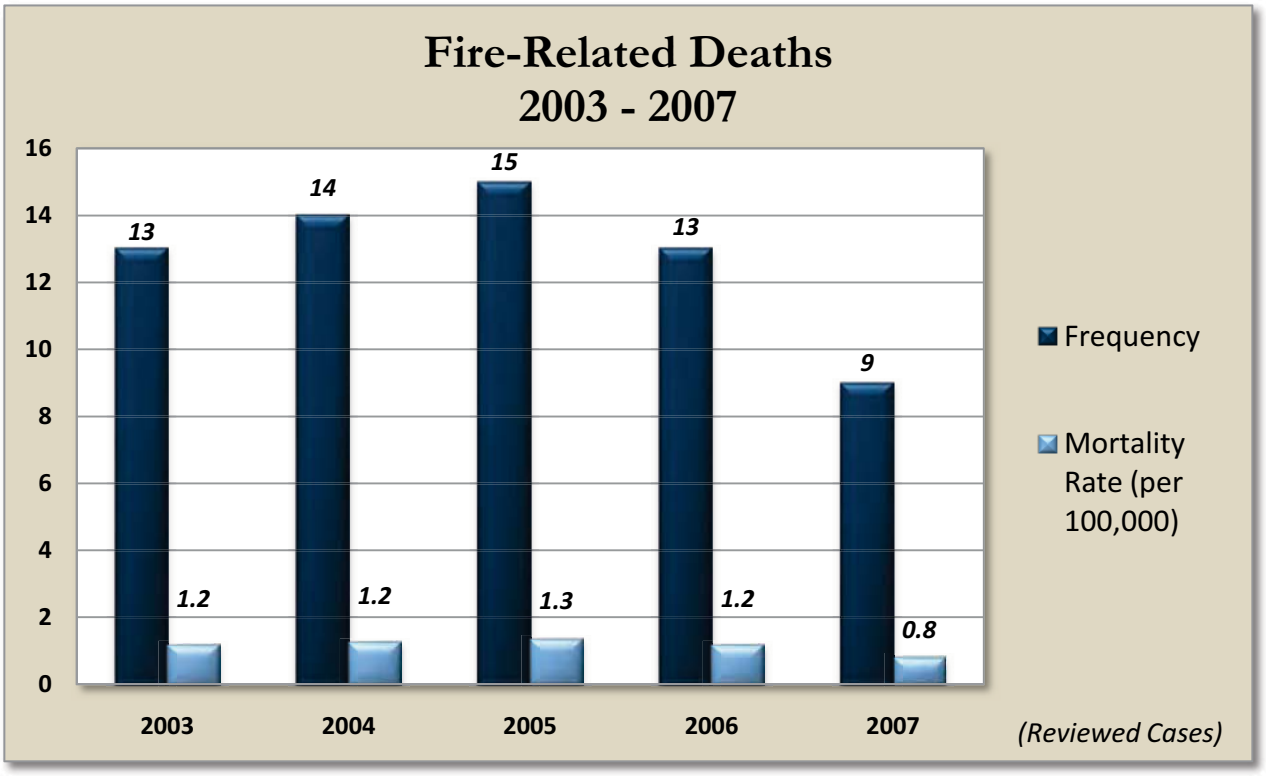
ALABAMA CHILD DEATHS
2003 – 2007



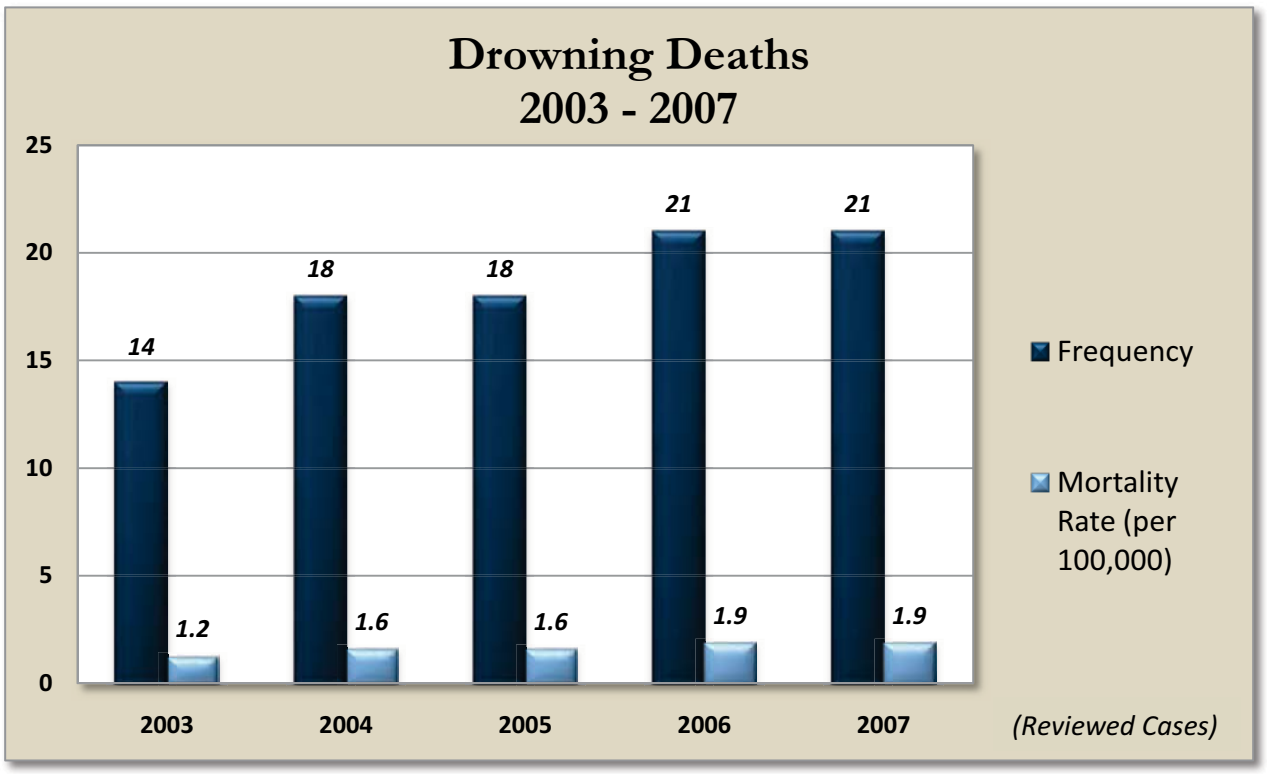
- The Sudden Infant Death Syndrome mortality rates show some variation over the five-year span.



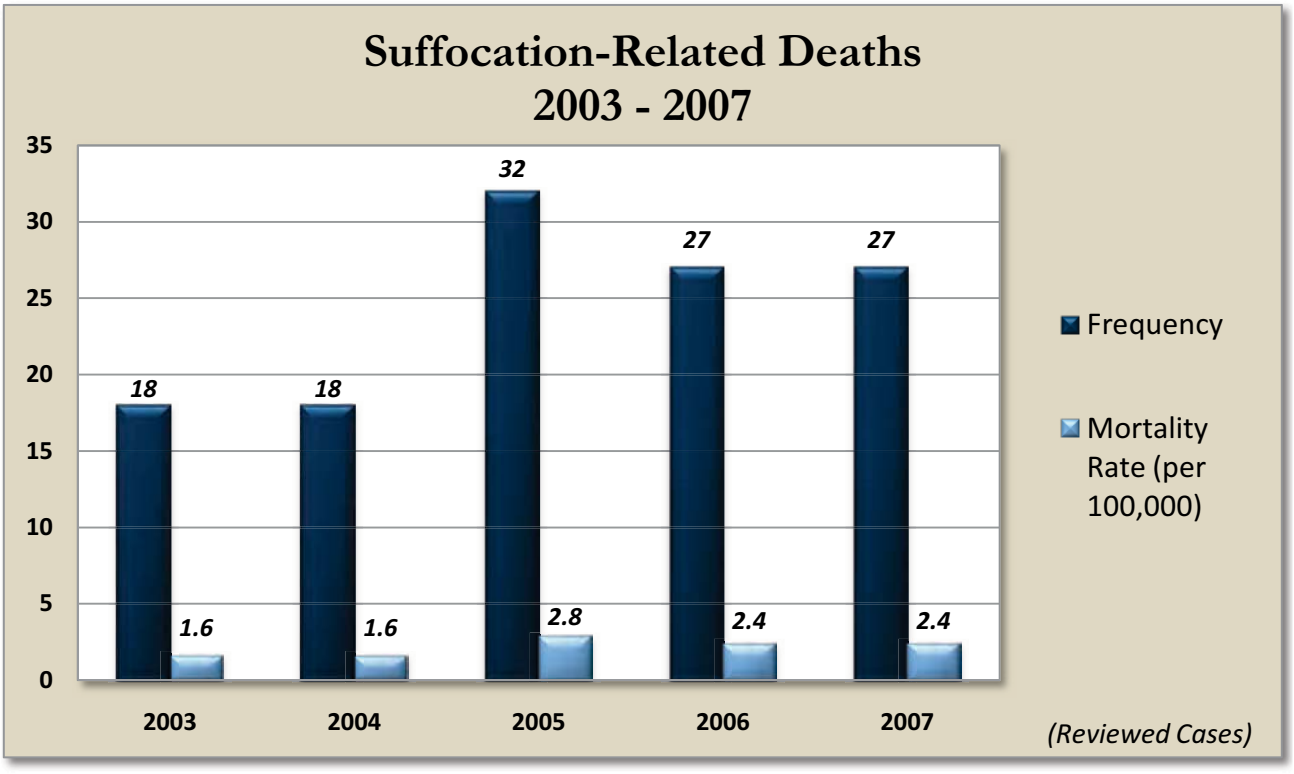
- Of the cases reviewed, the mortality rate has varied slightly over the five-year period.



