Alabama Child Death Review System
2013 Report

Learning from the Past to Protect the Future

ACDRS
ALABAMA CHILD DEATH REVIEW SYSTEM

ALABAMA PUBLIC HEALTH

Deaths Among Children in Alabama
Alabama Child Death Review System

Annual Report – 2013 Data

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This report is based on the most recent data available as of the end of 2017.

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Message from the Chairman

A 1997 Alabama law created the Alabama Child Death Review System (ACDRS), a prevention program within the Alabama Department of Public Health (ADPH). The mission of the ACDRS is to understand how, where, and why children die in Alabama in order to prevent similar deaths in the future.

Twenty years ago, the multidisciplinary methodology employed by child death review (CDR) began with the systematic investigation of child abuse and neglect and is now employed to review a much broader scope of deaths. ACDRS reviews the circumstances and underlying factors of all unexpected/unexplained infant and child deaths in Alabama. The de-identified findings of these reviews and their subsequent recommendations, such as the findings in this report, are reported to state officials, state agencies, and the general public in an effort to prevent the loss of another child.

Measurable improvements can be attributed to the involvement of ACDRS in successful outreach, awareness, and policy efforts statewide. Over the years, CDR findings and recommendations have informed the legislative process and have influenced the introduction and passage of several child injury and fatality prevention laws. Local team reviews and recommendations have reduced the dangers found within Alabama's roadways, homes, and neighborhoods.

While we celebrate the accomplishments and the huge differences this program has made in the lives of Alabama's children, our prevention efforts must continue. Vehicular deaths are still the leading category of preventable child deaths in our state, with infant sleep-related deaths continuing as a close second. Progress has been made to reduce these deaths, but we must never relax our efforts. The results of the other major child death categories, such as fires, poisoning, and drowning deaths, remain a challenge.

The ACDRS relies on the state and local review teams, our strategic partners, and the public to promote the mission of this program in its attempts to reduce child deaths through awareness, education, and prevention efforts.

As we celebrate our 20-year anniversary, and as you read this report, we hope that you will notice the improvements we have made, be encouraged by our progress, and be challenged to join us in our efforts to promote this program's mission!

INTRODUCTION

ALABAMA CHILD DEATHS

This report examines unexpected and unexplained[1] child deaths in Alabama for the 2013 year.

There were 694 infant and child deaths in the state of Alabama in 2013. Each of these deaths is a tragedy, especially for the family and friends of the children lost. However, each death also serves as a powerful warning that other children remain at risk. To better understand how and why children die, the state tasks ACDRS with the following responsibilities: 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 help reduce the risk and incidence of future unexpected or unexplained deaths in Alabama.

With this report, ACDRS seeks to honor the memory of all the children who have died in Alabama. The hope is that these efforts will lead to a better understanding of how Alabama can be a safer, healthier place for children.

THE ALABAMA CHILD DEATH REVIEW SYSTEM

All 50 states in the United States participate in an annual CDR. On September 11, 1997, the state of Alabama created the ACDRS state office and the local and state CDR teams.

ACDRS is a prevention program, driven largely by state and local review teams, with the express purpose of protecting the lives of as many of Alabama's infants and children as possible. ACDRS is tasked to review, evaluate, and help prevent cases of unexpected or unexplained child deaths in Alabama.

ACDRS is responsible for the following:

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

ACDRS is a system comprised of three major components: the ACDRS state office, SCDRT, and LCDRTs.

Located in ADPH, within the Behavioral Health Division of the Bureau of Prevention, Promotion, and Support, the ACDRS state office has three full-time staff members: Director, Administrative Support Assistant, and Public Health Educator.

Mission

The ACDRS mission is to understand how and why children die in order to prevent future child deaths.

Focus

The primary purpose of ACDRS is to promote prevention, not prosecution. Preventability refers to the ability of an individual or community to alter the conditions that led to a child's death, thereby preventing the child's death or reducing the likelihood of future deaths.

ACDRS achieves the prevention of child deaths through statistical analysis, education and advocacy efforts, and local community involvement.

Goals

ACDRS works toward the following 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.
- Reduction in preventable infant and child deaths in Alabama.

Funding

ACDRS funding originates from Alabama's portion of the National Tobacco Settlement (NTS), through the Children First Trust Fund (CFTF). The sum of the funding equals 1 percent of the total CFTF portion of NTS, but is not to exceed $300,000.

The Alabama Medicaid Agency also provides supplemental funding to ACDRS through a reimbursement agreement. These funds are used solely for education and outreach efforts.

[1] *In this report, unexpected or unexplained refers to all deaths that, prior to investigation, appear to be possibly caused by trauma, suspicious or obscure circumstances, child abuse or neglect, other agents, or Sudden Unexplained Infant Death (SUID).*

CHILD DEATH REVIEW TEAMS

STATE CHILD DEATH REVIEW TEAM (SCDRT)

The SCDRT is a 28-member, multidisciplinary team, chaired by the State Health Officer (Director of ADPH). SCDRT members include various state agency directors and representatives, medical professionals, judicial and law enforcement officials, state legislators, and private citizens appointed by the Governor.

The SCDRT serves as an advisory board with quarterly meetings to review findings and recommendations.

SCDRT MEMBERS

(Serving during 2016, including split terms.)

Thomas M. Miller, M. D.
Former State Health Officer/Chair

Gregory Davis, M.D.
Coroner/Medical Examiner, Jefferson County

Nancy Buckner, Commissioner
Alabama Department of Human Resources

Colonel John E. Richardson
Director, Alabama Department of Public Safety

Mary Murphy
Private Citizen, Governor Appointee

Representative Ralph Howard
Private Citizen, Governor Appointee

Dr. William D. King
Private Citizen, Governor Appointee

Jannah M. Bailey
Private Citizen, Governor Appointee

Chris Newlin
Private Citizen, Governor Appointee

Gina South
Network of Children's Advocacy Centers Appointee

Scott Anderson
Alabama District Attorney's Association Appointee

Sheriff Bobby Timmons
Executive Director, Alabama Sheriff's Association

Jim Perdue, Commissioner
Alabama Department of Mental Health

Debra Williams, M.D.
Alabama Academy of Pediatrics Appointee

Marian Loftin
Private Citizen, Governor Appointee

Sallye Longshore
Private Citizen, Governor Appointee

Jerry H. Williams
Private Citizen, Governor Appointee

Sheriff Bill Franklin
Alabama Sheriff's Association Appointee

Kathy Monroe, M.D.
Medical Association of the State of Alabama Appointee

Chief Steven Parrish
Alabama Association of Chiefs of Police Appointee

Representative April Weaver
Chair, House Health Committee

Michael Sparks, Director
Alabama Department of Forensic Sciences

Melissa Peters, M.D.
Alabama Department of Public Health Appointee

Steven Dunton, M.D.
Alabama Department of Forensic Sciences Appointee

Christy Cain
Private Citizen, Governor Appointee

Reverend Joseph Godfrey
Clergy, Governor Appointee

Melanie Bridgeforth
Private Citizen, Governor Appointee

Timothy Kimbrell
Alabama Coroners Association Appointee

Bill Adair
Alabama District Attorneys Association Appointee

Michael A. Taylor, M.D.
Private Citizen, Governor Appointee

Senator Gerald Dial
Chair, Senate Health Committee

LOCAL CHILD DEATH REVIEW TEAMS (LCDRTs)

LCDRTs review individual cases and, based upon their findings, complete the appropriate data collection allowed or required by the community to prevent additional deaths. LCDRTs are multidisciplinary and are required to meet at least once per year, although most meet more frequently.

Local teams are tasked with the following:

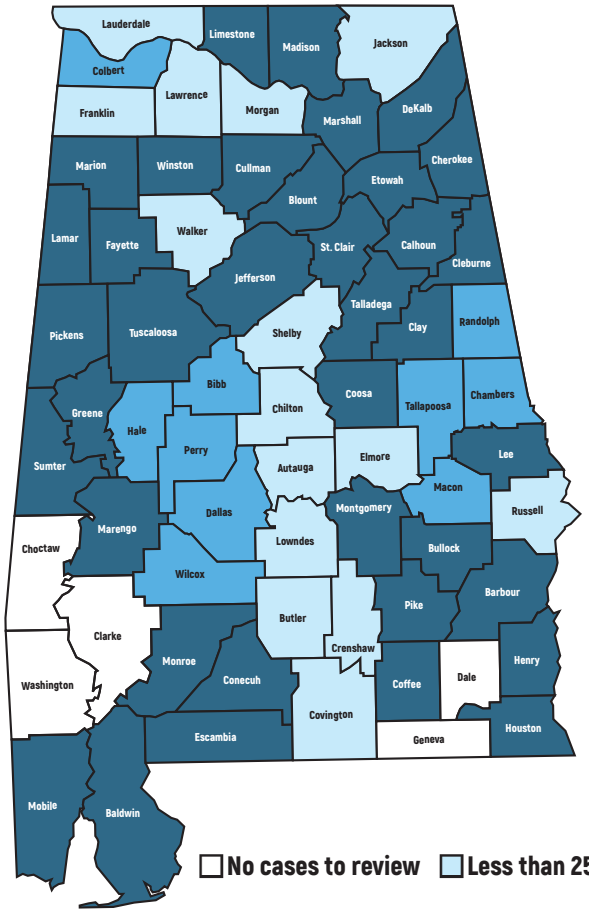
1. The identification of factors that put children at risk for injury or death.
2. The dissemination of information among agencies that provide services to children and families or investigate child deaths.
3. Improvements upon local investigations of unexpected/unexplained child deaths by additional services.
4. Improvements upon existing services and systems and identification of gaps in the community that require additional services.
5. The identification of trends relevant to unexpected/unexplained child deaths.
6. Educating the public about the causes of child deaths and its role in helping to prevent such tragedies.

LCDRT SUCCESS RATES

Between 2008 and 2013, 1,706 (65.8 percent) child deaths qualified for review under ACDRS. Of the qualifying deaths for the 2008-2013 span, LCDRTs reviewed and returned 1,288 cases (75.5 percent).

The map below illustrates the rate of completed reviews submitted to ACDRS by each LCDRT for 2013.

2013 Case Review Rates by LCDRTs



No cases to review | **Less than 25%** | **25%-49.99%** | **50%-74.99%** | **75% or greater**

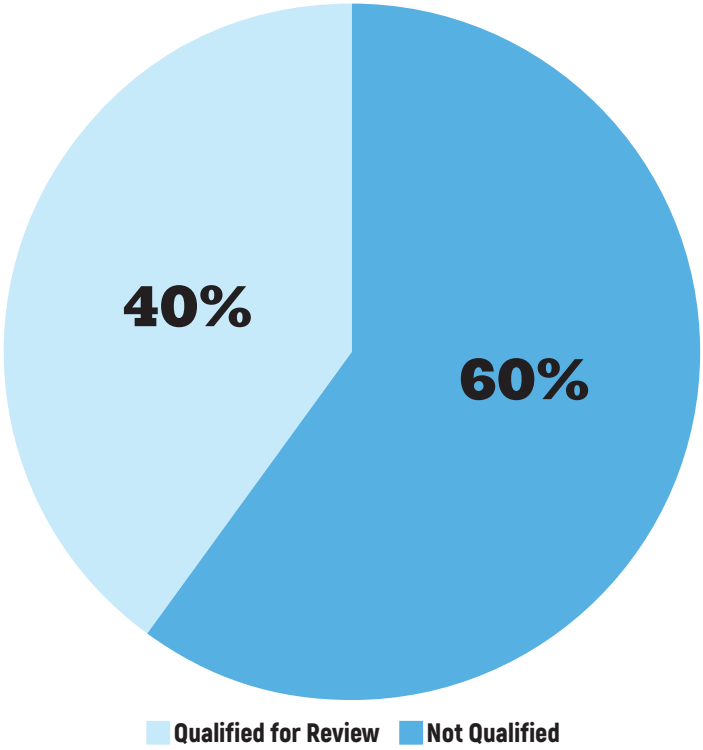
TEAMS

1 Choctaw, Clarke, Washington	**13** Mobile	**27** Marshall
2 Butler, Crenshaw, Lowndes	**14** Walker	**28** Baldwin
3 Barbour, Bullock	**15** Montgomery	**29** Talladega
4 Bibb, Dallas, Hale, Perry, Wilcox	**16** Etowah	**30** St. Clair
5 Chambers, Macon, Tallapoosa, Randolph	**17** Greene, Marengo, Sumter	**31** Colbert
6 Tuscaloosa	**18** Shelby	**32** Cullman
7 Calhoun, Cleburne	**19** Autauga, Chilton, Elmore	**33** Dale, Geneva
8 Morgan	**20** Henry, Houston	**34** Franklin
9 Cherokee, DeKalb	**21** Escambia	**35** Conecuh, Monroe
10A Jefferson	**22** Covington	**36** Lawrence
10B Bessemer Division	**23** Madison	**37** Lee
11 Lauderdale	**24** Fayette, Lamar, Pickens	**38** Jackson
12 Coffee, Pike	**25** Marion, Winston	**39** Limestone
	26 Russell	**40** Clay, Coosa
		41 Blount