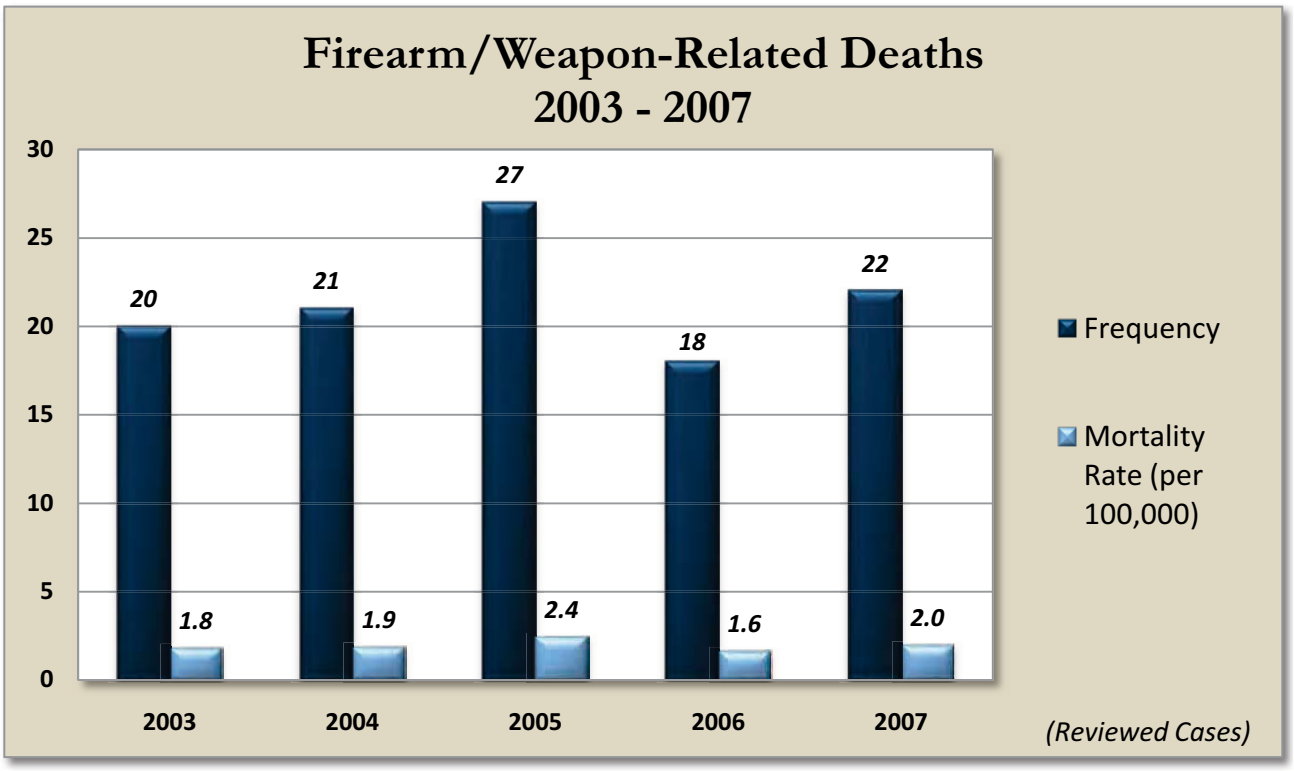
- Fire-related deaths have remained fairly constant for the five-year period.



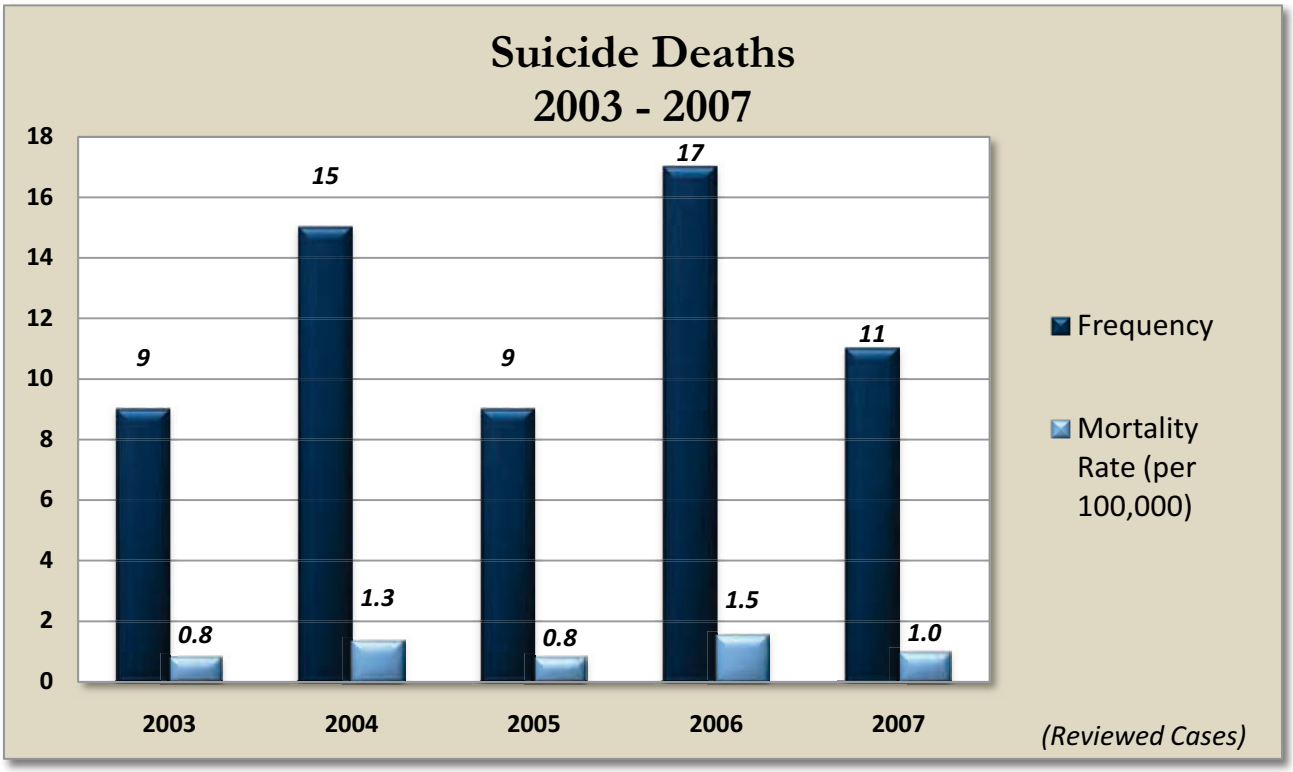
- With the exception of 2003, death rates due to drowning have been fairly constant.



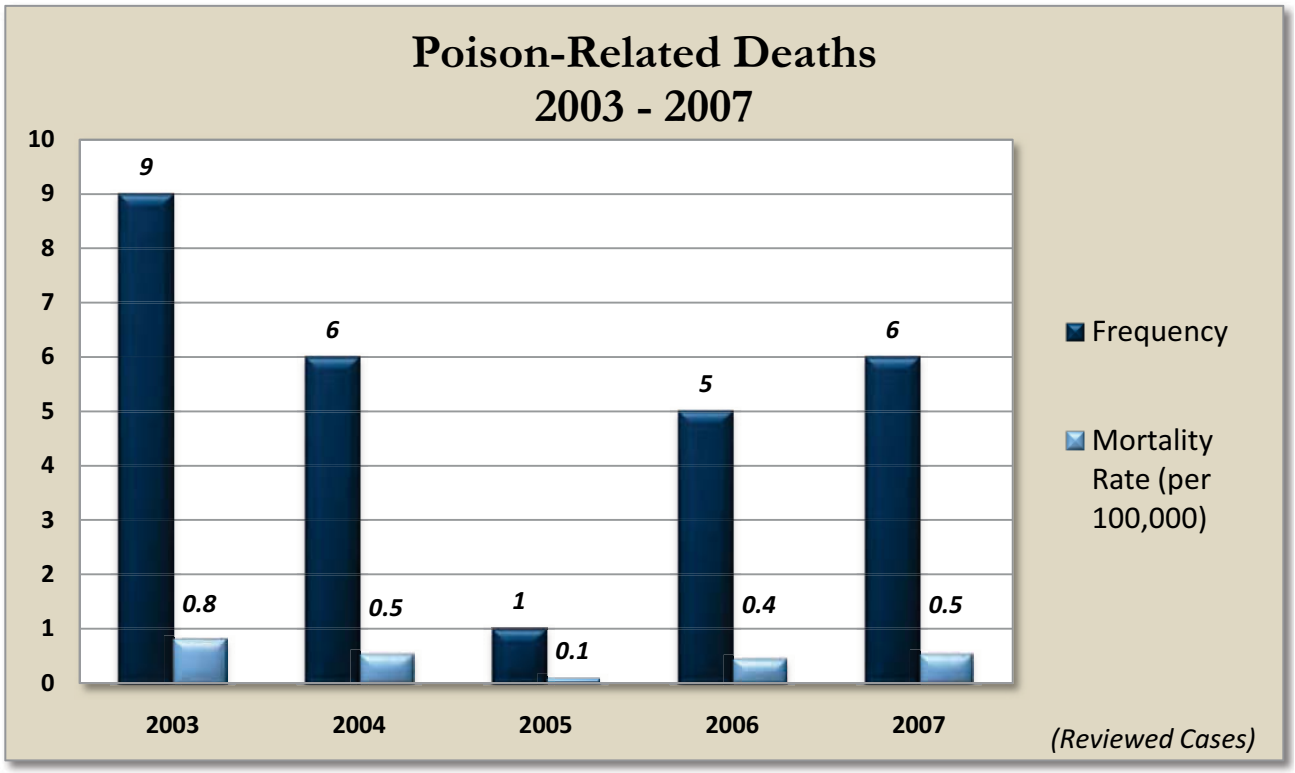
- Suffocation-related deaths show fluctuation over the five years examined.