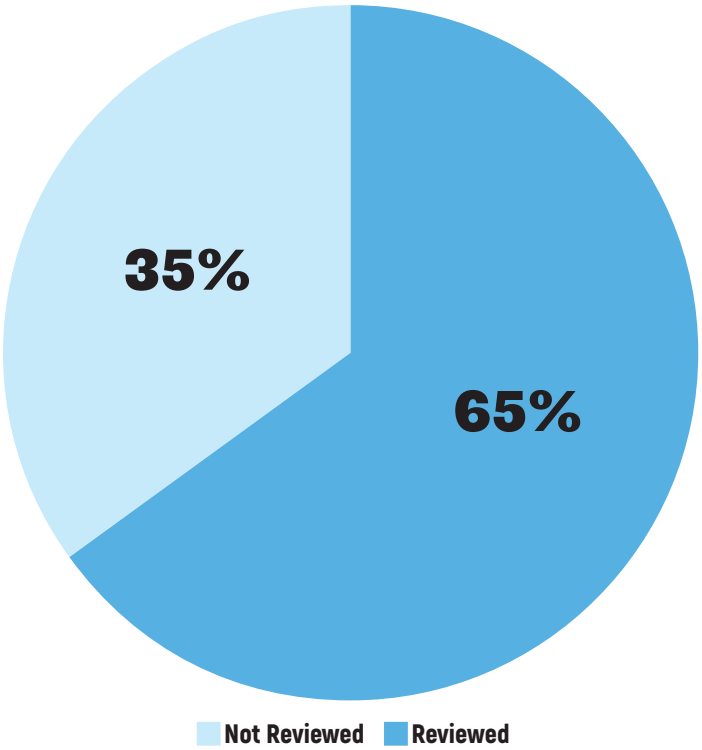
LCDRT SUCCESS RATE

There were 694 child deaths in 2013, including 280 deaths that qualified for review. Of those 280 qualifying deaths to date, local teams returned 183 reviews.

2013 Cases that Qualified for ACDRS Review



2013 Cases Reviewed by LCDRTs



LCDRT RECOGNITION

The ACDRS goal is to have case completion rates of 100 percent for each LCDRT. The table below recognizes the outstanding efforts of several LCDRTs that achieved this goal.

Circuit	Review Team	Number of Completed Cases
3	Barbour, Bullock	3
7	Calhoun, Cleburne	8
9	Cherokee, DeKalb	3
10A	Jefferson	34
10B	Bessemer Division	10
12	Coffee, Pike	4
13	Mobile	21
15	Montgomery	3
16	Etowah	8
17	Greene, Marengo, Sumter	3
20	Henry, Houston	11
21	Escambia	5
23	Madison	22
24	Fayette, Lamar, Pickens	5
25	Marion, Winston	6
27	Marshall	5
28	Baldwin	8
29	Talladega	7
30	St. Clair	5
32	Cullman	6
35	Conecuh, Monroe	3
37	Lee	6
39	Limestone	6
40	Clay, Coosa	1
41	Blount	2

REVIEW PROCESS AND TIMELINE

REVIEW PROCESS

The ACDRS state office receives copies of all Alabama death certificates issued for decedents under 18 years of age. ACDRS assesses each certificate to determine if it meets review criteria. Cases that meet the criteria are then assigned to the appropriate LCDRT on a case-by-case basis.

Upon reviewing individual cases, LCDRTs complete the appropriate data collection form and submit the information to the ACDRS state office. LCDRTs make recommendations to SCDRT and take appropriate actions within communities to prevent additional deaths.

The ACDRS state office collects and analyzes information submitted by the LCDRTs to answer requests for specific data and generate reports.

The SCDRT meets quarterly to review the statewide data, consider the LCDRT recommendations and performance, and conduct general ACDRS business. The SCRDT takes action on CDR issues in the form of education programs, informational publications, and other similar efforts.

Case Review Criteria

To be considered for ACDRS review, the case must meet the following 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.

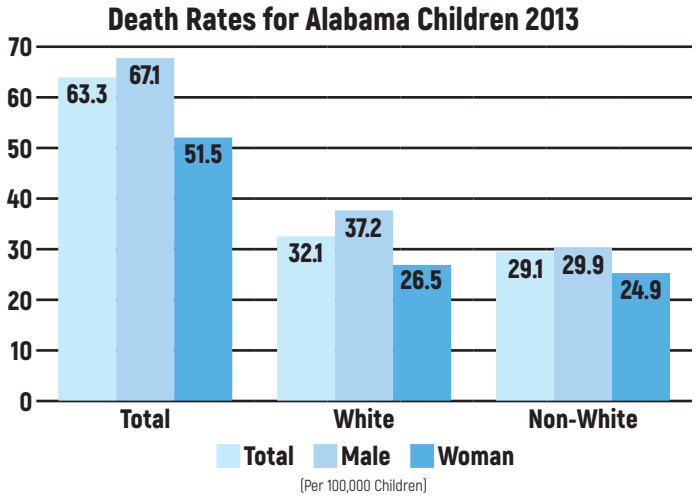
SAMPLE CASE REVIEW TIMELINE

Sample Case Review

- An infant or child death occurs on September 1.
- ACDRS state office receives the death certificate by November 1.*
- The case is assigned to the appropriate LCDRT by November 15.
- The LCDRT meets to review this specific case and others that year.**
- The ACDRS state office receives the last of the previous year's death certificates by July of the following year.
- LCDRTs must submit all reviewed and completed cases for a particular year to the ACDRS State Office by April 1, of the third calendar year.

ALABAMA CHILD DEATHS IN 2013

There were 694 infant and child deaths in 2013, or 63.3 deaths per 100,000 children. Of those deaths, 55.9 percent of children were male, 48.4 percent were non-white.



CHILD DEATHS BY CATEGORY

VEHICULAR ACCIDENT

This category includes all deaths occurring to children who are drivers, passengers, pedestrians, or occupants of all forms of vehicles, including bicycles, motorcycles, all terrain vehicles (ATVs), trains, etc. The manner of death is usually accidental, but can also include suicides or homicides.

As noted in the SCDRT 2017 Recommendations (p. 12-13), vehicular deaths are the leading category of preventable deaths to Alabama children less than 18 years of age and account for between one-third and one-half of all such deaths in any given year.

Vehicular Accident ACDRS Data for 2013

There were 53 reviewed cases of death by vehicular accident for 2013. This is an increase from the previous year, for which 42 such cases were reviewed.[2]

*Due to delays, certificates are sometimes received several months after the death occurs. **By law, each Local Team is required to meet only once per calendar-year. All information necessary to the review process may not be available for several months after the death occurs. [2]At the time of 2012 report printing.*

- In two cases, the child was a **pedestrian.**
- **Reckless driving** was the cause of accident in eleven cases.
- **Vehicle speed** exceeding the legal limit was cited as the cause of accident in sixteen cases.
- **Drugs and alcohol** were cited as causes of the accident in six cases.
- Four cases involved **young drivers** (16 – 18 years of age).
- The cause of accident for two cases was **driver inexperience.**
- The cause of accident for six cases was **driver distraction.**
- In three cases a **child** or **booster seat** was needed but not present. In three cases, the child seat was present, but was not used correctly. In one case a child seat was present, but was not in use.

Recommendations*

1. Support further enhancements and improvements to the Alabama Graduated Driver's License (GDL) Law, Alabama's Child Passenger Restraint Laws, and the enforcement thereof.
2. Promote the ACDRS Teen Driver Safety Campaign with the production and distribution of digital and print media.
3. Encourage auto dealerships to provide point-of-sale information resources on the proper installation and usage of child safety and booster seats when selling new or used vehicles.
4. Promote ATV safety and encourage the establishment of safety standards, including a minimum age for operating full-size ATVs.
5. Promote public awareness of the dangers of leaving children unattended in vehicles.

SUDDEN UNEXPLAINED INFANT DEATH (SUID)

This category includes all reviewed cases of SUID, including Sudden Infant Death Syndrome (SIDS).

SUID is a broad term used to describe sudden infant deaths from a variety of causes, both internal and external. SIDS is a very specific type of SUID, involving the sudden death of infants aged 1 month to 1 year that cannot be explained by a thorough investigation that eliminates all external contributing causes of death and includes a complete autopsy, toxicology, examination of the death scene, and review of the clinical history.

According to the Centers for Disease Control and Prevention (CDC), about 3,500 infants in the United States die suddenly and unexpectedly each year.[3] Although the cause of death in many of these cases cannot be explained, most occur while the infant is sleeping. As noted in the SCDRT 2017 Recommendations (p. 12-13), infant sleep-related deaths are the second leading category of ACDRS reviewed deaths.

SUID ACDRS Data for 2013

Eleven suspected cases of SUID were reviewed for 2013, two less cases than in 2012. The instance of reviewed SUID cases has decreased between 2008 and 2013.

Although the exact causes of SUID are unknown, safe sleep environments are shown to reduce the risks of such incidents. Of the reviewed cases, in one case, the infant in question was not sleeping alone.

Information on the sleep environment for the eleven reviewed cases is included below:

Initial Sleep Position

- On Back: Two cases.
- On Stomach: No cases reported.
- On Side: No cases reported.
- Unknown: Nine cases.

Sleep Location

- Crib: Two cases.
- Bassinette: Two cases.
- Adult Bed: Four cases.
- Playpen: One case.
- Couch: Two cases.

Recommendations*

1. Increase public awareness about the dangers associated with infants sleeping with adults in adult beds.
2. Increase public awareness of "Safe to Sleep" and "Babies Sleep Safest on their Backs" programs.
3. Teach and promote the use of Alabama's SUID investigation protocols.
4. Increase public knowledge of and encourage strict adherence to the American Academy of Pediatrics guidelines for infant safety and SIDS risk reduction.

**These recommendations are in addition to the SCDRT 2017 Recommendations (p.12-13). [3]http://cdc.gov/sids*

5. Ensure all child deaths in Alabama are reported to the appropriate authorities.
6. Ensure that forensic lab capacity is sufficient to meet state needs.

FIRE, BURNS, OR ELECTROCUTION

This category addresses deaths resulting from burns, smoke inhalation, and/or electrocution. The types of incidents include fire, scalding, etc. The documentation gathered for this report considers the source of ignition, heat, or electrocution; as well as, in the case of fire, the material first ignited and details about the building on fire if applicable.

Home fires account for 87 percent of all fire-related fatalities. Working smoke alarms reduce the chances of dying in a fire by nearly 50 percent.[4]

Fire, Burns, or Electrocution ACDRS Data for 2013

Six cases of fire, burns, or electrocution were reviewed for 2013, a decrease from the eight reviewed for the previous year, and a 5-year low since 2008.

Of these deaths, all six were the result of smoke inhalation. Three fires occurred in trailers or mobile homes.

Information regarding the ignition, heat, or electrocution source (where applicable) is as follows:

- Candle(s): One case.
- Space Heater(s): Two cases.
- Unknown: Three cases.

Recommendations*

1. Encourage the 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 to increase public knowledge of 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.

DROWNING

This category includes child deaths due to asphyxiation from submersion in a liquid.

The majority of infant drowning cases occur in bathtubs or large buckets. Swimming pools are the most common site of drowning occurrences among children aged 1-4 years. About three-fourths of U.S. pool submersion deaths occur at a home. Nationwide, African American children between the ages of 5 and 14 years drown at rates 2.8 times higher than those of white children.[5]

Drowning ACDRS Data for 2013

ACDRS reviewed 10 cases of drowning for 2013, a 5-year low since 2008, and half as many drowning deaths as occurred in 2012. Of these deaths, six occurred in a pool, hot tub, or spa. Two deaths occurred in open water, with one death occurring each in a lake and a river. No drowning deaths were reported in any oceans.