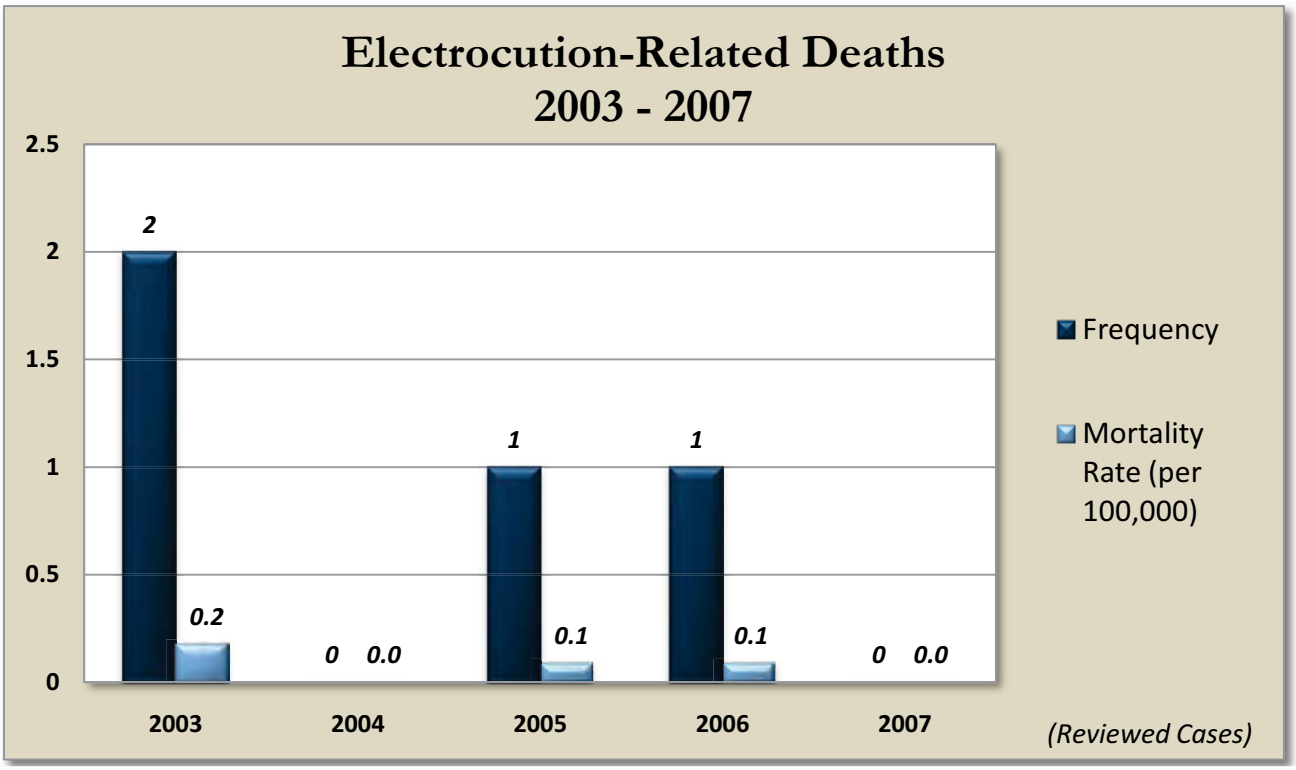
- With the exception of 2005, firearm/weapon-related deaths have been fairly constant.



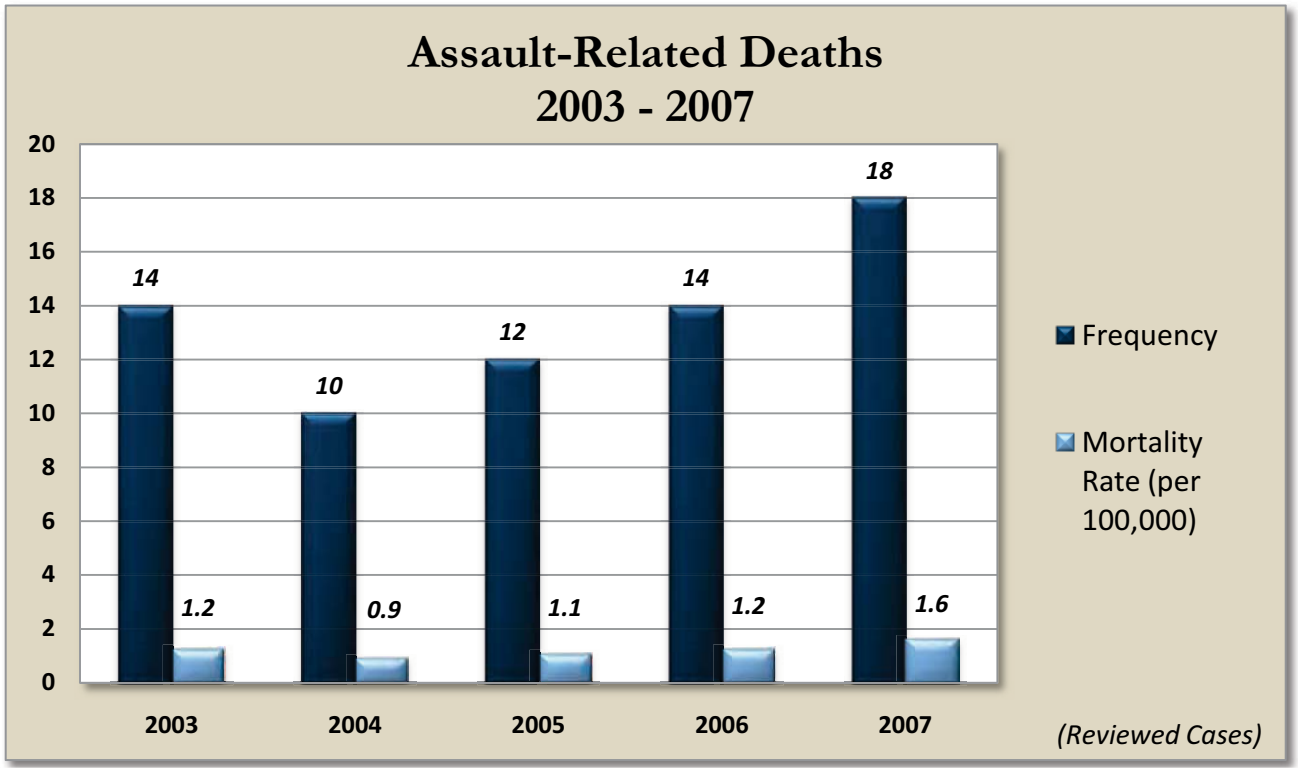
- Suicide deaths show a rise and fall over the five-year period.



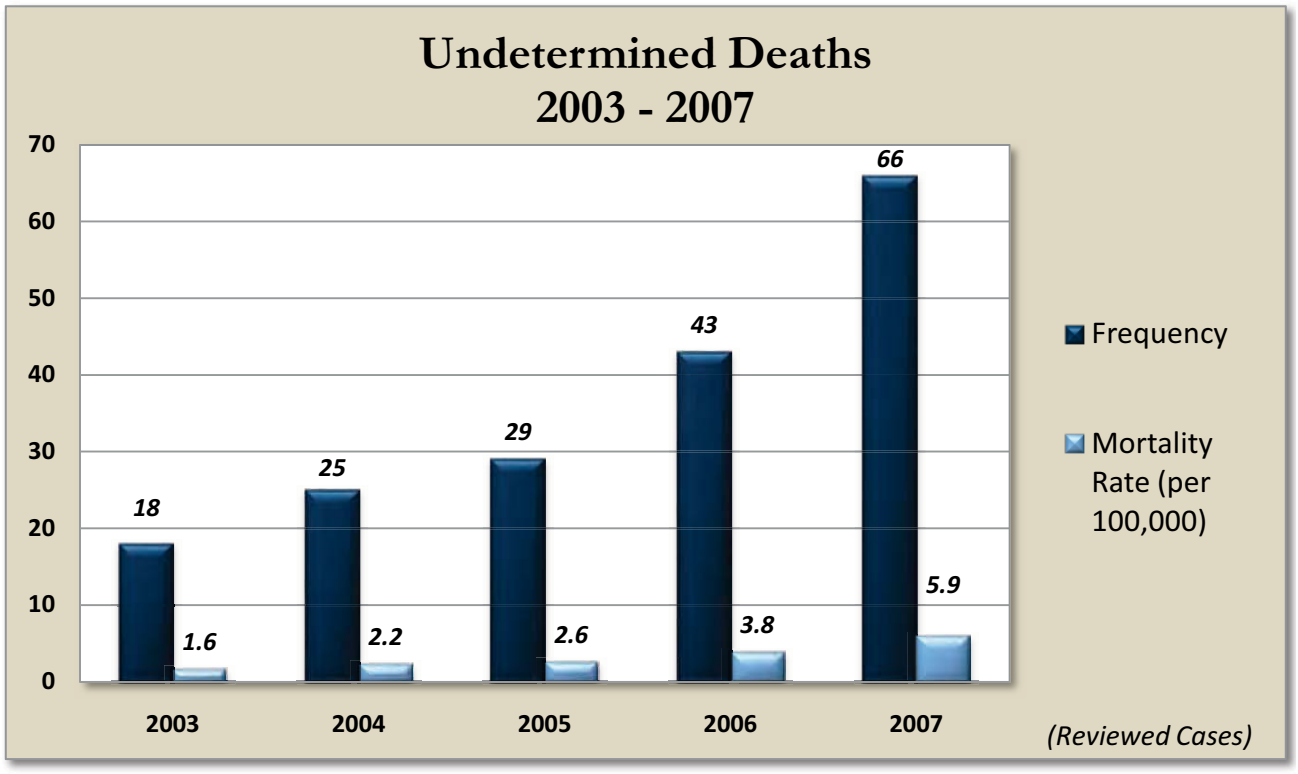
- Poison-related deaths seem to show a decline from 2003 through 2007. However, the numbers are of insufficient size to document a trend.