Key findings for these deaths are as follows:

- No personal flotation device: Three cases.
- Child unable to swim: One case.
- No barriers to water: One case.
- No adult supervision: Two cases.
- Unknown: Three cases.

Recommendations*

1. Support public education awareness campaigns about water safety, with a special emphasis on the need for appropriate constant supervision of children in pools, bathtubs, open bodies of water, etc.
2. Encourage the enforcement of ordinances regarding pool fencing and signage.
3. Persuade communities to make swimming lessons and water safety classes more readily available to children and parents.
4. Encourage the use of flotation devices and the "buddy system" for children boating, fishing, or swimming in/on/near open bodies of water.

*These recommendations are in addition to the SCDRT 2017 Recommendations (p.12-13) [4]https://www.safekids.org/fact-sheet/burns-and-fire-safety-fact-sheet-2015-pdf
[5]https://www.safekids.org/fact-sheet/swimming-and-boating-safety-fact-sheet-2015-pdf

SUFFOCATION

Child deaths recorded in this category include those that occurred due to the obstruction of the airway from any number of causes. Deaths due to suffocation can be accidents, suicides, or homicides. Most cases of suffocation fall within the following categories:

- **Sleep-related suffocation:** can include overlaying in which a person sleeping with the child unintentionally suffocates the child by rolling on top of them, or sleep-related positional asphyxia, in which the death is attributed to bedding, crib bumpers, pillows, etc.
- **Positional Suffocation:** the external airways (nose, mouth) are blocked by objects or materials, or the child becomes wedged in a small space, such as between a mattress and wall, blocking the external airways. May or may not be sleep-related.
- **Choking:** food or other small object that blocks the airway.
- **Confinement:** the child becomes trapped in an airtight place, such as a toy chest or automobile.
- **Strangulation:** a rope, cord, or other object wrapped around the child's neck restricts breathing.

Note: Some medical examiners or coroners will not list an infant death as suffocation due to overlaying or positional asphyxia unless there is unequivocal evidence, such as an eyewitness account. If there is no such evidence, these types of suffocation deaths may be listed as SUIDS, SIDS, or otherwise undetermined.

Suffocation ACDRS Data for 2013

For 2013, ACDRS reviewed 17 cases of death by asphyxiation. Nine deaths were attributed to suffocation. Of these nine deaths, seven cases were attributed to sleep-related suffocation; and of the sleep-related cases, four occurred in an adult bed. Suffocation due to confinement or containment in a small space resulted in one death.

Strangulation, accidental or otherwise, accounted for four cases and choking was the cause of death in one case. A rope, string, belt, or leash was the object causing strangulation in one event and there were two cases of accidental smothering.

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, especially for new and/or young parents.
3. Provide increased public education that encourages strict adherence to the American Academy of Pediatric guidelines for reducing the risks associated with infant sleep environments.

FIREARM/WEAPON-RELATED

This category includes deaths due to weapon-related injuries, accidentally or intentionally inflicted. Types of weapons include firearms, sharp or blunt instruments, a person's body part, explosive devices, etc. The use of the weapons in this category may be determined as self-injury; the result of violence, such as gang-related activity; the result of aggressive behavior, such as bullying or a heated argument; or accidental, as in cases of a child playing with the weapon or showing it to friends.

Firearm/Weapon-Related ACDRS Data for 2013:

ACDRS reviewed 25 cases of weapon-related deaths for 2013. Sixteen of these involved firearms, three were caused by a sharp object, and one was caused by the use of a body part as a weapon.

In one case of weapon-related death, the firearm was stored loaded. In two cases, the firearm was not stored. In four cases, the weapon was not licensed. In three cases, the person handling the weapon was a stranger. In three cases, the person handling the weapon was a parent (biological or stepparent).

Information regarding the use of a weapon at the time of the accident is as follows:

- Self-injury (intentional): Seven cases.
- Self-injury (accidental): Five cases.
- During the commission of a crime: Five cases.
- Random act of violence: One case.
- Used during an argument: One case.
- Used in self-defense: One case.
- Accidental (while playing with the weapon or showing it to others): One case.

*These recommendations are in addition to the SCDRT 2017 Recommendations (p.12-13)

Recommendations*

1. Encourage the safe and secure storage of all firearms.
2. Encourage gun safety education for children and parents in households with firearms.
3. Support crisis teams and victim advocacy for children who witness violence.
4. Support after-school, evening education, and other recreational programs for high-risk youth.
5. Encourage community-based violence prevention programs.

OTHER FINDINGS

MANNER OF DEATH

For the purposes of this report, *manner of death* refers to one of the six general categories of death listed on the Alabama Death Certificate.

The six categories are:

1. **Pending Investigation:** a death which is still under review.
2. **Accident:** a death resulting from a non-intentional injury.
3. **Homicide:** a death resulting from an intentional act committed by another person to cause fear, harm, or death.
4. **Suicide:** a death that results from an intentional, self-inflicted act committed to do self-harm or death.
5. **Undetermined Circumstances:** a death in which, after all available information has been considered, information pointing to one manner of death is no more compelling than one or more competing manners of death.
6. **Natural Causes:** death not due to external means (i.e., a death that occurred as the expected outcome of a disease, a birth defect, or a congenital anomaly). In other words, death resulting from natural/medical causes, such as illness or disease. Normally, ACDRS does not review such cases. However, cases in which the cause of death is initially classified as pending or unknown are often later discovered to have occurred by natural causes.

Findings for Manner of Deaths

At 50.3 percent, accidents were the most frequently reviewed manner of death in 2013. Homicide and suicide represent 8.7 percent and 6 percent of deaths in 2013, respectively.

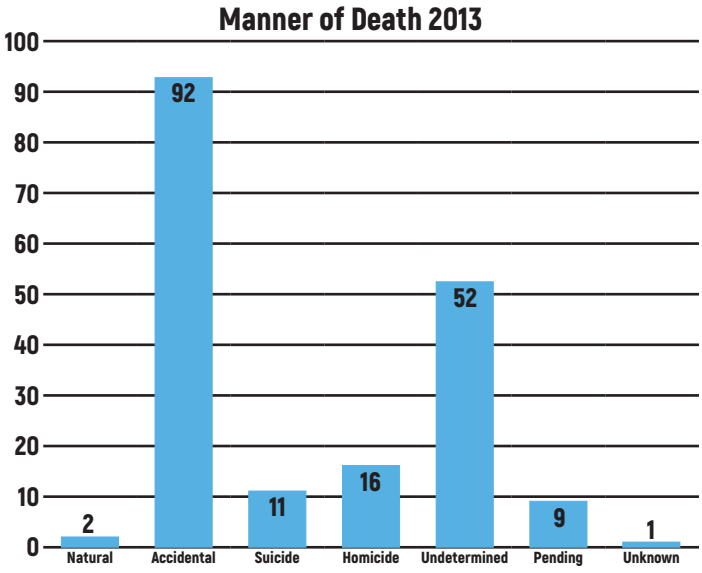
CAUSE OF DEATH

In this report, the term cause of death refers to the disease, injury, or action initiating the sequence of events that leads directly to death, or the circumstances of the accident or violence that produced the fatal injury.

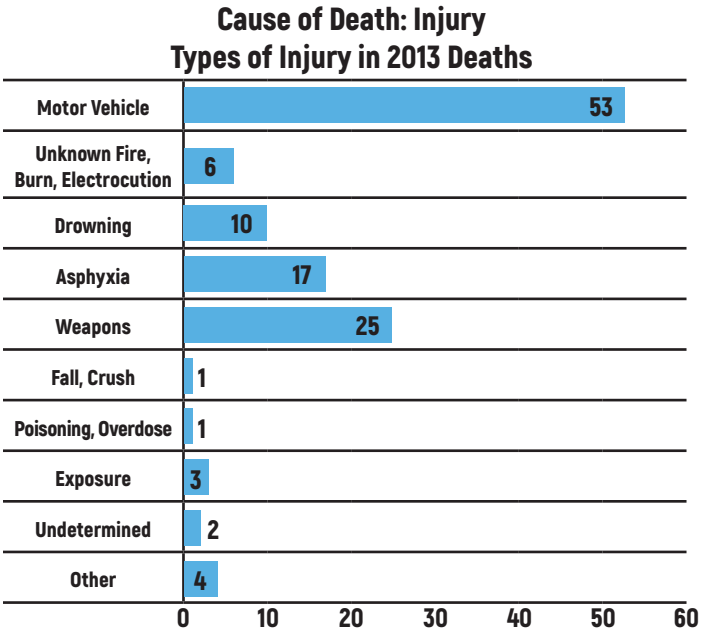
Injuries

In 2013, the four most frequently reviewed causes of death due to injury were:

1. Vehicular Involvement (53 cases).
2. Weapons (25 cases).
3. Asphyxiation (17 cases).
4. Drowning (10 cases).



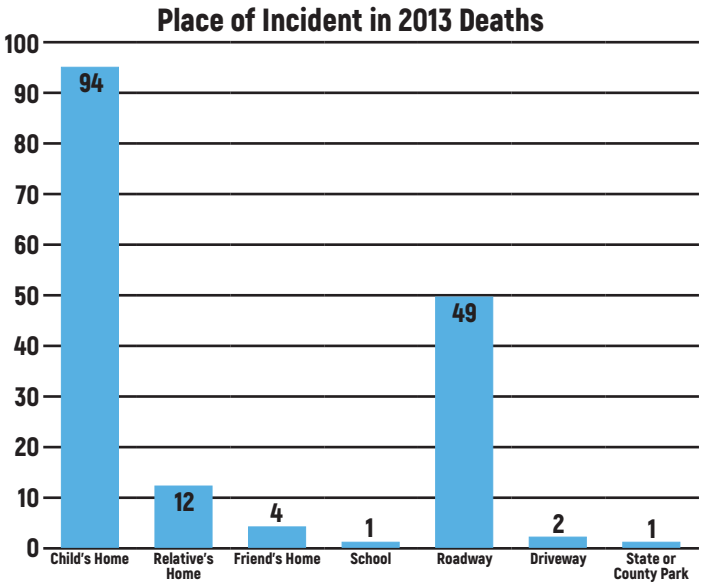
Note: Although SIDS is considered a natural cause of death, LCDRTs are required by law to review all SIDS deaths.



*These recommendations are in addition to the SCDRT 2017 Recommendations (p.12-13)

PLACE OF INCIDENT

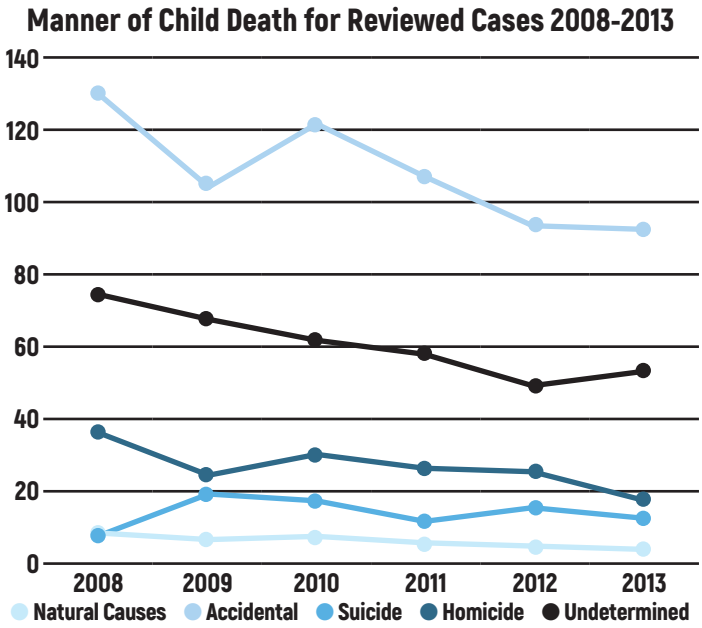
In 2013, the most frequent place of incident was the child's home (94 cases). The second most common location of death was a roadway (49 cases).