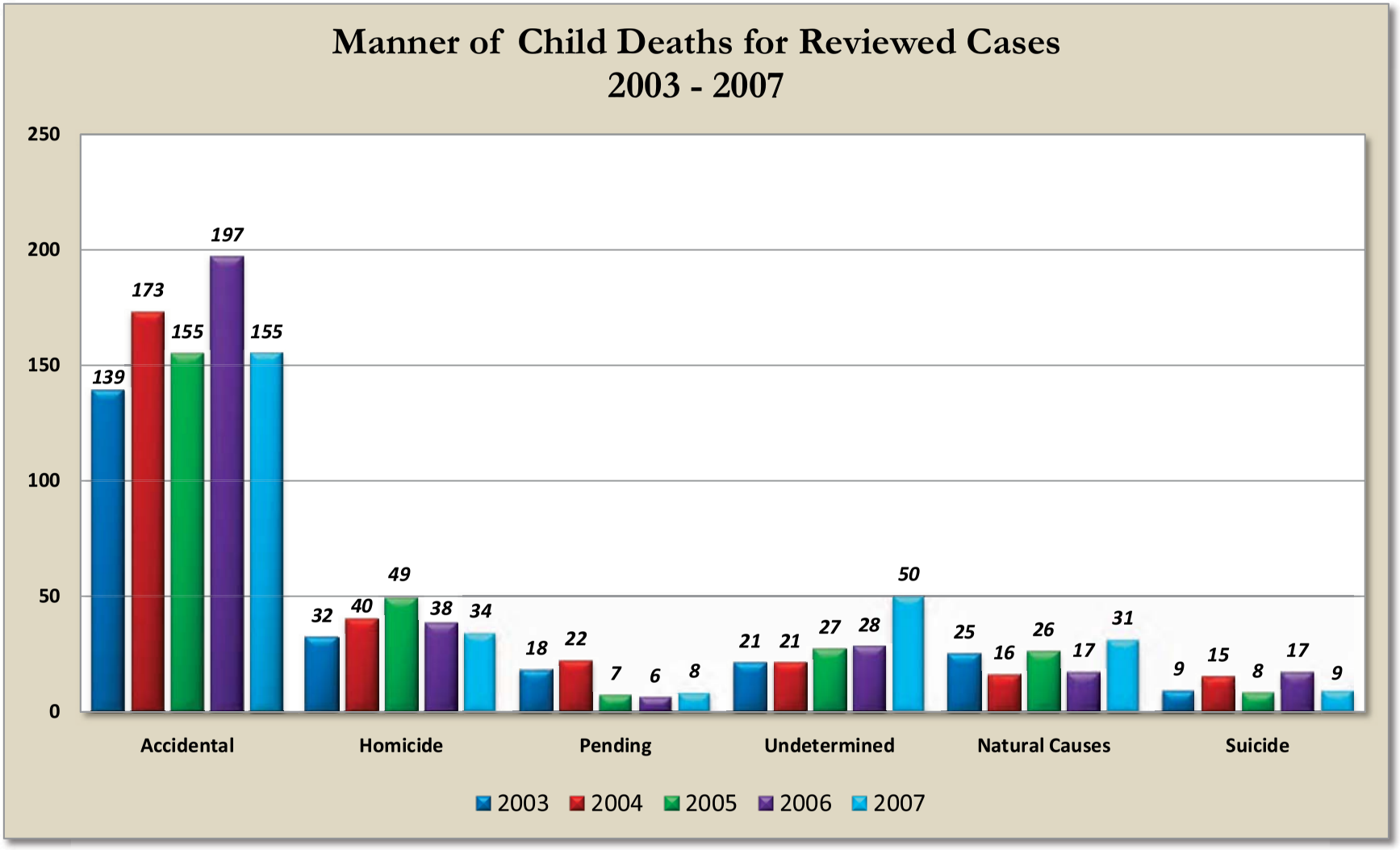
- Electrocution-related deaths appear to be fairly consistent over time.



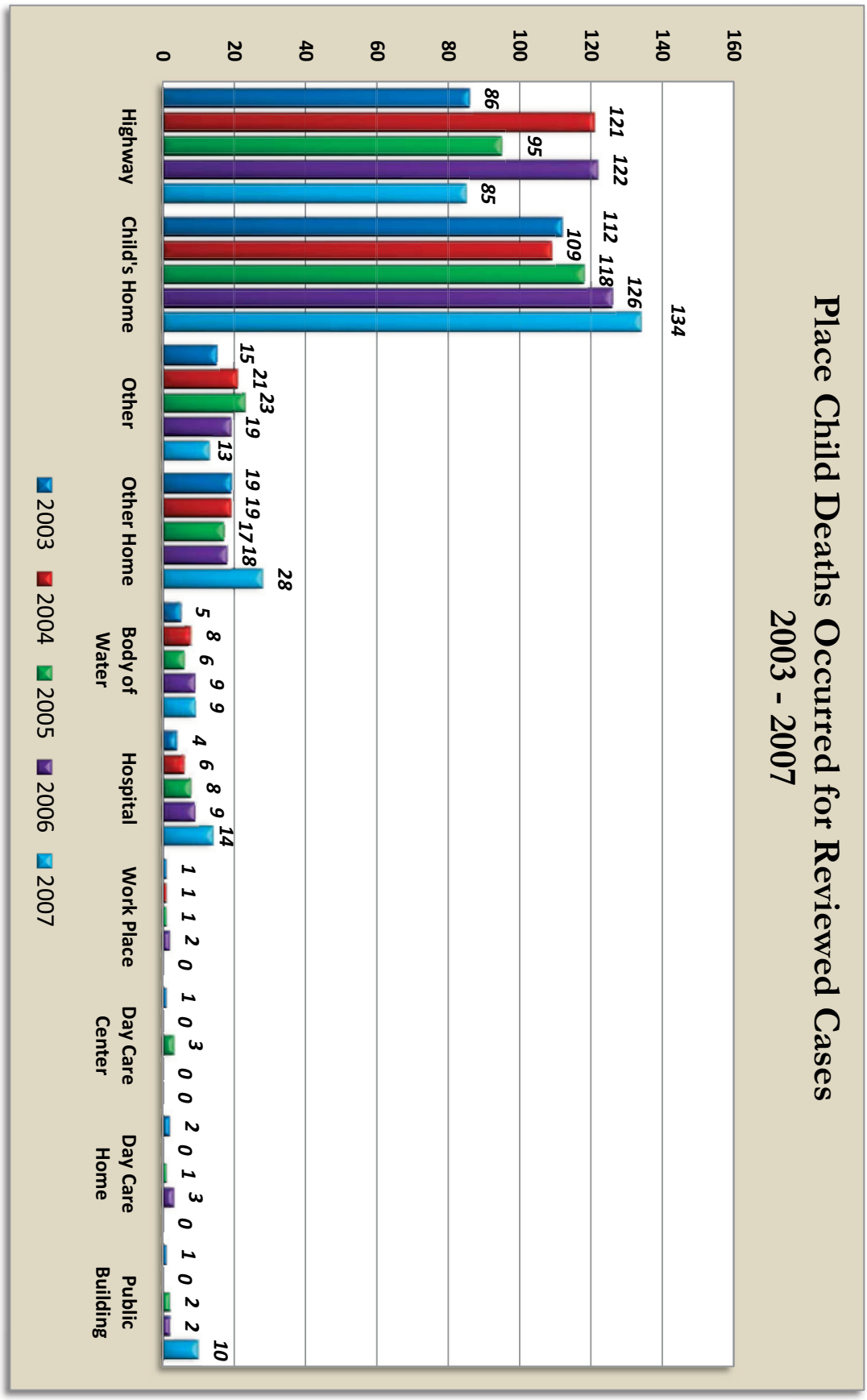
- Child assault-related deaths appear to be somewhat variable. However, the number of cases is of insufficient size to provide strong evidence for any implications.



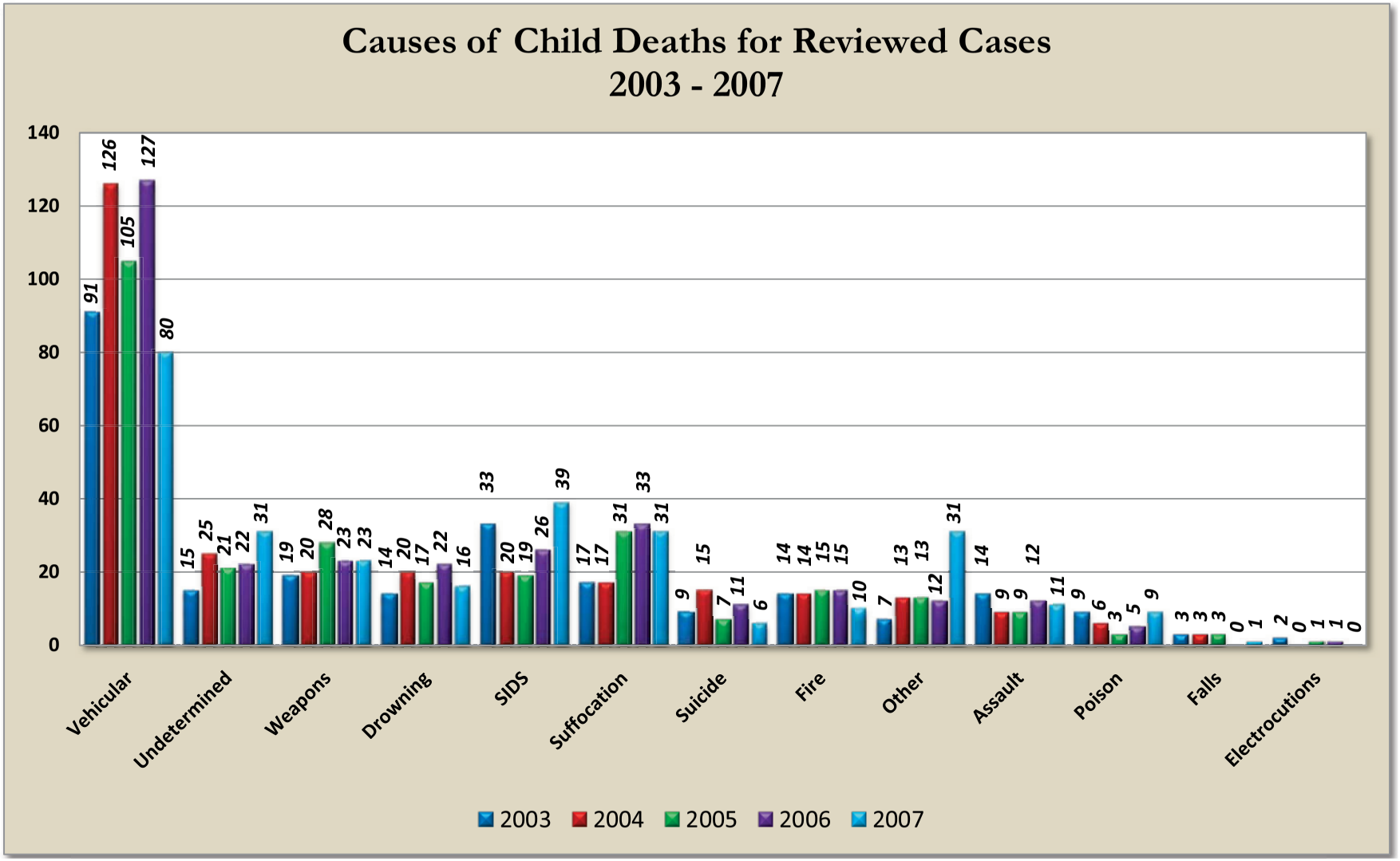
- The number of undetermined deaths from 2003 through 2007 appears to be increasing, although this upward trend is possibly due to reclassification of some child deaths.