TRENDS IN ALABAMA CHILD DEATHS: 2008-2013

TRENDS BY MANNER OF DEATH 2008-2013

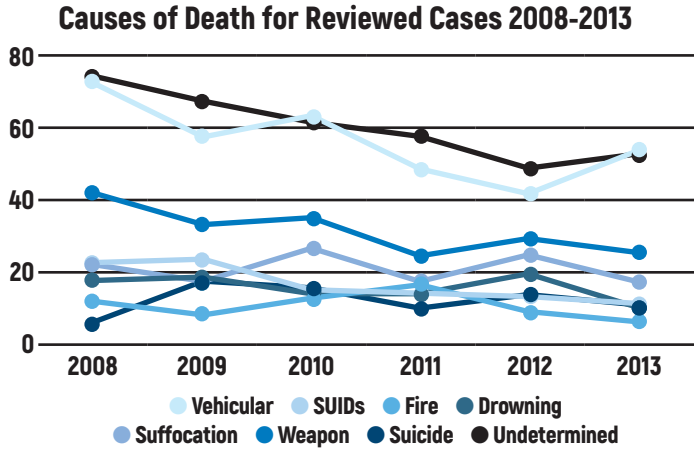
Accidents remain the leading manner of death for Alabama children, but the occurrence of these cases has decreased significantly since 2008.



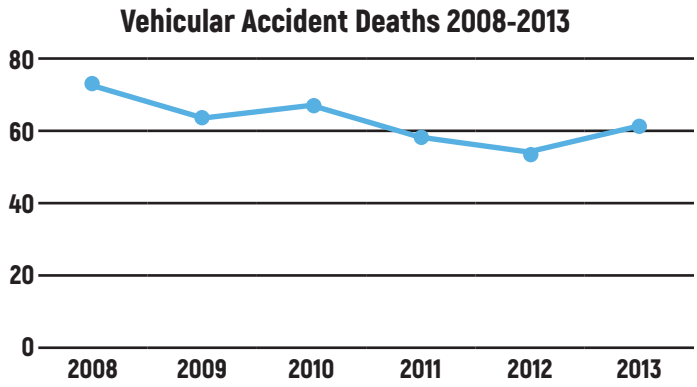
TRENDS BY CAUSE OF DEATH 2008-2013

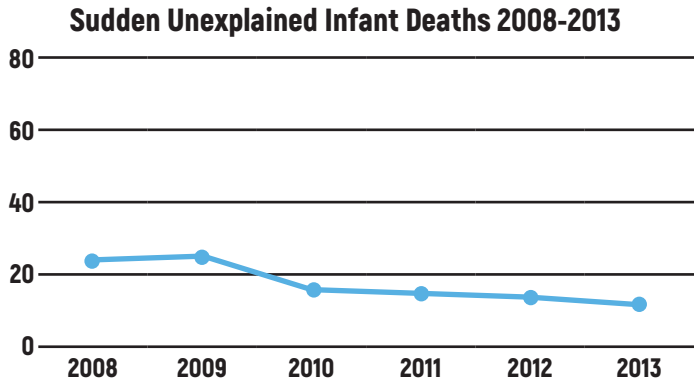
Excluding undetermined deaths, vehicular accidents have remained the leading cause of death for Alabama children since 2008, followed by firearm/weapon-related deaths. Deaths from vehicular accidents have, however, decreased greatly since 2008.

Undetermined deaths steadily declined, dropping to a 5-year low in 2012, but rising again in 2013.



The following graphs demonstrate the trends for each category of Alabama Child Cause of Death from 2008 to 2013.

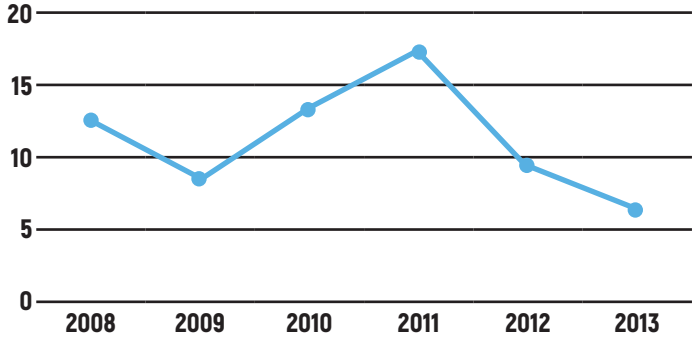




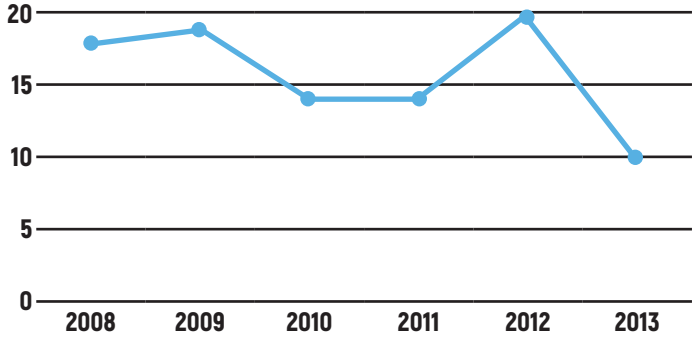
*These recommendations are in addition to the SCDRT 2017 Recommendations (p.12-13)

The following graphs demonstrate the trends for each category of Alabama Child Cause of Death from 2008 to 2013.

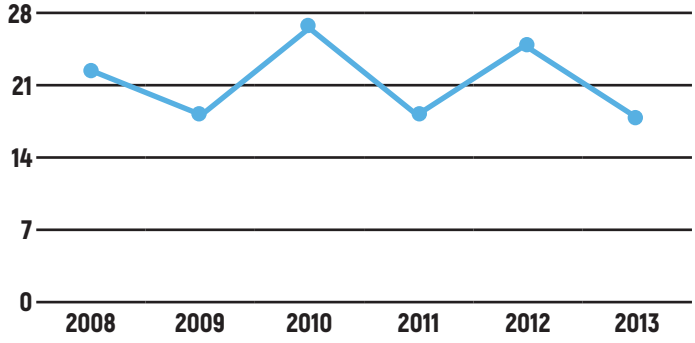
Fire, Burns, or Electrocution Deaths 2008-2013