- The chart displays some fluctuation by year, although undetermined deaths show a slight increase while natural causes have decreased. This is possibly explained by reclassification of some child-related deaths.



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

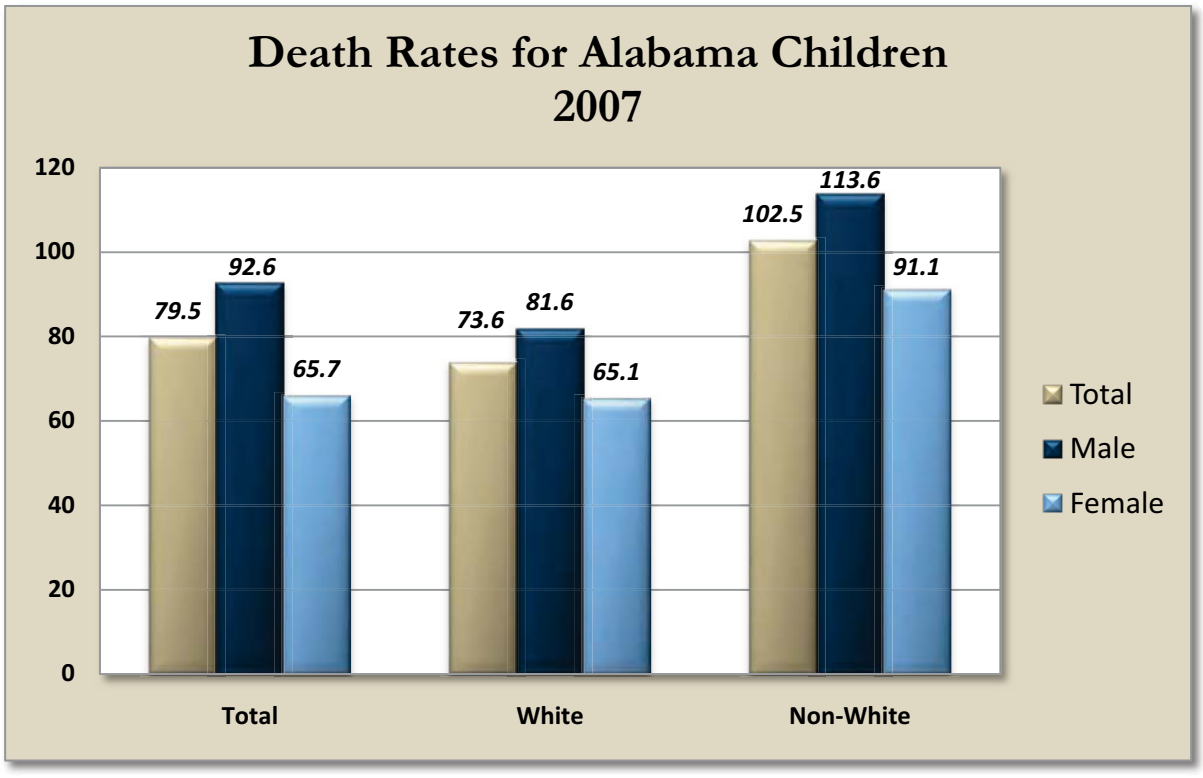


- Vehicular deaths are consistently the leading cause of preventable child death in Alabama. The second leading category is infant sleep-related deaths, which includes all of the SIDS deaths above, most of the undetermined deaths, and many of the suffocation deaths.

KEY FINDINGS

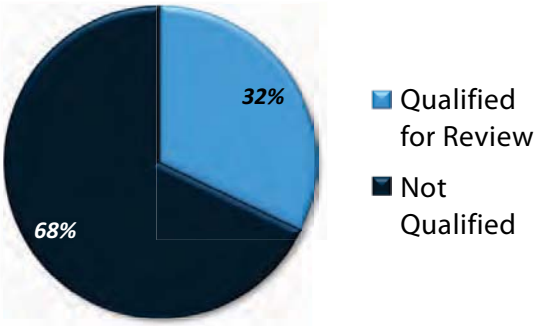
- There were 943 infant and child deaths (those under the age of 18) during 2007.
- The 2007 findings represent approximately 83.9 deaths per 100,000 children.
- Of the deaths, 56.7 percent were male children.
- Of the deaths, 43.6 percent were non-white children.

Below is a graph showing the total race-specific and gender-specific death rates (per 100,000 children) among children in Alabama in 2007. The graph allows for comparison of death rates among specific population groups.

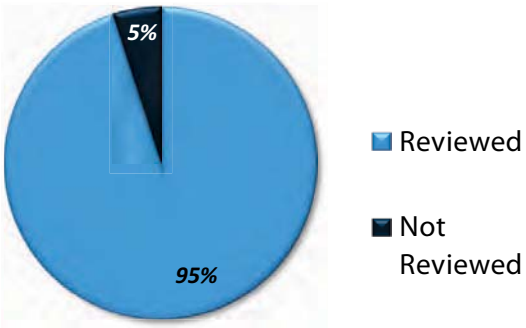


KEY FINDINGS

- As the chart below indicates, of the 943 child deaths in Alabama in 2007, there were 303 deaths that year that qualified for review under ACDRS.



- Of the deaths that qualified for review (303), the Local Child Death Review Teams reviewed and returned 288 reports (see chart below). There was no percentage change from 2006.

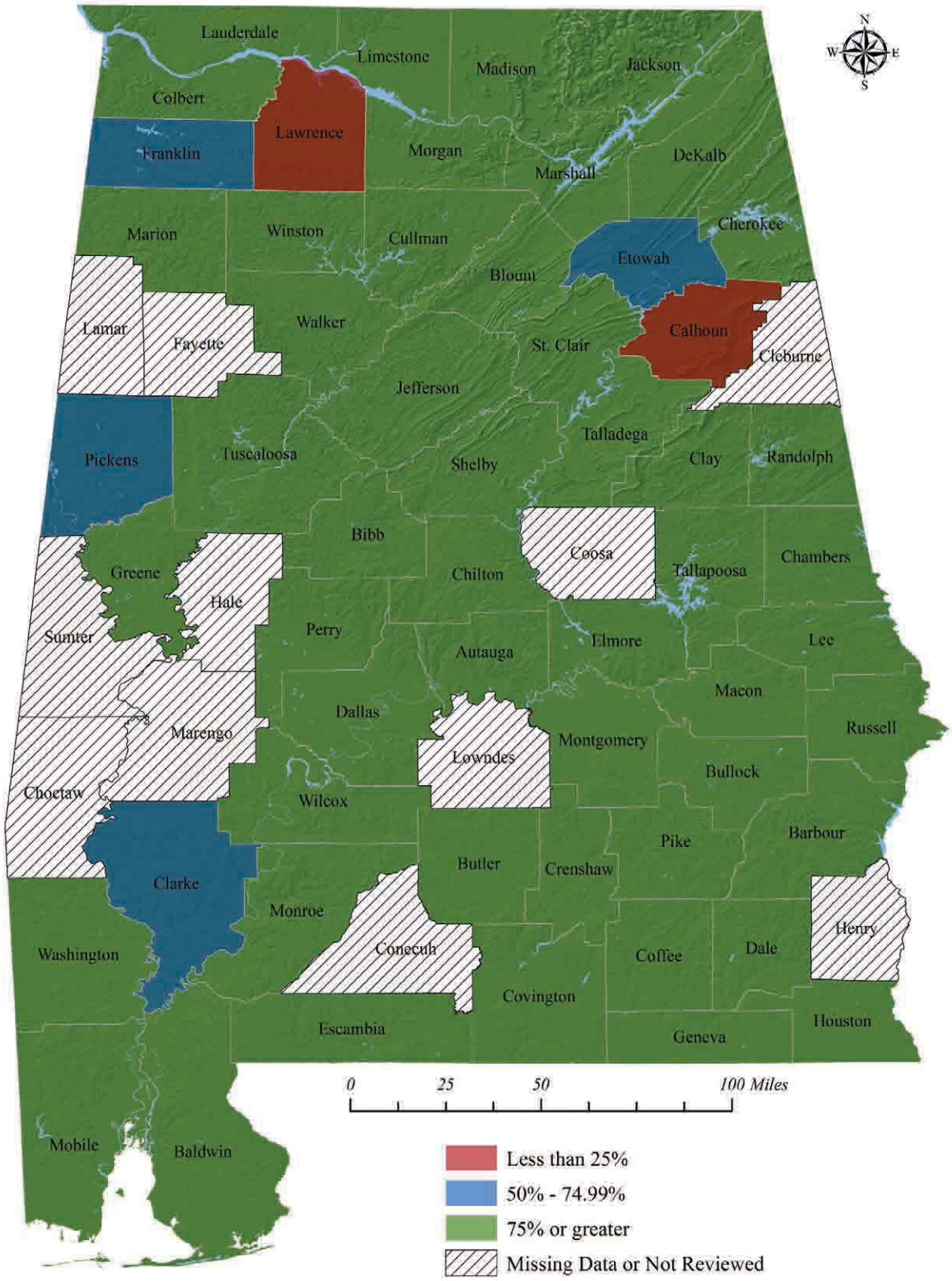


- In 2007, there were no significant race or gender differences in the proportion of cases reviewed compared to those cases not reviewed.

- While proportionately fewer neonates (those less than 28 days old) qualified for review in 2007 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*	*QUALIFIED BUT NOT REVIEWED*
< 28 days	403	14	12	2
28 days – < 1 year	226	103	97	6
1 year – < 5 years	70	33	31	2
5 years – < 10 years	61	24	23	1
10 years – < 16 years	80	46	44	2
16 years – < 18 years	105	83	79	4

- There was a wide variety in the percentage of qualified cases that were reviewed and returned in 2007. The map below indicates the return rate for each Local Child Death Review Team. The goal is a 100 percent return rate.



KEY FINDINGS

- A total of 80 cases were reviewed in 2007.
- Eighteen of these deaths (24.3 percent) involved young drivers (those 16 years to 17 years of age).
- Fourteen of these deaths (18.9 percent) involved underage drivers (those under the age of 16).
- Twelve of the deaths (15.6 percent) were listed as being due to an inexperienced driver.
- Forty-one of these deaths (54 percent) were the result of not using lap and shoulder belts or other appropriate safety restraints. Two deaths (2.6 percent) were the result of restraints not being used correctly.
- Additionally, 46 of these deaths (57.5 percent) were due to reckless driving and/or speeding, with 17 of these deaths (17.5 percent) classified as reckless driving, 16 deaths (18.8 percent) classified as speeding, and 14 deaths (17.5 percent) classified as both reckless driving and speeding.

RECOMMENDATIONS

1. Support further enhancements and improvements to the Alabama Graduated Driver's License Law, Alabama's Child Passenger Restraint Laws, and the enforcement thereof.
2. Promote ACDRS Teen Driver Safety Campaign (brochures, website, etc.).
3. Encourage auto dealerships to provide point-of-sale information resources about proper installation and usage of child safety seats and booster seats when selling new or used vehicles.
4. Promote All-Terrain Vehicle safety and encourage the establishment of safety standards, including a minimum age for operating full-size ATVs.
5. Reinstate and restore full funding for the former Alabama Child Passenger Safety Program.
6. Promote public awareness of the dangers of leaving a child unattended in a vehicle.

DEATHS DUE TO SUDDEN INFANT DEATH SYNDROME – 2007

KEY FINDINGS

- Thirty-nine suspected cases of Sudden Infant Death Syndrome (SIDS) were reviewed in 2007.
- The initial sleeping position of 36 percent of the babies whose deaths were reviewed is not known; however, 21 percent were placed on their stomachs, which is a known risk factor for SIDS.
- Of those cases reviewed, 30 percent of infants were sleeping in adult beds and 31 percent were not sleeping alone. These numbers may not fully represent the situation given our lack of knowledge about the deaths in cases where the position of the infant was unknown.
- Only eight of the reviewed cases involved families that did not smoke.
- Of all cases reviewed, at least six cases (19 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 and promote the use of Alabama's Sudden Unexplained Infant Death Investigation (SUIDI) protocols.
4. Provide increased public education and encourage strict adherence to the American Academy of Pediatrics guidelines for preventing SIDS and reducing risks associated with infant sleeping environment.
5. Ensure that all child deaths in Alabama are reported to the appropriate authorities.
6. Help to ensure that forensic lab capacity is sufficient to meet the needs of the state.

KEY FINDINGS

- Nine cases were reviewed in 2007.
- In one of these cases, (11.1 percent) fire was the result of an appliance in the child's place of residence.
- In eight of the cases (88.9 percent), it was not known whether the residence had a smoke alarm. One case did have a smoke alarm.
- Three cases (37.5 percent) occurred in a mobile home, while one case (12.5 percent) occurred in a brick-frame home and three cases (37.5 percent) occurred in a wood/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. Encourage families to prepare, discuss, and practice a "Home Fire/Emergency Plan" for their households.

DEATHS DUE TO DROWNING – 2007

KEY FINDINGS

- Twenty-one cases were reviewed in 2007.
- Seven of these deaths (36.8 percent) occurred in swimming and/or wading pools.
- Ten of these deaths (52.6 percent) occurred in open water.
- One of these deaths (5.26 percent) occurred in a bath tub.
- Of the 21 drowning deaths, 17 of these deaths (89.5 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 or boating/fishing on open bodies of water.

KEY FINDINGS

- Twenty-six cases were reviewed in 2007.
- At least nine of these deaths (34.6 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.)
- Fifteen of these victims (57.7 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-two cases were reviewed in 2007.
- Nineteen of these deaths (86.4 percent) were the result of firearm use, with 13 deaths (59.1 percent) caused by handgun use, and six deaths (27.3 percent) caused by rifle/shotgun use.
- The vast majority of these deaths, 13 (59.1 percent), were known to be due to an "intent to do harm."
- Six of the deaths (27.3 percent) reviewed in this category were reported to be the result of playing with firearms.
- Three of the 22 children (13.6 percent) were killed by a weapon being handled by a family member.

RECOMMENDATIONS

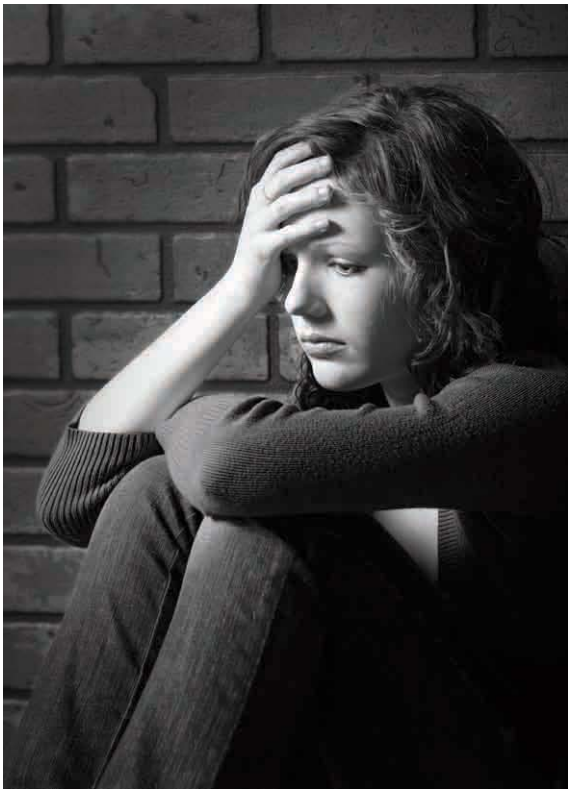
1. Encourage safe and secure storage of firearms.
2. Encourage gun safety education for children and parents.
3. Support crisis team and victim advocacy for children who witness violence.
4. Support after-school and evening education and recreation programs for high-risk youth.
5. Encourage community-based violence prevention programs.

KEY FINDINGS

- Eleven cases were reviewed in 2007.
- Four of these deaths (44.4 percent) were reported as being unexpected.
- Two of these deaths (20 percent) were the result of hanging while seven deaths (70 percent) resulted from the use of firearms.

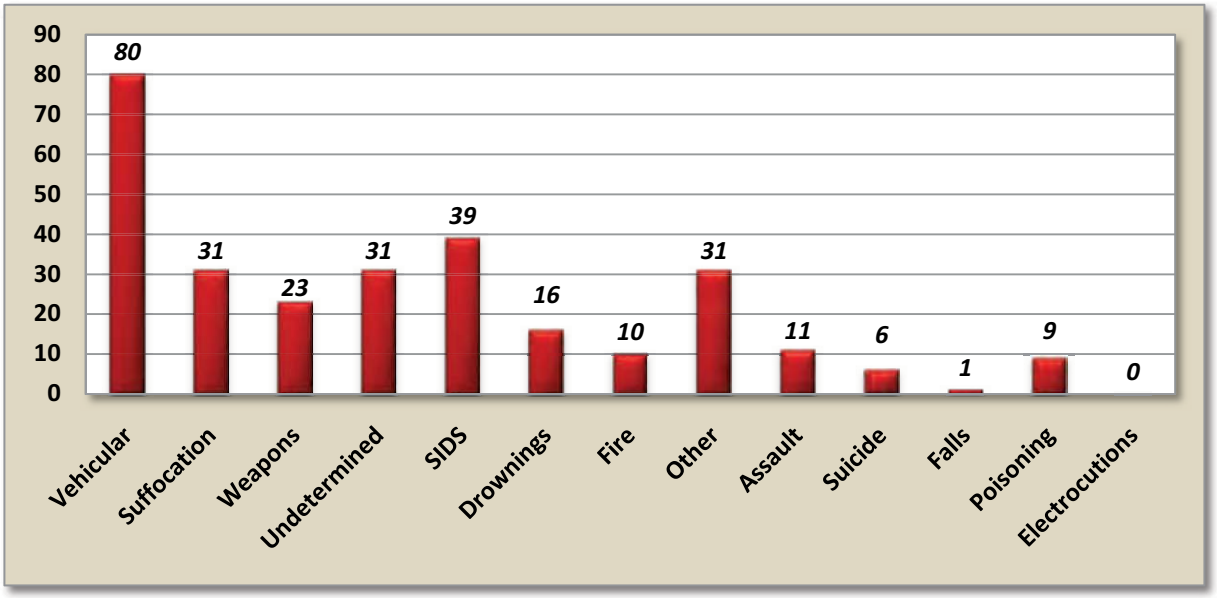
RECOMMENDATIONS

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



REVIEWED CASES ONLY

- Motor vehicle involvement was the most often (27 percent) reviewed cause of child death in 2007.