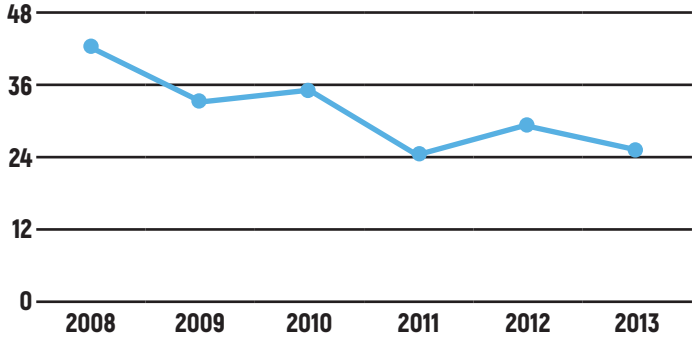
Drowning Deaths 2008-2013



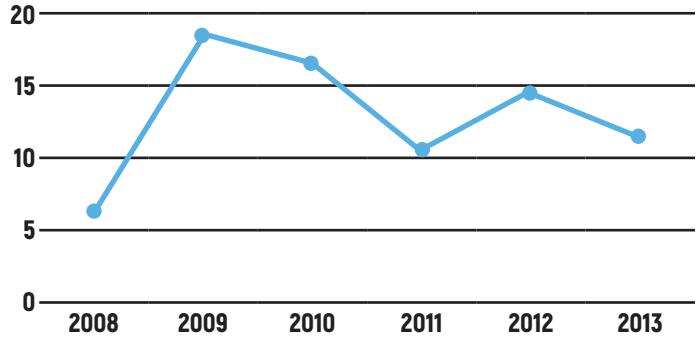
Suffocation-Related Deaths 2008-2013



Firearm/Weapon-Related Deaths 2008-2013



Suicide Deaths 2008-2013



STATE CHILD DEATH REVIEW TEAM 2017 RECOMMENDATIONS

Below are the 2017 Recommendations, based on the results of the 2013 evaluation period:

VEHICULAR DEATH

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 between one-third and one-half of all such deaths in any given year.

The SCDRT recommends:

- Comprehensive statewide awareness and education campaigns related to teen driver safety and child passenger safety.
- Enhancement of the current GDL Law by increasing the limitations on late-hour driving by graduated licensees and reconsidering the current exemptions.
- Enhancement of child passenger restraint laws in accordance with the latest American Academy of Pediatrics' recommendations.
- Promotion of the use of parent-teen driver contracts and log books.
- Establishment of a minimum age to operate ATVs.
- Safety training requirements for ATV operators.
- Prohibition of passengers on ATVs.
- Prohibition of passengers in open truck beds on public roads.

INFANT SLEEP-RELATED DEATH

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 SCDRT recommends:

- Expansion of statewide safe infant sleep awareness and education campaigns.
- Adherence to the protocols developed by the Alabama Sudden Unexplained Infant Death Investigation (SUIDI) Team.

FATALITY AND INJURY PREVENTION

Fatality prevention and injury prevention are closely related. Access to fatality data has proven essential to the accurate collection and analysis of fatality data required for effective fatality prevention efforts. At the same time, limited access to injury data in Alabama has been a significant barrier to injury prevention funding and efforts.

The SCDRT recommends:

- Securing access to comprehensive injury data in Alabama for the ADPH Fatality Review Branch.

KEY DATES FOR 2018

April National Child Abuse Prevention Month

April 1 Deadline for Completed 2015 Case Reviews

April State Team Meeting

July State Team Meeting

September National Infant Mortality Awareness Month

September National Suicide Prevention Awareness Month

September 10 World Suicide Prevention Day

September Child Passenger Safety Week

October National SIDS Awareness Month

October 7-13 National Fire Prevention Week

October State Team Meeting

October National Teen Driver Safety Week

APPENDICES

ALABAMA CHILD DEATH REVIEW SYSTEM SUCCESSES 2013

ACDRS is a grass-roots program driven largely by local citizen volunteers for the express purpose of protecting the lives of as many of Alabama's infants and children as possible. The work of very effective state and local teams has contributed significantly to a reduction in preventable child injuries and deaths. Significant progress is reflected in reporting both data collection and special interest programs.

Below are highlights of some of the ACDRS successes. Many others are identified throughout this report.

LCDRTs

LCDRTs are stationed in every judicial circuit in the state. These teams continue to meet and review child deaths that occurred within their jurisdictions. Following the delays and challenges related to the transition between data collection systems, most teams are now entering current data into the national online collection system and case completion rates continue to increase thanks to the impressive efforts of the local teams.

ACDRS Training

In the past, ACDRS has conducted statewide training every other year. After conducting smaller regionalized trainings in 2010, ACDRS returned to a 3-day statewide training conference in 2012. The 2014 conference was held in September in Orange Beach and culminated with a quarterly SCDRT meeting. The conference was well-attended and well-received.

Teen Driving Safety Campaign

In 2010, ACDRS began a multifaceted campaign to promote teen driving safety. The introduction of a website (www.alabamapublichealth.gov/teendriving) and a brochure, "Surviving Teen Driving," have been well-received. ACDRS conducted a media campaign to promote these new resources. This campaign was publicly commended by the U.S. Secretary of Transportation.

Vehicular deaths continue to be the leading cause of preventable child deaths in Alabama. Safe teen driving, including proper child passenger restraint and ATV safety, remains a primary issue of concern for ACDRS.

SUIDI Team

The CDC established standardized tools and protocols, adopted nationwide, for SUIDI. The ACDRS director chaired the Alabama SUIDI Team, which was codified as a sub-committee of the SCDRT. The team developed a formal SUIDI training course for Alabama. The course is now required for all coroners, deputy coroners, and certain law enforcement investigators. On-site training has been conducted for many groups of first responders statewide, and most of the state's coroners and deputy coroners received the training at their annual conference.

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 regarding infant deaths collected by ACDRS.

The Alabama Cribs for Kids Program

The Cribs for Kids Program in Alabama began as a pilot program in Montgomery. With the help of the Gift of Life Foundation, cribs and instructions for safe infant sleeping were provided to many qualifying families in the Montgomery County area. After the success of the pilot program, Gift of Life and ACDRS expanded the program to other counties in the state. Jefferson, Mobile, Baldwin, and Escambia counties have similar programs in place. The hope is to expand the Cribs for Kids Program efforts to other Alabama counties in the future.

Child Passenger Safety Efforts

The Booster Seat Advocacy Program is a joint effort of ACDRS, Children's Hospital Child Safety Institute, University of Alabama Birmingham Department of Pediatrics, and the ADPH Fatality Review Branch. 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 protection for children in passenger vehicles who are too large for infant seats but too small for adequate protection from seat belts alone. ACDRS Central Office staff are certified Child Passenger Safety (CPS) Technicians and routinely conduct local CPS clinics in conjunction with other partners.

ACDRS
ALABAMA
CHILD DEATH
REVIEW SYSTEM

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