POISON:

- Six cases were reviewed in 2007.
- Three of these cases were the result of prescription drug use.

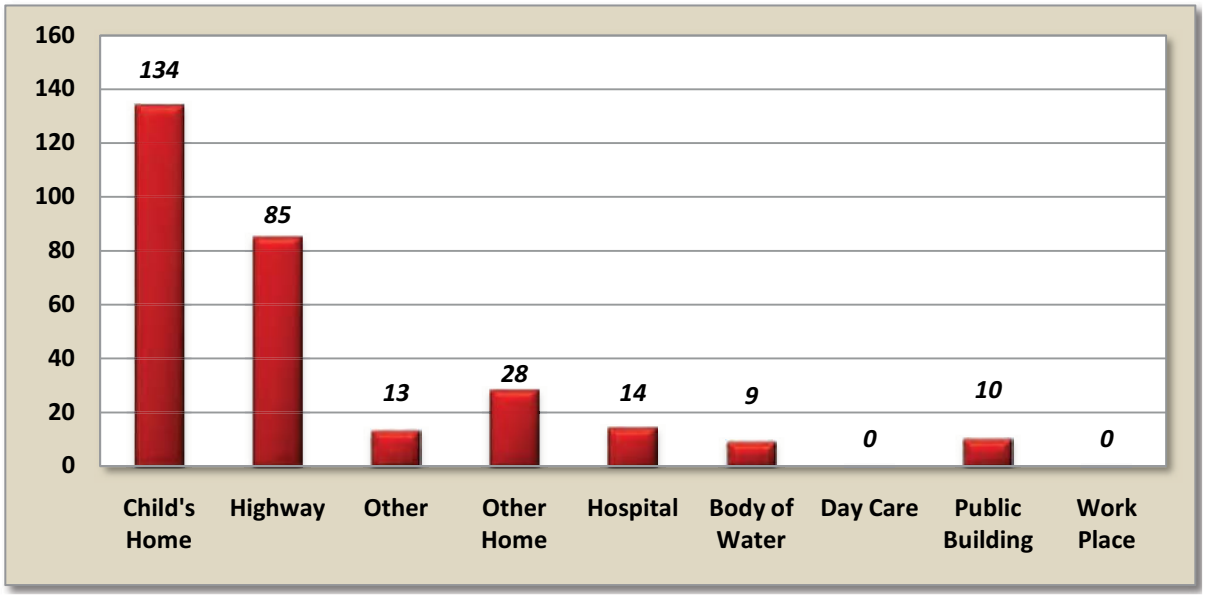
ASSAULT:

- Eighteen cases were reviewed in 2007.
- Of those, four deaths (22.2 percent) were caused by the use of hands and fists.
- Parents were responsible for four (22.2 percent) of the assault deaths.

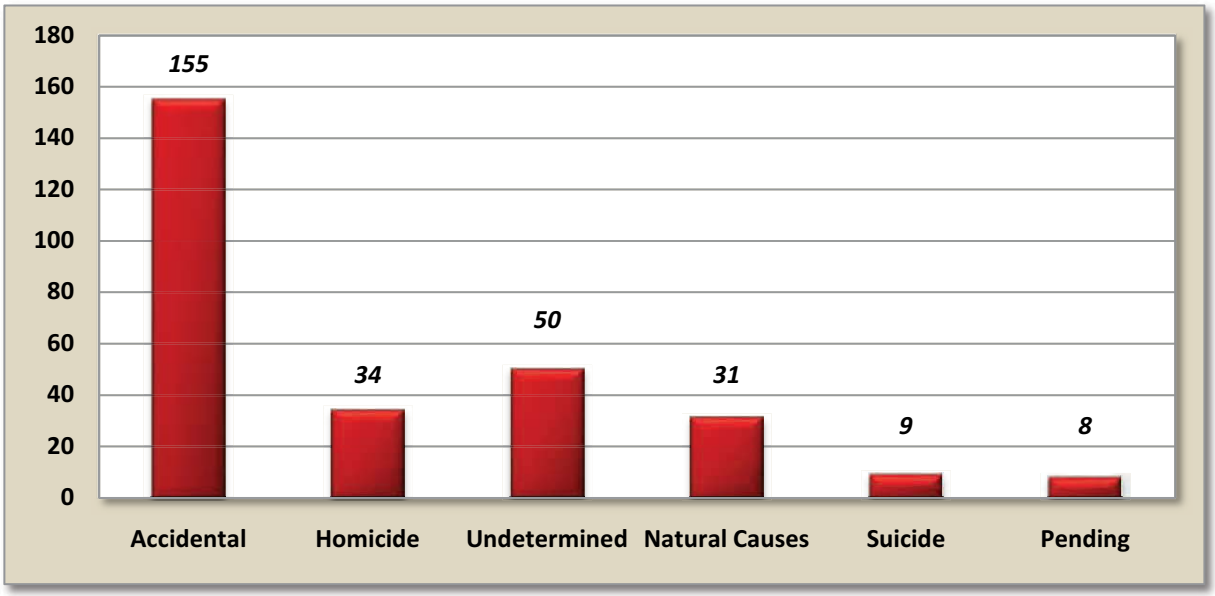
UNDETERMINED:

- Sixty-six cases were reviewed in 2007 in which the cause of death was undetermined.
- In 29 of the cases (43.9 percent), the infant was not sleeping alone.
- In 13 of the cases (19.7 percent), rollover was suspected.
- In 31 of the cases (47 percent), infants were found in an adult bed, an easy chair, or on the floor.

- The child's home was the single most frequent place of death (46 percent) followed by the highway (29 percent).



- Accident was the most frequent manner of death reviewed (53 percent).



ALABAMA CHILD DEATH REVIEW SYSTEM SUCCESSES – 2007

The Alabama Child Death Review System (ACDRS) is a grass-roots program driven by local citizens for the express purpose of protecting 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 injuries and deaths since 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

ACDRS 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. Not only are the teams formed, but they are also meeting and reviewing cases at record rates. ACDRS is happy to report that, as they did the previous year, LCDRTs reviewed greater than 95 percent of all qualifying 2007 cases. We are greatly pleased with the impressive efforts of our Local Teams.

ACDRS Training

In the past, ACDRS has conducted a multi-day Statewide Training Conference every other year, in even-numbered years. For 2010, in consideration of budget and travel restrictions affecting many of our Team members and partners, ACDRS instead conducted a series of six, one-day Regional Training Conferences. The conferences were held in the four corners of the state as well as north-central and south-central locations so that no one would have to travel very far or long and more people could attend.

Teen Driving Safety Campaign

In 2010, ACDRS began a multifaceted campaign to promote teen driving safety. We introduced a new website (www.acdrs.org/teendriving) and a new brochure, Surviving Teen Driving. We also conducted a media campaign to promote both of these new resources. Vehicular deaths continue to be the leading cause of preventable child deaths in Alabama and safe teen driving, along with proper child passenger restraint and all-terrain vehicle (ATV) safety, remain primary issues of concern for ACDRS.

Alabama SUIDI Team

The U.S. Centers for Disease Control and Prevention has established standardized tools and protocols for Sudden Unexplained Infant Death Investigations (SUIDI) that have been adopted nationwide. The ACDRS Director is proud to serve as one of the five members of the Alabama SUIDI Team, which has developed a formal SUIDI training course for Alabama. The Team has established and trained a cadre of trainers who are teaching 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 ACDRS collects regarding infant deaths.

The Infant Vitality Initiative

ACDRS has been a partner in the broad Alabama Infant Vitality initiative. We have collaborated with the Department of Child Abuse Prevention's efforts to establish a Pilot Project in Jefferson County that will bring community partners together to develop a plan to streamline prevention efforts to impact the problem of abuse and neglect in the age 0-3 years population. This project will bring some 20 non-profit agencies, nine area hospitals, public health, mental health, law enforcement, neighborhood associations, local businesses, the faith community, volunteers, colleges and universities, the Mayor's office, the District Attorney's office, and civic organizations together in this effort.

The Alabama Cribs for Kids Program

The Cribs for Kids Program in Alabama began in Montgomery as a pilot program. Cribs, along with personal instruction regarding safe infant sleeping, have been provided to many qualifying families in the Montgomery County area with the help of the Gift of Life Foundation. After the success of the initial program there, Gift of Life and ACDRS expanded the program to other counties in the state. Talladega and Escambia Counties have been added and we hope to expand our efforts with the Cribs for Kids Program to even more Alabama counties in the future. The aforementioned Jefferson County Pilot Project also plans to incorporate a Cribs for Kids component.

Booster Seat Advocacy Program

The Booster Seat Advocacy Program is a joint effort of ACDRS, Children's Hospital Child Safety Institute, the University of Alabama at Birmingham 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.

Vehicular deaths are the leading category of preventable deaths to Alabama children less than 18 years of age reviewed by ACDRS and, in fact, account for approximately half of all such deaths in any given year.

The State Child Death Review Team recommends:

Comprehensive statewide awareness and education campaigns related to teen driver safety and child passenger safety

Enhancements to the current Graduated Driver's License (GDL) Law to include:

Significantly reducing the number of passengers allowed for the GDL driver
Increasing the limitations on late-hour driving under the GDL
Prohibiting the GDL driver from using distracting electronic devices while driving

Enhancements to and stricter enforcement of child passenger restraint laws

Establishment of a minimum age to operate ATVs

Safety training requirements for ATV operators

Prohibition of passengers from open truck beds on public roads

Infant sleep-related deaths are the second-leading category of preventable deaths to Alabama children less than 18 years of age reviewed by ACDRS and are by far the most likely cases to be misdiagnosed as to their manners and causes.

The State Child Death Review Team recommends:

A comprehensive statewide safe infant sleep awareness and education campaign

Support and promote the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team's curriculum and training courses

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

2. **What is the "Mission" of ACDRS?**
   - To understand how and why children die in Alabama in order to prevent future child deaths.

3. **What is the primary focus of ACDRS?**
   - The primary purpose of 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 ACDRS organized?**
   - 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 multidisciplinary 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 ACDRS considers itself a "system."

5. How is 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 ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

6. What does 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 ACDRS operate?

- The ACDRS State Office receives a copy of all death certificates issued in Alabama for decedents less than 18 years of age. Each certificate is reviewed to determine whether it meets ACDRS review criteria. Cases meeting the criteria are then assigned to the appropriate LCDRT on a case-by-case basis.
- The LCDRT reviews the individual cases 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 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 used to answer requests for specific data and to generate reports.
- The SCDRT meets quarterly to discuss 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 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 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 rate by the LCDRTs
- Meaningful research and recommendations
- Increased public awareness and understanding of risks
- Reductions in preventable infant and child deaths in Alabama

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

- An infant or child death occurs on September 1, 2007.
- The death certificate is received at ACDRS State Office by November 1, 2007, barring delays.
- The case is assigned to the appropriate LCDRT by November 15, 2007.
- The LCDRT meets to review this specific case and others during 2008 and/or 2009. (By law, each Local Team is required to meet only once per calendar year and all information necessary to the review process may not be available for several months after the death.)
- The ACDRS State Office receives the last of the 2007 death certificates by July 2008.
- April 1, 2010, is the deadline by which the ACDRS State Office is to receive all 2007 cases that have been reviewed by the LCDRTs.
- The ACDRS Annual Report on 2007 data is completed during 2010.

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Alabama Department of Public Health
Montgomery, Alabama

People generally tend to be resistant to change, and most bureaucratic organizations are even more so. Nevertheless, change is often essential to success and, sometimes, even to survival. In the past couple of years, the Alabama Child Death Review System (ACDRS) has experienced more than its share of changes but fortunately, along with the corresponding challenges, we have enjoyed many opportunities to improve and excel.

It is rare that any organization experiences a complete turnover in full-time staff in a single year, but that is exactly what happened to ACDRS three years ago. But with new people came new ideas and fresh perspectives. In many ways, that drastic change freed the new staff and our strategic partners to try new approaches to long-standing issues. Knowing that "different" does not always mean "better," we strove not to change anything just for the sake of change, but rather to seek out evidence-based approaches with the greatest potential for effectiveness, whether they had been tried here before or not.

In 2008, I was honored to become one of the five members of the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team. We developed an Alabama-specific curriculum based upon the U.S. Centers for Disease Control and Prevention's SUIDI protocols, and then trained a group of instructors to provide the class to first-responders across the state. The purpose of the class is to train first-responders in knowledge and techniques specific to infant death scenes so that investigations of such will be improved and death diagnoses will be more accurate. The classes have been well-received and are still being taught by request on a regular basis.

Finally, as I write this, we are in the process of the most significant operational transition that ACDRS has experienced. For years, we have used a proprietary data collection system of our own creation, a cutting-edge system when introduced but limited in its ability to keep up with the tremendous technological advances of recent years. Having just retired that old system for good, we have adopted a new nationwide Child Death Review data collection system now in use by a majority of the states. A fully secure and interactive web-based system, it will be flexible enough to grow and evolve with the programs it serves. It also has the added advantage of being completely cost-free to us, thanks to an agreement with the National MCH Center for Child Death Review. ACDRS contributors at all levels have been trained on the new system and are using it today.

So, for ACDRS, as with life in general, changes have brought challenges and challenges have offered up new opportunities. And we faced those unique changes above while experiencing the common challenges faced by all agencies and programs these days with regard to budgets and the economy, demographic shifts, and governmental reforms. With an eye ever toward our mission to protect Alabama's children, we have tried to rise to each challenge and seize those promising opportunities. Our hope is to continue to do so. May we never do something simply because "that's how it's always been done."

Aretha D. Bracy, Assistant Director
Alabama Child Death Review System
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Montgomery, Alabama

Many of the terms and definitions used in the work of the Alabama Child Death Review System have recently changed. Here are some of the changes:

Co-Sleeping versus Bed Sharing

The American Academy of Pediatrics (AAP) actually recommends the practice of co-sleeping although the AAP makes a clear distinction between co-sleeping and bed sharing. The AAP does not recommend bed sharing for an infant. Co-sleeping describes a situation where an infant or child sleeps in the same room or in close proximity of the parent(s) or caregiver(s). This can be arranged by having a safe crib, bassinet, infant co-sleeper, firm mattress, or child's bed that is used exclusively for the child to sleep in alone. Bed sharing occurs when an infant or child shares a single, physical sleep surface (bed, couch, or other sleeping surface) with a parent or larger sibling. Through the findings of Alabama's Local Child Death Review Teams, the data supports the dangers of having an infant share the same sleep surface.

Sudden Unexplained Infant Death (SUID) versus Sudden Infant Death Syndrome (SIDS)

Sudden Unexplained Infant Death (SUID) is the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation. SUID is due to a variety of natural and unnatural causes and can be the result of metabolic disorders, hypothermia or hyperthermia, neglect or homicide, poisoning, or accidental suffocation. Sudden infant death syndrome (SIDS) is the sudden death of an infant greater than one month but less than one year of age that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history. A SIDS diagnosis should not be assigned if the infant was discovered on his or her back and not sleeping alone on an approved sleep surface.

Abusive Head Injury/Trauma versus Shaken Baby Syndrome

The AAP recommends that the term Abusive Head Trauma be used instead of Shaken Baby Syndrome. Since the AAP issued a formal policy statement regarding Abusive Head Trauma in Children, ACDRS has already seen changes in terminology in practical use, and this term is more universally accepted and understood. Clearly, the public has been made very familiar with the term Shaken Baby Syndrome by years of outreach and education efforts on the subject, and the term will likely continue to be used in such efforts for that very reason. However, in professional forensic and fatality review circles, Shaken Baby Syndrome has already been replaced in clinical use by Abusive Head Trauma.

MOTOR VEHICLE ACCIDENTS AND TEENAGERS

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In the United States and in Alabama, more teenagers die as the result of motor vehicle accidents than from any other cause. More teenagers die in motor vehicle accidents (MVAs) than any other age group. Nationwide, about 5,500 teenagers lose their lives in MVAs every year. In Alabama each year, we lose about one hundred teenagers to car wrecks. In recent years, Alabama has ranked among those states with particularly high numbers of teenage driver-related fatalities, as high as No. 2 in 2006.

Research points to a number of critical factors that seem to be contributing to these fatal accidents. Teenagers are new drivers, 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 an accident. 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 seat belts. In addition, teenagers are shown by research to be chronically sleep-deprived, and they 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 new crop of teenagers appear 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. The matter of distracted driving among teenagers and among all of us is finally beginning to get the kind of attention the problem deserves.

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 these 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 potential victims if there is a MVA.

Alabama does not have to lose, as it now does, a hundred or more teenagers annually in car accidents. In 2010, the Alabama Legislature passed a law strengthening restrictions on the youngest teen drivers, addressing many of the concerns discussed above. The Alabama Child Death Review System has developed a set of educational materials directed at both teenage drivers and their parents to raise awareness of the terrible risks of car crashes and to provide concrete tools and suggestions for reducing that risk. A new teen driving website is, as I write this, being unveiled by the Alabama Department of Public Health. These are hopeful signs.

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The loss of a baby during pregnancy or in early infancy can be devastating and life changing. A deep sense of grief and loss may be experienced and is not necessarily related to the length of the pregnancy or the age of the infant. Approximately 1,100 fetal and infant deaths occur in Alabama in a year. The Alabama Department of Public Health implemented the Fetal and Infant Mortality Review (FIMR) Program statewide in January 2009 as a strategy to address infant morbidity and mortality.

FIMR is a national program that was established in 1990 through collaboration of the federal Maternal and Child Health Bureau and the American College of Obstetricians and Gynecologists. The goal of FIMR is to identify significant social, economic, cultural, safety, health, and systems factors that contribute to mortality, and to design and implement community-based action plans based on information obtained from the reviews. Currently, there are 15 statewide programs as well as 220 community programs in more than 40 states across the nation.

After a fetal or infant death occurs, the FIMR process begins. The FIMR Program receives fetal death reports, birth certificates, and death certificates from the state's Center for Health Statistics. The State Perinatal Program regional directors collect data from a variety of sources, including physician and hospital records, WIC, and other social services, about the death and the services the woman and her family received. The mother is contacted and asked to participate in a maternal interview. If the mother agrees, an interview is conducted. Confidentiality of all information is strictly maintained, which means that names of the mother, provider, and institution are removed. The collected information is summarized and the case summary is presented to the Case Review Team (CRT). This team is a multi-disciplinary team consisting of a broad range of professional organizations and public and private agencies that provides services and resources for women, infants, and families. The Regional Perinatal Councils serve as the CRTs for each region.

Findings and recommendations of the CRT are presented to the Community Action Team (CAT). CATs review CRT recommendations, prioritize identified issues, then design and implement interventions to improve service systems and resources. CATs take the recommendations, develop an action plan, and implement the actions in the community. CATs consist of members who are in a position to direct change at the community level. CATs have been established in Baldwin, Calhoun/Cleburne/Talladega, Jefferson, Madison, Mobile, Montgomery, and Tuscaloosa counties.

We could not accomplish our goals without the members of the State Perinatal Advisory Council, Regional Perinatal Advisory Councils, CRTs, and CATs volunteering their time and expertise.

- **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 (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). 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 (SIDS) 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 that identifies 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 1 month to 1 year old 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 deaths from a variety of both internal and external causes.
- **Unexpected/Unexplained –** In referring to a child's death, this category includes all deaths that, 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 2011

- **January 20** – State Team Meeting
- **March 20-26** – National Poison Prevention Week
- **April** – National Child Abuse Prevention Month
- **April 1** – Deadline for submission of all calendar year 2008 case reviews
- **April 21** – State Team Meeting
- **July 21** – State Team Meeting
- **September** – National Infant Mortality Awareness Month
- **September 4-10** – National Suicide Prevention Week
- **October –** National SIDS Awareness Month
- **October 9-15** – National Fire Prevention Week
- **October 20** – State Team Meeting

...We are all part of the solution

ADPH

Alabama Department of Public Health